THE OHIO STATE UNIVERSITY

OFFICIAL PROCEEDINGS OF THE

ONE THOUSAND FIVE HUNDRED AND TWENTY-FIRST

MEETING OF THE BOARD OF TRUSTEES

Columbus, Ohio, August 15-17, 2023

The Board of Trustees and its committees met at Vitria on the Square in Columbus, Ohio, and virtually over Zoom on August 15-17, 2023, pursuant to adjournment.

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Minutes of the last meetings were approved.

**FULL-BOARD EXECUTIVE SESSION**

Board Chair Hiroyuki Fujita called the meeting of the Board of Trustees to order on Tuesday, August 15, 2023, at 8:59 a.m.

Members Present: Hiroyuki Fujita, Alan A. Stockmeister, John W. Zeiger, Gary R. Heminger, Elizabeth P. Kessler, Lewis Von Thaer, Jeff M.S. Kaplan, Elizabeth A. Harsh, Reginald A. Wilkinson, Tomislav B. Mitevski, Pierre Bigby, Juan Jose Perez, Bradley R. Kastan, George A. Skestos, Taylor A. Schwein, Joshua H.B. Kerner and James D. Klingbeil.

Members Present via Zoom:

Members Absent: Michael F. Kiggin

Dr. Fujita:

Will the Secretary please advise when a quorum is present?

Ms. Eveland:

A quorum is present.

Dr. Fujita:

Thank you. At this time, I would like to convene this meeting of the Board of Trustees and move that the Board recess into executive session to consult with legal counsel regarding pending or imminent litigation, to consider business-sensitive trade secrets required to be kept confidential by federal and state statutes, and to discuss personnel matters involving the appointment, employment and compensation of public officials, which are required to be kept confidential under Ohio law.

Upon the motion of Dr. Fujita, seconded by Mr. Kaplan, the Board of Trustees adopted the foregoing motion by unanimous roll-call vote, cast by trustees: Dr. Fujita, Mr. Stockmeister, Mr. Zeiger, Mr. Heminger, Ms. Kessler, Mr. Von Thaer, Mr. Kaplan, Mrs. Harsh, Dr. Wilkinson, Mr. Mitevski, Mr. Bigby, Mr. Perez, Mr. Kastan, Mr. Skestos, Ms. Schwein and Mr. Kerner.

The meeting entered executive session at 9:01 a.m. and adjourned at 11:51 a.m.

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**WEXNER MEDICAL CENTER BOARD MEETING**

Board Secretary Jessica Eveland called the meeting of the Wexner Medical Center Board to order on Tuesday, August 15, 2023, at 12:59 p.m.

Members Present: Leslie H. Wexner, Alan A. Stockmeister, John W. Zeiger, Gary R. Heminger, Tomislav B. Mitevski, Juan Jose Perez, Taylor A. Schwein, Stephen D. Steinour, Robert H. Schottenstein, Cindy Hilsheimer, Hiroyuki Fujita (ex officio), Melissa L. Gilliam (ex officio), Michael Papadakis (ex officio) and John J. Warner (ex officio)

Members Present via Zoom: Amy Chronis

Members Absent: W.G. Jurgensen

It was moved by Mr. Heminger, and seconded by Mr. Mitevski, that the committee recess into executive session to consider business-sensitive trade secrets and quality matters required to be kept confidential by federal and state statues, to consult with legal counsel regarding pending or imminent litigation, and to discuss personnel matters involving the appointment, employment and compensation of public officials, which are required to be kept confidential under Ohio law.

A roll-call vote was taken, and the committee voted to go into executive session with the following members present and voting: Mr. Wexner, Mr. Stockmeister, Mr. Zeiger, Mr. Heminger, Mr. Mitevski, Ms. Schwein, Mr. Steinour, Mr. Schottenstein, Ms. Hilsheimer, Ms. Chronis, Dr. Fujita, Dr. Gilliam, Mr. Papadakis and Dr. Warner.

The meeting entered executive session at 1:30 p.m. and adjourned at 4:19 p.m.

(See Appendix VI for Summary of Actions Taken, page 179)

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**TALENT, COMPENSATION & GOVERNANCE COMMITTEE**

Committee Chair John Zeiger called the meeting of the Talent, Compensation & Governance Committee of the Board of Trustees to order on Wednesday, August 16, 2023, at 8:01 a.m.

Members Present: John W. Zeiger, Elizabeth P. Kessler, Alan A. Stockmeister, Gary R. Heminger, Lewis Von Thaer, Jeff M.S Kaplan, Tomislav B. Mitevski and Hiroyuki Fujita (ex officio).

Members Present via Zoom: N/A

It was moved by Mr. Zeiger, and seconded by Mr. Heminger, that the committee recess into executive session to discuss business-sensitive trade secrets required to be kept confidential by federal and state statues, to discuss personnel matters regarding the appointment, employment, and compensation of public employees, and to consult with legal counsel regarding pending or imminent litigation.

A roll-call vote was taken, and the committee voted to go into executive session with the following members present and voting: Mr. Zeiger, Ms. Kessler, Mr. Stockmeister, Mr. Heminger, Mr. Von Thaer, Mr. Kaplan, Mr. Mitevski and Dr. Fujita.

The meeting entered executive session at 8:02 a.m. and reconvened in public session at 10:57 am. The committee adjourned at 11:06 a.m.

(See Appendix VII for Summary of Actions Taken, page 449)

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**LEGAL, AUDIT, RISK & COMPLIANCE COMMITTEE MEETING**

Committee Chair Elizabeth Kessler called the meeting of the Legal, Audit, Risk & Compliance Committee of the Board of Trustees to order on Wednesday, August 16, 2023, at 11:59 a.m.

Members Present: Elizabeth P. Kessler, Alan A. Stockmeister, Jeff M.S. Kaplan, Elizabeth A. Harsh, Juan Jose Perez, Joshua H.B. Kerner and Hiroyuki Fujita (ex officio)

Members Present via Zoom: Amy Chronis

Members Absent: Michael F. Kiggin

It was moved by Ms. Kessler, and seconded by Mr. Kaplan, that the committee recess into executive session to consult with legal counsel regarding pending or imminent litigation, to consider business-sensitive trade secrets required to be kept confidential by federal and state statues, to discuss personnel matters regarding the appointment, employment and compensation of public employees.

A roll-call vote was taken, and the committee voted to go into executive session with the following members present and voting: Ms. Kessler, Mr. Stockmeister, Mr. Kaplan, Mrs. Harsh, Mr. Perez, Mr. Kerner, Ms. Chronis and Dr. Fujita.

The meeting entered executive session at 12:35 p.m. and adjourned at 1:59 p.m.

(See Appendix VIII for Summary of Actions Taken, page 452)

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**ACADEMIC AFFAIRS & STUDENT LIFE COMMITTEE MEETING**

Committee Chair Jeff Kaplan called the meeting of the Academic Affairs & Student Life Committee of the Board of Trustees to order on Wednesday, August 16, 2023, at 2:30 p.m.

Members Present: Jeff M.S. Kaplan, Elizabeth A. Harsh, Ms. Elizabeth P. Kessler, Reginald A. Wilkinson, Pierre Bigby, Joshua H.B. Kerner, Susan E. Cole and Hiroyuki Fujita (ex officio)

Members Present via Zoom: N/A

Members Absent: Michael F. Kiggin

It was moved by Mr. Kaplan, and seconded by Ms. Kessler, that the committee recess into executive session to discuss business-sensitive trade secrets required to be kept confidential by federal and state statues, to consult with legal counsel regarding pending or imminent litigation, and to discuss personnel matters involving the appointment, employment and compensation of public officials, which are required to be kept confidential under Ohio law.

A roll-call vote was taken, and the committee voted to go into executive session with the following members present and voting: Mr. Kaplan, Mrs. Harsh, Ms. Kessler, Dr. Wilkinson, Mr. Bigby, Mr. Kerner, Dr. Cole and Dr. Fujita.

The meeting entered executive session at 3:11 p.m. and adjourned at 4:34 p.m.

(See Appendix IX for Summary of Actions Taken, page 487)

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**MASTER PLANNING & FACILITIES COMMITTEE MEETING**

Committee Vice Chair Alan Stockmeister called the meeting of the Master Planning & Facilities Committee of the Board of Trustees to order on Thursday, August 17, 2023, at 7:59 a.m.

Members Present: Alan A. Stockmeister, Reginald A. Wilkinson, Elizabeth A. Harsh, Pierre Bigby, Joshua H.B. Kerner (arrived late), Robert H. Schottenstein (arrived late) and Hiroyuki Fujita (ex officio).

Members Present via Zoom: James D. Klingbeil

Members Absent: N/A

It was moved by Mr. Stockmeister, and seconded by Dr. Wilkinson, that the committee recess into executive session to discuss the purchase of property, to consider business-sensitive trade secrets required to be kept confidential by federal and state statues, and to consult with legal counsel regarding pending or imminent litigation.

A roll-call vote was taken, and the committee voted to go into executive session with the following members present and voting: Mr. Stockmeister, Dr. Wilkinson, Mrs. Harsh, Mr. Bigby, Mr. Kerner, Mr. Klingbeil, Mr. Schottenstein and Dr. Fujita.

The meeting entered executive session at 9:20 a.m. and adjourned at 9:53 a.m.

(See Appendix X for Summary of Actions Taken, page 522)

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**FINANCE & INVESTMENT COMMITTEE MEETING**

Committee Chair Tomislav Mitevski called the meeting of the Finance & Investment Committee of the Board of Trustees to order on Thursday, August 17, 2023, at 10:01 a.m.

Members Present: Tomislav B. Mitevski, John W. Zeiger, Gary R. Heminger, Lewis Von Thaer, Pierre Bigby, Taylor A. Schwein and Hiroyuki Fujita (ex officio).

Members Present via Zoom: James D. Klingbeil, Amy Chronis and Kent M. Stahl

Members Absent: Michael F. Kiggin

It was moved by Mr. Mitevski, and seconded by Mr. Heminger, that the committee recess into executive session to consider business-sensitive trade secrets required to be kept confidential by federal and state statutes, and to consult with legal counsel regarding pending or imminent litigation.

A roll-call vote was taken, and the committee voted to go into executive session with the following members present and voting: Mr. Mitevski, Mr. Klingbeil, Mr. Zeiger, Mr. Heminger, Mr. Von Thaer, Mr. Bigby, Ms. Schwein, Ms. Chronis, Mr. Stahl and Dr. Fujita.

The meeting entered executive session at 11:06 a.m. and adjourned at 12:03 pm.

(See Appendix XI for Summary of Actions Taken, page 580)

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**RESEARCH, INNOVATION & STRATEGIC PARTNERSHIPS COMMITTEE MEETING**

Committee Chair Lewis Von Thaer called the meeting of the Research, Innovation & Strategic Partnerships Committee of the Board of Trustees to order on Thursday, August 17, 2023, at 12:59 p.m.

Members Present: Lewis Von Thaer, Reginald A. Wilkinson, Juan Jose Perez, Taylor A. Schwein, Phillip Popovich and Hiroyuki Fujita (ex officio).

Members Present via Zoom: N/A

Members Absent: N/A

It was moved by Mr. Von Thaer, and seconded by Dr. Wilkinson, that the committee recess into executive session to consider business-sensitive trade secrets required to be kept confidential by federal and state statutes and to consult with legal counsel regarding pending or imminent litigation.

A roll call vote was taken, and the committee voted to go into executive session with the following members present and voting: Mr. Von Thaer, Dr. Wilkinson, Mr. Perez, Ms. Schwein, Dr. Popovich and Dr. Fujita.

The meeting entered executive session at 1:28 p.m. and adjourned at 2:27 p.m.

(See Appendix XII for Summary of Actions Taken, page 689)

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**FULL-BOARD PUBLIC SESSION**

Board Chairman Hiroyuki Fujita reconvened The Ohio State University Board of Trustees on Thursday, August 17, 2023, at 2:59 p.m.

Members Present: Hiroyuki Fujita, Alan A. Stockmeister, John W. Zeiger, Elizabeth P. Kessler, Lewis Von Thaer, Jeff M.S. Kaplan, Elizabeth A. Harsh, Reginald A. Wilkinson,

Tomislav B. Mitevski, Pierre Bigby, Juan Jose Perez, Bradley R. Kastan, George A. Skestos, Taylor A. Schwein and Joshua H.B. Kerner.

Members Present via Zoom: James D. Klingbeil

Members Absent: Gary R. Heminger and Michael F. Kiggin

Dr. Fujita:

Good afternoon, everyone. Thank you for joining us. At this time, I would like to go ahead and convene this meeting of the Board of Trustees. Will the Secretary please note the attendance?

Ms. Eveland:

A quorum is present.

Dr. Fujita:

Thank you. Reminder to everyone that this meeting is being recorded and livestreamed for the public by WOSU. So that we are able to conduct the business of this meeting in an orderly fashion, I would ask that any sound on cell phones and other devices be turned off, and I would ask that all members of the audience observe rules of decorum proper to conducting the business at hand.

I would like to begin today by welcoming the Ohio State community to the start of the new academic year.

As you likely noted on your way here, “Move-In” is already underway for students on the Columbus campus. It will begin tomorrow for our regional campuses.

Among our returning students are thousands of new Buckeyes joining our university for the very first time. We are excited to welcome them, and their loved ones, into the Ohio State family.

And we are thrilled to see the impact their energy, ideas, and passion will have on our campuses and communities in the coming years.

The Board of Trustees is also pleased to welcome its newest member: Undergraduate Student Trustee Josh Kerner.

In addition to his studies at Fisher College of Business, Josh is a member of Men’s Glee Club and the “Buck-That!” “a cappella” group.

His connection to fellow students and campus life experience brings a unique perspective to this Board and further enhances the important work we do on behalf of Ohio State.

Ensuring our students can earn an affordable, high-quality education is chief among those responsibilities.

It was an honor to join many members of the board to recognize our summer graduates as they received their diplomas in the Schottenstein Center earlier this month. Ohio State alumna and U.S. Secretary for Housing and Urban Development Marcia Fudge delivered a wonderful message and reminded all of us of the difference we are capable of making.

Soon after we bid farewell to these Buckeyes, we learned that we will soon have to say goodbye to another: Senior Vice President and Wolfe Foundation Athletic Director Gene Smith.

During nearly two decades at Ohio State, he has set a new standard for athletic success, academic excellence, and student-athlete career development. His retirement in July 2024 is well-deserved, and the Board is deeply thankful for his contributions to Ohio State student-athletes and the university as a whole.

I also want to draw attention to an item on today's consent agenda: the appointment of Dr. Peter Mohler as executive vice president of research, innovation and knowledge.

He has served as interim leader since March, and this change received the unanimous support of the Talent, Compensation and Governance Committee yesterday.

Dr. Mohler is a proven leader and has done a great deal to enhance discovery, innovation and creative expression at the university since joining us in 2011─ and we are confident he will continue to help position Ohio State as one of the nation's premier research universities.

Finally, we know that many are eager for news of Ohio State's next president. I am pleased to report that we continue to make great progress in this work, and we look forward to sharing more information soon.

We remain grateful to the Ohio State community and members of the Presidential Search Committee for their engagement—and to the members of the President's Cabinet, whose leadership continues to drive The Ohio State University to new heights.

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**APPROVAL OF MINUTES**

Dr. Fujita:

Our first order of business is the approval of our May meeting minutes, which were distributed to all trustees. If there are no additions or corrections, the minutes will stand approved as distributed. *(Minutes were approved.)*

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**RECOGNITION OF DISTINGUISHED UNIVERSITY PROFESSORS**

Dr. Fujita:

Every year, the Board looks forward to hearing about the impressive scholarship of the Distinguished University Professors. Their presence on our faculty elevates the reputation of this institution, and we could not be prouder to recognize them today.

Provost Gilliam, I will ask you to do the honors …

Dr. Gilliam:

Mr. Chairman, and members of the Board it is my distinct honor to introduce you to The Ohio State University Distinguished University Professors for 2023. Before I make those introductions however, let me explain what the title of Distinguished University Professor means and what a singular recognition it represents.

In short, this is the highest honor bestowed by Ohio State. Since its creation more than 35 years ago, the Distinguished University Professor title has been awarded to no more than three exceptional faculty members per year, and they hold the title in perpetuity. Nominations are put forward by our colleges and, following an extremely rigorous review process of candidates' records in teaching, research, scholarly or creative work, and service, final recommendations are made by members of the President's and Provost's Advisory Committee.

Distinguished University Professors are awarded $30,000 as a one-time grant to support their academic work and they become members of the President's and Provost's Advisory Committee. That means Ohio State can benefit from their wisdom and expertise on how to promote the excellence of the university. This year's Distinguished University Professors are Dr. Stanley Lemeshow of the College of Public Health, Dr. Stuart Cooper of the College of Engineering, and Dr. Elena Irwin of the College of Food, Agricultural, and Environmental Sciences.

Dr. Lemeshow is travelling internationally and is unable to join us today. In addition, he recently retired from the university so I'm sure he's enjoying his next chapter of a very remarkable life. But Dr. Lemeshow is a founding dean of The Ohio State University's College of Public Health; he also served as director of Ohio State's Center for Biostatistics and the Biostatistics Core of the Comprehensive Cancer Center. His biostatistics research includes statistical modelling of medical data, sampling health disparities and cancer prevention. He has published extensively in the applied and methodological literature and has co-authored three textbooks. Dr. Lemeshow maintains an ongoing relationship with Aarhus University in Denmark as an honorary professor in biostatistics and he is a faculty member in the Erasmus Summer Program in Rotterdam, Holland. He has taught more than 100 short courses in biostatistical methods in this country and abroad, including eight European countries, Australia, China, and India. During the COVID-19 pandemic, Dr. Lemeshow was instrumental in three projects serving Ohio State, noted one of his nominators. He was critical to the design of the state's prevalent study in 2020, which helped the Ohio Department of Public Health and

Office of the Governor understand the scope and scale of spread giving a vital baseline for modeling. Dr. Lemeshow worked with the Ohio Hospital Association to help predict required bed capacity. In addition, he contributed to the wastewater surveillance team that monitored viral levels and catchment areas on campus and in other locations. His work immediately impacted policy and planning at a time of unprecedented need. Dr. Lemeshow's other notable awards include fellow of the American Association for the Advancement of Science, fellow of the American Statistical Association, UCLA's School of Public Health Alumni Hall of Fame, Lowell Reed Lectureship for the American Public Health Association, and the Wiley Lifetime Award.

May we now please see the video about Dr. Lemeshow.

(Video plays)

It is now my pleasure to introduce you to our two other Distinguished University Professors, would you please come forward, Dr. Irwin and Dr. Cooper.

We will now start with Distinguished University Professor Dr. Stuart Cooper. Dr. Cooper is a formidable scientist, leader, teacher, a member, mentor of world acclaim who has in many ways served as an inspiration to the fields of biomedical and biological engineering, according to one of Dr. Cooper's nominators. Known for his immense contributions to the fundamental understanding and technological application, Dr. Cooper is a true pioneer in the biomaterials field, having broken vital new ground in understanding interactions of polymeric materials with physiologic fluids and tissues. In addition, Dr. Cooper is a consummate scientific mentor who is welcoming and supportive of all ideas and able to stimulate individuals to think creatively. His reputation as a teacher and mentor extends to his outstanding graduate students for whom he has always been readily available, as well as to younger faculty and colleagues in the field. He mentored 62 PhD students, many of whom have succeeded at high levels. In 2018, he won the College of Engineering's Faculty Mentoring Award in celebration of these efforts. From 2004 – 2014 he served as chair of the William G. Lowrie Department of Chemical and Biomolecular Engineering. Dr. Cooper has won major national and international awards that drive not only from his brilliant work but his incredible service across a broad domain. His contributions were recognized at the highest level within the engineering profession when he was elected to the National Academy of Engineering. Other awards include Founders' Awards from both the American Institute of Chemical Engineers, and the Society for Biomaterials, founding fellow of the American Institute for Medical and Biological Engineering, the International Award for Achievement in Biomaterials of the Japanese Society for Biomaterials, Chemistry and Thermoplastic Elastomers Award from the American Chemical Society, and fellow of the American Chemical Society, polymer division.

May we now please see the video about Dr. Cooper.

(Video plays)

Dr. Cooper would you like to say a few words?

Professor Cooper:

Okay, I'll try to keep it to a few words. I am very pleased and honored to be awarded this Distinguished University Professorship designation; it's like a capstone to my long career. I've been working as a professor for 56 years today, almost 20 of them have been at Ohio State. I came to Ohio State in 2004 and served as chair of the Department of Chemical Engineering, soon to change its name to chemical and biomolecular engineering. The observation I had was, particularly early in the recruitment stage, it was that there were things I needed to do; the department was below critical size, I was the 13th hire. The department had gone from 11, to 12, to 13 and back again over the years, but at a place like Ohio State, for a chemical engineering department, it was undersized. I'm pleased that over the 10 years I was there, we went up to about 20 faculty, and very productive faculty I might say. The areas I was most pleased with were the faculty growth and mentoring, particularly the young women who joined the department, making sure they had the right space and the right access to graduate students.

The other big project was noticing, when I was interviewing even, how deficient the building was. It was called Koffolt Laboratories, named for the second department chair who served in the late 40s, 50s and the early 60s. He was a character and smoked cigars in the building. He told the undergraduates that if they didn't join the AIChE, which was the professional association student chapter, they wouldn't graduate. He insisted on being a placement service for them. He refused to let the recruiters that were interested in chemical engineers go into any kind of college interview space. He would have them in the department. Of course, that evolved quickly after he retired; now everything is centralized. Joe Koffolt believed in his students. He helped his students get their first jobs. If they lost their jobs, he would find another opportunity for them. In the summertime he would drive around the Midwest visiting the students and getting to know their families. He was an amazing guy; he was a "Mr. Chips." And even though he didn't have much in the way of resources, they were able to name the building for him, Koffalt Laboratories. Particularly, to have a new building you need to raise some matching funds to match the state funds and the university funds. The main contributors were people who graduated in the 50s and 60s, and were known as "Joe's Jewels."

One of "Joe's Jewels," and among them was a man named William Lowrie. Some of you may have heard of him. He's very active in all kinds of activities at Ohio State. He was on the development board and was chair of the development board. His career climaxed with his presidency at Amoco Corporation. One of the things I did even before I came here in 2004, is that summer before, I drive down to South Carolina, where he lived in a kind of place, they called a reserve. It had golf, equestrian activities, trap shooting, they had everything at this thing, it was a really interesting place. Anyway, he agreed during that visit to be the chair of a fundraising committee. I called it national committee for basically finding a building, supporting a building for the chemical engineering department. He was, I would say, essential in raising my sights. I thought we could get by with maybe renovating, filling in the high bay that we had for our pilot–plant type work, but he encouraged us to think big. We did think big, and we finally got into the que in the proper way and started on the building project. In terms of my major contribution at Ohio State, it was to dive in and take up the department/college obligation to liaise with all of the other entities that were involved in the building construction, and there were many entities. We had two months of almost daily interviewing processes for the architect, the design architect, the architect of record, the construction manager, the mechanical, electrical and plumbing. It just went on and on.

When we were through with that, we still had to deal with what were the unique features going to be of this building. We shared 50% of the research space with Chemistry, and they're just basically going to put labs. I had to worry about the proper accommodations for our undergraduate program. There was a little resistance to get the top floor of what we called the office tower to be a student lounge; it's a beautiful space on campus. Dow Chemical contributed $1 million toward our fundraising goal, and the lounge was named "Dow Student Lounge." Also, it wasn't easy to do this, we got an auditorium put in the building. There was a prescription that you couldn't put in new space beyond what was torn down, etc., and the three buildings that came down didn't have an auditorium in them. I couldn't believe that we would have a new building without a place for celebratory activities, so I lobbied hard. The dean at that time was Greg Washington. He helped out, and we got space allocated for an auditorium. It was very interesting, we had this prescription about what could go in and what couldn't go in, but when this was occurring we were transitioning from quarters to semesters, and there weren't enough right-sized spaces for the new alignment of the courses, and it was most welcome to have this new pool space for engineering and other disciplines to come in and have that space. We had a 122-seat auditorium.

So, it was very exciting! I had a long career before Ohio State: dean of engineering at Delaware, chief academic officer at Illinois Institute of Technology in Chicago, provost at North Carolina State University. At each of those places, and to some extent my first job at Wisconsin, I had to do some fundraising, so it came naturally. The department had already seeded the process by having very appreciative graduates from the department. We raised a total amount of $17.5 million, a lot of it due to Bill Lowrie's efforts. This committee didn't want to put anybody's name on the building like Lowrie. He could've had his name on the building. But rather it could be the chemical and biomolecular engineering buildings and they allowed us to put the name Koffolt Laboratories in print on the base of our research tower so that was a very, very nice thing. I will just quickly end by saying that this building was one of the rare constriction buildings on campus that came in on target timewise, under-budget, and eventually achieved a silver LEED designation. It helped because everything, when we started it was during the great recession, and everybody wanted to have a part of the activities to keep their workforce. The design architect was a firm called Pelli Clarke Pelli, and they're known for having designed the Petronas twin towers in Indonesia. We had a first-class operation and a great team of individuals from Ohio State helping to get this done. Thank you.

Dr. Gilliam:

Thank you. Are there any questions for Dr. Cooper?

Dr. Fujita:

Yes, Professor Cooper, on behalf of the Board of Trustees, I would like to extend my heartfelt congratulations to you for your visionary leadership and tremendous contributions you have made in the field. I would like to ask if you could share with us the biomaterials you have developed and studied, and where they are used today? Could you give us some examples?

Dr. Cooper:

Well, I did my PhD thesis at Princeton on polyurethane materials, long before they were extensively used in biomedical application. But also, interestingly, I did my thesis with a chemist even though I got my degree in chemical engineering at Princeton, so I was interdisciplinary from the beginning. When I went to Wisconsin, I built up a program studying the chemistry and physical properties of these materials. The most common one you could think of, and people could relate to, is spandex – very strong, rubbery system. But at National Institutes of Health there was some scientists that said some of these polyurethanes had interesting, potentially blood – compatibility characteristics. So, they're now used as pacemaker insulation, blood pumps, catheters, infusion sets and so on. It's a very versatile material. The way I got into that was the chairman of the Department of Surgery at Wisconsin came to me and said I'm putting in vena cava rings they're called, plastic little annular pieces in the vena cava of animals and measuring how long they took to clot. The only material he could test was what the injection molded plastic pieces was made of, polycarbonate, the material that's in compact discs – very tough plastic. So, he said, can you help me get some different chemistries on the surfaces so that I can see the effect of plastic A versus plastic B, etc.

So, I did that for him, and I soon realized I could make other contributions, and I had a professor from nephrology who talked to myself and one of my graduate students about it. An animal model, we have a shunt and could measure platelets and proteins absorbing on the surface. Ultimately, we did that experiment and finally teamed up with a hematologist who was very early in his study of proteins called fibronectin, thrombospondin and vitronectin, which are very important in the blood material interactions. So, it was a very exciting time. At Wisconsin I had 50 PhD students, at Delaware 12, that's where we did anti-infection issues, bacteria surface interactions and inflammation which is another big problem that occurs when you have an implant – white cell surface interactions. So, I had an active career, the second half of my career was more administrative, and I could tell you stories about that, but its best to be, I think, in research with students and carrying on. Before I close my comments – I apologize for speaking for so long – I want to thank my wife. We are celebrating our 57th anniversary next week, and I'm glad she's here with me.

Dr. Gilliam:

Thank you and congratulations to both of you. And now it is now my pleasure to introduce you to Distinguished University Professor, Elena Irwin. Dr. Irwin's research addresses the sustainability of human natural systems at local and regional scales, focusing on land use and ecosystem services across urban and rural areas. She has been co-principal investigator on multiple research projects, totaling more than $19 million in funding including from the National Science Foundation (NSF), U.S. Department of Agriculture, the James S. McDonnell Foundation, and other private and public sources. In August 2021, Dr. Irwin was appointed by the U.S. Environmental Protection Agency administrator as an advisory member of the chartered Science Advisory Board as well as the Agricultural Science Committee. She is also an elected member of the Agricultural and Applied Economics Association executive board.

In 2022 she was selected as a fellow of the Association of Environmental and Resource Economists, the associations highest honor. She has served on multiple national research committees with the national research council and national science foundation, including as a member of NSF's Advisory Committee for Environmental Research and Education subcommittee on Sustainable Urban Systems (SUS). As faculty director and co-founder of Ohio State's Sustainability Institute, Dr. Irwin provides leadership to interdisciplinary sustainability research and teaching across the university, including cultivating campus-wide collaborative research and curriculum-development efforts. Dr. Irwin's mentorship of students includes an emphasis on interdisciplinary research, for which she is well-known, along with a focus on inclusion in all aspects of the grant-writing and publication process and an overall dedication to their success, noted one of Dr. Irwin's nominators. In 2015, she was honored with the North American Colleges and Teachers of Agriculture Educator Award. May we now please see the video about Dr. Irwin.

(Video plays)

Dr. Irwin would you like to say a few words?

Professor Irwin:

I would. Thank you so much. And I have written my comments out, so I will read them because I had so much to say but I knew I had a very brief period of time. I am truly honored by this and thank you so very much. I have so many people to thank: to my current and past chairs of the Agricultural, Environmental Development, Economics department. All of them are here, actually; all three of them back there. To all of my Ohio State colleagues who have been so supportive over the many years that I have been here. My grad students, as you heard, just tremendous encouragement and passion for me, and I truly have learned so much from them. I am very grateful for the leadership of our college dean, Cathann Kress, and others who've always supported me and our department and really understood the unique contributions that apply to economists like me and my colleagues have to make. I am extremely grateful to Provost Gilliam and other university leaders, including Dr. Peter Mohler, who have been so supportive of the Sustainability Institute and to me in my role as faculty director.

To my partner in sustainability, Kate Bartter who is our executive director of the institute, and to our incredibly talented staff, a small but mighty team who work every day to do amazing things to advance sustainability education, research, partnerships and help with campus efforts. To my dad and sister, who are also here today, and my mom, who I hope is watching back in West Virginia, my biggest cheerleaders in life, I am so grateful to them for so many things including showing me the beauty of nature and the beauty of people. To my sons, Isaac and Elliot, who inspire me every day to follow my passions as they pursue theirs. My husband Brian Roe, here today. Life partner, fellow Ohio state professor, fellow fellow of the Agricultural and Applied Economics Association, thank you for being my rock. Nothing is possible without him. And to you all members of the board, I am grateful for your leadership, your stewardship of this amazing, complex, one-of-a-kind university and the commitment that you demonstrate, including recently as you defended our vital need for free speech and the importance of diverse views. That was so inspiring and reaffirming for so many of us. From the start and throughout, Ohio State

has been, or I meant to say THE Ohio State, has been the place for me. A place that has enabled me to discover, create, learn, teach and contribute in many ways. Someone once likened Ohio State, a faculty member once likened Ohio State, to being like a kid in a candy shop. So many opportunities to explore, so many people to meet, so many possibilities that can become a reality.

Ohio was and is the perfect laboratory for me, a land use economist. Over the years I've studied urban sprawl, water quality, agricultural land management, household location choices, globalization of food, energy, and water impacts all right here in Ohio and in the Midwest. I'm also here because of Ohio State's forward-looking leadership that really has enabled faculty like me and many others to be innovative and to pursue opportunities. As you heard from the video, in 2010 my colleague Jeff Sharp and I were inspired to propose Ohio State's first sustainability undergraduate major. We call it EEDS: Environment, Economy, Development, Sustainability. We were so well supported by the college and by respective units and chairs who gave us the resources and time to develop this major. Since then, we've graduated about 500 students going out into the world and making a big difference in their workplaces and in their communities. In 2015, I worked with faculty colleagues to propose a focus area in sustainability and resilience as part of the university's Discovery Themed Initiative. We hired and mentored dozens of new faculty who are still here pursuing cutting edge work. Working on climate, energy, water, and other sustainability challenges.

In 2019, Kate and I proposed and launched the Sustainability Institute. We've leveraged university investments to grow resources and support work on sustainable solutions and supporting the many researchers, faculty, staff and students who are working on those solutions. From transforming the energy economy to making our cities and communities more resilient and equitable, and managing land more sustainably. As the institute wraps up its first five years, I am gratified by the work we've done and the partnerships that we've built. I'm also so very grateful to be working with Provost Gilliam and other leaders to develop a broader vision for Ohio State to advance sustainability, including doing more to educate students and equip the workforce with the sustainability skills and knowledge that is urgently needed. There are now over 4,000 companies globally and countless cities and other local municipalities who have pledged to get to zero net carbon emissions by 2040, by 2050 and other sustainability targets. And, honestly, they don't exactly know how they're going to get there. They need the skills and the knowledge, and that's where we come in.

Finally, there's one thing I want to mention. I'm also here because of Ohio State's inclusive policies. Way back in 1998 when Brian and I were graduating from the University of Maryland with our PhDs and on the market, Ohio State was the place that invited us both to interview and ultimately turned a single position into two full-time tenure-track positions – well before spousal hiring was the norm across the nation. A real turning point came for me in 2002, and it's chronicled actually in the Boston Globe article that I think you may have in front of you. As an assistant professor, I was ready to walk away and call it quits. I had a two-year-old, I had another on the way, and I was just really overwhelmed with trying to balance work and family. When I went to Alan Randall, who was my department chair at the time, and said "what I really want is a part-time position, but I know that's not possible because I can't keep my tenure track." He said, "don't assume."

Thanks to the visionary work of others who have come before me, including Joan Herbers, who is here also today, was then an Ohio State professor who was leading the charge for more flexible work arrangements, it turned out that Ohio State was one of the few places that already had a policy on the books for part-time tenure. I ended up receiving tenure as a part-time assistant professor, and I maintained my part-time status for several years after that. And I'm deeply grateful to the institution, Allen and Joanne and others whose support was invaluable. As I enter my 26th year at Ohio State I don't know what my next steps will be on my Buckeye journey, but I am certain they will be there and I'm certain they're going to be exciting. There's plenty more candy to be had, opportunities to explore, people to meet, and one-of-a-kind possibilities to be realized that are only possible at a place that's this comprehensive and this committed as Ohio State University. Thank you.

Dr. Gilliam:

Thank you, Dr. Irwin. Board members, would you like to ask Distinguished University Professor, Dr. Irwin about her numerous achievements?

Mrs. Harsh:

Provost Gilliam, I do have a question, but first my heartfelt congratulations to Professor Irwin. You are very deserving of this award and so pleased your home is within the College of Food, Agriculture, and Environmental Sciences. So, my question is how has your research in land use evolved over your time here at Ohio State, and what are some of the practical applications of your research there?

Professor Irwin:

Yeah, thank you for that question. I came in as an assistant professor who was very interested in questions of urban sprawl. And so, moving to a place like Columbus was a great laboratory as I said. At the time, Delaware county was exploding with growth, so it was also at a time where new data was available. Before, when people were studying land, it kind of only had this very aggregate data, at the county level or something like that. And with the advent of GIS, (geographic information systems), that track data at very spatially explicitly, fine scaled levels, we're really able to understand land-use change in a different way. In a much more spatially explicit and articulated way, and that's so important because you know when you think about it, what is it that makes someone want to move out into a less developed area? Or move back into a city? You know for example, from a suburb. A lot of that has to do with things that are at a very localized scale, like how close am I to the grocery store, where is the nearest park? Things like that. And before, we didn't have the data to really see that and understand it, so I just happened to get lucky that I was coming into this work at a time when all this new data became available. And so, we were able to answer questions we just simply couldn't have answered before.

And then my research has evolved because I've always been interested in interdisciplinary work. But it evolved more and more in that direction. But the thing about land is nobody knows, is it a human thing or is it an environmental thing, and the answer

is yes. It's both. I really, truly believe it's everything. And so, if we look at issues like water pollution in the Great Lakes, or if we look at issues like carbon sequestration, how are we going to support our farmers to do the work that needs to be done to sequester and store carbon in the soils. These are all land questions and so doing this work with an interdisciplinary mindset, working with other people, that's really where I've also been able to shine at Ohio State because there's so many other people here to collaborate with.

Provost Gilliam:

Thank you. Chairman Fujita will you please join me in presenting the medallions to our 2023 Distinguished University Professors.

Dr. Fujita:

Thank you, Provost Gilliam, and thank you to both of our Distinguished University Professors for being here with us today and for sharing your stories. We greatly admire your accomplishments and your dedication to Ohio State. The university is incredibly fortunate to have you both on its faculty.

On behalf of the Board, congratulations for this tremendous honor. Please, can we have one more round of applause?

(See Appendix XIII for background information, page 714)

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**CONSENT AGENDA**

Dr. Fujita:

Thank you. We have now arrived at our consent agenda. We have eighteen (18) resolutions on the consent agenda today for the Board's consideration and approval, which includes the two hand-carried resolutions from our Talent, Compensation & Governance Committee — personnel actions and the adoption of an Ohio State philosophy on institution and leadership statements.

Please note that we have placed one (1) item for action directly on the consent agenda today — our Resolutions in Memoriam, which recognize the passing of emeritus faculty members.

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**RESOLUTIONS IN MEMORIAM**

Resolution No. 2024-16

**NORMAN KENT BOOTH**

Synopsis: The Board of Trustees of The Ohio State University expresses its sorrow regarding the death on April 3, 2023 of Norman Kent Booth, Professor Emeritus of Landscape Architecture in the Austin E. Knowlton School of Architecture in the College of Engineering.

Professor Booth taught Landscape Architecture at Ohio State for 30 years, from 1973–2004, when he retired from academia. He attained the rank of professor and served as head of the Landscape Architecture Section from 1996 to 2003. He was honored in 1999 by being designated a Fellow of the American Society of Landscape Architects.

During his teaching career, Professor Booth authored two widely used landscape architecture textbooks, *Basic Elements of Landscape Architectural Design* in 1983 (reprinted in 2012 as *Foundations of Landscape Architecture*) and *Residential Site Design* in 1985. Booth co-authored *Residential Landscape Architecture* with his colleague James E. Hiss in 1991.

As detailed in *Testing Grounds: 100 Years of Landscape Architecture at the Ohio State University*, Booth's work had an influential impact on the design education model, "integrating elements of traditional site planning and environmentalism with a graphic style derived from 1950s modernism and the new informality of the 1970s."

In *Testing Ground*s, Professor Booth reflected on how the Landscape Architecture Section evolved in the early 1970's

"I was hired about a year or two after Jot Carpenter was hired [1972], at the beginning of a rather rapid buildup and enlargement of the program, so we were all rather young faculty with virtually no teaching experience prior to starting to teach. We pretty much had the ability to shape the program, and during the '73, '74, '75 time period there was a lot of effort put forward to define what the program was all about and to set the course for many years to come. I think the core of that was a weekend retreat - we went to Mohican State Park for a whole weekend - and out of that came the direction that the program would take for the next twenty-five, thirty years. Even though that evolved over time and always changed, the core of that was really set early on in those years, and I think there were a number of things that were unique. One, that we had the ability to do that, and two that there was a lot of emphasis on making a program where the graduates were prepared to walk into an office, either a private practice or government service, so that students we're job-ready and had the necessary education and background."

On behalf of the university community, the Board of Trustees expresses to the family of Professor Norman Booth its deepest sympathy and sense of understanding of their loss. It is directed that this resolution be inscribed upon the minutes of the Board of Trustees and that a copy be tendered to his family as an expression of the board's heartfelt sympathy and appreciation.

**RICHARD E. BURKART**

Synopsis: The Board of Trustees of The Ohio State University expresses its sorrow regarding the death on March 13, 2023, of Richard E. Burkart, Professor Emeritus in the School of Music in the College of Arts and Sciences. He was 91.

Richard E. Burkart was born in 1931 in New Orleans, LA. He began practicing and studying the cornet at age 8. He later attended Jesuit High School in New Orleans where he was appointed Solo Cornet in the Band and Orchestra. Burkart later graduated from LSU in 1955 (BME Music Ed., BM trumpet performance, MM trumpet performance). Upon graduation he was hired as the Professor of Brass at Lamar University in Beaumont, TX where he also played Principal Trumpet with the Chicago Little Symphony, and the

Beaumont Symphony Orchestra. After 14 years at Lamar, Burkart was accepted into the DMA program at the University of Wisconsin, a relatively novel degree at the time.

After completing his doctoral degree in 1971, Burkart was offered the position of Professor of Trumpet and Graduate Studies in Brass at The Ohio State University. In his new teaching position, he played with the Columbus Symphony Orchestra, the Faculty Brass Quintet, the Lancaster Festival Orchestra, Ringling Brothers Circus, and the Robert Shaw tour of France in 1992. He was also known to have played in and conducted the Longhorn Rodeo Band in Texas, Ohio and around the country. In his retirement years Burkart returned to his musical roots from New Orleans as a member of the Toll House Jazz Band performing Dixieland Jazz around Central Ohio and touring Germany, Austria, and Italy in 1997.

With his colleagues Tom Battenberg and Robert Hightshoe, he co-hosted the 1980 International Trumpet Guild (ITG) Conference at OSU. In 1988 Burkart was instrumental in the partnership between the ITG and The Columbus Foundation to establish the Ellsworth Smith International Trumpet Competition which he hosted at OSU in 1988 and 1994.

Through his teaching at Lamar and OSU, Dr. Burkart has had a profound influence on generations of our nation's outstanding trumpet players and teachers. His former students have become highly respected band directors, soloists, service band members, orchestral musicians, as well as college professors of trumpet throughout the country.

Above all his accomplishments, Burkart was a devoted family man, who raised six children and dealt with hardships that would have crushed a lesser spirit, including a daughter rendered quadriplegic in a car accident as well as his dear wife Janet's long battle with Parkinson's disease.

Richard Burkart died peacefully at his home on March 13, 2023. He was 91 and was preceded in death by his wife Janet in 2014 and his daughter Elizabeth in 2018.

On behalf of the entire university community, the Board of Trustees expresses to the family and loved ones of Professor Richard E. Burkart its deepest sympathy and compassion for their loss. It is directed that this resolution be inscribed upon the minutes of the Board of Trustees and that a copy be tendered to his family as an expression of the board's heartfelt sympathy and appreciation.

**JOSEPH A. LEVEY**

Synopsis: The Board of Trustees of The Ohio State University expresses its sorrow regarding the death on January 26, 2023, of Joseph A. Levey, Professor Emeritus in the School of Music in the College of Arts and Sciences. He was 97.

Professor Levy received his BM from West Virginia University Department of Music, his MM from Northwestern University and his DME from the University of Oklahoma. He was a member of the Theory and Composition faculty from 1965 to 1988. His compositions were performed by the Columbus Symphony String Quartet, the Faculty String Quartet, the Brass Choir, the OSU Chorale, the Concert Band, the Jazz Ensemble, and the Dance faculty.

Dr. Levy assembled the Bachelor of Music Degree in Jazz Studies, wrote the curriculum, and became its first Director. He organized the first Spring Jazz Festival and the first Summer Jazz Camp for high school musicians. He acted as jazz clinician

at the Pennsylvania Music Educators Convention, the Ohio Music Educators Convention, and the West Virginia Music Educators Meeting. He was a Director of the OSU Jazz Ensemble and his students played in major big bands such as Stan Kenton, Woody Herman, Buddy Rich, Maynard Ferguson, Ray Charles, and Las Vegas show bands

Dr. Levey performed on tenor sax, clarinet, and flute with the Jerry Kaye Orchestra to back up such performers as Rosemary Clooney, Carmen McRae, Natalie Cole, Mel Torme, Vic Damone, Al Martino, Sonny and Cher, Bob Hope, and many others.

A skilled conductor, Dr. Levey acted as Music Director for several Theater Department musical productions. They included ONCE UPON A MATTRESS, YOUR OWN THING, THE FANTASTICKS, A FUNNY THING HAPPENED ON THE WAY TO THE FORUM, and MOTHER COURAGE.

He has been published by Broadcast Music Inc., Shawnee Press, Prentice Hall, and University Press of America.

Dr. Levey is survived by his daughter and son-in-law, Jan and Anthony Roppo of Sunrise, FL; granddaughter and grandson-in-law, Emily and John Trahan, of Orlando, FL; niece, Eve Selman of Tampa, FL, and nephew, Jeff Selman of Denver, CO.

He is preceded in death by his wife, Elizabeth Levey, and grandson, Anthony Roppo.

On behalf of the entire university community, the Board of Trustees expresses to the family and loved ones of Professor Joseph A. Levey its deepest sympathy and compassion for their loss. It is directed that this resolution be inscribed upon the minutes of the Board of Trustees and that a copy be tendered to his family as an expression of the board's heartfelt sympathy and appreciation.

**AARON J. MILLER**

Synopsis: The Board of Trustees of The Ohio State University expresses its sympathy regarding the death on May 19, 2023, of Professor Emeritus Aaron J. "AJ" Miller, who upon his retirement chaired what was then the Department of Educational Studies: Humanities, Science, Technological and Vocational in the College of Education. He was 93.

Miller arrived at Ohio State in 1966 from Oklahoma, where he had earned a master's in trade and industrial education and an EdD in higher education from Oklahoma State University. While at Oklahoma State, he became an assistant professor and head of the electronics technology department. He then became chairman of the technical education department. He left that role to become director of Vocational, Technical and Adult Education for Oklahoma City Public Schools.

With that substantial experience, which included five years as an electronics field engineer for RCA and service in the U.S. Air Force during the Korean War, he came to Ohio State and joined the Center for Vocational and Technical Education, which later became the National Center for Research in Vocation Education. He rose to the position of associate director of field services and special projects.

While with the center, Miller became well known as project director for one of the first national initiatives in career education. With funding from the U.S. Office of Education, he

created and tested the Comprehensive Career Education Model for K-12 schools. Key to the model was uniting students, their parents, schools, the community and employers in a cooperative educational venture. The goal was to ensure students gained information and experiences representing the entire world of work, starting in their earliest years.

During field research, Miller validated a definition of career education, which was not standardized at the time. He then recruited six school districts in different states to develop, test and validate curriculum materials and educational strategies based on the model. The model and the curricula have served as the basis for many career education programs across the country.

In 1973, Miller left the research center to join the faculty of the College of Education as chair of its Vocational-Technical Education Program. He later served as acting associate dean of the college for a period of time.

Miller had a long service record associated with the field of vocational, career and technical education. He was involved with what is today the Association for Career and Technical Education, what was then the Association of Industrial and Technical Teacher Educators, as well as the University Council for Vocational Education. His work is preserved in what is today the ERIC Clearinghouse on Adult, Career and Vocational Education. He authored many papers in professional journals, presented at conferences and consulted in many countries, including Kenya, the People's Republic of China, the Republic of Mauritius and the United Arab Emirates.

Miller retired from Ohio State in 1993, after which he served as commissioner for what is today called the Accrediting Commission of Career Schools and Colleges.

On behalf of the entire university community, the Board of Trustees expresses to the family and friends of Professor Emeritus Aaron J. Miller its deepest sympathy for their loss. It is directed that this resolution shall be inscribed upon the minutes of the Board of Trustees, and a copy will be tendered to his family as an expression of the board's heartfelt appreciation.

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**PERSONNEL ACTIONS**

Resolution No. 2024-17

BE IT RESOLVED, That the Board of Trustees hereby approves the personnel actions as recorded in the personnel budget records of the university since the May 18, 2023, meeting of the Board, including the following appointments and contract amendments:

New Hire

Name: Peter Mohler
Title: Executive Vice President, Enterprise for Research, Innovation and Knowledge
Unit: Office of the President
Term: August 17, 2023

Severance Update

Name: Jessica Eveland
Title: Secretary, Board of Trustees
Unit: Office of the President
Term: August 1, 2023

Name: Stacy Rastauskas
Title: Vice President, Government Affairs
Unit: Office of the President
Term: August 1, 2023

***

**RATIFICATION OF COMMITTEE APPOINTMENTS FY2024-2025**

Resolution No. 2024-18

BE IT RESOLVED, That the Board of Trustees hereby approves that the ratification of committee appointments for Fiscal Year 2024-2025 are as follow:

**Academic Affairs & Student Life:**
Jeff M.S. Kaplan, Chair
Elizabeth A. Harsh, Vice Chair
Elizabeth P. Kessler
Reginald A. Wilkinson
Michael Kiggin
Pierre Bigby
**JOSHUA H.B. KERNER**
Susan E. Cole (faculty member)
Hiroyuki Fujita (ex officio)

**Finance & Investment:**
Tomislav B. Mitevski, Chair
James D. Klingbeil, Vice Chair
John W. Zeiger
Gary R. Heminger
Lewis Von Thaer
Michael Kiggin
Pierre Bigby
**TAYLOR A. SCHWEIN**
Amy Chronis
Kent M. Stahl
Hiroyuki Fujita (ex officio)

**Legal, Audit, Risk & Compliance:**
Elizabeth P. Kessler, Chair
Michael Kiggin, Vice Chair
Alan A. Stockmeister
Jeff M.S. Kaplan
Elizabeth A. Harsh
Juan Jose Perez
**JOSHUA H.B. KERNER**
Amy Chronis
Hiroyuki Fujita (ex officio)

**Master Planning & Facilities:**
**ALAN A. STOCKMEISTER, CHAIR**
**REGINALD A. WILKINSON, VICE CHAIR**
Elizabeth A. Harsh
Pierre Bigby
**JOSHUA H.B. KERNER**
James D. Klingbeil
Robert H. Schottenstein
Hiroyuki Fujita (ex officio)

**Research, Innovation & Strategic Partnerships:**
Lewis Von Thaer, Chair
Reginald A. Wilkinson, Vice Chair
Juan Jose Perez
**TAYLOR A. SCHWEIN**
Phillip Popovich (faculty member)
Hiroyuki Fujita (ex officio)

**Talent, Compensation & Governance:**
John W. Zeiger, Chair
Elizabeth P. Kessler, Vice Chair
**ALAN A. STOCKMEISTER**
Gary R. Heminger
Lewis Von Thaer
Jeff M.S. Kaplan
Tomislav B. Mitevski
Hiroyuki Fujita (ex officio

**Wexner Medical Center:**
Leslie H. Wexner, Chair
Alan A. Stockmeister
John W. Zeiger
Gary R. Heminger
Tomislav B. Mitevski
**JUAN JOSE PEREZ**
**TAYLOR A. SCHWEIN**
Stephen D. Steinour
Robert H. Schottenstein
W.G. Jurgensen
Cindy Hilsheimer
Amy Chronis
Hiroyuki Fujita (ex officio, voting)
Melissa L. Gilliam (ex officio, voting)
Michael Papadakis (ex officio, voting)
**JOHN J. WARNER (EX OFFICIO, VOTING)**

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**APPROVAL OF AMENDMENTS TO THE BYLAWYS FOR THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER BOARD**

Resolution No. 2024-20

Synopsis: Recommended approval of the attached amendments to the *Bylaws of The Ohio State University Wexner Medical Center Board* is proposed.

WHEREAS pursuant to 3335-1-09 (C) of the Administrative Code, the rules and regulations for the university may be adopted, amended or repealed by a majority vote of the University Board of Trustees at any regular meeting of the board; and

WHEREAS a periodic review of the board's bylaws is a governance best practice; and

WHEREAS the last revisions to the *Bylaws of The Ohio State University Wexner Medical Center Board* took place in November 2022; and

NOW THEREFORE

BE IT RESOLVED, That the Quality and Professional Affairs Committee hereby recommends to the Wexner Medical Center Board and the University Board of Trustees the attached amendments to the *Bylaws of The Ohio State University Wexner Medical Center Board.*

(See Appendix XIV for background information, page 716)

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**APPROVAL TO ESTABLISH A DOCTOR OF EDUCATION IN TEACHING AND LEARNING**

Resolution No. 2024-21

IN THE COLLEGE OF EDUCATION AND HUMAN ECOLOGY

Synopsis: Approval to establish a Doctor of Education in Teaching and Learning degree with a specialization in practitioner inquiry of equity-based advocacy in the College of Education and Human Ecology is proposed.

WHEREAS the need for such a program was identified through stakeholder engagement with department faculty and local educators, in addition to benchmarking programs at similar institutions; and

WHEREAS the new degree program will enhance the Department of Teaching and Learning's engagement with school districts through teaching, research, and outreach; and

WHEREAS the program will draw on the expertise of the faculty to prepare educational professionals to develop knowledge, skills, and dispositions for transforming their communities toward equity-based advocacy; and

WHEREAS the program will require a practice-based educational research project to take place in school settings where the degree candidate involves schools and districts in the design and implementation of the project, thus respecting the district's culture, strengths and assets; and

WHEREAS the program plans to focus locally within Franklin County's 19 school districts for educators with master's degrees looking to earn a doctoral degree, with the intent of expanding recruitment across the state and beyond; and

WHEREAS the proposal was reviewed and approved by the Council on Academic Affairs at its meeting on February 1, 2023; and

WHEREAS the University Senate approved this proposal on March 23, 2023:

NOW THEREFORE

BE IT RESOLVED, That the Board of Trustees hereby approves the proposal to establish a Doctor of Education in Teaching and Learning degree program in the College of Education and Human Ecology.

(See Appendix XV for background information, page 717)

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**FACULTY PERSONNEL ACTIONS**

Resolution No. 2024-22

BE IT RESOLVED, That the Board of Trustees hereby approves the faculty personnel actions as recorded in the personnel budget records of the university since the May 17, 2023, meeting of the board, including the following appointments, appointments/reappointments of chairpersons, faculty professional leaves and emeritus titles:

Appointments

| | |
|---|---|
| Name: | SHEIKH AKBAR |
| Title: | Professor (2023 Alumni Award for Distinguished Teaching) |
| College: | Office of Academic Affairs |
| Term: | N/A |

| | |
|---|---|
| Name: | FLOOR BACKES |
| Title: | Professor (The Larry J. Copeland, M.D. Professorship in Gynecologic Oncology) |
| College: | Medicine |
| Term: | September 1, 2023, through June 30, 2027 |

| | |
|---|---|
| Name: | STEVEN BENGAL |
| Title: | Lecturer (2023 Provost's Award for Distinguished Teaching by a Lecturer) |
| College: | Office of Academic Affairs |
| Term: | N/A |

| | |
|---|---|
| Name: | MICAH BERMAN |
| Title: | Professor (The Stephen F. Loebs Professorship in Health Services Management and Policy) |
| College: | Public Health |
| Term: | August 15, 2023, through August 14, 2028 |

| | |
|---|---|
| Name: | LIJUAN BI |
| Title: | Lecturer, Newark (2023 Provost's Award for Distinguished Teaching by a Lecturer) |
| College: | Office of Academic Affairs |
| Term: | N/A |

| | |
|---|---|
| Name: | NICHOLAS BREITBORDE |
| Title: | Professor (The Charles F. Sinsabaugh Chair in Psychiatry) |
| College: | Medicine |
| Term: | August 1, 2023, through June 30, 2027 |

| | |
|---|---|
| Name: | STEVEN BROWN |
| Title: | Associate Professor-Clinical (2023 Alumni Award for Distinguished Teaching) |
| College: | Office of Academic Affairs |
| Term: | N/A |

| | |
|---|---|
| Name: | AMY BRUNELL |
| Title: | Professor (2023 Alumni Award for Distinguished Teaching) |
| College: | Office of Academic Affairs |
| Term: | N/A |

| | |
|---|---|
| Name: | NICK BRUNELLI |
| Title: | Associate Professor (Ervin G. Bailey Chair in Energy Conversion) |
| College: | Engineering |
| Term: | July 1, 2023, through June 30, 2028 |

| | |
|---|---|
| Name: | CHRISTIN BURD |
| Title: | Associate Professor (2023 Alumni Award for Distinguished Teaching) |
| College: | Office of Academic Affairs |
| Term: | N/A |

Name: CARLOS CASTRO
Title: Professor (The Ralph W. Kurtz Chair in Mechanical Engineering)
College: Engineering
Term: July 1, 2023, through June 30, 2028

Name: NATALIA HIGUITA CASTRO
Title: Associate Professor (College of Engineering Innovation Scholar)
College: Engineering
Term: July 1, 2023, through June 30, 2028

Name: WEI-LUN (HARRY) CHAO
Title: Assistant Professor (Distinguished Assistant Professor of Engineering Inclusive Excellence)
College: Engineering
Term: August 15, 2023, through June 30, 2028

Name: TED CLARK
Title: Professor (2023 Provost's Award for Distinguished Teaching by a Lecturer)
College: Office of Academic Affairs
Term: N/A

Name: STUART COOPER
Title: Professor (Distinguished University Professor)
College: Office of Academic Affairs
Term: N/A

Name: GREG DAVIS
Title: Professor (The George R. and Genevieve B. Gist Endowed Chair in Ohio State University Extension)
College: Food, Agricultural, and Environmental Sciences
Term: July 1, 2023, through June 30, 2028

Name: LAURA DEETER
Title: Professor (Sandy and Andy Ross Endowed Director of the Chadwick Arboretum and Learning Gardens)
College: Food, Agricultural, and Environmental Sciences
Term: August 15, 2023, through August 14, 2028

Name: LIN DING
Title: Professor (2023 Alumni Award for Distinguished Teaching)
College: Office of Academic Affairs
Term: N/A

Name: MOLLY DOWNING
Title: Assistant Professor-Practice (2023 Provost's Award for Distinguished Teaching by a Lecturer)
College: Office of Academic Affairs
Term: N/A

| | |
|---|---|
| Name: | THEODORA DRAGOSTINOVA |
| Title: | Professor (2023 Alumni Award for Distinguished Teaching) |
| College: | Office of Academic Affairs |
| Term: | N/A |

| | |
|---|---|
| Name: | RACHEL GETMAN |
| Title: | Professor (Bernice L. Claugus Endowed Chair in Chemical and Biomolecular Engineering) |
| College: | Engineering |
| Term: | August 15, 2023, through June 30, 2028 |

| | |
|---|---|
| Name: | ERIC GREEN |
| Title: | Professor (Excellence in Veterinary Care Diagnostic Imaging Professorship in the College of Veterinary Medicine) |
| College: | Veterinary Medicine |
| Term: | July 1,2022, through June 30, 2027 |

| | |
|---|---|
| Name: | L. CAMILLE HEBERT |
| Title: | Professor (Robert J. Lynn Chair in Law) |
| College: | Law |
| Term: | August 15, 2023, through August 15, 2028 |

| | |
|---|---|
| Name: | ELENA IRWIN |
| Title: | Professor (Distinguished University Professor) |
| College: | Office of Academic Affairs |
| Term: | N/A |

| | |
|---|---|
| Name: | JULIE JOHNSON* |
| Title: | Professor (Dr. Samuel T. and Lois Felts Mercer Professor of Medicine and Pharmacology) |
| College: | Medicine |
| Term: | October 9, 2023, through October 8, 2027 |

| | |
|---|---|
| Name: | KAY BEA JONES |
| Title: | Professor (2023 President and Provost’s Award for Distinguished Faculty Service) |
| College: | Office of Academic Affairs |
| Term: | N/A |

| | |
|---|---|
| Name: | JOSHUA JOSEPH |
| Title: | Associate Professor (Endowed Professorship for Research in Internal Medicine) |
| College: | Medicine |
| Term: | July 1, 2023, through June 30, 2027 |

| | |
|---|---|
| Name: | ZAK KASSAS |
| Title: | Professor (The Transportation Research Center, Inc. Chair in Intelligent Transportation Systems) |
| College: | Engineering |
| Term: | July 1, 2023, through June 30, 2028 |

| | |
|---|---|
| Name: | STANLEY LEMESHOW |
| Title: | Professor (Distinguished University Professor) |
| College: | Office of Academic Affairs |
| Term: | N/A |

| | |
|---|---|
| Name: | JASON LEMON |
| Title: | Dean and Vice Provost for Online Learning |
| College: | Office of Academic Affairs |
| Term: | July 1, 2023 |

| | |
|---|---|
| Name: | ZAIBO LI |
| Title: | Professor-Clinical (University Pathology Services Anatomic Pathology Professorship) |
| College: | Medicine |
| Term: | July 1, 2023, through June 30, 2027 |

| | |
|---|---|
| Name: | TREVON LOGAN |
| Title: | Professor (ENGIE-Axium Endowed Professorship) |
| College: | Office of Academic Affairs |
| Term: | August 15, 2023, through May 1, 2028 |

| | |
|---|---|
| Name: | STEVEN LOPEZ |
| Title: | Associate Professor (2023 President and Provost's Award for Distinguished Faculty Service) |
| College: | Office of Academic Affairs |
| Term: | N/A |

| | |
|---|---|
| Name: | BERNADETTE MELNYK |
| Title: | Professor (Vice President for Health Promotion and Chief Wellness Officer) |
| College: | Office of Academic Affairs |
| Term: | July 1, 2023, through June 30, 2025 |

| | |
|---|---|
| Name: | TODD MONROE |
| Title: | Research Professor (Distinguished Professor of Aging Research) |
| College: | Nursing |
| Term: | April 24, 2023, through April 24, 2028 |

| | |
|---|---|
| Name: | STEVE OGHUMU |
| Title: | Associate Professor (Excellence in Research and Education Leadership Professorship in the College of Medicine) |
| College: | Medicine |
| Term: | July 1, 2023, through June 30, 2027 |

| | |
|---|---|
| Name: | JOEL PAULSON |
| Title: | Assistant Professor (The H.C. 'Slip' Slider Professorship in Chemical and Biomolecular Engineering) |
| College: | Engineering |
| Term: | September 1, 2023, through June 30, 2028 |

Name: ASHLEY PEREZ
Title: Assistant Professor (2023 Alumni Award for Distinguished Teaching)
College: Office of Academic Affairs
Term: N/A

Name: DANIEL GALLEGO PEREZ
Title: Associate Professor (The Edgar C. Hendrickson Designated Chair in Biomedical Engineering)
College: Engineering
Term: July 1, 2023, through June 30, 2028

Name: STEPHEN QUAYE
Title: Professor (2023 Alumni Award for Distinguished Teaching)
College: Office of Academic Affairs
Term: N/A

Name: EDUARDO REATEGUI
Title: Associate Professor (College of Engineering Innovation Scholar)
College: Engineering
Term: July 1, 2023, through June 30, 2028

Name: KATELYN SWINDLE REILLY
Title: Associate Professor (College of Engineering Innovation Scholar)
College: Engineering
Term: July 1, 2023, through June 30, 2028

Name: VINCENT ROSCIGNO
Title: Professor (2023 Alumni Award for Distinguished Teaching)
College: Office of Academic Affairs
Term: N/A

Name: ABDOLLAH SHAFIEEZADEH
Title: Professor (2023 Alumni Award for Distinguished Teaching)
College: Office of Academic Affairs
Term: N/A

Name: JENNY SHELDON
Title: Assistant Professor-Clinical (2023 Provost's Award for Distinguished Teaching by a Lecturer)
College: Office of Academic Affairs
Term: N/A

Name: PATRICK SOURS
Title: Senior Lecturer (2023 Provost's Award for Distinguished Teaching by a Lecturer)
College: Office of Academic Affairs
Term: N/A

| | |
|---|---|
| Name: | HUAN SUN |
| Title: | Associate Professor (College of Engineering Innovation Scholar) |
| College: | Engineering |
| Term: | August 15, 2023, through June 30, 2028 |

| | |
|---|---|
| Name: | PIERS NORRIS TURNER |
| Title: | Associate Professor (2023 President and Provost's Award for Distinguished Faculty Service) |
| College: | Office of Academic Affairs |
| Term: | N/A |

| | |
|---|---|
| Name: | DEVINA PURMESSUR WALTER |
| Title: | Associate Professor (College of Engineering Innovation Scholar) |
| College: | Engineering |
| Term: | July 1, 2023, through June 30, 2028 |

| | |
|---|---|
| Name: | KARLA ZADNIK |
| Title: | Interim Dean |
| College: | Public Health |
| Term: | July 1, 2023, through June 30, 2024, or until a new Dean is appointed |

| | |
|---|---|
| Name: | PATRICIA ZETTLER |
| Title: | Professor (John W. Bricker Professorship in Law) |
| College: | Law |
| Term: | August 15, 2023, through August 22, 2028 |

Reappointments

| | |
|---|---|
| Name: | STUART COOPER |
| Title: | Professor (Distinguished Professor of Engineering) |
| College: | Engineering |
| Term: | September 1, 2023, through June 30, 2028 |

| | |
|---|---|
| Name: | ISABELLE DESCHENES |
| Title: | Professor and Chair (Bernie Frick Research Chair in Heart Failure and Arrhythmia) |
| College: | Medicine |
| Term: | August 1, 2023, through June 30, 2027 |

| | |
|---|---|
| Name: | LIANG-SHIH FAN |
| Title: | Distinguished University Professor (The C. John Easton Professor in Engineering) |
| College: | Engineering |
| Term: | July 1, 2023, through June 30, 2028 |

| | |
|---|---|
| Name: | GERALD FRANKEL |
| Title: | Professor (Distinguished Professor of Engineering) |
| College: | Engineering |
| Term: | September 1, 2023, through June 30, 2028 |

| | |
|---|---|
| Name: | ANDREW GLASSMAN |
| Title: | Professor and Chair (Frank J. Kloenne Chair of Orthopaedic Surgery) |
| College: | Medicine |
| Term: | July 1, 2023, through June 30, 2025 |

| | |
|---|---|
| Name: | WILLIAM MARRAS |
| Title: | Professor (The Honda Chair in Transportation) |
| College: | Engineering |
| Term: | July 1, 2023, through June 30, 2028 |

| | |
|---|---|
| Name: | HARVEY MILLER |
| Title: | Professor (Bob and Mary Reusche Chair in Geography) |
| College: | Arts and Sciences |
| Term: | August 1, 2023, through June 30, 2028 |

| | |
|---|---|
| Name: | UMIT OZKAN |
| Title: | Professor (Distinguished Professor of Engineering) |
| College: | Engineering |
| Term: | July 1, 2023, through June 30, 2028 |

| | |
|---|---|
| Name: | BOYD PANTON |
| Title: | Professor (Lincoln Electric Company Endowed Professor) |
| College: | Engineering |
| Term: | September 1, 2023, through June 30, 2028 |

| | |
|---|---|
| Name: | MARK PARTRIDGE |
| Title: | Professor (The C. William Swank Chair in Rural and Urban Policy Fund) |
| College: | Food, Agricultural, and Environmental Sciences |
| Term: | July 1, 2023, through June 30, 2024 |

| | |
|---|---|
| Name: | KINH LUAN PHAN |
| Title: | Professor and Chair (Jeffrey Schottenstein Endowed Chair of Psychiatry and Resilience) |
| College: | Medicine |
| Term: | July 1, 2023, through June 30, 2027 |

| | |
|---|---|
| Name: | GIORGIO RIZZONI |
| Title: | Professor (The Ford Motor Company Chair in Electromechanical Systems) |
| College: | Engineering |
| Term: | July 1, 2023, through June 30, 2028 |

| | |
|---|---|
| Name: | BRIAN ROE |
| Title: | Professor (The Fred N. Van Buren Professorship in Farm Management) |
| College: | Food, Agricultural, and Environmental Sciences |
| Term: | July 1, 2023, through June 30, 2028 |

| | |
|---|---|
| Name: | IAN SHELDON |
| Title: | Professor (The Andersons Endowed Chair in Agricultural Marketing, Trade and Policy) |
| College: | Food, Agricultural, and Environmental Sciences |
| Term: | July 1, 2023, through June 30, 2028 |

| | |
|---|---|
| Name: | LINDA WEAVERS |
| Title: | Professor (John C. Geupel Chair) |
| College: | Engineering |
| Term: | July 1, 2023, through June 30, 2028 |

| | |
|---|---|
| Name: | MARCIA WORLEY |
| Title: | Professor (Merrell Dow Professorship in Pharmaceutical Administration) |
| College: | Pharmacy |
| Term: | July 1, 2023, through June 30, 2026 |

**Extensions**

| | |
|---|---|
| Name: | WENDY FRANKEL |
| Title: | Professor and Chair (Ralph W. and Helen Kurtz Chair in Pathology) |
| College: | Medicine |
| Term: | July 1, 2023, through June 30, 2024 |

*New Hire

(See Appendix XVI for background information, page 726)

***

**APPROVAL OF FISCAL YEAR 2024 CAPITAL INVESTMENT PLAN**

Resolution No. 2024-23

Synopsis: Authorization and acceptance of the Capital Investment Plan for the fiscal year ending June 30, 2024, as proposed.

WHEREAS the university has presented the recommended capital expenditures for the fiscal year ending June 30, 2024; and

WHEREAS the recommended capital expenditures are the result of the university's comprehensive annual capital planning process; and

WHEREAS only those projects outlined in these recommendations will be approved for funding;

NOW THEREFORE

BE IT RESOLVED, That the Board of Trustees hereby approves the Capital Investment Plan for the fiscal year ending June 30, 2024, as described in the accompanying documents; and

BE IT FURTHER RESOLVED, That any request for authorization to proceed with any project contained in these recommendations must be submitted individually by the university for approval by the Board of Trustees, as provided for by Board policy.

(See Appendix XVII for background information, page 730)

***

**APPROVAL TO ENTER INTO/INCREASE PROFESSIONAL SERVICES AND ENTER INTO CONSTRUCTION CONTRACTS**

Resolution No. 2024-24

**APPROVAL TO ENTER INTO PROFESSIONAL SERVICES CONTRACTS**
BATTERY CELL RESEARCH & DEMONSTRATION CENTER

**APPROVAL TO ENTER INTO/INCREASE PROFESSIONAL SERVICES AND CONSTRUCTION CONTRACTS**
AIRPORT - TAXIWAY A REHABILITATION
DEPARTMENT OF ECONOMICS RELOCATION
WATERMAN - MULTI-SPECIES ANIMAL LEARNING CENTER (MALC)

Synopsis: Authorization to enter into/increase 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 contracts for the following project; and

| | Prof. Serv. Approval Requested | Total Requested | |
|---|---|---|---|
| Battery Cell Research & Demonstration Center | $2.3M | $2.3M | Grant funds (NIST)<br>Partner funds |

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

| | Prof. Serv. Approval Requested | Construction Approval Requested | Total Requested | |
|---|---|---|---|---|
| Airport – Taxiway A Rehabilitation | $1.0M | $3.5M | $4.5M | Grant funds (NIST)<br>Partner funds |
| Department of Economics Relocation | $1.1M | $0.7M | $1.8M | University funds |
| Waterman – Multi-Species Animal Learning Center (MALC) | $1.9M | $47.0M | $48.9M | University debt<br>University funds<br>Fundraising<br>State funds |

WHEREAS the Master Planning and Facilities Committee has reviewed the projects listed above for alignment with all applicable campus plans and guidelines; and

WHEREAS the Finance Committee has reviewed the projects listed above for alignment with the Capital Investment Plan and other applicable financial plans.

NOW THEREFORE

BE IT RESOLVED, that the Board of Trustees hereby approves that the President and/or Senior Vice President for Business and Finance be authorized to enter into/increase 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.

(See Appendix XVIII for background information, page 732)

***

**APPROVAL OF FRAMEWORK 3.0**

Resolution No. 2024-25

SYNOPSIS: Authorization is requested to approve Framework 3.0, an update to the university's master plan, including planning principles, recommendations, and the vision for the Columbus campus.

WHEREAS Framework 3.0 builds upon the strong foundation of the previous Framework plans by reinforcing and refining previous planning ideas while establishing near and long-term concepts that strengthen the physical campus in support of academic and research excellence; and,

WHEREAS the university began the planning process by completing a comprehensive assessment of existing space across campus to understand utilization and programmatic needs; and,
WHEREAS the space assessment indicated a need for additional classrooms, class laboratories, research laboratories, and amenity spaces which enhance the student and faculty experience; and,

WHEREAS robust engagement with faculty, staff and students was instrumental in developing a flexible vision for both near and long term development of campus anchored by the planning principles of stewardship, connectivity, experience and community; and

WHEREAS Framework 3.0 incorporates parallel planning efforts for Student Life facilities, the Wexner Medical Center and Carmenton: and,

WHEREAS Framework 3.0 will replace the previous Framework Plan that the Board of Trustees adopted in 2017; and,

WHEREAS Framework 3.0 lives alongside the strategic and capital plans of the university to create a shared vision for development while enabling the university to revise and re-envision as future conditions warrant:

NOW THEREFORE

BE IT RESOLVED, That the Board of Trustees hereby adopts Framework 3.0 as the guiding vision for the physical environment and directs the appropriate university offices to proceed with planning consistent with the Framework principles and long-term vision.

(See Appendix XIX for background information, page 736)

***

**APPROVAL TO ENTER INTO A JOINT USE AGREEMENT**

Resolution No. 2024-26

BETWEEN THE OHIO STATE UNIVERSITY
AND OHIO MANUFACTURING AND INNOVATION CENTER

Synopsis: Authorization to enter into a Joint Use Agreement (JUA) with the Ohio Manufacturing and Innovation Center (OMIC), an Ohio non-profit agency, to document the value and permit the release of funds appropriated in the State Capital Bill to expand the existing facility.

WHEREAS The Ohio State University was allocated $500,000 in the 2023-2024 State Capital Bill that was specifically designated for use by OMIC; and

WHEREAS the OMIC will utilize the funds to partially fund design and construction of capital improvements to an existing facility, upgrading and renovating the existing structure to facilitate OMIC's mission of addressing known gaps in the Ohio technology development cycle; and

WHEREAS OMIC commits to making the facilities available for the university's use; and

WHEREAS the terms and conditions for this university use shall be more favorable than the terms and conditions of use by any other entity to a degree that reasonably reflects the magnitude of the university's investment in the OMIC facilities for the term of the agreement; and
WHEREAS except for the funds used to cover the university's reasonable administrative costs related to the project, the funds provided under this JUA shall be used by OMIC only for capital improvements or purchases and shall not be used for operating expenses; and

WHEREAS the university's use of OMIC space will further the University's mission to conduct groundbreaking research, provide unique active learning environments to students, and promote technological development and commercialization; and

WHEREAS before the state capital appropriation may be released to OMIC, the Ohio Department of Higher Education requires that a JUA between the university and the OMIC be signed to document the value of the appropriation to Ohio State and to ensure the benefits to the university will continue for a minimum period of 20 years:

NOW THEREFORE

BE IT RESOLVED, That the Board of Trustees hereby approves that the President and/or Senior Vice President for Business and Finance and/or Administration and Planning be authorized to take any action required to effect this Joint Use Agreement containing terms and conditions deemed to be in the best interest of the university.

(See Appendix XX for background information, page 742)

***

**APPROVAL TO ENTER INTO A JOINT USE AGREEMENT**

Resolution No. 2024-27

BETWEEN THE OHIO STATE UNIVERSITY
AND THE CITY OF UPPER ARLINGTON

Synopsis: Authorization to enter into a Joint Use Agreement (JUA) with the City of Upper Arlington, an Ohio municipal corporation, to document the value and permit the release of funds appropriated in the State Capital Bill to construct a new facility; and

WHEREAS The Ohio State University was allocated $450,000 in the 2023-2024 State Capital Bill that was specifically designated for use by the City of Upper Arlington; and

WHEREAS the City of Upper Arlington will utilize the funds to partially fund design and construction of the Upper Arlington Community Center to improve health and wellness opportunities in Central Ohio; and

WHEREAS the City of Upper Arlington commits to making the facilities available for the university's use; and

WHEREAS the terms and conditions for this university use shall be more favorable than the terms and conditions of use by any other entity to a degree that reasonably reflects the magnitude of the university's investment in the facilities for the term of the agreement; and

WHEREAS except for the funds used to cover the university's reasonable administrative costs related to the project, the funds provided under this JUA shall be used by the City of Upper Arlington only for capital improvements or purchases and shall not be used for operating expenses; and

WHEREAS the university's use of the Community Center will promote the University's mission to improve health, wellness, and opportunity in Ohio through accessibility, innovation, and clinical excellence through our statewide network of facilities, personnel, and partnerships; and

WHEREAS before the state capital appropriation may be released to the City of Upper Arlington, the Ohio Department of Higher Education requires that a JUA between the university and the City of Upper Arlington be signed to document the value of the appropriation to the university and to ensure the benefits to the university will continue for a minimum period of 20 years:

NOW THEREFORE

BE IT RESOLVED, That the Board of Trustees hereby approves that the President and/or Senior Vice President for Business and Finance and/or Administration and Planning be authorized to take any action required to effect this Joint Use Agreement containing terms and conditions deemed to be in the best interest of the university.

(See Appendix XXI for background information, page 743)

***

**APPROVAL OF FISCAL YEAR 2024 OPERATING BUDGET**

Resolution No. 2024-28

Synopsis: Approval of the Operating Budget for the Fiscal Year ending June 30, 2024, is proposed.

WHEREAS The State of Ohio Biennial Budget for State Fiscal Years 2024 and 2025, including funding levels for State institutions of higher education, has been signed into law; and

WHEREAS Tuition and mandatory fee levels for the Columbus and Regional Campuses for the Academic Year 2023-2024, were approved at the July 14, 2023, Board of Trustees meeting; and

WHEREAS The Administration now recommends approval of the Fiscal Year 2024 Operating Budget for the University for the Fiscal Year ending June 30, 2024.

NOW THEREFORE

BE IT RESOLVED, That the University's Operating Budget for the Fiscal Year ending June 30, 2024, as described in the accompanying Fiscal Year 2024 Operating Budget Book for the Fiscal Year ending June 30, 2024, be approved, with authorization for the President, or Board appointed designee, to make expenditures within the projected income.

(See Appendix XXII for background information, page 744)

***

**APPOINTMENT TO THE SELF-INSURANCE BOARD**

Resolution No. 2024-29

Synopsis: Appointment of a member to the Self-Insurance Board is proposed.

WHEREAS the Board of Trustees directed that a Self-Insurance Board be established to oversee the University Self-Insurance Program; and

WHEREAS all members of the Self-Insurance Board are appointed by The Ohio State University Board of Trustees upon recommendation of the President; and

WHEREAS in the absence of a president, the recommendation is from the senior vice president and general counsel; and

WHEREAS the term of member James Gilmour expired on June 30, 2023:

NOW THEREFORE

BE IT RESOLVED, That the Board of Trustees hereby approve that the following individual be appointed as a member of the Self-Insurance Board effective September 1, 2023 for the term specified below:

D. Brent Mulgrew, term ending June 30, 2025

BE IT FURTHER RESOLVED, That this appointment entitles each member to any immunity, insurance or indemnity protection to which officers and employees of the University are, or hereafter may become, entitled.

***

**UNIVERSITY FOUNDATION REPORT**

Resolution No. 2024-30

Synopsis: Approval of the University Foundation Report as of June 30, 2023, is proposed.

WHEREAS monies are solicited and received on behalf of the university from alumni, industry, and various individuals in support of research, instructional activities, and service; and

WHEREAS such gifts are received through The Ohio State University Foundation; and

WHEREAS this report includes: (i) the establishment of two (2) endowed professorships: the John & Christine Olsen Professorship in Head and Neck Radiation Oncology, the John & Christine Olsen Professorship in Head and Neck Surgical Oncology; one (1) designated chair, the Edgar C. Hendrickson Designated Chair Fund; two (2) scholarships as part of the Scarlet and Gray Advantage Endowed Matching Gift Program; and twenty-two (22) additional named endowed funds; (ii) the revision of three (3) named endowed funds:

NOW THEREFORE

BE IT RESOLVED, that the Board of Trustees hereby approves The Ohio State University Foundation Report as of June 30, 2023.

(See Appendix XXIII for background information, page 797)

***

**NAMING OF THE DR. IRA S. NIEDWESKE (DVM, MS '77) ORGANIC CHEMISTRY LAB**

Resolution No. 2024-31

IN CELESTE LABORATORY

Synopsis: Approval for the naming of the organic chemistry lab (Room 410) in Celeste Laboratory, located at 120 West 18th Avenue, is proposed.

WHEREAS The renovation of Celeste Laboratory, a facility that provides instructional and research space for approximately 10,000 students per semester—more than 15 percent of the Columbus campus population—will have a significant impact on all students in STEM fields; and

WHEREAS updated spaces in Celeste Laboratory will empower undergraduates to collaborate with faculty and graduate students on innovative research and provide hands-on experience to complement classroom instructions, creating more well-rounded students who will go on to be leaders in science, health and medicine and engineering; and

WHEREAS Dr. Ira S. Niedweske and Jill Crawford Niedweske have provided significant contributions to Celeste Laboratory and the Department of Chemistry and Biochemistry; and

WHEREAS the naming has been reviewed according to the approval process outlined in the Naming of University Spaces and Entities policy:

NOW THEREFORE

BE IT RESOLVED, That in acknowledgement of Dr. Ira S. Niedweske and Jill Crawford Niedweske's philanthropic support, the Board of Trustees hereby approves, in accordance with paragraph (D) of rule 3335-1-08 of the Ohio Administrative Code, that for the life of the physical facility the aforementioned space be named the Dr. Ira S. Niedweske (DVM, MS '77) Organic Chemistry Lab.

***

**NAMING OF INTERNAL SPACES**

Resolution No. 2024-32

IN CONARD HALL AT THE OHIO STATE UNIVERSITY AT MANSFIELD

Synopsis: Approval for the naming of internal spaces in Conard Hall, located at 1760 University Drive in Mansfield, is proposed.

WHEREAS Ohio State Mansfield helps to serve the university's land grant mission by providing access to affordable education in all areas of Ohio; and

WHEREAS the recent renovations to Conard Hall have served to meet the needs of BSET students, increasing learning opportunities and providing adaptive and multi-functional spaces to benefit BSET students; and

WHEREAS the donors listed below have provided significant contributions toward the BSET program; and

- Richland County Foundation
- Charter Next Generation Films

WHEREAS the naming has been reviewed according to the approval process outlined in the Naming of University Spaces and Entities policy:

NOW THEREFORE

BE IT RESOLVED, That in acknowledgement of the aforementioned donors' philanthropic support, the Board of Trustees hereby approves, in accordance with paragraph (D) of rule 3335-1-08 of the Ohio Administrative Code, that for the life of the physical facility the aforementioned spaces be named the following:

- The Richland County Foundation Smart Manufacturing Lab (room 232)
- The Charter Next Generation Films PLC Lab (room 233)

***

**NAMING OF THE BOYCE FAMILY LACROSSE SHOOTING ROOM**

Resolution No. 2024-33

AT THE LACROSSE STADIUM

Synopsis: Approval for the naming of the shooting room at the Lacrosse Stadium, located at 630 Irving Schottenstein Drive, Columbus, OH 43210, is proposed.

WHEREAS The new state-of-the-art, 2,500-seat lacrosse stadium will be the new practice and competition space for the men's and women's varsity lacrosse teams; and

WHEREAS the lacrosse stadium will serve the community and grow the sport of lacrosse through camps and clinics hosted within the space; and

WHEREAS the shooting room will serve as an athletic classroom for lacrosse student-athletes to hone their skills; and

WHEREAS Melissa and Collis Boyce as well as Natalie and Sandford Boyce have provided significant contributions to the men's lacrosse program and the construction of the new lacrosse stadium; and

WHEREAS the naming has been reviewed according to the approval process outlined in the Naming of University Spaces and Entities policy:

NOW THEREFORE

BE IT RESOLVED, That in acknowledgement of Melissa and Collis Boyce's, and Natalie and Sandford Boyce's philanthropic support, the Board of Trustees hereby approves, in accordance with paragraph (D) of rule 3335-1-08 of the Ohio Administrative Code, that for the life of the physical facility the aforementioned space be named the Boyce Family Lacrosse Shooting Room.

***

**ADOPTION OF OHIO STATE PHILOSOPHY ON INSTUTIONAL AND LEADERSHIP STATEMENTS IN SUPPORT OF THE CHICAGO PRINCIPLES**

Resolution No. 2024-34

Synopsis: Adoption of The Ohio State University's philosophy on institutional and leadership statements, which is consistent with the University of Chicago's 2014 Report of the Committee on Freedom of Expression ("Chicago Principles"), which was created in confirmation of the University of Chicago's 1967 Kalven Committee Report on the University's Role in Political and Social Action ("Kalven Report").

Universities have a vital role to play in contributing to the local, state, and national discourse. Ohio State and other institutions of higher education advance society by supporting the free expression of ideas and providing academic community members the freedom to share their research and study through discussion, debate, and publication of ideas without censorship or limitation.

Ohio State takes seriously its role in promoting and supporting public discourse and is steadfastly committed to protecting the First Amendment right to free speech and expression. Since the university's founding, its land-grant mission has been to create pathways to accessible education, promote the exchange of ideas, and encourage debate and civil discourse.

The Board of Trustees believes that the Chicago Principles provide an important framework for carrying out this mission. While diverse groups of individuals will naturally and inevitably disagree with each other over issues of consequence, the Chicago Principles recognize that the fact of such disagreement alone is not cause for a university to limit ideas or restrict speech. Further, though the university can reasonably regulate the time, place, and manner of speech to protect its operations, and may address speech that, for example, violates the law or constitutes harassment or threatening behavior, these are rare exceptions to the general rule of supporting free expression broadly.

While universities have an independent right, and in some cases a responsibility, to speak on their own behalf, the Board of Trustees recognizes that institutional speech carries a corresponding responsibility to be judicious and transparently principled in deciding if, when, and how to engage in such speech so as not to harm the core values of free expression and intellectual diversity.

The Board of Trustees therefore wishes to reconfirm the university's foundational commitment to free speech, register support for the vision set forth in the Kalven Report and the Chicago Principles, and adopt Ohio State's philosophy on institutional and leadership statements, which sets forth the principles to which the institution holds itself in determining when to engage in speech.

WHEREAS the Board of Trustees recognizes that as the state's flagship public, land-grant university Ohio State's mission is to create and support an intellectually diverse community empowered to engage in free and open debate, expression, and research in the pursuit of knowledge and the betterment of society; and

WHEREAS, because of its sustained commitment to supporting this educational community, and because of the exemplary academic work of the students, faculty and staff who make up this community, Ohio State has a reputation for excellence

both nationally and internationally, which gives the university's voice significant weight across the world; and

WHEREAS the Board of Trustees affirms that institutional speech may properly be made to defend and uphold the university's mission and values, but that such speech must be limited to issues of foundational importance to the university to protect its commitment to intellectual diversity; and

WHEREAS the Board of Trustees recognizes that the university has established a thoughtful and consistent set of principles for evaluating if, when, and how statements will benefit the university and

the state of Ohio without causing unintended consequences to the academic community that drives its success, or its commitment to intellectual diversity and free speech; and

WHEREAS, the Board of Trustees agrees that Ohio State should only issue public statements in situations that directly impact the university and its operations; that impact its students, faculty or staff in such a way that the university must respond to provide support, resources or articulate what the institution is doing to resolve a situation; or that are of importance to the city, region or state and the university can play a vital role in sharing information with the public; and

WHEREAS, regardless of whether the university engages in speech on a particular issue, the Board of Trustees believes the university's role appropriately includes taking action to support impacted members of its community, and encourages impactful, targeted outreach by appropriate representatives of the university in such situations; and

WHEREAS the Board of Trustees has already adopted a university free speech policy affirming the principles of campus free speech and in alignment with the university's Shared Values:

NOW THEREFORE

BE IT RESOLVED, that the Board of Trustees hereby acknowledges support for the Chicago Principles, and adopts the attached university philosophy on institutional and leadership statements.

(See Appendix XXIV for background information, page 805)

***

Dr. Fujita:

> We will now hold two roll-call votes. First, we will vote on item No. 7 — "Approval of Fiscal Year 2024 Capital Investment Plan" and No. 12 — "Approval of Operating Budget for Fiscal Year 2024." Mr. Kaplan has been advised to abstain. I will make a MOTION to approve these items.

Upon motion of Dr. Fujita, seconded by Mr. Von Thaer, the Board of Trustees adopted the foregoing resolutions by majority roll-call vote, cast by the following trustees: Dr. Fujita, Mr. Stockmeister, Mr. Zeiger, Ms. Kessler, Mr. Von Thaer, Mrs.

Harsh, Dr. Wilkinson, Mr. Mitevski, Mr. Bigby, Mr. Perez, Mr. Kastan, Mr. Skestos, Ms. Schwein and Mr. Kerner. Mr. Kaplan abstained.

Ms. Eveland:

Motion carries.

Dr. Fujita:

Thank you. Now we will vote on the remainder of the items listed on the consent agenda. I will make a motion to approve these items.

Upon motion of Dr. Fujita, seconded by Mr. Mitevski, the Board of Trustees adopted the foregoing resolutions by a unanimous roll-call vote, cast by the following trustees: Dr. Fujita, Mr. Stockmeister, Mr. Zeiger, Ms. Kessler, Mr. Von Thaer, Mr. Kaplan, Mrs. Harsh, Dr. Wilkinson, Mr. Mitevski, Mr. Bigby, Mr. Perez, Mr. Kastan, Mr. Skestos, Ms. Schwein and Mr. Kerner.

Ms. Eveland:

Motion carries.

Dr. Fujita:

Thank you — we appreciate everyone's participation in our meetings this week. If there is no further business, this meeting is adjourned.

The meeting adjourned at 3:51 p.m.

Attest:

Hiroyuki Fujita
Chairman

Jessica A. Eveland
Secretary

THE OHIO STATE UNIVERSITY

Board of Trustees

University Square South
15 East 15th Avenue, 5th Floor
Columbus, OH 43201

Phone (614) 292-6359
Fax (614) 292-5903
trustees.osu.edu

**SUMMARY OF ACTIONS TAKEN**

*August 15, 2023 - Wexner Medical Center Board Meeting*

**Members Present:**

| | | |
|---|---|---|
| Leslie H. Wexner | Juan Jose Perez | Hiroyuki Fujita (ex officio) |
| Alan A. Stockmeister | Taylor A. Schwein | Melissa L. Gilliam (ex officio) |
| John W. Zeiger | Stephen D. Steinour (left 3:33 pm) | Michael Papadakis (ex officio) |
| Gary R. Heminger | Robert H. Schottenstein | John J. Warner (ex officio) |
| Tomislav B. Mitevski | Cindy Hilsheimer | |

**Members Present via Zoom:**

Amy Chronis

**Members Absent:**

W.G. "Jerry" Jurgensen

**PUBLIC SESSION**

The Wexner Medical Center Board convened for its 47th meeting on Tuesday, August 15, 2023, at Vitria on the Square, 14 E. 15th Avenue, Columbus, OH, 43201, and virtually over Zoom. Board Secretary Jessica A. Eveland called the meeting to order at 12:59 p.m.

***Item for Action***

1. Approval of Minutes: No changes were requested to the May 16, 2023, meeting minutes; therefore, a formal vote was not required, and the minutes were considered approved.

***Items for Discussion***

2. Chief Executive Officer's Report: Dr. John J. Warner, EVP at Ohio State and CEO of the Wexner Medical Center, began with the 2023-24 U.S. News and World Report Best Hospital rankings. The Best Hospital report is created by analyzing data from more than 4,500 eligible hospitals; only the top 50 hospitals in the country are selected for ranking based on outcomes, structure, patient experience, and expert opinion. The Ohio State University Wexner Medical Center made the rankings for the 31st consecutive year, once again, leading as the top hospital in Columbus, and No. 2 in the state of Ohio.

   In addition, the Ohio State Wexner Medical Center was nationally recognized in the 10 following specialties:

   - Cancer (No. 33)
   - Cardiology and Heart Surgery (No. 36)
   - Diabetes and Endocrinology (No. 20)
   - Ear, Nose and Throat (No. 35)
   - Gastroenterology and GI Surgery (No. 45)
   - Neurology and Neurosurgery (No. 44)
   - Obstetrics and Gynecology (No. 37)

- Pulmonology and Lung Surgery (No. 37)
- Rehabilitation (No. 27)
- Urology (No. 24)

Other rankings for the Ohio State Wexner Medical Center include recognition as "high performing" in Geriatrics and Orthopedics – which places these specialties in the top 10% of all rated hospitals; also rated as "high performing" in 15 common procedures and conditions – such as knee replacement, stroke, heart attack care and lung cancer surgery.

The ultimate goal is not just to advance in the rankings. The top priority is – and always will be – putting patients first in everything we do and providing the very best care for everyone, every single time.

Dr. Warner also shared that several residency programs at The Ohio State University College of Medicine and Ohio State Wexner Medical Center were recently recognized by Doximity's annual Residency Navigator as being among the top competitive accredited programs in the nation by physician reputation. Tools like Doximity Residency Navigator offer insight into training programs and help new physicians decide where to continue their post-graduate learning.

Four Ohio State residency programs earned top 10 recognition this year: Otolaryngology residency program, combined Internal Medicine and Pediatrics residency program in partnership with Nationwide Children's Hospital, General Surgery residency program, and Child Neurology residency program.

Earning recognition by these tools speaks to the caliber of learning that resident candidates can expect when choosing to continue their training as a Buckeye. Most impressively, our Graduate Medical Education program drew the highest percentage of students ever from U.S. News & World Report top 30 medical research schools.

3. James Cancer Hospital Report: Dr. David Cohn, interim chief executive officer and chief medical officer of The James Cancer Hospital, gave an overview of Pelotonia's 15th ride weekend and recounted the event of 11,000 participants and more than 6,500 riders. He shared the research impact of fundraising and highlighted the following research studies at Ohio State funded by Pelotonia:

    - Breast cancer team studying novel immunotherapy options in combination with standard chemotherapy to improve outcomes for our patients,
    - Lymphoma team funded to conduct a first-in-humans study investigating expansion of T cells, another immune population that is a novel approach to harvest the body's own immune system to fight against cancer,
    - Head and neck team and the brain cancer team are both working on molecular gas pedals. Things that accelerate the cancer response and strategies to boost the anti-cancer treatments currently existing,
    - Lung cancer team is investigating some adjuncts to talk therapy to address a pressing need in behavioral health. We know the rates of depression, anxiety and suicidality in their patient population is much higher than it ever needs to be.

    Dr. Cohn promoted Gravel Day on September 30. It is a road-bike cycling event on unpaved roads and gravel roads, where you see more than 100% more livestock and crops than cars and people with 100% of the funds raised benefiting research funds at The James.

    Additionally, Dr. Cohn discussed the James Outpatient Center's community day and tours, as well as the official opening which occurred on July 17. He detailed some of the efficiencies and services provided at The James Outpatient Care center, including how it allows for significant cancer care in expansion of services — treatment of chronic blood and genitourinary cancers, care for aging

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cancer patients, expanded infusion diagnostic, interventional radiology, and clinical trial services. In the fall it will open the first and only proton therapy center in central Ohio.

Dr. Cohn concluded with many accomplishments of The James Cancer Hospital and its employees:

- The James continues to be ranked among the top cancer hospital in the U.S.;
- New growth of cancer program with new leadership — Regina Crawford, director, Sickle Cell Program; Rosa Lapalombella, co-leader, Leukemia Research Program; Susan Tsai, director, Division of Surgical Oncology; Diane Von Ah, OSUCCC co-leader, Cancer Control Program;
- The James nursing accomplishment of Magnet Status for the third consecutive cycle with nine exemplars;
- BMT program earned third Beacon Award for Excellence.

(See Attachment I for background information, page 190)

4. Wexner Medical Center Financial Report:

   Mr. Vincent Tammaro, chief financial officer of the Wexner Medical Center, provided a high-level report out of the medical center's year-end financial performance for FY23.

   (See Attachment II for background information, page 201)

***Items for Action***

5. Resolution No. 2024-05: Recommend for Approval Amendments to the Bylaws for the The Ohio State University Wexner Medical Center Board:

   Synopsis: Recommended approval of the attached amendments to the *Bylaws of The Ohio State University Wexner Medical Center Board* is proposed.

   WHEREAS pursuant to 3335-1-09 (C) of the Administrative Code, the rules and regulations for the university may be adopted, amended or repealed by a majority vote of the University Board of Trustees at any regular meeting of the board; and

   WHEREAS a periodic review of the board's bylaws is a governance best practice; and WHEREAS the last revisions to the *Bylaws of The Ohio State University Wexner Medical Center Board* took place in November 2022; and

   NOW THEREFORE

   BE IT RESOLVED, That the Quality and Professional Affairs Committee hereby recommends to the Wexner Medical Center Board and the University Board of Trustees the attached amendments to the *Bylaws of The Ohio State University Wexner Medical Center Board.*

   (See Attachment III for background information, page 207)

6. Resolution No. 2024-06: Ratification of Committee Appointments for FY2023-24:

   BE IT RESOLVED, That the Wexner Medical Center Board hereby approves that the ratification of appointments to the Quality and Professional Affairs Committee for FY2024-25 are as follows:

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**Quality and Professional Affairs Committee**

Alan A. Stockmeister, Chair
Juan Jose Perez
**TAYLOR A. SCHWEIN**
Melissa L. Gilliam
Michael Papadakis
John J. Warner
**ERIC ADKINS**
**DOREEN AGNESE**
Jay M. Anderson
Carol R. Bradford
Stacy A. Brethauer
David E. Cohn
Scott A. Holliday
Elizabeth Seely
**DEANA SIEVERT**
Corrin Steinhauer
Andrew M. Thomas

7. Resolution No. 2024-07: Approval of the OSU Wexner Medical Center FY24 Clinical Quality Management, Patient Safety and Patient Experience Plan:

OHIO STATE UNIVERSITY HOSPITALS d/b/a OSU WEXNER MEDICAL CENTER

Synopsis: Approval of the annual review of The Ohio State University Wexner Medical Center Clinical Quality Management, Patient Safety, and Patient Experience Plan for FY24 for the hospitals at the Ohio State University Hospitals d/b/a OSU Wexner Medical Center, including Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital, is proposed.

WHEREAS the mission of the Ohio State University Hospitals is to improve people's lives through the provision of high-quality patient care; and

WHEREAS The Ohio State University Wexner Medical Center Clinical Quality Management, Patient Safety, and Patient Experience Plan for FY24 outlines assessment and improvement of processes in order to deliver safe, effective, optimal patient care and services in an environment of minimal risk for inpatients and outpatients of the University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital; and

WHEREAS the annual review of The Ohio State University Wexner Medical Center Clinical Quality Management, Patient Safety, and Patient Experience Plan for FY24 was approved by the University Hospitals Medical Staff Administrative Committee on July 12, 2023; and

WHEREAS on July 25, 2023, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the Clinical Quality Management, Patient Safety, and Patient Experience Plan for FY24:

NOW THEREFORE

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BE IT RESOLVED, That the Wexner Medical Center Board hereby approves Clinical Quality Management, Patient Safety, and Patient Experience Plan for FY24 for the Ohio State University Hospitals, including Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital.

(See Attachment IV for background information, page 208)

8. Resolution No. 2024-08: Approval of the James Cancer Hospital FY24 Clinical Quality, Patient Safety, and Experience Council Plan:

THE OHIO STATE UNIVERSITY COMPREHENSIVE CANCER CENTER
ARTHUR G. JAMES CANCER HOSPITAL AND RICHARD J. SOLOVE RESEARCH INSTITUTE

Synopsis: Approval of the annual review of The James Quality, Safety, and Experience Council Plan for FY24 for the Ohio State Comprehensive Cancer Center — James Cancer Hospital and Solove Research Institute, is proposed.

WHEREAS the mission of The James is to eradicate cancer from individuals' lives by generating knowledge and integrating groundbreaking research with excellence in education and patient-centered care; and

WHEREAS The James Quality, Safety, and Experience Council Plan for FY24 outlines assessment and improvement of processes in order to deliver safe, effective, optimal patient care and services in an environment of minimal risk for inpatients and outpatients of The James; and

WHEREAS the annual review of The James Quality, Safety, and Experience Council Plan for FY24 was approved by James Quality, Safety and Experience Council on July 20, 2023; and

WHEREAS the annual review of The James Quality, Safety, and Experience Council Plan for FY24 was approved by The James Medical Staff Administration Committee on July 21, 2023; and

WHEREAS on July 25, 2023, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve The James Quality, Safety, and Experience Council Plan for FY24:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves The James Quality, Safety, and Experience Council Plan for FY24 for The James.

(See Attachment V for background information, page 235)

9. Resolution No. 2024-09: Approval of Amendments to the Bylaws of the Medical Staff of the Ohio State University Hospitals:

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

WHEREAS a summary of the proposed amendments to the Bylaws of the Medical Staff of The Ohio State University Hospitals is attached; and

WHEREAS the proposed amendments are also attached; and

WHEREAS the proposed amendments to the Bylaws of the Medical Staff of The Ohio State University Hospitals were approved by a joint University Hospitals and James Medical Staff

THE OHIO STATE UNIVERSITY

Bylaws Committee on May 31, 2023; and

WHEREAS the proposed amendments to the Bylaws of the Medical Staff of The Ohio State University Hospitals were approved by the University Hospitals Medical Staff Administrative Committee on July 12, 2023; and

WHEREAS on July 25, 2023, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the Amendments to the Bylaws of the Medical Staff of The Ohio State University Hospitals plan for patient care services:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the Amendments to the Bylaws of the Medical Staff for the Ohio State University Hospitals, including Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital.

(See Attachment VI for background information, page 255)

10. Resolution No. 2024-10: Approval of Amendments to the Bylaws of the Medical Staff of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute:

THE OHIO STATE UNIVERSITY COMPREHENSIVE CANCER CENTER
ARTHUR G. JAMES CANCER HOSPITAL AND RICHARD J.
SOLOVE RESEARCH INSTITUTE

Synopsis: The amendments to the Bylaws of the Medical Staff of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute are recommended for approval.

WHEREAS a summary of the proposed amendments to the Bylaws of the Medical Staff of the James Cancer Hospital is attached; and

WHEREAS the proposed amendments are also attached; and

WHEREAS the proposed amendments to the Bylaws of the Medical Staff of the James Cancer Hospital were approved by a joint University Hospitals and James Medical Staff Bylaws Committee on May 31, 2023; and

WHEREAS the proposed amendments to the Bylaws of the Medical Staff of the James Cancer Hospital were approved by the James Cancer Hospital Medical Staff Administrative Committee on July 21, 2023; and

WHEREAS on July 25, 2023, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the amendments to the Bylaws of the Medical Staff of the James Cancer Hospital:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the amendments to the Bylaws of the Medical Staff of the James Cancer Hospital for The James.

(See Attachment VII for background information, page 322)

11. Resolution No. 2024-11: Approval of Amendments to the Medical Staff Rules and Regulations of The Ohio State University Hospitals:

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OHIO STATE UNIVERSITY HOSPITALS d/b/a OSU WEXNER MEDICAL CENTER

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

WHEREAS a summary of the proposed amendments to the Rules and Regulations of the Medical Staff of The Ohio State University Hospitals is attached; and

WHEREAS the proposed amendments are also attached; and

WHEREAS the proposed amendments to the Rules and Regulations of the Medical Staff of The Ohio State University Hospitals were approved by a joint University Hospitals and James Medical Staff Bylaws Committee on May 31, 2023; and

WHEREAS the proposed amendments to the Rules and Regulations of the Medical Staff of The Ohio State University Hospitals were approved by the University Hospitals Medical Staff Administrative Committee on July 12, 2023; and

WHEREAS on July 25, 2023, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the amendments to the Rules and Regulations of the Medical Staff of The Ohio State University Hospitals:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the amendments to the Rules and Regulations of the Medical Staff for the Ohio State University Hospitals, including Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital.

(See Attachment VIII for background information, page 381)

12. Resolution No. 2024-12: Approval of Amendments to the Medical Staff Rules and Regulations of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute:

THE OHIO STATE UNIVERSITY COMPREHENSIVE CANCER CENTER
ARTHUR G. JAMES CANCER HOSPITAL AND
RICHARD J. SOLOVE RESEARCH INSTITUTE

Synopsis: The amendments to the 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 a summary of the proposed amendments to the Rules and Regulations of the Medical Staff of the James Cancer Hospital is attached; and

WHEREAS the proposed amendments are also attached; and

WHEREAS the proposed amendments to the Rules and Regulations of the Medical Staff of the James Cancer Hospital were approved by a joint University Hospitals and James Medical Staff Bylaws Committee on May 31, 2023; and

WHEREAS the proposed amendments to the Rules and Regulations of the Medical Staff of the James Cancer Hospital were approved by the James Cancer Hospital Medical Staff Administrative Committee on July 21, 2023; and

THE OHIO STATE UNIVERSITY

WHEREAS on July 25, 2023, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the amendments to the Rules and Regulations of the Medical Staff of the James Cancer Hospital:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the amendments to the Rules and Regulations of the Medical Staff for The James.

(See Attachment IX for background information, page 384)

13. Resolution No. 2024-13: Approval of the OSU Wexner Medical Center Plan for Patient Care Services:

OHIO STATE UNIVERSITY HOSPITALS d/b/a OSU WEXNER MEDICAL CENTER

Synopsis: Approval of the annual review of the plan for patient care services for the hospitals at the Ohio State University Hospitals d/b/a OSU Wexner Medical Center, including: Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and The Ohio State University Wexner Medical Center East Hospital, is proposed.

WHEREAS the mission of the Ohio State University Hospitals is to improve people's lives through the provision of high-quality patient care; and

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

WHEREAS the annual review of the plan for patient care services was approved by the University Hospitals Medical Staff Administration Committee on May 10, 2023; and

WHEREAS on June 27, 2023, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the plan for patient care services:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the plan for patient care services for the Ohio State University Hospitals, including Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital.

(See Attachment X for background information, page 404)

14. Resolution No. 2024-14: Approval of the James Cancer Hospital Plan for Patient Care Services:

THE OHIO STATE UNIVERSITY COMPREHENSIVE CANCER CENTER
ARTHUR G. JAMES CANCER HOSPITAL AND RICHARD J. SOLOVE RESEARCH INSTITUTE

Synopsis: Approval of the annual review of the plan for patient care services for the Ohio State Comprehensive Cancer Center — James Cancer Hospital and Solove Research Institute, is proposed.

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WHEREAS the mission of The James is to eradicate cancer from individuals' lives by generating knowledge and integrating groundbreaking research with excellence in education and patient-centered care; and

WHEREAS The James plan for patient care services describes the integration of clinical departments and personnel who provide care and services to patients at The James; and

WHEREAS the annual review of the plan for patient care services was approved by The James Medical Staff Administrative Committee on April 21, 2023:

WHEREAS on June 27, 2023, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the plan for patient care services:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the plan for patient care services for The James.

(See Attachment XI for background information, page 417)

15. Resolution No. 2024-15: Approval of the OSU Wexner Medical Center Direct Patient Care Services Contracts and Patient Impact Services Contracts Evaluation:

OHIO STATE UNIVERSITY HOSPITALS d/b/a OSU WEXNER MEDICAL CENTER

Synopsis: Approval of the annual review of the direct patient care service contracts and patient impact service contracts for the hospitals at the Ohio State University Hospitals d/b/a OSU Wexner Medical Center, including: Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital, is proposed.

WHEREAS the mission of the Ohio State University Hospitals is to improve people's lives through the provision of high-quality patient care; and

WHEREAS the Ohio State University Hospitals direct patient care services contracts and patient impact service contracts are evaluated annually to review the scope, nature, and quality of services provided to clinical departments and personnel who provide care and services for inpatient and outpatient care at University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital; and

WHEREAS the annual review of these contracts was approved by the University Hospitals Medical Staff Administrative Committee on May 10, 2023; and

WHEREAS on June 27, 2023 the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the annual review of the direct patient care service contracts and patient impact service contracts for University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the annual review of the direct patient care service contracts and patient impact service contracts for University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital as outlined in the attached University Hospitals Contracted Services Annual Evaluation Report.

(See Attachment XII for background information, page 433)

THE OHIO STATE UNIVERSITY

16. Resolution No. 2024-16: Approval of the James Cancer Hospital Direct Patient Care Services Contracts and Patient Impact Service Contracts Evaluation:

THE OHIO STATE UNIVERSITY COMPREHENSIVE CANCER CENTER ARTHUR G. JAMES CANCER HOSPITAL AND RICHARD J. SOLOVE RESEARCH INSTITUTE

Synopsis: Approval of the annual review of the direct patient care services contracts and patient impact service contracts for the Ohio State Comprehensive Cancer Center — James Cancer Hospital and Solove Research Institute, is proposed.

WHEREAS the mission of The James is to eradicate cancer from individuals' lives by generating knowledge and integrating groundbreaking research with excellence in education and patient-centered care; and

WHEREAS The James direct patient care services contracts and patient impact service contracts are evaluated annually to review the scope, nature, and quality of services provided to clinical departments and personnel who provide care and services for inpatient and outpatient care at The James; and

WHEREAS the annual review of these contracts was approved by the The James Medical Staff Administrative Committee on May 19, 2023; and

WHEREAS on June 27, 2023 the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the annual review of the direct patient care service contracts and patient impact service contracts for The James:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the annual review of the direct patient care service contracts and patient impact service contracts for The James as outlined in the attached The James Contracted Services Annual Evaluation Report.

(See Attachment XIII for background information, page 441)

**Action:** Upon the motion of Mr. Stockmeister, seconded by Mr. Heminger, the Wexner Medical Center Board recommended agenda item No. 5 – Recommend for Approval Amendments to the Bylaws for The Ohio State University Wexner Medical Center Board for final approval by majority roll call vote with the following members present and voting: Mr. Wexner, Mr. Stockmeister, Mr. Zeiger, Mr. Heminger, Mr. Mitevski, Mr. Perez, Ms. Schwein, Mr. Steinour, Mr. Schottenstein, Ms. Hilsheimer, Ms. Chronis, Dr. Fujita, Dr. Gilliam, Mr. Papadakis and Dr. Warner.

**Action:** Upon the motion of Mr. Stockmeister seconded by Dr. Warner, the Wexner Medical Center Board approved agenda item No. 6 – Quality and Professional Affairs Committee Items by majority roll call vote with only the votes of the following members used for approval: Mr. Wexner, Mr. Stockmeister, Mr. Zeiger, Mr. Heminger, Mr. Mitevski, Mr. Perez, Ms. Schwein, Mr. Steinour, Mr. Schottenstein, Ms. Hilsheimer, Ms. Chronis, Dr. Fujita, Dr. Gilliam, Mr. Papadakis and Dr. Warner.

**EXECUTIVE SESSION**

It was moved by Mr. Heminger and seconded by Mr. Mitevski that the Wexner Medical Center Board recess into executive session to consider business-sensitive trade secrets and quality matters required to be kept confidential by federal and state statutes, to consult with legal counsel regarding pending or imminent

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litigation, and to discuss personnel matters involving the appointment, employment and compensation of public officials, which are required to be kept confidential under Ohio law.

A roll call vote was taken, and the board voted to go into executive session with the following members present and voting: Mr. Wexner, Mr. Stockmeister, Mr. Zeiger, Mr. Heminger, Mr. Mitevski, Mr. Perez, Ms. Schwein, Mr. Steinour, Mr. Schottenstein, Ms. Hilsheimer, Ms. Chronis, Dr. Fujita, Dr. Gilliam, Mr. Papadakis and Dr. Warner.

The Wexner Medical Center Board entered executive session at 1:30 p.m. and adjourned at 4:19 p.m.


# OSUCCC – James
# Wexner Medical Center Board Report

David Cohn, MD, MBA
Interim Chief Executive Officer
Chief Medical Officer
James Cancer Hospital and Solove Research Institute

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

# Pelotonia's 15th ride weekend a success!

- 11,000 participants
- More than 6,500 Riders
- Thanks to all for your support of this great event! We're just getting started!



The James
The Ohio State University
Comprehensive Cancer Center

SEPT. 30

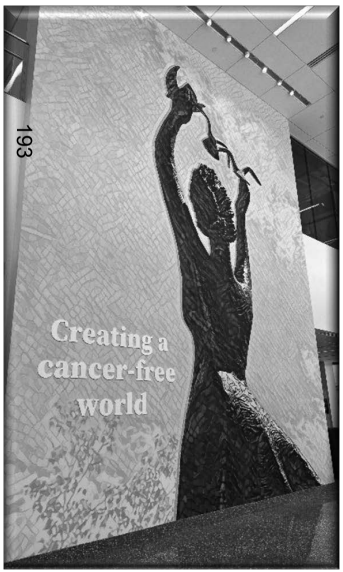
# GRAVEL DAY

**Join us for Pelotonia's NEW cycling event on unpaved roads!**

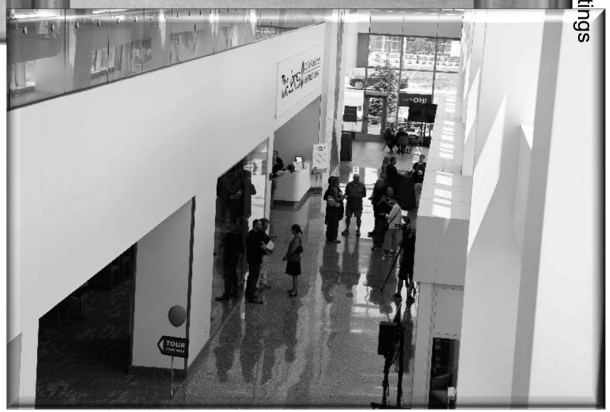
teambuckeye.osu.edu

# The James Outpatient Care Opening Events June 9-10

More than 450 people celebrated the opening of The James Outpatient Care.





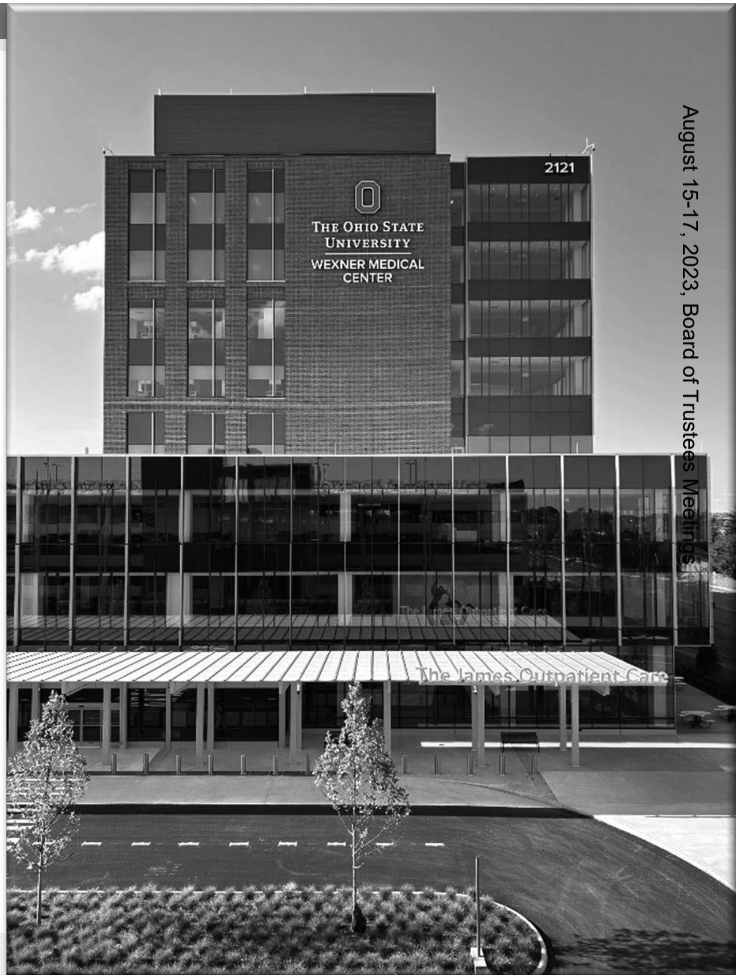
# The James Outpatient Care: Expanding to serve more cancer patients

- 384,000 square feet with new patient parking garage for easy access
- 1st Proton Therapy Center in central Ohio (opening this fall in collaboration with Nationwide Children's Hospital)
- 1st James outpatient surgery center
- Genitourinary and Hematology clinics
- Cancer and Aging Resiliency (CARE) Clinic for the unique needs of older adults with cancer
- Extensive imaging, diagnostic, surgical, radiation, clinical trial, infusion, survivorship and supportive services in a single location

# The James Outpatient Care opens to patients July 17

First week:

- 1,567 patients seen
- 113 new patient appointments
- 45 surgeries
- Continued focus on exceptional patient experience:
  - Extra staff on site to greet and direct patients and visitors
  - Small welcome gifts and treats given to patients (as well as staff)



# *U.S. News and World Report*

2023-24 Rankings released August 1st

- **Nationally Ranked for 25 years**
- #2 in the State of Ohio
- #1 in Columbus

# New Leaders in the Cancer Program

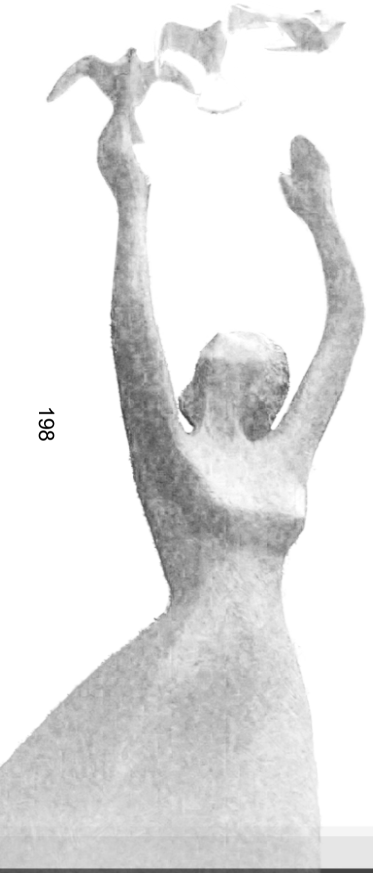


Regina Crawford, MD
Director, Sickle Cell Program

Rosa Lapalombella, PhD
OSUCCC Co-Leader,
Leukemia Research
Program

Susan Tsai, MD
Director, Division of Surgical
Oncology

Diane Von Ah, PhD, RN, FAAN
OSUCCC Co-Leader,
Cancer Control Program



# James Nursing Accomplishments

- Achieved Magnet® Status – with 9 exemplars
- BMT program earned its 3rd Beacon Award for Excellence
- 26 ongoing and two new IRB-approved nursing studies
- Hosted 2023 biennial James Cancer Care Conference

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

AACN BEACON AWARD FOR EXCELLENCE®

# New Options for Patients with CLL

Jennifer Woyach, MD,
Study First Author &
Co-leader of the OSUCCC
Leukemia Research Program

- Researchers continue to refine and improve targeted drug therapies that have changed the most common form of adult leukemia – from an incurable to a chronic condition.
- New data published in the *New England Journal of Medicine* offers another treatment option for patients who have stopped responding to the first- and second-generation drugs.
- This study was co-led by the OSUCCC – James.

The NEW ENGLAND JOURNAL of MEDICINE

The James
The Ohio State University
Comprehensive Cancer Center


The James
THE OHIO STATE UNIVERSITY
COMPREHENSIVE CANCER CENTER
cancer.osu.edu
The James Cancer Hospital and Solove Research Institute


# Wexner Medical Center Board
# Public Session
# Financial Report

August 15, 2023

# FY2023 Year in Review

# The Ohio State University Health System

*Consolidated Statement of Operations*
*For the YTD ended: June 30, 2023*
*(in thousands)*

| | Actual | Budget | Act-Bud Variance | Budget % Var | Prior Year | PY % Var |
|---|---|---|---|---|---|---|
| **OPERATING STATEMENT** | | | | | | |
| Total Operating Revenue | 3,973,827 | 3,941,728 | 32,099 | 0.8% | 3,642,443 | 9.1% |
| Operating Expenses | | | | | | |
| Salaries and Benefits | 1,704,019 | 1,645,928 | (58,091) | -3.5% | 1,483,686 | -14.9% |
| Resident/Purchased Physician Services | 196,010 | 189,337 | (6,673) | -3.5% | 162,789 | -20.4% |
| Supplies/Pharmaceuticals/Other | 1,503,145 | 1,458,202 | (44,943) | -3.1% | 1,383,633 | -8.6% |
| Depreciation | 211,560 | 223,573 | 12,013 | 5.4% | 186,704 | -13.3% |
| Interest | 44,443 | 44,443 | - | 0.0% | 42,275 | -5.1% |
| Total Expense | 3,659,177 | 3,561,483 | (97,694) | -2.7% | 3,259,087 | -12.3% |
| Gain (Loss) from Operations (pre MCI) | 314,650 | 380,245 | (65,595) | -17.3% | 383,356 | -17.9% |
| Medical Center Investments | (230,816) | (230,816) | - | 0.0% | (202,353) | -14.1% |
| Income from Investments | 42,241 | 31,466 | 10,775 | 34.2% | (726) | --- |
| Other Gains (Losses) | 27,541 | 26,427 | 1,114 | --- | 26,186 | --- |
| Excess of Revenue over Expense | $ 153,616 | $ 207,322 | $ (53,706) | -25.9% | $ 206,463 | -25.6% |
| Non-Budgeted One-Time Recognitions | $ 147,953 | $ - | $ 147,953 | 0.0% | $ 120,447 | --- |
| Margin with Non-Budgeted One-Time Recognitions | $ 301,569 | $ 207,322 | $ 94,247 | 45.5% | $ 326,910 | -7.8% |
| Margin Percentage | 7.6% | 5.3% | 2.3% | 44.3% | 9.0% | -1.4% |
| EBIDA | $ 557,572 | $ 475,338 | $ 82,234 | 17.3% | $ 555,889 | 0.3% |
| EBIDA Margin Percentage | 14.0% | 12.1% | 2.1% | 16.4% | 15.3% | -1.2% |





*Pre-Audit*

# The Ohio State University Wexner Medical Center

*Combined Statement of Operations*
*For the YTD ended: June 30, 2023*
*(in thousands)*

| | Actual | Budget | Act-Bud Variance | Budget % Var | Prior Year | PY % Var |
|---|---|---|---|---|---|---|
| **OPERATING STATEMENT** | | | | | | |
| Total Revenue | $ 5,377,845 | $ 5,295,881 | $ 81,964 | 1.5% | $ 4,719,380 | 14.0% |
| Operating Expenses | | | | | | |
| Salaries and Benefits | 2,990,436 | 2,910,018 | (80,418) | -2.8% | 2,461,801 | -21.5% |
| Resident/Purchased Physician Services | 196,010 | 189,337 | (6,673) | -3.5% | 162,789 | -20.4% |
| Supplies/Pharmaceuticals/Other | 1,763,083 | 1,691,166 | (71,917) | -4.3% | 1,627,043 | -8.4% |
| Depreciation | 230,179 | 241,415 | 11,236 | 4.7% | 192,362 | -19.7% |
| Interest | 44,649 | 44,708 | 60 | 0.1% | 45,614 | 2.1% |
| Total Expense | 5,224,357 | 5,076,645 | (147,712) | -2.9% | 4,489,610 | -16.4% |
| Gain (Loss) from Operations | $ 153,488 | $ 219,237 | $ (65,749) | -30.0% | $ 229,770 | -33.2% |
| Excess of Revenue over Expense | $ 153,488 | $ 219,237 | $ (65,749) | -30.0% | $ 229,770 | -33.2% |
| Non-Budgeted One-Time Recognitions | $ 147,953 | $ - | $ 147,953 | 0.0% | $ 120,447 | 0.0% |
| Margin with Non-Budgeted One-Time Recognitions | $ 301,441 | $ 219,237 | $ 82,204 | 37.5% | $ 350,217 | -13.9% |
| EBIDA | $ 576,269 | $ 505,360 | $ 70,908 | 14.0% | $ 588,194 | -2.0% |
| **Financial Metrics** | | | | | | |
| Integrated Margin Percentage | 5.6% | 4.1% | 1.5% | 35.4% | 7.4% | -1.8% |
| EBIDA Margin Percentage | 10.7% | 9.5% | 1.3% | 12.3% | 12.5% | -1.7% |

* 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.





*Pre-Audit*

# The Ohio State University Wexner Medical Center

*Combined Balance Sheet*
*As of June 30, 2023*
*(in thousands)*

| | June 2023 | June 2022 | FY23-FY22 Change |
|---|---|---|---|
| Cash | $ 1,392,047 | $ 1,626,628 | $ (234,581) |
| Net Patient Receivables | 603,817 | 556,491 | 47,326 |
| Other Current Assets | 332,343 | 281,496 | 50,846 |
| Assets Limited as to Use | 990,687 | 1,300,769 | (310,081) |
| Property, Plant & Equipment - Net | 3,295,841 | 2,794,254 | 501,586 |
| Other Assets | 685,320 | 664,415 | 20,905 |
| Total Assets | $ 7,300,054 | $ 7,224,053 | $ 76,001 |
| | | | |
| Current Liabilities | $ 622,904 | $ 766,723 | $ (143,819) |
| Other Liabilities | 321,464 | 326,765 | (5,301) |
| Long-Term Debt | 1,258,678 | 1,340,497 | (81,819) |
| Net Assets - Unrestricted | 4,374,010 | 4,070,175 | 303,835 |
| Net Assets - Restricted | 722,999 | 719,893 | 3,106 |
| Liabilities and Net Assets | $ 7,300,054 | $ 7,224,053 | $ 76,001 |
| Net Days in Accounts Receivable | 48.2 | 49.0 | 0.8 |

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.

*Pre-Audit*

# Thank You

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## OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER BOARD BYLAWS

**3335-97-03 Quality and professional affairs committee.**

(B) Composition. The committee shall consist of: no fewer than four voting members of the university Wexner medical center board, appointed annually by the chair of the university Wexner medical center board, one of whom shall be appointed as chair of the committee. The executive vice president and chief executive officer; the chief executive officer of the Ohio state university health system; the chief clinical officer of the medical center; the chief administrative officer of the Ohio state university health system; the director of medical affairs of the James; the medical director of credentialing for the James; the chief of the medical staff of the university hospitals; the chief of the medical staff of the James; the associate dean of graduate medical education; the chief quality and patient safety officer; the chief nursing ~~executive~~ officer for ~~the Ohio state health system~~ University Hospital; and the chief nursing officer for the James shall serve as ex-officio, voting members. Such other members as appointed by the chair of the university Wexner medical center board, in consultation with the chair of the quality and professional affairs committee.

**3335-101-05 Appointment to the medical staff and assignment of clinical privileges.**

Upon recommendation of the medical staff of university hospitals or the James cancer hospital and in accordance with the medical staff bylaws, the university Wexner medical center board may appoint and reappoint physicians, dentists, psychologists, and podiatrists meeting the qualifications prescribed in the medical staff bylaws, to membership on the medical staff of the university hospitals and the James cancer hospital and shall grant clinical privileges to such practitioners. Appointment to the medical staff carries with it full responsibility for the treatment of patients of the university Wexner medical center subject to such limitations as may be imposed by the university Wexner medical center board or the medical staff bylaws, rules, and regulations of the medical staff. ~~Appointment and reappointment to the medical staff shall be for a period not to exceed two years and shall be renewable in accordance with the reappointment procedure set forth in the medical staff bylaws.~~ The chief medical officer of the medical center and the director of medical affairs for the James cancer hospital are delegated the responsibility by the university Wexner medical center board to grant temporary clinical privileges. The granting of temporary privileges shall be limited to situations which fulfill an important patient care need, and shall not be granted for a period of more than one hundred twenty days.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

# QUALITY LEADERSHIP COUNCIL

## The Ohio State University Wexner Medical Center Clinical Quality Management, Patient Safety, & Patient Experience Plan

**FY 2024**

**July 1, 2023 - June 30, 2024**

# Clinical Quality Management, Patient Safety, & Patient Experience Plan

**Table of Contents**

# The Ohio State University Wexner Medical Center
## Clinical Quality Management, Patient Safety, and Patient Experience Plan

### Ambition, Mission, Vision and Values
**Ambition:** To be a top 20 (Honor Roll) academic health center driving breakthrough healthcare solutions to improve people's lives and the communities in which we live.
**Mission:** To improve health in Ohio and across the world through innovations in research and transformation in research, education, patient care and community engagement.
**Vision:** By pushing the boundaries of discovery and knowledge, we will solve significant health problems and deliver unparalleled care.
**Values:** Inclusiveness, Determination, Empathy, Sincerity, Ownership and Innovation

### Definition
The Clinical Quality Management, Patient Safety and Patient Experience Plan is the health system approach to the systematic assessment and improvement of process design and performance aimed at improving quality of care, patient safety, and patient experience.
The approach to clinical quality management, patient safety, and patient experience is leadership-driven and involves significant staff and provider engagement. The activities within the health system are multi-disciplinary and rooted in the system's ambition, mission, vision, and values. The plan embodies a culture of continuously measuring, assessing, and initiating changes to improve outcomes. The health system employs the following principles which support the Institute of Medicine's six aims of care (Safe, Timely, Effective, Efficient, Equitable and Patient Centered). These principles are:

**Customer Focus:** Knowledge and understanding of internal and external customer needs and expectations.
**Leadership & Governance:** Dedication to continuous improvement instilled by leadership and the Board.
**Education**: Ongoing development and implementation of a curriculum for quality, safety & service for of all staff, employees, clinicians, patients, and learners.
**Everyone is involved:** All members have mutual respect for the dignity, knowledge, and potential contributions of others. Everyone is engaged in improving the processes in which they work.
**Data Driven:** Decisions are based on knowledge derived from data.
**Process Improvement:** Analysis of processes for redesign and variance reduction using a scientific approach.
**Continuous:** Measurement and improvement are ongoing.
**Just Culture:** A culture that is open, honest, transparent, collegial, team-oriented, accountable and non-punitive when system failures occur.
**Personalized Health Care:** Incorporate evidence-based medicine in patient centric care that considers the patient's health status, genetics, cultural traditions, personal preferences, values family situations and lifestyles.

The Plan was developed in accordance with The Joint Commission (TJC) accreditation standards and the Center for Medicare & Medicaid Services (CMS) Conditions of Participation outlining a Quality Assurance and Performance Improvement (QAPI) program. In addition to

the principles outlined above, the following will also serve as fundamental components of the plan.

### Consistent Level of Care

Certain elements of the OSUWMC Clinical Quality Management, Patient Safety, & Patient Experience Plan assure that patient care standards for the same or similar services are comparable in all areas throughout the health system. For example,

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

### Performance Transparency

The OSUWMC Medical and Administrative leadership, in conjunction with the Board of Trustees, has a strong commitment to transparency of performance as it relates to clinical, safety and patient experience performance. As supported by the long-range quality plan, the organization is committed to providing transparency to our patients and communities regarding our performance.

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

### Confidentiality

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

## Scope/Purpose

The Clinical Quality Management, Patient Safety & Patient Experience Plan includes all inpatient and outpatient facilities in The OSU Wexner Medical Center (OSUWMC) and appropriate entities across the continuum of care and in any clinical setting. The execution of the Clinical Quality Management, Patient Safety & Patient Experience Plan will demonstrate measurable improvements in health outcomes and the value of patient care provided within the OSUWMC.

As part of the Quality Assurance and Performance Improvement (QAPI program), the organization provides oversight for contracted services. The contracts are reviewed annually by the Medical Staff Administrative Committee (MSAC) and then forwarded to the Quality and Professional Affairs Committee of the governing body for review and approval.

## Objectives

- Continuously monitor, evaluate, and improve outcomes and sustain improved performance
- Implement reliable system changes that will improve patient care and safety by assessing, identifying, and reducing risks within the organization and responding accordingly when undesirable patterns or trends in performance are identified, or when events requiring intensive analysis occur
- Assure optimal compliance with accreditation standards, state, federal and licensure regulations
- Develop, implement, and monitor adherence to evidenced-based practice guidelines and companion documents in accordance with best practice to standardize clinical care and reduce practice variation
- Improve patient experience and perception of treatment, care and services by identifying, evaluating, and improving performance based on patient needs, expectations, and satisfaction
- Improve value by providing the best quality of care at the minimum cost possible. Incorporate value metrics, specifically the cost of care, into quality data and discussions where appropriate
- Provide a mechanism by which the governance, medical staff and health system staff members are educated in quality management principles and processes
- Provide appropriate levels of data transparency to both internal and external customers
- Create a level of accountability for all system-wide quality improvement initiatives at the dyad/triad leadership level and assure processes involve an interdisciplinary teamwork approach
- Improve processes to prevent patient harm
- Improve clinical documentation to accurately reflect the severity of illness for the patients in which we provide care

**Structure for Quality Oversight:**


The Quality Leadership Council serves as the single, multidisciplinary quality and safety oversight committee for the OSUWMC. In accordance with the Long Range Quality Plan **(Appendix A),** The Quality Leadership Council utilizes criteria **(Appendix B)** to determine priorities for the health system that are reported in the Quality & Safety Priorities **(Appendix C)**. Given the James Cancer Hospital has a separate provider number with a requirement for a distinct QAPI program, they have a specific substructure that ultimately reports to QPAC **(Appendix D)**.

## Committees

### Medical Center Board

The Ohio state university Wexner medical center board ("Medical Center Board") is the governing body responsible to the Ohio state university board of trustees ("University Board of Trustees") for operation, oversight, and coordination of the Ohio state university Wexner medical center.

Under the ultimate authority of the university board of trustees and consistent with Ohio law, the university board of trustees has authorized and designated the university Wexner medical center board to act as a governing body on behalf of the university for certain quality and patient care matters, for all of the hospitals and clinics of the university. In accordance with that responsibility, as authorized by the university board of trustees, the university Wexner medical center board is responsible for the following:

(A) Assuring the quality of patient care throughout the university Wexner medical center, including the planning and delivery of patient services and formation of quality assessments, improvement mechanisms and monitoring the achievement of quality standards and patient safety goals;

(B) Oversight for the purposes of accreditation and licensure; and

(C) Approval of clinical privileging forms, medical and dental staff appointments, clinical privileges, medical staff operations, including the approval, adoption, and amendment of medical staff bylaws and rules and regulations, and the conducting of peer review and professional review actions for medical staff and credentialed providers within university board of trustees-defined and approved parameters.

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

### Quality Professional Affairs Committee (QPAC)

**Composition:**

The committee shall consist of: no fewer than four voting members of the university Wexner medical center board, appointed annually by the chair of the university Wexner medical center board, one of whom shall be appointed as chair of the committee. The chief executive officer of the Ohio state university health system; chief medical officer of the medical center; the director of medical affairs of the James; the medical director of credentialing for the James; the chief of the medical staff of the university hospitals; the chief of the medical staff of the James; the associate dean of graduate medical education; the chief quality and patient safety officer; the chief nurse executive for the OSU health system; and the chief nursing officer for the James shall serve as ex-officio, voting members. Such other members as appointed by the chair of the university Wexner medical center board, in consultation with the chair of the quality and professional affairs committee.

**Function:**

The QPAC shall be responsible for the following specific duties:

- Reviewing and evaluating the patient safety and quality improvement programs of the university Wexner medical center;
- Overseeing all patient care activity in all facilities that are a part of the university Wexner medical center, including, but not limited to, the hospitals, clinics, ambulatory care facilities, and physicians' office facilities;
- Monitoring quality assurance performance in accordance with the standards set by the university Wexner medical center;
- Monitoring the achievement of accreditation and licensure requirements;
- Reviewing and recommending to the university Wexner medical center board changes to the medical staff bylaws and medical staff rules and regulations;
- Reviewing and approving clinical privilege forms;
- Reviewing and approving membership and granting appropriate clinical privileges for the credentialing of practitioners recommended for membership and clinical privileges by the university hospitals medical staff administrative committee and the James medical staff administrative committee;
- Reviewing and approving membership and granting appropriate clinical privileges for the expedited credentialing of such practitioners that are eligible by satisfying minimum approved criteria as determined by the university Wexner medical center board and are

recommended for membership and clinical privileges by the university hospitals medical staff administrative committee and the James medical staff administrative committee;
- Reviewing and approving reinstatement of clinical privileges for a practitioner after a leave of absence from clinical practice;
- Conducting peer review activities and recommending professional review actions to the university Wexner medical center board;
- Reviewing and resolving any petitions by the medical staffs for amendments to any rule, regulation or policy presented by the chief of staff on behalf of the medical staff pursuant to the medical staff bylaws and communicating such resolutions to the university hospitals medical staff administrative committee and the James medical staff administrative committee for further dissemination to the medical staffs; and
- Such other responsibilities as assigned by the chair of the university Wexner medical center board.

**Medical Staff Administrative Committees (MSACs)**
**Composition:** Refer to Medical Staff Bylaws and Rules and Regulations
**Function:** Refer to Medical Staff Bylaws and Rules and Regulations

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

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

**Quality Leadership Council (QLC)**
**Composition***:* Refer to Medical Staff Bylaws and Rules and Regulations
**Function:** Refer to Medical Staff Bylaws and Rules and Regulations

The QLC is responsible for designing and implementing systems and initiatives to enhance clinical care, outcomes and the patient experience throughout the integrated health care delivery system. The QLC serves as the oversight council for the Clinical Quality Management, Patient Safety and Patient Experience plan. Quality improvement activities within the Quality Accountability Team will be reported up to the QLC to ensure alignment of priorities for system-wide quality improvement projects and to provide consistent interventions (toolkits) to all stakeholders in the system.

**Quality Accountability Team (QAT)** ***New***
The QAT will serve as the functional arm of Quality and Patient Safety to implement specific quality improvement initiatives within the Health System. QAT will leverage the triad/dyad teams and selected leaders across the system to establish a clear level of accountability for quality improvement activities. QAT will use data provided by ACE to identify and prioritize quality issues that exist across the system. Once a priority is established for system improvement, QAT will utilize existing or ad hoc subject matter experts to develop

implementation toolkits consistent with best practice. These toolkits will decrease variation in how quality improvement efforts are undertaken across the system for common issues such as falls, hospital acquired infections, and patient safety indicators. QAT members will be responsible for the successful implementation and maintenance of these QI efforts within their areas of responsibility.

**Composition:**
QAT will be co-chaired by the Chief Quality and Patient Safety Officer and the Senior Director of Quality and Patient Safety. The QAT will consist of existing and future triad and dyad leaders across the system and selected business unit, nursing, pavilion, as well educational and administrative leaders.

**Function:**

1. Role of the QAT to be clearly defined with a focus on system-wide implementation of quality improvement efforts for specific quality opportunities impacting a broad patient population.
2. QAT activities will limit its scope to acute care inpatient opportunities that impact multiple service lines, specialties, or business units.
3. QAT is not intended to replace any service line or business unit level quality committee or activity but is intended to align QI efforts across the system for specific opportunities.
4. Priorities will be established based on current performance and identified gaps in performance when compared to industry leaders; data will be provided from the ACE and quality teams.
5. High performers and subject matter experts (existing committees or ad hoc SME's) will be tasked with creating a system-wide QI plan to improve performance to include a standardized toolkit for implementation.
6. QAT will coordinate with ACE to develop process measures, adherence reports, and outcome reporting for the project.
7. After implementation, QAT leaders will be responsible for ongoing surveillance of process adherence and outcomes for their respective units.
8. QAT will report priorities, progress, and results to the QLC as appropriate.

**Clinical Practice Guideline Committee (CPGC)**
**Composition:**
The CPGC consists of multidisciplinary representatives from Hospital Administration, Medical Staff, Information Technology, Pharmacy, Nursing, and other allied health professionals. An active member of the medical staff chairs the committee. The CPGC reports to QLC and shares pertinent information with the Medical Staff Administrative Committees.

## Function:

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

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

3. Develop measures to evaluate guideline use, processes, and outcomes of care.

**Clinical Quality and Patient Safety Committee (CQPSC)**
**Composition:**
The CQPSC consists of multidisciplinary representatives from Hospital Administration, Medical Staff, Information Technology, Nursing, Pharmacy, Laboratory, Respiratory Therapy, Diagnostic Testing and Risk Management. An active member of the Medical Staff chairs the Committee. The committee reports to QLC and additional committees as deemed applicable. The primary role of the CQPSC is to ensure that OSUWMC is compliant with the Joint Commission and CMS Requirements for Participation.

**Function:**

1. Creates a culture of safety which promotes organizational learning and minimizes individual blame or retribution for reporting or involvement in a medical/health care error
2. Assure optimal compliance with patient safety-related accreditation standards
3. Proactively identifies risks to patient safety and initiates actions to reduce risk with a focus on process and system improvement
4. Oversees completion of proactive risk assessment as required by TJC
5. Oversees education & risk reduction strategies as they relate to Sentinel Event Alerts from TJC
6. Provides oversight for clinical quality management committees
7. Evaluates and, when indicated, provides recommendations to improve clinical care and outcomes
8. Ensures actions are taken to improve performance whenever an undesirable pattern or trend is identified
9. Receive reports from committees that have a potential impact on the quality & safety in delivering patient care

**Patient Experience Council(s)**
**Composition:**
The Patient Experience Councils consists of executive, physician, and nursing leadership spanning the inpatient and outpatient care settings. The University Hospitals Council is co-chaired by the Chief Nurse Executive for the Health System, The Chief Administrative Officer for the Hospitals Division, and Chief Quality and Patient Safety Officer. The committee reports to the QLC and reports out to additional committees as applicable. The James Patient Experience Council reports to the James Quality, Patient Safety and Experience Council which then reports to QPAC. The Council's key strategic initiatives center on empathy, trust, and personal connections as well as leveraging technology to enhance communication with patients and families.

**Function:**

1. Create a culture and environment that delivers an unparalleled patient experience consistent with the OSU Medical Center's mission, vision and values focusing largely on service quality
2. Set strategic goals and priorities for improving the patient experience to be implemented by area specific patient experience councils and teams
3. Serve as a communication hub reporting out objectives and performance to the system
4. Serve as a coordinating body for subcommittees working on specific aspects of the patient experience
5. Measure and review voice of the customer information in the form of Patient and Family Experience Advisor Program and related councils, patient satisfaction data, comments, letters and related measures
6. Monitor publicly reported and other metrics used by various payers to ensure optimal reimbursement
7. Collaborate with other departments to reward and recognize faculty and staff for service excellence performance

**Practitioner Evaluation Committee (PEC)**
**Composition:**
The Practitioner Evaluation Committee (PEC) **(Appendix E)** is the Peer Review committee that provides medical leadership in overseeing the Peer Review process. The PEC is co-chaired by the CQPSO and a CMO appointee. The committee is composed of the Chair of the Clinical Quality and Patient Safety Committee, physicians, and advanced practice licensed health care providers from various business units & clinical areas as appointed by the CMO & Physician in Chief at the James**.** The Medical Center CMO & Physician-in-Chief at the James serves Ex-Officio. In FY24, a subcommittee of PEC will be established to review OPPE outliers and to report these concerns to PEC.

**Function:**

1. Provide leadership for the clinical quality improvement processes within the OSUWMC
2. Provide clinical expertise to the practitioner peer review process within the OSUWMC by thorough and timely review of clinical care and/or patient safety issues referred to the Practitioner Evaluation Committee
3. Advises the CMO & Director of Medical Affairs at the James regarding action plans to improve the quality and safety of clinical care at the OSUWMC
4. Develop follow up plans to ensure action is successful in improving quality and safety.
5. Monitor OPPE reports (via subcommittee) to identify outliers in the faculty prior to their recredentialling review every three years
6. Establish Peer Review Process Policy to clearly define the scope, methods, and timing of peer review events

**Sentinel Event Team**
**Composition:**
The OSUWMC Sentinel Event Team (SET) includes an Administrator, the Chief Quality and Patient Safety Officer, the Administrative Director for Quality & Patient Safety, a member of the

Physician Executive Council, a member of the Nurse Executive Council, representatives from Quality and Operations Improvement and Risk Management and other areas as necessary.

**Function:**

1. Approves & makes recommendations on sentinel event determinations and teams, and action plans as received from the Sentinel Event Determination Group
2. Evaluates findings, recommendations, and approves action plans of all root cause analyses

**The Sentinel Event Determination Group (SEDG)**

The SEDG is a sub-group of the Sentinel Event Team and determines whether an event will be considered a sentinel event, a significant event or a non-event. SED has the authority to assign the Root Cause Analysis (RCA) Executive Sponsor, RCA Workgroup Leader, RCA Workgroup Facilitator, and recommends the Workgroup membership to the Executive Sponsor. When the RCA is presented to the Sentinel Event Team, the RCA Workgroup Facilitator will attend to support the members.

**Composition:**

The SEDG voting membership includes the CQPSO or designee, Director of Risk Management, and Quality Director of respective business unit for where the event occurred (or their designee). Additional guests attend as necessary.

**Clinical Quality & Patient Safety Sub-Committees**

**Composition:**

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

**Function:**

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

**Process Improvement Teams**

**Composition:**

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

**Function:**

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

## Roles and Responsibilities

### Chief Executive Officer and Executive Vice President (CEO)
The CEO of the Wexner medical center, under the direction of the university president, is responsible for the oversight of the institution's healthcare enterprise, including the planning and delivery of medical services, patient safety and satisfaction, operation, oversight and coordination of all clinical entities, the development and strategic allocation of resources, budgeting and fiscal performance, philanthropic performance, and hiring and review of Wexner medical center executive performance.

Additionally, the CEO serves in an ex-officio role for the Medical Center Board, as well as being a member of the Quality and Professional Affairs committee.

### Chief Operating Officer (COO)
The COO for the Medical Center is responsible for providing leadership and oversight for the overall Clinical Quality Management, Patient Safety and Patient Experience Plan across the OSUWMC.

### Chief Clinical Officer (CCO)
The CCO for the Medical Center is responsible for facilitating the implementation of the overall Clinical Quality Management, Patient Safety & Patient Experience Plan at OSUWMC. The CCO is responsible for facilitating the implementation of the recommendations approved by the various committees under the Quality Leadership Committee (QLC).

### Chief Quality and Patient Safety Officer (CQPSO)
The CQPSO reports to the Chief Operating Officer and provides oversight and leadership for the OSUWMC in the conceptualization, development, implementation and measurement of the OSUWMC approach to quality, patient safety and patient experience.

### Senior Director, Quality and Safety ***New***
The Senior Director of Quality and Safety works in dyad partnership with the CQPSO to provide oversight and leadership for the OSUWMC in the conceptualization, development, implementation and measurement of the OSUWMC approach to quality, patient safety and patient experience.

### Associate Chief Quality and Patient Safety Officers
The Associate Chief Quality and Patient Safety Officers supports the CQPSO in the development, implementation and measurement of OSUWMC's approach to quality, safety and patient experience.

### Medical Director/Director of Medical Affairs
Each business unit Medical Director is responsible for the review, implementation and oversight of the Clinical Quality Management, Patient Safety & Patient Experience Plan.

### Associate Medical Directors
The Associate Medical Directors assist the CQPSO in the oversight, development, and implementation of the Clinical Quality Management, Patient Safety & Patient Experience Plan

as it relates to the areas of quality, safety, evidence-based medicine, clinical resource utilization and service.

**Chief Administrative Officers – Acute Care Division/Post-Acute and Home-Based Care Division/Outpatient and Ambulatory Division/Clinical and Physician Network**
The OSUWMC Chief Administrative Officers are responsible to the Board for implementation of the Clinical Quality Management, Patient Safety & Patient Experience Plan for their respective divisions.

**Business Unit Executive Directors**
The OSUWMC staff, under the direction of the Health System Chief Administrative Officer and Hospital Administration, implements the program throughout the organization. Hospital Administration provides authority and supports corrective actions within its realm for clinical quality management, patient safety and patient experience activities.

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

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

**House Staff Quality Forum (HQF)**
The House Staff Quality Forum (HQF) is comprised of representatives from each Accreditation Council for Graduate Medical Education (ACGME) program. HQF has Executive Sponsorship from the CQPSO and the Associate CQPSO.

The purpose of the HQF is to provide post-graduate trainees an opportunity to participate in clinical quality, patient safety and patient experience-related initiatives while incorporating the perspective of the frontline provider. HQF will work on quality, safety and patient experience related projects and initiatives that are aligned with the health system goals and will report to the Clinical Quality and Patient Safety committee. The Chair HQF will serve as a member of the Leadership Council.

**Nursing Quality**
The primary responsibility of the Nursing Quality and Evidence-Based Practice (EBP) Department is to monitor and evaluate performance of the nursing staff in support of organizational quality, safety and patient experience goals, submit required data to the National Database for Nursing Quality Indicators (NDNQI), review benchmark data and identify opportunities for improvement, use the literature to guide recommended changes to nursing practice and policy, coordinate and facilitate nursing quality improvement initiatives, facilitate

participation/collaboration with system-wide patient safety activities, and use EBP and research to improve both the delivery and outcomes of personalized nursing care.

Nursing Quality team members serve as internal consultants for the development and evaluation of quality improvement, patient safety, and EBP activities. The department maintains human and technical resources for team facilitation, use of performance improvement tools, data collection, statistical analysis, and reporting.

### Hospital Department Directors

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

### Health System Staff

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

- Reporting events, including near misses or “good catches” via the internal Patient Safety Reporting System (PSRS)
- Suggesting processes to improve quality, safety and service
- Monitoring activities and processes, such as patient complaints and patient satisfactionParticipating in focus groups
- Attending staff meetings
- Participating in efforts to improve quality and safety including Root Cause Analysis and Proactive Risk Assessments

### Quality and Operations Improvement

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

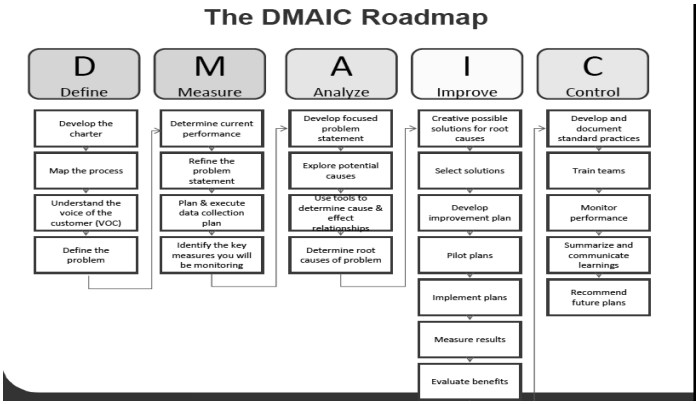
The department is comprised of five main functions – Clinical Quality, Patient Safety, Analytics, Disease and Outcome Management, and Peer Review. **Appendix F** shows the current organizational structure.

**Patient Experience**
The primary responsibility of the Patient Experience team is to coordinate and facilitate a service-oriented approach to providing healthcare throughout the Health System. This is accomplished through both strategic and program development as well as through managing operational functions within the Health System. The implementation and evaluation of service-related activities resides in each department/program; however, the Patient Experience staff also serves as an internal consultant for the development and evaluation of service quality activities as well as a representative of the "voice of the patient" throughout the organization by reflecting or providing patient feedback to shape decision making. The Patient Experience Department maintains human and technical resources for interpreter services, information desks, patient relations, pastoral care, team facilitation, survey management, and performance improvement. The department also oversees the Patient and Family Experience Advisor Program which is a group of current/former patients, or their primary caregivers, who have had experiences at any OSU facility. These individuals are volunteers who serve as advisory members on committees and workgroups, complete public speaking engagements and review materials.

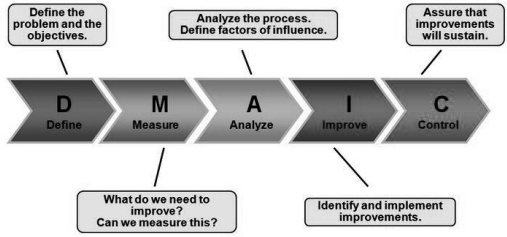
## Approach to Clinical Quality, Patient Safety & Patient Experience Management

**Systematic Approach/Model to Process Improvement**
The OSUWMC embraces change and innovation as one of its core values. Organizational focus on process improvement and innovation is embedded within the culture through the use of a general Process Improvement Model that includes 1) an organizational expectation that the entire workforce is responsible for enhancing organizational performance and 2) active involvement of multidisciplinary teams and committees focused on improving processes.

With the increased organizational emphasis on utilizing metric-driven approaches to reducing unintended medical errors, eliminating rework, and enhancing the efficiency/effectiveness of our work processes, the DMAIC methodology will be instrumental as a tool to help focus our process improvement efforts.



**DMAIC Roadmap**


## Determining Priorities

The OSUWMC has a process in place to identify and direct resources toward quality management, patient safety, and patient experience activities. The OSUWMC criteria are approved and reviewed by QLC and the Medical Center Board. The prioritization criteria are reevaluated annually according to the mission and strategic plan of the OSUWMC. The leaders may also set performance improvement priorities and reevaluate on an ad hoc basis in response to unusual or urgent events.

## Data Measurement and Assessment

### Determination of Data Needs

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

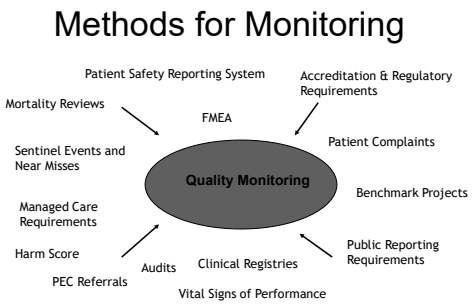
### Collection/Measurement

Data, including patient demographic and clinical information, are systematically collected throughout the OSUWMC through various mechanisms including:

- Administrative and clinical registries and databases
- Retrospective and concurrent medical record review (e.g., infection surveillance)
- Reporting systems (e.g., patient safety reporting system)
- Surveys (i.e. patients, families, and staff)

**Assessment**
Statistical methods such as control charts, g-charts, confidence intervals, and trend analysis are used to identify undesirable variance, trends, and opportunities for improvement. The data is compared to previous performance, and external benchmarks. Accepted standards of care and aspirational performance targets are used to establish metrics and goals. Annual goals are established as a means to evaluate performance. Where appropriate, OSUWMC has adopted the philosophy of setting multi-year aspirational targets. Annual targets are set as steps to achieve the aspirational goal.

**Surveillance**
The OSUWMC systematically collects and assesses data in different areas to monitor and evaluate the quality and safety of services, including measures related to accreditation and other requirements. Data collection also functions as a surveillance system for timely identification of undesired variations or trends in quality indicators. Other mechanisms by which data may be obtained are outlined in the graphic below.




**Benchmark data**
Both internal and external benchmarking provides value to evaluating performance.

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

- External Benchmarking
  OSUWMC participates in various database systems, clinical registries and focused benchmarking projects to compare performance with that of peer institutions. Vizient, The US News & World Report, National Database of Nursing Quality Indicators, and The Society of Thoracic Surgery are examples of several external organizations that provide benchmarking opportunities.

### External reporting requirements

There are a number of external reporting requirements related to quality, safety, and service. These include regulatory, governmental, payer, and specialty certification organizations. An annual report is given to the Compliance Committee to ensure all regulatory requirements are met.

## Communication of Data/Performance

**Metric Headquarters (Metric HQ)**

Metric HQ is a newly launched set of dashboards designed to consolidate quality and safety data across the OSUWMC. The intent of Metric HQ is to become the single source of truth for quality and safety performance across the organization. Specific data within Metric HQ is available at the system, business unit, and unit level. Additional plans are underway to provide process measure data as leading indicators for established outcomes or priorities. Examples of data available within Metric HQ is the following:

**Vital Signs of Performance**

The Vital Signs of Performance is an online dashboard available to everyone in the Medical Center with a valid user account that shows Mortality, Length of Stay, Patient Safety Indicators, and Readmission data over time. The data can be displayed at the health system, business unit, clinical service, and nurse station level.

**Patient Satisfaction Dashboard**

The Patient Satisfaction dashboard consists of patient experience indicators and comments gathered from surveys after discharge or visit to a hospital or outpatient area. The dashboard covers performance in areas such as overall experience, physician communication, nurse communication, responsiveness, and environment. It also measures process indicators, such as joint physician-nurse rounding and nurse leader rounding, as well as serves as a resource for best practices. The information contained on the dashboard is shared in various forums with staff, clinicians, administration, including the Boards.

## Performance Based Physician Quality & Credentialing

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

### Profiling Process:

- Data gathering from multiple sources
- Report generation and indicator analysis

- Department chairs (division directors as well) have online access 24/7 to physician profiles for their ongoing review
    - Individual physician access to their profiles 24/7
- Discussion at Credentialing Committee
- Final Recommendation & Approval:
    - Medical Staff Administrative Committees
    - Medical Director
    - Hospital Board

**Service-Specific Indicators**
Several of the indicators are used to profile each physician's performance. The results are included in a physician profile which is reviewed with the department chair as part of credentialing process.

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

**Purpose of Medical Staff Evaluation**

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

**Conflict of Interest**
Any person, who is professionally involved in the care of a patient being reviewed, should not participate in peer review deliberations and voting. A person is professionally involved if they are responsible for patient care decision making either as a primary or consulting professional and/or have a financial interest (as determined by legal counsel) in the case under review. Persons who are professionally involved in the care under review are to refrain from participation except as requested by the appropriate administrative or medical leader. During peer review evaluations, deliberations, or voting, the chairperson will take steps to avoid the presence of any person, including committee members, professionally involved in the care

under review. The chairperson of a committee should resolve all questions concerning whether a person is professionally involved. In cases where a committee member is professionally involved, the respective chairperson may appoint a replacement member to the committee. Participants and committee members are encouraged to recognize and disclose, as appropriate, a personal interest or relationship they may have concerning any action under peer review.

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### Annual Approval and Continuous Evaluation

The Clinical Quality Management, Patient Safety & Patient Experience Plan is approved by the QLC, the Medical Staff Administrative Committees, and the Medical Center Board on an annual basis. The annual evaluation includes a review of the program activities and an evaluation of the effectiveness of the structure.

# Appendix A: Long Range Quality Plan

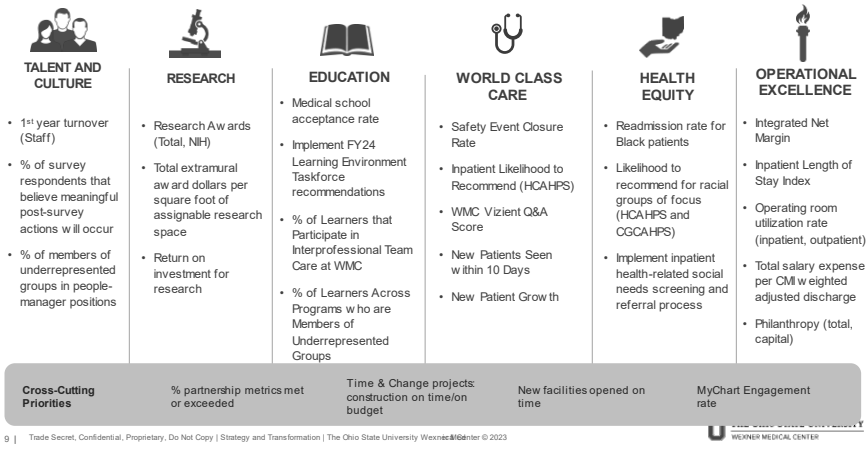
## Appendix B: Priority Criteria

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

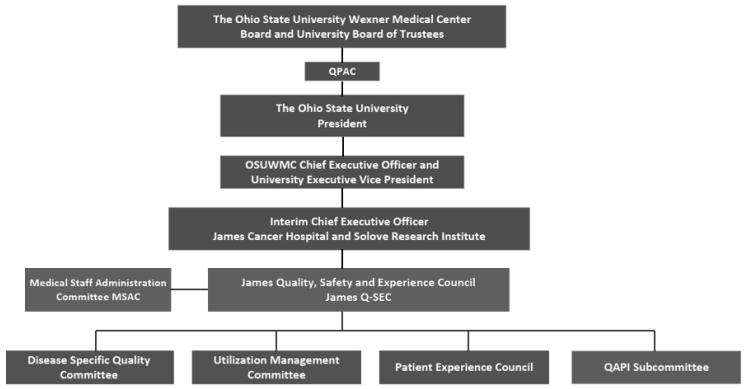
1. Ties to strategic initiatives and is consistent with hospital's mission, vision, and values
2. Reflects areas for improvement in patient safety, appropriateness, quality, and/or medical necessity of patient care (e.g., high risk, serious events, problem-prone)
3. Has considerable impact on our community's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

# Appendix C: FY24 Priorities/Metrics

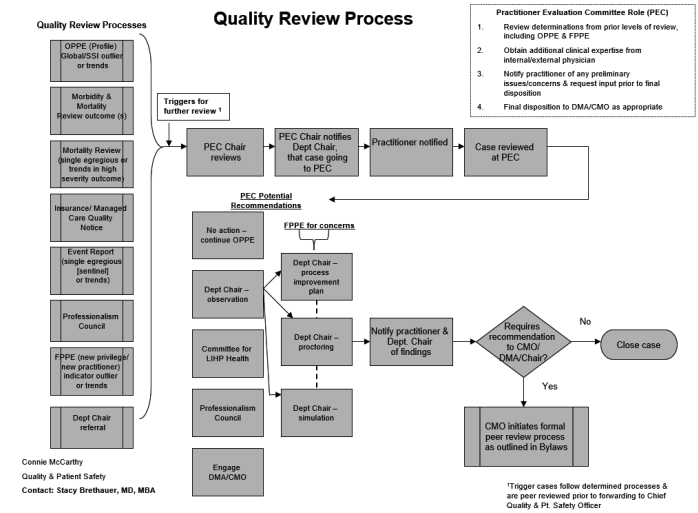
## FY 24 Enterprise Metrics



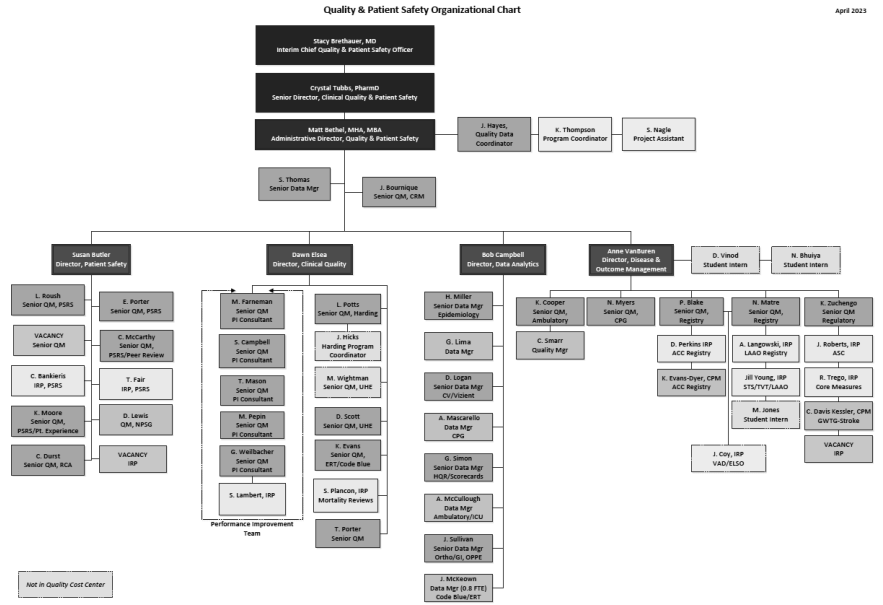
## Appendix D: Quality Structure for The James Cancer Hospital & Solove Research Institute



# Appendix E: Quality Review Process & Physician Performance Based Profile



# Appendix F: Quality Organizational Structure



# The James Cancer Hospital Quality, Safety and Experience Council Plan

**The Ohio State University**
**James Cancer Hospital and**
**Solove Research Institute**
**The Comprehensive Cancer Center**
**(The James and CCC)**

**Fiscal Year 2024**

**July 1, 2023 through June 30, 2024**

The James

THE OHIO STATE UNIVERSITY
COMPREHENSIVE CANCER CENTER

# The James Cancer Hospital Quality, Safety and Experience Council Plan

# The James Cancer Hospital & Solove Research Institute

## The James Quality, Safety and Experience Council Plan

### Mission, Vision, and Values:

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

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

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

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

### Definition:

The James Quality Safety, and Experience Council Plan (hereinafter The Plan) of The James Cancer Hospital/Solove Research Institute is our organization-wide approach to systematic assessment of process design and performance improvement targeting quality of care, patient safety, and patient experience. The Plan serves to provide direction for how clinical care and activities are to be designed to enrich patient outcomes, reduce harm, and improve value-added care and service to the cancer patient population.

### Scope:

As a Prospective-Payment-System-exempt (PPS-exempt) hospital, which serves as the clinical care delivery-arm of an NCI-designated Comprehensive Cancer Center, The James has a unique opportunity to ensure value-added services and research expertise are provided to our patients, families, and the community – both nationally and internationally. The Plan encompasses all clinical services. Through close partnership with the Comprehensive Cancer Center, the Plan includes quality and patient safety goals for process improvements related to functions and processes that involve both the Cancer Center and the hospital and ambulatory clinics/treatment areas.

With a close partnership within OSUWMC, this Plan helps provide oversight of the clinical contracted services and serves as a component of the Quality Assurance and Performance Improvement (QAPI) requirements from the Center for Medicaid and Medicare Services. These services are evaluated on an annual basis by The James Quality, Safety and Experience Council, The James Medical Staff Administrative Committee (MSAC), and then forwarded each year to the Quality and Professional Affairs Committee (QPAC) as a part of the governing body, to ensure quality and safety of care is provided to all James' patients.

**Purpose:**
The purpose of the Plan is to provide guidance for the resources and processes available to ensure measurable improvements to patient care are occurring. The James recognizes the vital importance of creating and maintaining a safe environment for all patients, visitors, employees, and others within the organization to bring about personalized care through evidence-based medicine.

**Objectives:**
The central objectives of The James Quality Safety, and Experience Council Plan are to:

1. Provide guidance for monitoring and evaluation of effort(s) in clinical care to sustain high performance and improved outcomes for all patients.
2. Evaluate and recommend system changes to improve patient care and safety by assessing, identifying, and reducing risk within the organization when undesirable patterns or trends in performance are identified, or when events requiring intensive analysis occur.
3. Assure overall compliance which meets or exceeds accreditation standards, state, federal and licensure regulations.
4. Provide information for adherence to evidence-based practice guidelines to standardize clinical care and reduce practice variation.
5. Improve patient satisfaction and perception of treatment, care, and services by continuously identifying, evaluating, and improving performance based on needs, expectations, and satisfaction results.
6. Enhance the patient experience by providing safe and high-quality care at the best value.
7. Provide education to the governance, faculty and staff regarding quality management principles and processes for improving systems.
8. Provide appropriate levels of data transparency.
9. Assure quality and patient safety processes developed are with an approach of always involving trans-disciplinary teamwork.
10. Provide improvement processes to clinical systems to prevent or eliminate patient harm.

**Structure for Quality Oversight:**
The James Quality, Safety and Experience Council serves as the primary entity within The James to develop annual goals which are consistent with goals from the Health System, however these goals for The James are designed to target a specific focus for the cancer patient population and cancer research agendas.

**Governance and Committees:**
**Governing Body**
The Wexner Medical Center Board is the governing body, responsible to The Ohio State University Board of Trustees, for operation, oversight and coordination of the Wexner Medical Center and The James Cancer Hospital. The Wexner Medical Center Board is composed of sixteen voting members, plus an additional group of university and medical center senior leaders who serve in ex-officio roles. The Quality & Professional Affairs Committee (QPAC) reports to the Wexner Medical Center Board and is responsible for, among other things, reviewing and evaluating at least annually The James Quality Safety, and Experience Council Plan, along with goals and process improvements made for improved patient safety and quality programs, as well as granting clinical privileges for the credentialing of practitioners. The Board of Trustees and its committees meet throughout the year with focused agendas and presentations.

**Quality and Professional Affairs Committee (QPAC):**

***Composition:***
This committee consists of no fewer than four voting members of the University Wexner Medical Center Board of Trustees. Members are appointed each year by the Chair of the OSUWMC Board, and one of these shall be assigned as the Chair of the committee. The CEO of the OSU Health System; CMO of the University Medical Center; CMO of The James; the medical director of credentialing for The James; the Chief of Medical Staff of the University hospitals; the Chief of Medical Staff for The James; the Associate Dean of Graduate Medical Education; the Chief Quality and Patient Safety Officer; The Chief Nurse Executive for the OSU Health System; and the Chief Nursing Officer for The James serve in ex-officio, voting positions. Other members as may be appointed by The Chair of the OSUWMC board, in consultation with the Chair of Quality and Professional Affairs committee.
***Function:***
The QPAC shall be responsible for the following specific duties:

1. Reviewing and evaluating the Quality and Patient Safety programs of OSUWMC.
2. Overseeing all patient care activity in all facilities as a part of OSUWMC, including but not limited to, hospitals, clinics, ambulatory care, and physician office facilities.
3. Monitoring quality assurance performance in accordance with the standards set by OSUWMC.
4. Monitoring the achievement of accreditation and licensure requirements.
5. Reviewing and then recommending to the OSUWMC board changes to the medical staff bylaws and medical staff rules and regulations.
6. Reviewing and approving clinical privilege forms.
7. Reviewing and approving membership, as well as granting appropriate clinical privileges for the credentialing of practitioners recommended for membership and clinical privileges by the hospital's Medical Staff Administrative Committee (MSAC).
8. Reviewing and approving membership and granting appropriate clinical privileges for the expedited credentialing of such practitioners that are eligible by satisfying the minimum approved criteria which is determined by the OSUWMC board and recommended for membership and clinical privileges to the MSACs of OSUWMC and The James.
9. Reviewing and approving reinstatement of clinical privileges for a practitioner after a leave of absence from clinical practice.
10. Conducting Peer Review activities and recommending professional review actions to the OSUWMC board.
11. Reviewing and resolving any petitions by the medical staff for amendments to any rule, regulation or policy presented by the Chief of Staff on behalf of the behalf of the medical staff pursuant to the medical staff bylaws and communicating such resolutions to the hospitals MSACs.
12. Such other responsibilities as assigned by the Chair of the OSUWMC Board.

**The James Medical Staff Administrative Committee (MSAC)**

***Composition****:*
*Refer to Medical Staff Bylaws and Rules and Regulations*
***Function:***
*Refer to Medical Staff Bylaws and Rules and Regulations*
The organized medical staff, under the direction of the Director of Medical Affairs/Chief Medical Officer, implements The Plan throughout the clinical departments. The MSAC reviews reports, and recommendations related to clinical quality management, patient safety, and service quality activities.

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

**The James Quality, Safety and Experience Council**

***Composition:***

The James Quality, Safety and Experience Council consists of representatives from Medical Staff, Administration, Advanced Practice Providers, and staff from Cancer Program Analytics, Epidemiology, Environmental Services, Clinical Informatics, Laboratory, Nursing, Pharmacy/Medication Safety, Patient Experience, Social Work and Risk Management. This Council reports to Executive Leadership and MSAC.

***Function:***

- Create a culture which promotes organizational learning and recognition of clinical quality (improving outcomes) and patient safety (reducing harm).
- Develop and sustain a culture of safety which strives to embed Just Culture principles in the follow up of healthcare errors.
- Assure compliance with patient safety-related accreditation standards.
- Proactively identify risks to patient safety and creates a call-to-action to reduce risk with a focus on process and system improvement.
- Oversee education & risk reduction strategies as they relate to Sentinel Event Alerts from The Joint Commission.
- Evaluate standards of care and evidence-based practices and provide recommendations to improve clinical care and outcomes.
- Ensures actions are taken to improve performance whenever an undesirable pattern or trend is identified.
- Receive reports from committees that have a potential impact on the quality & safety in delivering patient care such as, but not limited to, Environment of Care, BMT & Acute Leukemia, Radiation Oncology, Translational Research, Patient Experience, and Infection Prevention Committees.
- Receive reports from Shared Services as they represent the metrics for quality and safety of care for the cancer patient population.
- Maintain follow-up on Shared Services action plans as necessary for improving metrics for quality and safety of care for the cancer patient population.

**The James Patient Experience Council**

***Composition:***

The Patient Experience Council consists of multidisciplinary representatives from Hospital Administration, Medical Staff, Nursing, Nutrition Services, Environmental Services, Communications, and the Patient Experience Department. The Patient Experience Council has a liaison member connected to The James Quality, Safety and Experience Council.

***Function:***

- Create a culture and environment to deliver exceptional patient experience consistent with the mission, vision and values focused on service quality.
- Measure and review voice of the customer information in the form of patient satisfaction, comments, letters, and related measures. Recommend system goals and expectations for a consistent patient experience.

- Provides guidance and oversight on patient experience improvement efforts ensuring effective deployment and accountability throughout the system.
- Oversees the service excellence reward and recognition program.
- Communicates the work of the Council throughout the organization.

**The James Utilization Management Committee (JUMC)**

***Composition:***
The James Utilization Management Committee is co-chaired by the Associate Chief Medical Officer of the Care Continuum and the Director of Patient Care Resource Management. Committee membership will include James Physician Advisors and Emergency Department Physician Advisors, physician members of the medical staff, representatives from the Patient Care Resource Management (PCRM) Department, Administration, Finance, Advance Practice Professionals, Providers, Quality and Safety, Revenue Cycle and Compliance, Nursing and Service Line Administration. Other departments in The James will be invited to join meetings as necessary when opportunities have been identified for improvement and input. JUMC members will not include any individual who has a financial interest in any hospital in the health system. No JUMC member will be included in the review process for a case when that member has direct responsibility for patient care in the case being reviewed.
***Function:***
The JUMC has responsibility to establish and implement The James Utilization Management Plan. The JUMC implements procedures for reviewing the efficient utilization of care and services, including, but not limited to admissions, continued stays, readmissions, over and under-utilization of services, the efficient scheduling of services, appropriate stewardship of hospital resources, access and throughput and timeliness of discharge planning. Any quality or utilization opportunities identified by the JUMC through utilization review activities are acted upon by the committee or referred to the appropriate entity for resolution. The JUMC provides education on care and utilization issues to all health care professionals and medical staff at The James.

**Practitioner Evaluation Committee (PEC)**

***Composition:***
The Practitioner Evaluation Committee (PEC) is the medical staff peer review committee that provides leadership in overseeing the peer review process. The PEC is composed of the Chair of the Clinical Quality and Patient Safety Committee, medical staff, and advanced practice providers from various business units & clinical areas as appointed by the Chief Medical Officer (CMO) of the Health System the Director of Medical Affairs/Chief Medical Officer for *Function*

- Provide leadership for the provider clinical quality improvement processes.
- Provide clinical expertise to the practitioner peer review process by thorough and timely review of clinical care and/or patient safety issues referred to the PEC.
- Give advice to the Director of Medical Affairs/CMO at The James regarding action plans to improve the quality and safety of clinical care.
- Provide input to the Director for Advanced Practice Providers when there is an APP Peer Review completed.
- Develop follow up plans to ensure action is successful in improving quality and patient safety.

**Health System Information Systems Steering Team (HSISST)**

***Composition:***
The HSISST is a multidisciplinary team chaired by the Chief Medical Information Officer of OSUWMC.
***Function:***
The HSISST oversees information technology for both The James and OSUWMC. The team is responsible for oversight of information technology and processes currently in place, as well as reviewing replacement and/or introduction of new systems, and related policies/procedures. Individual team members are charged with responsibility to communicate and receive input from their various communities of interest on relevant topics discussed at committee meetings and other forums.

**Sentinel Event Committee and Sentinel Event Determination Group (SEDG):**

***Composition:***
The Sentinel Event Team includes membership from both The James and the OSUWMC. Membership from The James includes: the Executive Director Medical Affairs/Chief Medical Officer, the Quality Medical Director for The James, the Quality Medical Director for Perioperative services, and the Director of Quality & Patient Safety and Nursing Quality Director. Members from the Medical Center include: an Administrator, Chief Medical Officer, Chief Quality Officer, Associate Chief Quality and Patient Safety Officer, Associate Executive Director of Quality & Safety, a member of the Physician Executive Council, Quality and Operations Improvement, and Medication Safety Officer. Members from Risk Management are also included.

The Sentinel Event Determination Group (SEDG) is a sub-group of the Sentinel Event Team which is comprised of quality leaders from The James and OSUWMC and are chaired by the Health System Chief Quality Officer. The SEDG membership includes the CQO, Associate CQO, Director of Risk Management, James Quality Medical Director, Directors of Quality & Patient Safety and Nursing Quality Directors of respective business units. The SEDG meets weekly to review sentinel event and significant events. Once an event is determined to be a significant or sentinel event, SEDG members assign a Root Cause Analysis (RCA) Team who includes Executive Sponsor, RCA Workgroup Leader, and RCA Workgroup Facilitator. The James Director of Quality and Patient Safety serves as the executive sponsor for the RCA, and receives the input from SEDG, collaborates with facilitators and physician leaders to finalize the team membership, initiate team charters, and ensure that team meetings and action plans are completed in accordance with requirements to satisfy regulatory compliance.
***Function:***
Approve & make recommendations on sentinel event determinations and teams, and action plans as received from the Sentinel Event Determination Group. Results of a sentinel event, significant event or near-miss information are considered confidential according to Ohio Revised Code Section 2305.25 and are not externally reported or released.

**The James Quality, Safety and Experience Council QAPI Sub-Committee**

***Composition:***
The James Quality, Safety and Experience QAPI Sub-Committee refers to the sub-committee functioning under the quality oversight structure of the James Quality, Safety and Experience Council (Q-SEC). Membership on this sub-committee represents the major clinical and support services throughout the hospitals and/or clinical departments, as well as members from The James Quality, Safety and Experience

Council. The QAPI Sub-committee will identify department barriers requiring escalation to the James Quality, Safety and Experience Council (Q-SEC), or as defined by the Plan.

***Function:***

Serve as the central resource and interdisciplinary work groups for the continuous process of monitoring and evaluating the quality and services provided throughout a hospital, clinical department, and/or a group of similar clinical departments. Conducts department reviews for services provided by the The James and services received from Wexner Medical Center, including process/patient safety metrics and PSRS events reviews.

**The James Continuous Quality Improvement Teams**

***Composition:***

For the purposes of this plan, Quality Improvement Teams are considered as ad-hoc committees, disease specific workgroups, performance improvement teams, taskforces, etc., that function under the quality oversight structure and are time-limited in nature, as well as the new Health System groups that will report up to Q-SEC (an example is the Hospital Acquired Infection group). Continuous Quality Improvement teams are comprised of owners or participants in the process under study. The process may be clinical or non-clinical. The members fill the following roles: team leader, Process Engineer or facilitator, physician advisor, administrative sponsor, and technical experts.

***Function:***

Improve current practice or processes using traditional continuous process improvement tools such as rapid cycle improvements, LEAN principles and DMAIC/DMADV/PDCA.

**Roles and Responsibilities**

The management of clinical quality, patient safety and excellence are responsibilities of all faculty, staff, and volunteers.

**Chief Executive Officer (CEO)**

The CEO for The James reports to the OSUWMC Chief Executive Officer and is responsible for providing leadership and oversight for the overall functions within The James. The CEO has authority for the James Quality Safety, and Experience Council Plan and collaborates with all employees and medical staff to ensure safe care is delivered to our patients to achieve quality outcomes for each encounter.

**Director of Medical Affairs/Chief Medical Officer (CMO)**

The Director of Medical Affairs is the Chief Medical Officer for The James Cancer Hospital who provides leadership and strategic direction for the faculty, medical staff, and other providers to ensure the delivery of high quality, cost-effective health care consistent with The James mission. The CMO has oversight of the medical staff responsibilities for progress towards goals and process improvements. The CMO is a member of The James Medical Staff Administrative Committee (MSAC) and is the medical director for provider credentialing within The James.

**Quality Medical Director**

The James Quality Medical Director reports to the Chief Medical Officer and is responsible for assisting the Quality Department with medical review for all patient safety and quality outcomes. This physician also works collaboratively with the health system quality medical directors and the Chief Quality and Patient Safety Officer in determining sentinel and significant events, as well as reporting events, when necessary, through the peer review process. The Quality Medical Director is a member of both the James

Quality, Safety and Experience Council and a member of The James Medical Staff Administrative Committee (MSAC).

**Medical Director**
Each business unit Medical Director is responsible to review the recommendations from The Plan and implement quality goals and plans, along with maintaining oversight in their clinical areas.

**Medical Staff**
Medical staff members are responsible to achieve the highest standard of care and services within their scope of practice. As a requirement for membership on the medical staff, members are expected to and must participate in the functions and expectations set forth in The Plan. In addition, members serve on quality management/patient safety committees and/or continuous quality improvement teams throughout the year.

**Executive Director, Clinical Services,**
The James Executive Director for Clinical Services provides leadership and oversight of The Plan and works collaboratively with the OSUWMC Quality Leadership Council (QLC) initiatives. The Executive Director is integral to the establishment and implementation of The Plan, organization-wide quality goals, and performance improvement achievements.

**Chief Nursing Officer**
The James CNO reports to the Executive Director of Clinical Services to work and provide senior leadership within the nursing structure to influence the nursing process and practices. The CNO ensures the overall James Quality Safety, and Experience Council Plan is utilized to assist with the development, implementation, and initiating of The James Nursing Strategic Plan. The CNO has oversight of the nursing shared governance model and the nursing leadership which establishes and implements annual nursing-sensitive goals.

**Nursing Leadership**
The Chief Nursing Officer, as well as the Associate Chief Nursing Officer(s), and Directors of Nursing are responsible to implement, maintain oversight, and incorporate opportunities and goals identified in collaboration with the OSUWMC- QLC Committee.

Nursing directors and managers are to implement recommendations or participate in action plans for individual employees or the department. They provide input regarding committee memberships, and serve as participants in the departmental, hospital and Health System quality/patient safety committees. Clinical Nurse Specialists (CNS) support quality improvement initiatives by providing leadership in the application and use of evidence-based practice. The James nursing staff is responsible to provide the highest standard of care and services within their scope of practice.

**Quality and Patient Safety Leadership**
The Sr. Director of Integrated Care Management and Quality, Director for Quality and Patient Safety, and the Director of Clinical Outcomes collaborates directly with the executive leaders as well as the directors and managers of all areas to evaluate, plan and improve on patient safety and quality outcomes. In addition, the Directors have leadership oversight of the quality improvement goals, patient safety improvements, and facilitates team(s) charged for implementation of annual hospital level goals.

**The James Quality Improvement and Patient Safety Department**

The primary responsibilities of The James Quality Improvement and Patient Safety Department is:

- Track and trend quality events as well as Sentinel Events.
- Coordinate and facilitate clinical quality management for improved outcomes.
- Monitor patient safety incidents and work with the management teams for elimination or reduction of risk/harm to patients.
- Improve patient care services by assuring the voice of the patient is heard throughout The James.
- Assist managers with evaluations of situations by use of the Just Culture algorithm and training.

While primary responsibility for the implementation and evaluation of clinical quality, patient safety, and service activities resides within each department/program, The James Quality and Patient Safety staff also serve as internal consultants for the development, evaluation, and on-going monitoring of those activities. The James Quality Improvement & Patient Safety Departments including The James Operations Improvement staff, and the Cancer Program Analytics staff, maintain human and technical resources for team facilitation, use of performance improvement tools, data collection, statistical analysis, and reporting.

**Hospital Management Team**

Each associate executive director, all service line administrators, department directors and managers are responsible to ensure the standards of care and service are maintained or exceeded within their department(s), and are responsible to implement, monitor, and evaluate activities in their areas and assist clinical staff members in developing appropriate mechanisms for data collection and evaluation. Department directors, managers and/or assistant managers participate in action plans for individual employees or the department. All department directors/managers provide input regarding committee memberships and serve as participants on quality management/patient safety committees and/or quality improvement teams. Managers and staff are engaged through formal and informal processes related to quality improvement and clinical patient safety efforts, including but not limited to:

- Suggesting process improvements and reporting medical/health care events and near misses.
- Implementing evidence-based practices.
- Monitoring and responding to activities and processes, such as patient complaints and patient satisfaction.
- Participating in audits, observations and peer-to peer review and feedback; and,
- Participating in efforts to improve patient outcomes and enhance patient safety.

**The James Patient Experience/Guest Services Department**

The primary responsibility of The James Patient Experience and Guest Services Department is to coordinate and facilitate a service-oriented approach to providing healthcare. This is accomplished through both strategic program developments as well as by managing operational functions. The Patient Experience staff serves as an internal consultant for the development and evaluation of service-quality activities. The Department maintains human and technical resources for interpreter services, information desks, patient relations, team facilitation, and use of performance improvement tools, data collection, statistical analysis, and reporting. The Department also oversees the Patient/Family Advisor Program which consists of current and former patients, or their primary caregivers, who have had experiences at any James facility. These individuals are volunteers who serve on committees and workgroups, as Advisory Council members, complete public speaking engagements and review materials.

**Philosophy of Patient Care Services**

The James provides innovative and patient-focused comprehensive cancer care and services which includes the following:

- A mission statement that outlines the relationship between patient care, research, and teaching.
- Long-range, strategic planning conducted by leadership to determine the services to be provided.
- Establishing annual goals and objectives that are consistent with the hospital mission, and which are based on a collaborative assessment of patient/family and the community's needs.
- Provision of services appropriate to meet the needs of patients.
- Ongoing evaluation of services provided such as: performance assessment and improvement activities, budgeting, and staffing plans.
- Integration of services through the following: continuous quality improvement teams; clinical interdisciplinary quality programs; performance assessment and improvement activities; communications through management operations meetings, nursing shared governance structure, Medical Staff Administrative Committee, administrative staff meetings; participation in OSUWMC and OSU governance structures, special forums; and leadership and employee education/development.
- Maintaining competent patient care leadership and staff by providing education and ongoing competency reviews which are focused towards identified patient care needs.
- Respect for each patient's rights and decisions as an essential component in the planning and provision of care.
- Utilizing the Relationship Based Care principles which encompass Care of Patient, Care of Colleague, Care of Self and Care of the Community.
- Embracing the principles of a Just Culture and honoring a Culture of Safety for all team members, faculty, and staff.

**Principles**

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

- ***Safe:*** Care should be as safe for patients in health care facilities as in their homes.
- ***Effective:*** The science and evidence behind health care should be applied and serve as the standard in the delivery of care.
- ***Efficient:*** Care and service should be cost effective, and waste should be removed from the system.
- ***Timely:*** Patients should experience no waits or delays in receiving care and service.
- ***Patient centered:*** The system of care should revolve around the patient, respect patient preferences, and put the patient in control; and
- ***Equitable:*** Unequal treatment should be a fact of the past; disparities in care should be eradicated.

The IOM *10 Rules for Redesign* are guiding principles for the provision of safe and quality care. These are:

1. ***Care is based on continuous healing relationships***. Patients should receive care whenever they need it and, in many forms, not just face-to-face visits. This implies that the health care system must be always responsive, and access to care should be provided over the Internet, by telephone, and by other means in addition to in-person visits.

2. ***Care is customized according to patient needs and values.*** The system should be designed to meet the most common types of needs but should have the capability to respond to individual patient choices and preferences.
3. ***The patient is the source of control***. Patients should be given the necessary information and opportunity to exercise the degree of control they choose over health care decisions that affect them. The system should be able to accommodate differences in patient preferences and encourage shared decision making.
4. ***Knowledge is shared and information flows freely.*** Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.
5. ***Decision making is evidence-based.*** Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.
6. ***Safety is a system property.*** Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.
7. ***Transparency is necessary.*** The system should make available to patients and their family's information that enables them to make informed decisions when selecting a health plan, hospital, or clinical practice, or when choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.
8. ***Needs are anticipated.*** The system should anticipate patient needs, rather than simply react to events.
9. ***Waste is continuously decreased.*** The system should not waste resources or patient time.
10. ***Cooperation among clinicians is a priority.*** Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

Following these principles, The James has instituted the following guidelines as the approach to quality, safety, and experience services:

- **Customer Focus:** Knowledge and understanding of internal and external customer needs and expectations.
- **Leadership & Governance:** Dedication to continuous improvement instilled by leadership and the Board.
- **Education:** Ongoing development and implementation of curricula for quality, safety, and reliability for all faculty, staff, volunteers, and students.
- **Involvement:** All team members must have mutual respect for the dignity, knowledge, and contributions of others. Everyone is engaged in improvement of processes where they work.
- **Data-driven decision making:** Decisions for quality, safety, and reliability are based on the knowledge derived from data.
- **Continuous Process Improvement:** Analysis of processes for design, redesign and to reduce variations are accomplished by use of an approach using science and LEAN/DMAIC/PDCA. Measures and improvements are ongoing.
- **Just Culture:** Our framework of quality, safety, and reliability services are based on a culture that is open, honest, transparent, collegial, team-oriented, accountable, and non-punitive when system failures have occurred.

- **Personalized Health Care:** The incorporation of evidence-based medicine in patient-centered care which considers the patient's health status, genetics, cultural tradition, personal preferences, and values family and lifestyle situations.
- **Reducing Health Disparities:** Ongoing commitment to make health care disparities an organizational quality and safety priority by assessing, identifying trends in data, developing, and implementing action plans, and communicating progress to key stakeholders.

**Consistent Level of Care**

Certain elements of The Plan help to ensure that patient care standards for the same or similar services are comparable in all areas. These elements include, but are not limited to:

- Policies and procedures and services provided are not payer driven and is standardized to promote high quality and safe care.
- Application of a single standard for physician credentialing.
- Cancer care delivery is based upon nationally recognized standards of care from the National Comprehensive Cancer Network (NCCN).
- Use of monitoring tools to measure like processes in areas of the Health System and The James.

**Performance Transparency**

The James Medical and Administrative leadership have a long-standing and strong commitment to transparency of performance as it relates to clinical quality, safety, and service performance.

Performance data is shared internally with faculty and staff through a variety of methods. The purpose of providing data internally is to assist faculty and staff in having real-time performance results and to use those results to drive change and improve performance when applicable. Transparency of information that is provided is within the limits of the Ohio law that protects attorney –client privilege, quality inquiries and reviews, as well as peer review. Current quality data is shared on The James internal intranet site. Cancer Program Analytics has worked with many departments to build and enhance quality and safety dashboards, as well as display of other important metrics to build on the equation of value for our patients.

**Confidentiality**

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

**Conflict of Interest**

A person is professionally involved if they are responsible for patient care decision making either as a primary or consulting professional and/or have a financial interest (as determined by legal counsel) in a case under review. Persons who are professionally involved in the care under review are to refrain from participation except as requested by the appropriate administrative or medical leader. During peer review evaluations, deliberations, or voting, the chairperson will take steps to avoid the presence of any person, including committee members,

professionally involved in the care under review. The chairperson of a committee should resolve all questions concerning whether a person is professionally involved. In cases where a committee member is professionally involved, the respective chairperson may appoint a replacement member to the committee. Participants and committee members are encouraged to recognize and disclose, as appropriate, a personal interest or relationship they may have concerned any action under peer review.

**Priority Criteria**

The following criteria are used to prioritize clinical value enhancement initiatives and continuous quality improvement opportunities, to ensure the appropriate allocation of resources.

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

**Determining Priorities**

The James has a process in place to identify and direct resources toward quality management, patient safety, and service excellence activities. The prioritization criteria are reevaluated annually according to the mission and strategic plan. The leaders set performance improvement priorities and reevaluate annually in response to unusual or urgent events. Whenever possible, NCI, ADCC or other appropriate cancer specific benchmarks are utilized to compare performance metrics for The James, to assist with determination of priorities each year to improve performance.

**Design and evaluation of new processes**

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

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

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

**Data Measurement and Assessment**

**Determination of Needs**

Data needs are determined according to improvement priorities and surveillance needs. The James Cancer Program Data Analytics and the Quality and Patient Safety departments collect data for monitoring important processes and outcomes related to patient care. In addition, each department is responsible for identifying quality indicators specific to their area of service. The quality management committee of each area is responsible for monitoring and assessment of the data collected. Quality and Safety monitoring is on-going and reviewed by The James Quality, Safety and Experience Council each year.

**External reporting requirements**
The reporting requirements related to quality, safety, and service. These include regulatory, governmental, payer, and specialty certification organizations.

**Collection of Data**
Data, including patient demographic and diagnosis, are systematically collected by various mechanisms including but not limited to:

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

**Assessment of Data**
Statistical methods are used to identify undesirable variance, trends, and opportunities for improvement. The data are compared to the previous performance, external benchmarks, and accepted standards of care to establish goals and targets. Annual goals are established to evaluate performance.

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

**The James Quality and Safety Scorecard**
Patient Safety is the highest priority for all faculty and staff at The James. As a crucial element to caring for our patients, there is an on-going process of monitoring safety events and any untoward trends from patient care. The James Patient Quality and Safety Scorecard (hereinafter The Scorecard) is a set of indicators related to those events considered potentially preventable and which cause level of harm to the patient. The Scorecard covers the areas such as sentinel events, mortality, and mortality related to sepsis, hospital acquired infections, falls with injury, hospital-acquired pressure ulcers, medication events that reach the patient and cause harm, as well as other categories.

The information is shared in various quality forums with the medical staff, clinicians, James's administration, and senior staff, and the Quality and Professional Affairs Committee (QPAC) at the Wexner Medical Board. The indicators to be included in the scorecard are reviewed each year to represent the priorities of the Quality and Patient Safety program. The Patient Safety program evaluates opportunities each quarter at The James Quality Safety and Experience Council, as well as monthly at the Medical Staff Administrative Committee. Annually, safety goals are reviewed and adjusted as necessary by use of event trending, regulatory changes, needs identified from the culture of safety surveys and/or national cancer benchmarks.

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

**Quality and Patient Safety Staff Education**

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

- Online videos
- Newsletters
- Classroom forums
- Simulation training
- Computerized Based Learning Modules (e-learning/CBLs)
- Curriculum Development within College of Medicine
- Websites (internal OneSource and external OSUMC)
- Patient Safety/Quality Lesson's Learned and Patient Safety Alerts

**The James Benchmark data**

Both internal and external benchmarking provides value when evaluating performance.

***Internal Benchmarking***

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

***External Benchmarking***

The James participates in various database systems and focused benchmarking projects to compare performance with that of cancer hospital - peer institutions. The James Cancer Hospital utilizes and joins other comprehensive cancer centers for benchmarking such as C4QI (Comprehensive Cancer Center Consortium for Quality Improvement) and ADCC (Alliance of Dedicated Cancer Centers), National Cancer Institute (NCI). Also, The James participates in national benchmarking efforts through the following: The Vizient, The US News Report, and the Ohio Department of Health, Press Ganey, and National Database of Nursing Quality Indicators.

**Performance Based Provider Quality & Credentialing**

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

**Profiling Process:**

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

**Service-Specific Indicator**
Indicators are used to profile each physician's performance. The results are included in a physician profile, which is reviewed with the department chair as part of the credentialing process. The definition of service/department-specific indicators is the responsibility of the director/chair of each unit. The performance of these indicators is used as evidence of competence to grant privileges in the re-appointment process. The clinical departments/divisions are required to collect the performance information related to these indicators and report that information to the Department of Quality & Operations Improvement.

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

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

**Annual and On-Ongoing Evaluations**

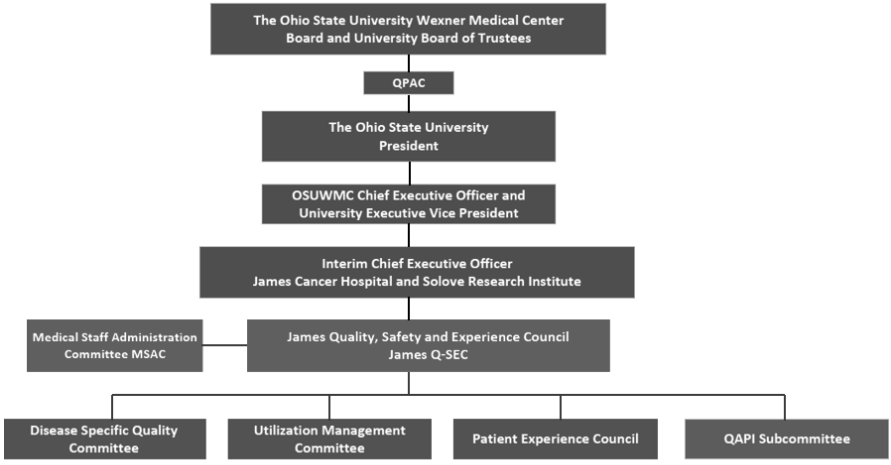
The James Quality Safety, and Experience Council Plan is approved annually by The James Quality, Safety and Experience Council and QPAC.

**Enterprise-Wide Alignment and Strategic Plan**

The James Quality, Safety and Experience Plan has been developed in alignment with the OSUWMC Enterprise-Wide Long Range Quality Plan (Attachment A). The Long-Range Quality Plan focuses on the foundations and three pillars of patient centered care that have been deemed priorities by the OSUWMC QLC.

**Attachment A: Long Range Quality Plan**


**Attachment B: The James Quality, Safety and Experience Council Structure**



**Approved:**
UH Bylaws Committee *5/31/23*
UH MSAC *6/14/23*
UH Medical Staff Vote *6/22/23*
Quality & Professional Affairs Committee
Wexner Medical Center Board
Ohio State University Board of Trustees



## UH Medical Staff Bylaws

***Summary of proposed changes***

***The proposed changes outlined below may be referenced in multiple sections of the bylaws, which have been updated accordingly in the full redlined document.***

**43-02 Purpose & 43-03 Patients.**

**Sections A-*References to membership categories***

- updates the names of membership categories in alignment with proposed changes in section 43-07

**43-04 Membership**

**Section A(3) – *Annual eLearnings***

- removes the requirement that all annual eLearnings are presented and approved by the UH Medical Staff Administrative Committee (MSAC)
  - some annual elearnings (such as HIPAA) are assigned by the medical center to all faculty and staff, regardless of role or work location so this change will align language with current process
  - Medical Staff Administrative Committee (MSAC) approval will continue to be required for elearnings assigned specifically to the full medical staff

**Section A(4) – *Waiver to eligibility criteria***

- language is removed in this section and rewritten in new section A(6)

**Section A(6) – *Waiver to eligibility criteria***

- section a-d is unchanged
- adds language in (e) – (f) will permit an initial applicant or credentialed provider up for reappointment the ability to request a waiver of the requirement to participate in government programs (i.e Medicare)
  - clarifies that waiver requests to this requirement will be considered on a case-by-case basis if the applicant has voluntarily opted-out and is not on an exclusion list
- adds language will prohibit an applicant to request a waiver of any requirements mandated by external accrediting or regulatory bodies

**Section C-*Reappointment Cycle***

- changes credentialing reappointment cycle from 24 months to 36 months in alignment with updates to Joint Commission standards
  - timelines for FPPE and OPPE will not change
  - other areas of bylaws where reappointment cycle is referenced are also updated

**Section E(3) - *Faculty appointments; credentialing process for drug screens & background checks for new applicants***

- language is updated in alignment with proposed changes to membership category criteria *(additional information on category changes is below)*
- language change will permit remote drug screens and background checks on initial applicants if the entities performing these duties meet the standards established by the medical center and in compliance with medical center policies
  - currently, drug screens and background checks are required to occur on-site so this will change will reduce the burden for new providers who live outside of Columbus

**43-06 Hearing and Appeal process**

**Section A(2) – *right to request a hearing***

- removes the right for a physician in the community affiliate B and C category to request a hearing if the individual's medical staff membership is terminated by the medical center board

**43-07 Categories of the Medical Staff**

There are no proposed changes to the medical staff categories listed below.

| # | Current Category Name | Proposed Category Name | Description |
|---|---|---|---|
| 1 | Physician Scholar | **Physician Scholar** | No proposed changes to this category. |
| 2 | Attending | **Attending** | No proposed changes to this category. |
| 3 | Consulting | **Consulting** | No proposed changes to this category. |

*Proposed changes to medical staff membership categories are detailed on the next page.*

**43-07 Categories of the Medical Staff**

Proposed changes:

| Medical Staff Category | Definition | Clinical Privileges to care for patients at an OSUWMC facility | Faculty Appointment Required | Rights to Vote on Medical Staff Issues | Access to IHIS | eLearnings Required |
|---|---|---|---|---|---|---|
| **Community Affiliate A** | Currently named Courtesy A. Credentialed community providers (i.e. Peds that see newborns) or OSUP employed/contracted physicians who are granted clinical privileges to admit and treat patients at any OSUWMC IP or OP facility. | **Yes** | Yes | Yes | Yes | Yes |
| **Community Affiliate B** *(New category)* | Physicians or groups employed by OSUP who need to be credentialed for enrollment in managed care plans or for other OSUP business purposes (i.e. billing). | **No** | No | No | Some may need access | HIPAA only if IHIS access is permitted |
| **Community Affiliate C** | Currently named Courtesy B. Credentialed community physicians who wish to be associated with OSUWMC to refer and follow patients; may attend medical staff activities, meetings, grand rounds, etc. | **No** | Yes | No | No | No |
| **Community Affiliate D** | Currently named Community Affiliate. Credentialed physicians who were grandfathered on to the medical staff when Ohio State purchased Park Hospital (now OSU East Hospital). This membership category will sunset when remaining physicians do not seek reappointment. | **Yes** | No | No | Yes | Yes |
| **Contracted** *(New category)* | Physicians who are not affiliated with OSUP and are providing clinical services as part of a contract with the organization (i.e., anesthesiology group working at OSUWMC ASCs; radiologists providing services remotely). | **YES** | No | No | Yes | HIPAA only if remote; all required if on-site |

**43-08 Organization of the medical staff**

**Section B & C – *administrative changes***

- adds Dermatology to the list of clinical departments as approved by the university
- removes the requirement for the UH Medical Staff Administrative Committee (MSAC) to approve divisions

**43-09 Elected officers of the medical staff**

**Section A(10) – *administrative change***

- removes language requiring the chief of staff to have meetings with elected officers, committee members and leadership; this can occur at the request of the chief of staff or any elected officer and does not need to be included in the bylaws

**Section E (1) – *administrative change***

- removes reference to paper ballots; all voting is completed electronically

**43-10 Administration of the medical staff**

**Section D (1) - *medical staff committee appointment process clarification***

- clarifies that hospital medical directors participate in the appointment of medical staff committees

**Section E (3) - *Executive Session of MSAC***

- adds section to provide consistency in the request to call Executive Session (voting members only) upon the recommendation of the credentialing committee
  - discussion in Executive Session may include issues that are considered confidential in nature (i.e. issues that may impact a credentialed provider's clinical privileges or membership on the medical staff)

**Section G(2) - *administrative change***

- removes 'independent' from "licensed independent practitioner" per Joint Commission update

**43-12 Meetings and Dues**

**Section A – *administrative change***

- updates language to permit medical staff meetings to occur at least annually at the discretion of the chief of staff

**43-13 Amendments and adoption**

**Section B – *voting timeline***

- reduces the timeline for the medical staff to vote on bylaws and rules and regs changes from 30 to 14 days
- removes reference to paper ballot

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

**Chapter 3335-43 - Bylaws of the Medical Staff of The Ohio State University Hospitals**

*Last revision: February 8, 2022*

**3335-43-01 Medical staff name.**

The board of trustees of the Ohio state university, by official action on September 13, 1963, established "the Ohio state university hospitals." In accordance with Chapters 3335-93-01 to 3335-93-03 and 3335-101-04 of the Administrative Code, the Ohio state university Wexner medical center board (herein called Wexner medical center board) has delegated to the medical staff of the Ohio state university hospitals the responsibility to prepare and recommend adoption of these bylaws. "The medical staff of the Ohio state university hospitals" shall be the name of the hospitals' medical staff organization.

(Board approval date: 5/14/2010, 11/7/2014)

**3335-43-02 Purpose.**

The purpose of the self-governing, democratically organized medical staff, which is accountable to the Ohio state university Wexner medical center board for the quality of care provided to the patients of the Ohio state university hospitals, shall be:

(A) To strive to maintain quality standards of patient care for all patients admitted to the Ohio state university hospitals, consistent with an active teaching environment, realizing that the care and treatment of the individual patient is the medical responsibility of the member of the attending, ~~courtesy A,~~ community affiliate A, and community affiliate D medical staff to whose care the patient is admitted or transferred.

(B) To support educational and research programs; elevate and advance the educational standards of our professions, including, but not limited to, pre- and post-M.D. students, nurse students, graduate nurse students, students of the allied medical professions, and students of other health professional colleges; and provide research programs to enhance and advance the educational and patient-care programs.

(C) To provide a means whereby medical problems may be reviewed; policies and procedures discussed; and to provide a means for establishing and maintaining standards of professional, medical and educational performance, organization, and discipline within the medical staff and harmonious cooperation and understanding among the units comprising the Ohio state university hospitals.

(D) To provide service, education and research programs to benefit the mental, physical, and environmental health of the citizens of the state of Ohio; dedicate itself to be responsive to the needs of its patients and to communicate effectively concerning matters of patient care; and encourage dissemination of medical knowledge to health professionals and the public, and conduct research for the prevention and treatment of disease.

(E) To govern medical staff and credentialed practitioners these bylaws are not intended to and shall not create any contractual rights between the Ohio state university Wexner medical center and any practitioner. Any and all contracts of affiliation, association or employment shall control contractual and financial relationships between the Ohio state university Wexner medical center and such practitioners.

(Board approval dates: 6/7/2002, 2/2/2007, 9/19/2008, 4/8/2011, 11/7/2014, 4/6/2018)

**3335-43-03 Patients.**

(A) The continuous care and treatment of individual patients is the medical responsibility of the member of the attending, ~~courtesy A~~community affiliate A, ~~and~~ and community affiliate D medical staff to whose care the patient is admitted or transferred within the Ohio state university hospitals and to licensed health care professionals being granted clinical privileges under these bylaws.

(B) There shall be only one category or classification of patients in the Ohio state university hospitals, and those patients are the private patients of the medical staff under whose care they are admitted. Patients admitted to the Ohio state university hospitals who, at the time of admission, have not requested or selected a member of the medical staff to attend them shall be assigned by the chief of the appropriate clinical division or department or their designees, to a member of the medical staff for their care and treatment.

(C) All patients admitted to the Ohio state university hospitals should cooperate and be an integral part of the teaching program of the college of medicine. Should a patient, or on the behalf of the patient, the patient's representative, refuse to participate or cooperate in the teaching program of the Ohio state university hospitals or the college of medicine, the medical staff member responsible for the care and treatment of the patient will encourage participation in the Ohio state university's teaching programs, but will simultaneously inform patients, or when appropriate, the patient's representative, of their right to refuse participation. Students, including pre- and post-M.D., but not limited thereto, shall be under the direction and control of the members of the medical staff to whom the patient is assigned upon admission to the Ohio state university hospitals or transfer within the Ohio state university hospitals' services. The Ohio state university hospitals respect the patient's right to participate in decisions about his or her care, treatment and services, and further respects the patient's right to refuse care treatment and services, in accordance with law and regulation.

(Board approval dates: 6/7/2002, 2/2/2007, 9/19/2008, 4/8/2011, 11/7/2014)

**3335-43-04 Membership.**

(A) Qualifications.

(1) Membership on the medical staff of the Ohio state university hospitals is a privilege extended to doctors of medicine, osteopathic medicine, dentistry, and to practitioners of psychology and podiatry who consistently meet the qualifications, standards, and requirements set forth in the bylaws, rules and regulations of the medical staff, the Wexner medical center board and the board of trustees of the Ohio state university. Membership on the medical staff is available on an equal opportunity basis without regard to race, color, creed, religion, sexual orientation, national origin, gender, age, handicap, or veteran/military status. Doctors of medicine, osteopathic medicine, dentistry, and practitioners of psychology and podiatry in faculty and administrative positions who desire medical staff membership shall be subject to the same procedures as all other applicants for the medical staff.

(2) All members of the medical staff of the Ohio state university hospitals shall, except as specifically provided in these bylaws, be members of the faculty of the Ohio state university college of medicine, or in the case of dentists, of the Ohio state university college of dentistry. All members, except for physician scholar medical staff, shall be duly licensed or certified to practice in the state of Ohio. Members of the limited staff shall possess a valid training certificate, or an unrestricted license from the applicable state board based on the eligibility criteria defined by that board. All members of the medical staff and limited staff and licensed health care professionals with clinical privileges shall comply with provisions of state law and the regulations of the state medical board or other state licensing board if applicable. Only those physicians, dentists, and practitioners of psychology and podiatry who can document

their education, training, experience, competence, adherence to the ethics of their profession, dedication to educational and research-goals, and ability to work with others with sufficient adequacy to assure the Wexner medical center board and the board of trustees of the Ohio state university that any patient treated by them at university hospitals will be given the high quality of medical care provided at university hospitals, shall be qualified for membership on the medical staff of the Ohio state university hospitals.

All applicants for membership, clinical privileges, and members of the medical staff must provide basic health information to fully demonstrate that the applicant or member has, and maintains, the ability to perform requested clinical privileges. The chief medical officer of the medical center, medical directors, the department chairperson, the credentialing committee, the medical staff administrative committee, the quality and professional affairs committee of the Ohio state university Wexner medical center board, or the Ohio state university Wexner medical center board may initiate and request a physical or mental health evaluation of an applicant or member. Such request shall be in writing to the applicant. All members of the medical staff and licensed health care professionals will comply with medical staff and the Ohio state university policies regarding employee and medical staff health and safety; uncompensated care; and will comply with appropriate administrative directives and policies to avoid disrupting those operations of the Ohio state university hospitals which adversely impact overall patient care or which adversely impact the ability of the Ohio state university hospitals employees or staff to effectively and efficiently fulfill their responsibilities. All members of the medical staff and licensed health care professionals shall agree to comply with bylaws, rules and regulations, and policies and procedures adopted by the medical staff administrative committee and the Wexner medical center board, including but not limited to policies on professionalism, behaviors that undermine a culture of safety,~~.~~ ~~a~~Annual education and training approved by the medical staff administrative committee or as required by the Wexner medical center to meet accreditation standards, federal regulations, or quality and safety goals is required for medical staff members with clinical privileges in addition to conflict of interest disclosure. ~~(list approved by the medical staff administrative committee and maintained in the chief medical officer's office), conflict of interest, HIPAA compliance, and access and communication guidelines.~~ Medical staff members and licensed health care professionals with clinical privileges must also comply with the university integrity program requirements including but not limited to billing, self-referral, ethical conduct and annual education.

Medical staff members and licensed health care professionals with clinical privileges must immediately disclose to the chief medical officer and the department chairperson the occurrence of any of the following events: a licensure action in any state, any malpractice claims filed in any state or an arrest by law enforcement.

(3) All members of the medical staff and credentialed providers must maintain continuous uninterrupted enrollment with all governmental health care programs.

(a) It shall be the duty of all medical staff members and credentialed providers to promptly inform the chief medical officer and the corporate credentialing office of any investigation, action taken, or the initiation of any process which could lead to an action taken by any governmental programs.

(b) Exclusion of any medical staff member or credentialed provider from participation in any federal or state government program or suspension from participation, in whole or part, in any federal or state government reimbursement program, shall result in immediate lapse of membership on the medical staff of the Ohio state university hospitals and the immediate lapse of clinical privileges at the Ohio state university hospitals as of the effective date of the exclusion or suspension. Medical staff members may submit a request to resign their medical staff membership to the Chief Medical Officer in lieu of automatic termination. The resignation in lieu of automatic

termination shall be discussed at the next credentialing committee and medical staff administrative committee in order to provide recommendations to the Quality and Professional Affairs Committee of the Wexner Medical Center Board. A final determination should be decided by the Quality and Professional Affairs Committee at its next regular meeting.

(c) If the medical staff member's or credentialed provider's participation in all governmental programs is fully reinstated, the affected medical staff member or credentialed provider shall be eligible to apply for membership and clinical privileges at that time.

(4) An applicant for membership shall at the time of appointment or reappointment, be and remain board certified in his or her primary are of practice at the Ohio state university hospitals. This Board certification must be approved by at least one of the American board of medical specialties, or other applicable certifying boards, including certifying boards if applicable for doctors of osteopathy, podiatry, psychology, and dentistry. All applicants must be and remain certified within the specific areas for which they have requested clinical privileges. Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years will be eligible for medical staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training. Applicants must maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification will be assessed at reappointment. Failure to meet or maintain board certification shall result in immediate termination of membership on the medical staff of the Ohio state university hospitals. ~~Waiver of this threshold eligibility criteria is as follows:~~

~~(a) A request for a waiver will only be considered if the applicant provides information sufficient to satisfy his or her burden of demonstrating that his or her qualification are equivalent to or exceed the criterion in question and that there are exceptional circumstances that warrant a waiver. The clinical department chief must endorse the request for waiver in writing to the credentialing committee.~~

~~(b) The credentialing committee may consider supporting documentation submitted by the prospective applicant, any relevant information from third parties, input from the relevant department chiefs, and the best interests of the hospital and the communities it serves. The credentialing committee will forward its recommendation, including the basis for such, to the medical staff administrative committee.~~

~~(c) The medical staff administrative committee will review the recommendation of the credentialing committee and make a recommendation to the quality and professional affairs committee of the Ohio state university Wexner medical center and the Wexner medical center board regarding whether to grant or deny the request for a waiver and the basis for its recommendation.~~

~~(d) The Ohio state university Wexner medical center board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and does not give rise to a right to a hearing. The prospective applicant who requested the waiver in a particular case is not intended to set a precedent for any other applicant. A determination to grant a waiver does not mean that an appointment will be granted. Waivers of threshold eligibility criteria will not be granted routinely. No applicant is entitled to a waiver or to a hearing if a waiver is not granted.~~

(5) All applicants must demonstrate recent clinical activity in their primary area of practice during the last two years to satisfy minimum threshold criteria for privileges within their clinical departments.

(6) Waiver requests for the threshold eligibility requirements listed in paragraphs (A)(3) through (A)(5) may be requested and considered as follows:

(a) A request for a waiver will only be considered if the applicant provides information sufficient to satisfy his or her burden of demonstrating that his or her qualifications are equivalent to or exceed the criterion in question and that there are exceptional circumstances that warrant a waiver. The clinical department chief must endorse the request for waiver in writing to the credentialing committee.

(b) The credentialing committee may consider supporting documentation submitted by the prospective applicant, any relevant information from third parties, input from the relevant department chiefs, and the best interests of the hospital and the communities it serves. The credentialing committee will forward its recommendation, including the basis for such, to the medical staff administrative committee.

(c) The medical staff administrative committee will review the recommendation of the credentialing committee and make a recommendation to the quality and professional affairs committee of the Ohio state university Wexner medical center and the Wexner medical center board regarding whether to grant or deny the request for a waiver and the basis for its recommendation.

(d) The Ohio state university Wexner medical center board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and does not give rise to a right to a hearing. The prospective applicant who requested the waiver in a particular case is not intended to set a precedent for any other applicant. A determination to grant a waiver does not mean that an appointment will be granted. Waivers of threshold eligibility criteria will not be granted routinely. No applicant is entitled to a waiver or to a hearing if a waiver is not granted.

(e) Waiver requests for the threshold eligibility requirement listed in paragraph (A)(3) of this rule may only be considered for applicants who have voluntarily opted out of governmental health care programs. Applicants who have been excluded or suspended shall be ineligible to request a waiver.

(f) Waivers to requirements prescribed by regulatory, accrediting, or other external agencies will not be granted.

~~(6)~~

(7) Any medical staff member whose membership has been terminated pursuant to paragraph (A)(3) or (A)(4) of this rule shall not be entitled to request a hearing and appeal in accordance with rule 3335-43-06 of the Administrative Code. Any licensed health care professional whose clinical privileges have been terminated pursuant to paragraph (A)(4) of this rule may not request an appeal in accordance with paragraph ~~(H)~~(G) (~~8~~3)~~(j)~~ of rule 3335-43-07 of the Administrative Code.

(8) No applicant shall be entitled to medical staff membership and or clinical privileges merely by the virtue of fulfilling the above qualifications or holding a previous appointment to the medical staff.

(B) Application for membership.

Initial application for medical staff membership for all categories of the medical staff shall be made by the applicant to the chief of the clinical department on forms prescribed by the medical staff administrative committee stating the qualifications and references of the applicant and giving an account of the applicant's current licensure, relevant professional training and experience, current competence and ability to perform the clinical privileges requested. All applications for appointment must specify the clinical privileges requested. Applications may be made only if the applicant meets the qualifications outlined in paragraph (A) of this rule. The application shall include written statements of the applicant to abide by the bylaws, rules and regulations and policies and procedures of the medical staff, the Wexner medical center board, and the board of trustees of the Ohio state university. The applicant shall produce a government-issued photo identification to verify his/her identity pursuant to hospital/medical staff policy. The applicant shall agree that membership on the medical staff requires participation in the peer review process of evaluating credentials, medical staff membership and clinical privileges, and that a condition for membership requires mutual covenants between all members of the medical staff to release one another from civil liability in this review process as long as the peer review was taken in the reasonable belief that it was in furtherment of quality health care based upon a reasonable review and appropriate procedural due process. In order to optimize the clinical organization resource utilization and planning of the Ohio state university hospitals, the chief of the clinical department may require that the community affiliate D medical staff member identify categories of diagnosis, extent of anticipated patient activity, and service areas to be utilized and may prepare a statement of participation for the applicant, which shall be made a part of the application for appointment. A separate record shall be maintained for each applicant requesting appointment to the medical staff.

(C) Terms of appointment. Initial appointment to the medical staff shall be for a period not to exceed ~~twenty-four~~ thirty-six months. During the first six months of the initial appointment, except for medical staff appointments without clinical privileges, appointees shall be subject to focused professional practice evaluation (FPPE) in order to evaluate the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization pursuant to these bylaws. FPPE requires the evaluation by of the chief of the clinical department with oversight by the credentials committee and the medical staff administrative committee. Following the six-month FPPE period, the chief of the clinical department may:

(1) recommend the initial appointee to transition to ongoing professional practice evaluation (OPPE), which is described later in these bylaws to the medical staff administrative committee;

(2) extend the FPPE period, which is not considered an adverse action, for an additional six months not to exceed a total of twelve months for purposes of further monitoring and evaluation; or

(3) terminate the initial appointee's medical staff membership and clinical privileges. In the event that the medical staff administrative committee recommends that an adverse action be taken against an initial appointee, the initial appointee shall be entitled to the provisions of due process as outlined in these bylaws.

(D) Ethics and ethical relationship. The code of ethics as adopted, or as may be amended, by the American medical association, the American dental association, the American psychological association, American osteopathic association and the American podiatric medical association shall govern the professional ethical conduct of the respective members of the medical staff.

(E) Procedure for appointment.

(1) The written and signed application for membership on the medical staff shall be presented to the applicable chief of the clinical department. The applicant shall include in the application a signed statement indicating the following:

(a) If the applicant should be accepted to membership on the medical staff, the applicant agrees to be governed by the bylaws, rules and regulations of the medical staff, the Wexner medical center board and the board of trustees of the Ohio state university.

(b) The applicant consents to be interviewed in regard to the application.

(c) The applicant authorizes the Ohio state university hospitals to consult with members of the medical staffs of other hospitals with which the applicant has been or has attempted to be associated, and with others who may have information bearing on the applicant's competence, character and ethical qualifications.

(d) The applicant consents to the Ohio state university hospitals' inspection of all records and documents that may be material to the evaluation of the applicant's professional qualifications and competence to carry out the clinical and educational privileges for which the applicant is seeking as well as the applicant's professional ethical qualifications for medical staff membership.

(e) The applicant releases from any liability:

i. All representatives of university hospitals for acts performed in connection with evaluating the applicant’s credentials or releasing information to other institutions for the purpose of evaluating the applicant’s credentials in compliance with these bylaws performed in good faith; and

ii. All third parties who provide information, including otherwise privileged and confidential information, to members of the medical staff, the Ohio state university hospitals staff, Ohio state university Wexner medical center board members and members of the Ohio state university board of trustees concerning the applicant’s credentials performed in good faith.

(f) The applicant has an affirmative duty to disclose any prior termination, voluntary or involuntary, current loss, restriction, denial, or the voluntary or involuntary relinquishment of any of the following: professional licensure, board certification, DEA registration, membership in any professional organization or medical staff membership or privileges at any other hospital or health care facility.

(g) The applicant further agrees to disclose to the chief medical officer of the Ohio state university hospitals the initiation of any process which could lead to such loss or restriction of the applicant’s professional licensure, board certification, DEA registration, membership in any professional organization or medical staff membership or privileges at any other hospital or health care facility.

(h) The applicant agrees that acceptance of membership on the medical staff of the Ohio state university hospitals authorizes the Ohio state university hospitals to conduct any appropriate health assessment including but not limited to drug or alcohol screens on a practitioner at any time during the normal pursuit of medical staff duties,

based upon reasonable cause as determined by the chief of the practitioner's clinical department or the chief medical officer of the Ohio state university hospitals or their authorized designees.

(2) The purpose of the health assessment shall be to ensure that the member of the medical staff is able to fully perform and discharge the clinical, educational, administrative and research responsibilities which the member is permitted to exercise by reason of medical staff membership. If, at the time of the initial request for a health assessment, and at any time a medical staff member refuses to participate as needed in a health assessment, including but not limited to a drug or alcohol screening, this shall result in automatic lapse of membership, privileges, and prerogatives until remedied by compliance with the requested health assessment. Upon request of the medical staff administrative committee or Wexner medical center board, the applicant will provide documentation the applicant's physical and mental status with sufficient adequacy to demonstrate that any patient treated by the applicant will receive care of a generally professionally recognized level of quality and efficiency. The conditions of this paragraph shall be deemed continuing and may be applicable to issues of continued good standing as a member of the medical staff.

(3) An application for membership on the medical staff shall be considered complete when all the information requested on the application form is provided, the application is signed by the applicant and the information is verified. A completed application must contain:

(a) Peer recommendation from at least three individuals with "first hand" knowledge about the applicant's clinical and professional skills.

(b) Evidence of required immunizations.

(c) Evidence of current professional medical malpractice liability coverage required for the exercise of clinical privileges.

(d) Satisfaction of ECFMG requirements, if applicable. If an individual receives a conceded eminence certificate or a clinical research faculty certificate from the state medical board of Ohio, the requirement for ECFMG certification may be waived at the discretion of the Wexner medical center board.

(e) Verification by primary source documentation of:

i. Current and previous state licensure;

ii. Faculty appointment (not required for community affiliate B, community affiliate C, community affiliate D or contracted category);

iii. DEA registration when required for exercise of clinical privileges;

iv. Graduation from an accredited medical or professional school;

v. Successful completion or record of post graduate medical or professional education; and

vi. Board certification or active candidacy for board certification (may not be required for community affiliate B, community affiliate C and community affiliate D categories) or applicant qualifies for a waiver pursuant to paragraph (A) (4)(6) of rule 3335-43-04 of the Administrative Code.

(f) Information from the national practitioner data bank.

(g) Verification that the applicant has not been excluded from any federally funded health care program.

(h) Complete disclosure by applicant of all past and current claims, suits, and settlements, if any.

(i) Completion of a criminal background investigation that meets the requirements of the Wexner medical center. ~~criminal history check by Ohio state university medical center security department.~~

(j) Completion of ~~Ohio state university medical center~~ drug testing for substances required for individuals applying for clinical privileges and in accordance with Wexner medical center approved testing protocols.

(k) Verification of completion of annual educational requirements approved by the medical staff administrative committee and maintained in the chief medical officer's office.

(l) Demonstration of recent active clinical practice during the last two years required for exercise of clinical privileges.

(m) Attestation of current Ohio automated Rx reporting system ("OARRS") account for all applicants who have a DEA registration.

(4) The chief of the applicable clinical department shall be responsible for investigating and verifying the character, qualifications, and professional standing of the applicant by making inquiry of the primary source of such information and shall within thirty days of receipt of the complete application, submit a report of those findings along with a recommendation on membership and clinical privileges to the chief medical officer of the Ohio state university hospitals.

(5) The chief medical officer shall receive all initial signed and verified applications from the chief of the clinical department and shall make an initial determination as to whether the application is complete. The credentials committee, the medical staff administrative committee, the quality and professional affairs committee, and the Wexner medical center board have the right to render an application incomplete, and therefore not able to be processed, if the need arises for additional or clarifying information.

The chief medical officer shall forward all complete applications to the credentials committee. The applicant shall have the burden of producing information for an adequate evaluation of applicant's qualifications for membership and for the clinical privileges requested. If the applicant fails to complete the prescribed forms or fails to provide the information requested within sixty days of receipt of the signed application, processing of the application shall cease and the application shall be deemed to have been voluntarily withdrawn which action is not subject to hearing or appeal pursuant to rule 3335-43-06 of the Administrative Code.

If the chief of the applicable clinical department does not submit a report and recommendation on a timely basis, the completed application shall be forwarded to the chief medical officer for presentation to the credentials committee on the same basis as other applicants.

(6) Completed applications shall be acted upon as follows:

(a) By the credentials committee within thirty days after receipt of a completed application from the chief medical officer.

(b) By the medical staff administrative committee within thirty days after receipt of a completed application and the report and recommendation of the credentials committee.

(c) By the quality and professional affairs committee through the expedited credentialing process or Wexner medical center board within sixty days after receipt of a completed application and the report and recommendation of the medical staff administrative committee.

All applications shall be acted upon by the Ohio state university Wexner medical center board within one hundred twenty days of receipt of a completed application. These time periods are deemed guidelines only and do not create any right to have an application processed within these precise periods. These periods may be stayed or altered pending receipt and verification of further information requested from the applicant, or if the application is deemed incomplete at any time. If the procedural rights specified in rule 3335-43-06 of the Administrative Code are activated, the time requirements provided therein govern the continued processing of the application.

(7) The credentials committee shall review the application, evaluate and verify the supporting documentation, references, licensure, the chief of the clinical department's report and recommendation, and other relevant information. The credentials committee shall examine the character, professional competence, professional conduct, qualifications and ethical standing of the applicant and shall determine, through information contained in personal references and from other sources available to the credentials committee, including an appraisal from the chief of the clinical department in which clinical privileges are sought, whether the applicant has established and meets all of the necessary qualifications for the category of medical staff membership and clinical privileges requested.

The credentials committee shall, within thirty days from receipt of a complete application, make a recommendation to the chief medical officer that the application be accepted, rejected, or modified. The chief medical officer shall forward the recommendation of the credentials committee to the medical staff administrative committee. The credentials committee or the chief medical officer may recommend to the medical staff administrative committee that certain applications for appointment be reviewed in executive session. The recommendation of the medical staff administrative committee regarding an appointment decision shall be made within thirty days of receipt of the credentials committee recommendation and shall be communicated by the chief medical officer, along with the recommendation of the chief medical officer to the quality and professional affairs committee of the Wexner medical center board, and thereafter to the Wexner medical center board. When the Ohio state university Wexner medical center board has acted, the chairperson of the board shall instruct the chief medical officer to transmit the final decision to the chief of the clinical department and applicant and, if appropriate, to the director of the applicable clinical division.

(8) At any time, the medical staff administrative committee first recommends non-appointment of an initial applicant for medical staff membership or recommends denial of any clinical privileges requested by the applicant, the medical staff administrative committee shall require the chief medical officer to notify the applicant by certified return receipt mail that the applicant may request an evidentiary hearing as provided in paragraph (D) of rule 3335-43-06 of the Administrative Code. The applicant shall be notified of the requirement to request a hearing

as provided by paragraph (B) of rule 3335-43-06 of the Administrative Code. If a hearing is properly requested, the applicant shall be subject to the rights and responsibilities of rule 3335-43-06 of the Administrative Code. If an applicant fails to properly request a hearing, the medical staff administrative committee shall accept, reject, or modify the application for appointment to membership and clinical privileges.

The final recommendation of the medical staff administrative committee shall be directly communicated to the Wexner medical center board by the chief medical officer, who shall make a separate recommendation to the Wexner medical center board.

When the Ohio state university Wexner medical center board has acted, the chairperson of the board shall instruct the chief medical officer to transmit the final decision to the chief of the clinical department and applicant and, if appropriate, to the director of the applicable clinical division. The chairperson of the board shall also notify the dean of the college of medicine and the chief executive officer of the Ohio state university hospitals of the decision of the board.

(F) Procedure for reappointment.

(1) At least ninety days prior to the end of the medical staff member's appointment period, the chief of the clinical department shall provide each medical staff member with an application for reappointment to the medical staff on forms prescribed by the medical staff administrative committee. The reappointment application shall include all information necessary to update and evaluate the qualifications of the medical staff member. The chief of the clinical department shall review the information available on each medical staff member, and the chief of the clinical department shall make recommendations regarding reappointment to the medical staff and for granting clinical privileges for the ensuing appointment period. The chief of the clinical department's recommendation shall be transmitted in writing along with the signed and completed reappointment forms to the chief medical officer at least forty-five days prior to the end of the medical staff member's appointment period.

The terms of paragraphs (A), (B), (C), (D), (E)(1), and (E)(2) of this rule shall apply to all applicants for reappointment. Reappointment to the medical staff shall be done on a regular basis for a period not to exceed ~~twenty-four~~thirty-six months. Only completed applications for reappointment shall be considered by the credentials committee. An application for reappointment is complete when all the information requested on the reappointment application form is provided, the reappointment form is signed by the applicant, and the information is verified, and no need for additional or clarifying information is identified. A completed reappointment application form must contain:

(a) Evidence of required immunizations if applicable since last appointment.

(b) Evidence of current professional medical malpractice liability insurance required for the exercise of clinical privileges.

(c) Verification of primary source documentation of:

i. State licensure;

~~ii. Faculty appointment (not required for community affiliate category);~~

~~iii.~~ii. DEA registration when required for clinical privileges;

~~iv.~~iii. Successful completion or record of additional post graduate medical or professional education; and

~~v.~~iv. Board certification, re-certification, or continued active candidacy for

certification (may not be required for community affiliate category) or applicant qualifies for a waiver pursuant to paragraph (A) ~~(4)~~(6) of rule 3335- 43-04 of the Administrative Code.

(d) Information from the national practitioner data bank.

(e) Verification that the applicant has not been excluded from any federally funded health care program.

(f) Specific requests for any changes in clinical privileges sought at reappointment with supporting documentation as required by credentialing guidelines.

(g) Specific requests for any changes in medical staff category.

(h) A summary of the member's clinical activity during the previous appointment period.

(i) Patterns of care as demonstrated through quality assurance records.

(j) Verification of completion of annual educational requirements approved by the medical staff administrative committee and maintained in the chief medical officer's office.

(k) Complete disclosure by medical staff members of claims, suits, and settlements, if any.

(l) Continuing medical education and applicable continuing professional education activities. Documentation of category one CME that at least in part relates to the individual medical staff member's specialty or sub-specialty area and are consistent with the licensing requirements of the applicable Ohio state licensing board shall be required.

(m) Attestation of current OARRS account for all applicants who have a DEA registration.

(2) The member for reappointment shall be required to submit any reasonable evidence of current ability to perform the clinical privileges requested. The chief of the clinical department shall review and evaluate the reappointment application and the supporting documentation. The chief of the clinical department shall evaluate all matters relevant to recommendation, including the member's professional competence; clinical judgment; clinical or technical skills; ethical conduct; participation in medical staff affairs; compliance with the bylaws, rules and regulations of the medical staff, the Wexner medical center board, and the board of trustees of the Ohio state university; cooperation with the Ohio state university hospitals' personnel and the use of the Ohio state university hospitals' facilities for patients; relations with other physicians, other health professionals or other staff, and maintenance of a professional attitude toward patients; and the responsibility to the Ohio state university hospitals and the public.

(3) The chief medical officer shall forward the reappointment forms and the recommendations of the chief of the clinical department to the credentials committee. The credentials committee shall review the request for reappointment in the same manner, and with the same authority as an original application for medical staff membership. The credentials committee shall review all aspects of the reappointment application including source verification of the member's quality assurance record for continuing membership qualifications and for clinical privileges.

The credentials committee shall review each member's performance-based profile to ensure that the same level of quality of care is delivered by all medical staff members with similar delineated clinical privileges across all clinical departments and across all categories of medical staff membership.

(G) The credentials committee shall forward its recommendations to the chief medical officer at least thirty days prior to the end of the period of appointment. The chief medical officer shall transmit the completed reappointment application and the recommendation of the credentials committee to the medical staff administrative committee.

Failure of the member to submit a reappointment application shall be deemed a voluntary resignation from the medical staff and shall result in automatic expiration of membership and all clinical privileges at the end of the medical staff member's current appointment period, which action shall not be subject to a hearing or appeal pursuant to rule 3335-43-06 of the Administrative Code. A request for reappointment subsequently received from a member who has been automatically expired shall be processed as a new appointment.

Failure of the chief of the clinical department to act timely on an application for reappointment shall be the same as provided in paragraph (E)(5) of this rule.

(1) The medical staff administrative committee shall review each request for reappointment in the same manner and with the same authority as an original application for medical staff membership. The medical staff administrative committee shall accept, reject, or modify the request for reappointment in the same manner and with the same authority as an original application for medical staff membership. The recommendation of the medical staff administrative committee regarding reappointment of a member shall be communicated by the chief medical officer, along with the recommendation of the chief medical officer, to the quality and professional affairs committee of the Wexner medical center board, and thereafter to the Wexner medical center board.

(2) When the Ohio state university Wexner medical center board has acted, the chairperson of the board shall instruct the chief medical officer to transmit the final decision to the chief of the clinical department and applicant and, if appropriate, to the director of the applicable clinical division.

(3) When the decision of the medical staff administrative committee results in a decision of non-reappointment or reduction, suspension or revocation of clinical privileges, the medical staff administrative committee shall instruct the chief medical officer to give written notice to the affected member of the decision, the stated reason for the decision, and the member's right to a hearing pursuant to paragraphs (A) and (B) of rule 3335-43-06 of the Administrative Code. This notification and an opportunity to exhaust the appeal process shall occur prior to an adverse decision unless the provisions outlined in paragraph (D) of rule 3335-43-05 of the Administrative Code apply. The notice by the chief medical officer shall be sent certified return receipt mail to the affected member's last known address as determined by the Ohio state university records.

(4) If the affected member of the medical staff does not make a written request for a hearing to the chief medical officer within thirty-one days after receipt of the adverse decision, it shall be deemed a waiver of the right to any hearing or appeal as provided in rule 3335-43-06 of the Administrative Code to which the staff member might otherwise have been entitled on the matter.

(5) If a timely, written request for hearing is made, the procedures set forth in rule 3335-43-06 of the Administrative Code shall apply.

(H) Resumption of clinical activities following leave of absence.

(1) A member of the medical staff or credentialed provider shall request a leave of absence in writing for good cause shown such as medical reasons, educational and research reasons or military service to the chief of clinical service and the chief medical officer. Such leave of absence shall be granted at the discretion of the chief of the clinical service and the chief medical officer provided, however, such leave shall not extend beyond the term of the member's or credentialed provider's current appointment. A member of the medical staff or credentialed provider who is experiencing health problems that may impair his or her ability to care for patients has the duty to disclose such impairment to his or her chief of clinical department and the chief medical officer and the member or credentialed provider shall be placed on immediate medical leave of absence until such time the member or credentialed provider can demonstrate to the satisfaction of the chief medical officer that the impairment has been sufficiently resolved and can request for reinstatement of clinical activities. During any leave of absence, the member or credentialed provider shall not exercise his or her clinical privileges, and medical staff responsibilities and prerogatives shall be inactive.

(2) The member or credentialed provider must submit a written request for the reinstatement of clinical privileges to the chief of the clinical service. The chief of the clinical service shall forward his recommendation to the credentialing committee which, after review and consideration of all relevant information, shall forward its recommendation to the medical staff administrative committee and quality and professional affairs committee of the Wexner medical center board. The credentials committee, the chief medical officer, the chief of the clinical service or the medical staff administrative committee shall have the authority to require any documentation, including advice and consultation from the member's or credentialed provider's treating physician or the committee for practitioner health that might have a bearing on the medical staff member's or credentialed provider's ability to carry out the clinical and educational responsibilities for which the medical staff is seeking privileges. Upon return from a leave of absence for medical reasons the medical staff member or credentialed provider must demonstrate his or her ability to exercise his or her clinical privileges upon return to clinical activity.

(3) All members of the medical staff or credentialed providers who take a leave of absence for medical or non-medical reasons must be in good standing upon resumption of clinical activities. No member shall be granted leave of absence in excess or his or her current appointment and the usual procedures for appointment and reappointment, including deadlines for submission of application as set forth in this rule, will apply irrespective of the nature of the leave. Absence extending beyond his or her current term or failure to request reinstatement of clinical privileges shall be deemed a voluntary resignation from the medical staff and of clinical privileges, and in such event, the member or credentialed provider shall not be entitled to a hearing or appeal.

(Board approval dates: 9/1/1999, 10/1/1999, 10/5/2001, 6/7/2002, 9/6/2002, 3/5/2003, 5/30/2003, 6/4/2004, 5/6/2005, 11/4/2005, 2/2/2007, 2/1/2008, 9/19/2008, 9/18/2009, 10/29/2009, 5/14/2010, 4/8/2011, 8/31/2012, 2/1/2013, 1/31/2014, 11/7/2014, 11/6/2015, 9/2/2016, 4/6/2018)

**3335-43-05 Peer review and corrective action.**

(A) Informal peer review.

(1) All medical staff members agree to cooperate in informal peer review activities that are solely intended to improve the quality of medical care provided to patients at the Ohio state university hospitals.

(2) Information indicating a need for informal review, including patient complaints, disagreements, questions of clinical competence, inappropriate conduct and variations in clinical practice identified by the clinical departments or divisions and medical staff committees shall be referred to the chair of the practitioner evaluation committee.

(3) The practitioner evaluation committee chair or his or her designee may obtain information or opinions from medical staff members or credentialed providers as well as external peer review consultants pursuant to criteria outlined in these bylaws. The information or opinions from the informal peer review may be presented to the practitioner evaluation committee or another designated peer review committee.

(4) Following the assessment by the practitioner evaluation committee chair or his or her designee, the practitioner evaluation committee may make recommendations for educational actions of additional training, sharing of comparative data or monitoring or provide other

(5) forms of guidance to the medical staff member to assist him or her in improving the quality of patient care. Such actions are not regarded as adverse, do not require reporting to any governmental or other agency, and do not invoke a right to any hearing.

(6) At the conclusion of the evaluation, the practitioner evaluation committee chair or his or her designee submits a report to the applicable clinical department chief and the chief medical officer. The chief of the clinical department and the chief medical officer shall evaluate the matter to determine the appropriate course of action. They shall make an initial written determination on whether:

(a) The matter warrants no further action;

(b) Informal resolution under this paragraph is appropriate. The chief of the clinical department and the chief medical officer shall determine whether to include documentation of the informal resolution in the medical staff member's file. If documentation is included in the member's file, the affected member shall have an opportunity to review it and may make a written response which shall also be placed in the file. Informal review under this paragraph is not a procedural prerequisite to the initiation of formal peer review under paragraph (B) of this rule; or

(c) Formal peer review under paragraph (B) of this rule is warranted.

(7) In cases where the chief of the clinical department and chief medical officer cannot agree on the need for formal peer review, the matter shall be submitted for formal peer review and determined as set forth in paragraph (B) of this rule.

(B) Formal peer review.

(1) Formal peer review may be initiated when a member of the medical staff of the Ohio state university hospitals:

(a) Fails to adhere to standards of patient care and professional conduct appropriate for a physician practicing in an academic medical center as determined by the medical staff;

(b) Is disruptive to the operation of the Ohio state university hospitals;

(c) Violates the bylaws, rules and regulations of the medical staff, the Ohio state university Wexner medical center board, or the board of trustees of the Ohio state university;

(d) Violates state or federal law; or

(e) Is responsible for acts or omissions detrimental to patient safety or to the quality or efficiency of patient care within the Ohio state university hospitals; or

(f) Is responsible for acts or omissions damaging to the reputation of the medical staff of the Ohio state university hospitals.

(2) Formal peer review may be initiated by a chief of a clinical department, the chief medical officer, any member of the medical staff, the chief executive officer of the Ohio state university hospitals, the dean of the college of medicine, any member of the board of the Ohio state university hospitals, or the vice president for health services. All requests for formal peer review shall be in writing, shall be submitted to the chief medical officer, and shall specifically state the conduct or activities which constitute grounds for the requested action.

(3) The chief medical officer shall promptly deliver a written copy of the request for formal peer review to the affected member of the medical staff, in a confidential manner. The chief medical officer shall then conduct a preliminary review to verify the facts related to the request for formal peer review, and within thirty days, make a written determination. If the chief medical officer decides that no further action is warranted, the chief medical officer shall notify the person(s) who filed the request for formal peer review and the member accused, in writing, that no further action will be taken.

(4) Whenever the chief medical officer determines that formal peer review is warranted, he or she shall refer the request for formal peer review to the formal peer review committee. The affected member of the medical staff shall be notified of the referral to the formal peer review committee and be informed that these medical staff bylaws shall govern all further proceedings.

(5) The executive vice president for health sciences or designee shall exercise any or all duties or responsibilities assigned to the chief medical officer under these rules for implementing corrective action and appellate procedure if:

(a) The chief medical officer is the medical staff member charged;

(b) The chief medical officer has a financial interest or a relationship with any person that may have an improper effect on the exercise of his or her judgment in the matter, or may be perceived to have such an effect.

(6) The formal peer review committee shall investigate every request and shall deliver written findings and recommendations for action to the chief of the clinical department. The formal peer review committee may recommend a reduction, suspension or revocation of the medical staff member's clinical privileges or other action as it deems appropriate. In making its recommendation the formal peer review committee may consider, relevant literature and clinical practice guidelines, the opinions and views expressed throughout the review process, information or explanations provided by the member under review, and other relevant information. Prior to making its report, the committee shall afford the medical staff member against whom the action has been requested an opportunity for an interview. At such interview, the medical staff member shall be informed of the specific actions or omissions alleged to constitute grounds for formal peer review and shall be given copies of any statements, reports, opinions or other information compiled at prior stages of the proceedings. The medical staff member may furnish written or oral information to the formal peer review committee at this time and shall be given an opportunity to discuss, explain, or refute the allegations and to respond to any statements, reports or opinions previously compiled in the proceedings.

However, such interview shall not constitute a hearing, but shall be investigative in nature. The medical staff member shall not be represented by an attorney at this interview. The written findings and recommendations for action are expected to be submitted within 90 days, unless an extension is deemed necessary by the committee.

(7) Upon receipt of the written report and recommendation from the formal peer review committee, the chief of the clinical department shall make his or her own written recommendation for corrective action and forward that recommendation along with the findings and recommendations of the formal peer review committee to the chief medical officer.

(8) The chief medical officer shall decide whether to accept, reject or modify the recommendation of the chief of the clinical department. If the chief medical officer decides the grounds are not substantiated, the chief medical officer will notify the formal peer review committee, the chief of the clinical department, the person(s) who filed the complaint and the affected medical staff member, in writing, that no further action will be taken.

If the chief medical officer finds the grounds for the requested corrective action are substantiated, the chief medical officer shall promptly notify the affected medical staff member of that decision and the corrective action that will be taken. This notice shall advise the affected medical staff member of his or her right to request a hearing before the medical staff administrative committee pursuant to rule 3335-43-06 of the Administrative Code and shall also include a statement that failure to request a hearing in the timeframe prescribed in this rule shall constitute a waiver of rights to a hearing and to an appeal on the matter and the affected medical staff member shall also be given a copy of the rule 3335-43-06 of the Administrative Code. This notification and an opportunity to exhaust the administrative hearing and appeal process shall occur prior to the imposition of the proposed corrective action unless the emergency provisions outlined in paragraph (D) of this rule apply. This written notice by the chief medical officer shall be sent certified return receipt mail to the affected medical staff member's last known address as determined by university records.

(9) If the affected member of the medical staff does not make a written request for a hearing to the chief medical officer within thirty-one days after receipt of the adverse decision, he or she shall be deemed to have waived the right to any review by the medical staff administrative committee to which the staff member might otherwise have been entitled on the matter.

(10) If a timely, written request for hearing is made, the procedures set forth in rule 3335-43-06 of the Administrative Code shall apply.

(C) Composition of formal peer review committee.

(1) When the determination that formal peer review is warranted is made, the chief of the clinical department shall select three members of the medical staff to serve on a formal peer review committee.

(2) Whenever the questions raised concern the clinical competence of the member under review, the chief of the clinical department shall select members of the medical staff to serve on the formal peer review committee who shall have similar levels of training and qualifications as the member who is subject to formal peer review.

(3) An external peer review consultant may serve as a member of the peer review committee whenever:

(a) A determination is made by the chief of the clinical department and the chief medical officer that the clinical expertise needed to conduct the review is not available on the medical staff;

(b) The objectivity of the review may be compromised; or

(c) Whenever the chief medical officer determines that an external review is otherwise advisable.

If an external reviewer is recommended, the chief of the clinical department shall make a written recommendation to the chief medical officer for selection of an external reviewer. The chief medical officer shall make the final selection of an external reviewer.

(D) Summary suspension.

(1) Notwithstanding the provisions of this rule, a member of the medical staff shall have all or any portion of his or her clinical privileges suspended or appointment terminated by the chief medical officer or the chief of the member's clinical department whenever such action must be taken immediately, when there is imminent danger to patients or to the patient care operations. Such summary suspension shall become effective immediately upon imposition and the medical staff member shall be subsequently notified in writing of the suspension by the chief medical officer. Such notice shall be issued by certified return mail to the affected medical staff member's last known address as determined by university records.

(2) A medical staff member whose privileges have been summarily suspended or whose appointment has been terminated shall be entitled to a hearing and appeal of the suspension pursuant to rule 3335-43-06 of the Administrative Code. If the affected member of the medical

staff does not make a written request for a hearing to the chief medical officer within thirty-one days after receipt of the adverse decision, it shall be deemed a waiver of the right to any review by the medical staff administrative committee to which the staff member might otherwise have been entitled on the matter. If a timely, written request for a hearing is made, the procedures of rule 3335-43-06 of the Administrative Code shall apply.

(3) Immediately upon the imposition of a summary suspension, the chief medical officer or the appropriate chief of a clinical department shall have the authority to provide for alternative medical coverage for the patients of the suspended medical staff member who remain in the Ohio state university hospitals at the time of suspension. The wishes of the patient shall be considered in the selection of such alternative medical coverage.

While a summary suspension is in effect, the member of the medical staff is ineligible for reappointment to the medical staff. Medical staff and hospital administrative duties and prerogatives are suspended during the summary suspension.

(E) Automatic suspension and termination.

(1) Notwithstanding the provisions of this rule, a temporary lapse of a medical staff member's admitting privileges, effective until medical records are completed, may be imposed automatically by the chief medical officer after a warning, in writing, of delinquency for failure to complete medical records as defined by the rules and regulations of the medical staff. The chief medical officer shall notify the chief executive officer of the Ohio state university hospitals of the action taken.

(2) Action by the Ohio state boards of licensure revoking or suspending a medical staff member's license or placing the member upon probation shall automatically impose the same restrictions to that member's Ohio state university hospitals' privileges.

(3) Failure to maintain the minimum required type and amount of professional liability insurance with an approved insurer, shall result in immediate and automatic suspension of a medical staff member’s appointment and privileges until such time as proof of appropriate insurance

coverage is furnished.

In the event such proof is not provided within ten days of notice of such suspension, the medical staff member or credentialed provider shall be deemed to no longer comply with medical staff requirements under 3335-43-04 and automatically relinquish his or her appointment and privileges.

(4) Upon exclusion, debarment, or other prohibition from participation in any state or federal health care reimbursement program, or a federal procurement or non-procurement program, the medical staff member's appointment and privileges shall immediately and automatically terminate, unless resignation in lieu of automatic terminations is permitted to rule 3335-43-04(A)(3).

(5) If a medical staff member pleads guilty to or is found guilty of a felony which involves: violence or abuse upon a person, conversion, embezzlement, or misappropriation of property; fraud, bribery, evidence tampering, or perjury; or a drug offense, the medical staff member's appointment and privileges shall be immediately and automatically terminated.

(6) Whenever a medical staff member's drug enforcement administration (DEA) or other controlled substances number is revoked, he or she shall be immediately and automatically divested of his or her right to prescribe medications covered by the number.

(7) When a medical staff member's DEA or other controlled substances number is suspended or restricted in any manner, his or her right to prescribe medications covered by the number is similarly automatically suspended or restricted during the term of the suspension or restriction.

(8) No medical staff member shall be entitled to the procedural rights set forth in rule 3335-43-06 of the Administrative Code as a result of an automatic suspension or termination. As soon as practicable after the imposition of an automatic suspension, the medical staff administrative committee shall convene to determine if further corrective action is necessary. Any further action with respect to an automatic suspension must be taken in accordance with this rule.

(9) Resignation, termination, or non-reappointment to the faculty of the Ohio state university shall result in immediate termination of membership on the medical staff of the Ohio state university hospitals.

(F) Reporting responsibility.

When a decision on corrective action is taken which constitutes a "formal disciplinary action" as may be defined in Ohio state law, or as may be required to be reported pursuant to federal law, including the health care quality improvement act, the chief medical officer shall ensure that a report of said action is made in order to maintain compliance with applicable state or federal law or regulations. The chief medical officer shall ensure that such reports are amended as may be required to reflect subsequent actions taken under the hearing and appeal rights afforded in these bylaws.

When applicable, any recommendations or actions that are the result of a review or hearing and appeal shall be monitored by the chief medical officer on an ongoing basis through the Ohio state university hospitals' quality management activities.

(Board approval dates: 6/7/2002, 5/6/2005, 2/1/2008, 9/19/2008, 9/18/2009, 5/14/2010, 4/8/2011, 11/7/2014, 11/6/2015, 4/6/2018)

**Chapter 3335-43 - *Bylaws of the Medical Staff* of The Ohio State University Hospitals**
Updated February 8, 2022

**3335-43-06 Hearing and appeal process.**

(A) Right to hearing and to an appeal.

(1) When a member of the medical staff who has exhausted all remedies under paragraphs (E) and (F) of rule 3335-43-04 of the Administrative Code on appointment or reappointments; or under rule 3335-43-05 of the Administrative Code for corrective action; or who has been summarily suspended under paragraph (D) of rule 3335-43-05 of the Administrative Code, the staff member shall be entitled to an adjudicatory hearing.

(2) A medical staff member shall not be entitled to a hearing under the following circumstances:

(a) Denial by the Wexner medical center board to grant a waiver of board certification for a medical staff member.

(b) Termination of a medical staff member because of exclusion from participation in any government reimbursement program.

(c) Voluntary withdrawal of a medical staff application.

(d) Failure to submit a reappointment application.

(e) A leave of absence extending beyond current appointment or failure to request reinstatement of clinical privileges following a leave of absence.

(f) Actions or recommendations resulting from an informal peer review.

(g) Termination of ~~courtesy B~~community affiliate B and community affiliate C medical staff appointments upon approval by the Wexner medical center board.

(3) All hearings and appeals shall be in accordance with the procedural safeguards set forth in this rule to assure that the affected medical staff member is accorded all rights to which the member is entitled.

(B) Request for hearing.

(1) The request for a hearing shall be submitted in writing by the affected medical staff member to the chief medical officer within thirty days of notification by the chief medical officer of the intended action. The chief medical officer shall forward the request to the medical staff administrative committee along with instructions to convene a hearing.

(2) The failure of a medical staff member to request a hearing, to which the member is entitled by these bylaws within the time and in the manner herein provided, shall be deemed a waiver of the right to any review by the medical staff administrative committee. The chief medical officer shall then implement the decision and that action shall become and remain effective against the medical staff member in the same manner as a final decision of the Ohio state university Wexner medical center board as provided for in paragraph (F) of rule 3335-43-05 of the Administrative Code. The chief medical officer shall promptly inform the affected medical staff member that the proposed decision, which had entitled the medical staff member to a hearing, has now become final.

(C) Notice of hearing.

(1) After receipt of a timely request for hearing by the chief medical officer from a medical staff member entitled to such hearing, the medical staff administrative committee shall be notified of the request for hearing by the chief medical officer and shall at the next scheduled meeting take the following action:

(a) Instruct the chief medical officer and chief of staff to jointly appoint within seven days a hearing committee, consisting of five members of the medical staff who are not members of the medical staff administrative committee, are not direct competitors, do not have a conflict of interest, and who have not previously participated in the formal peer review of the matter under consideration.

(b) Instruct the hearing committee to schedule and arrange for a hearing which hearing shall be conducted not less than thirty days nor more than sixty days from the date of the receipt of the request for hearing by the chief medical officer; provided, however, that a hearing for a medical staff member who is under suspension, which is then in effect, shall be held as soon as arrangements may be reasonably made.

(2) The medical staff member shall be given at least ten days prior notice of the scheduled hearing, provided that this notice may be waived in writing by the medical staff member. Notice shall be by certified return receipt mail to the staff member at the staff member's last known address as reflected by university records. The notice of hearing shall state in concise language the acts or omissions with which the medical staff member is charged; a list of representative medical records or documents being used; names of potential witnesses to be called; and any other reason or evidence that may be considered by the hearing committee during the hearing.

(D) Conduct of hearing.

(1) The hearing committee shall select a chairperson from the committee to preside over the hearing. The chairperson may require a representative for the individual and for the medical staff administrative committee (or the Wexner medical center board) to participate in a pre-hearing conference. At the pre-hearing conference, the chairperson shall resolve all procedural questions, including any objections to exhibits or witnesses, the role of legal counsel, and determine the time to be allotted to each witness's testimony and cross-examination.

(2) The hearing committee shall have benefit of Ohio state university legal counsel. The hearing committee may grant continuances, recesses, and the chairperson may excuse a member of the hearing committee from attendance temporarily for good cause, provided that there shall be at no time less than four members of the hearing committee present unless the affected staff member waives this requirement.

All members of the hearing committee must be present to deliberate and vote. No member may vote by proxy. The person who has taken action from which the affected staff member has requested the hearing shall not participate in the deliberation or voting of the hearing committee. The hearing shall be a de novo hearing, although evidence of the prior recommendations and decisions may be presented.

(3) An accurate record of the hearing shall be kept. The mechanism for taking the record shall be by the use of a professional stenographer. This record shall be available to the affected member of the medical staff upon request at the member's expense.

(4) The personal presence of the medical staff member for whom the hearing has been scheduled shall be required. A medical staff member who fails without good cause to appear and proceed at such hearing shall be deemed to have waived all rights to appear and to have a hearing before the medical staff administrative committee in the same manner as provided in paragraph (B) of this rule, and to have accepted the adverse recommendation or decision involved and the same shall therein become and remain in effect as provided in paragraph (B) of this rule. The medical staff administrative committee may, in its own discretion, order the hearing committee to proceed with the hearing without the medical staff member and impose a sanction which is greater or lesser than that originally imposed.

(5) The hearing need not be conducted strictly according to the rules of law related to the examination of witnesses or presentation of evidence. Any relevant matters upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The member of the medical staff for whom the hearing is being held shall, prior to, or during the hearing, be entitled to submit memoranda concerning any issues of procedure or of fact and such memoranda shall become a part of the hearing record.

(6) The affected medical staff member shall have the following rights: to be represented by an attorney at law and to call and examine witnesses; to introduce evidence; to cross-examine any witnesses on any matter relevant to the issue of the hearing; and to challenge any witness and to rebut any evidence. If the medical staff member does not testify in his or her own behalf, the staff member may be called and examined as if under cross-examination.

(7) The hearing committee shall request the person who has taken the action from which the affected staff member has requested the hearing to present evidence to the hearing committee in support of the adverse recommendation. The hearing committee may proceed to hear evidence and testimony from either party in whatever order the hearing committee deems appropriate. The hearing committee may call its own witnesses, may recall any parties witnesses, and may question witnesses as it deems appropriate. All parties shall be responsible to secure the attendance of their own witnesses. All witnesses and evidence received by the hearing committee shall be open to challenge and cross-examination by the parties. Witnesses shall not be placed under oath. At the close of the evidence the hearing committee may request each party to make summary statements, either oral or written. The hearing committee may request legal representation from the Ohio state university.

(8) The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. The hearing committee shall make its best effort to expeditiously determine the issues presented. The hearing committee may elect to limit its proceedings when sufficient material has been received. The parties may be required by the hearing committee to provide evidence in oral or written form. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the medical staff member for whom the hearing was convened.

(9) Within sixty days after its appointment, the hearing committee shall forward its written report and recommendation together with the transcript of the hearing and all other documentation provided by the parties to the medical staff administrative committee. The affected medical staff member shall be notified of the recommendation of the hearing committee including a statement of the basis for the recommendation. The medical staff administrative committee shall accept, reject, or modify the recommendation of the hearing committee. The medical staff administrative committee may conduct further hearings as it deems necessary or may remand the matter back to the hearing committee for further action as directed. The medical staff administrative committee may impose a greater or lesser sanction than that recommended by the hearing committee.

(10) The medical staff administrative committee shall submit a written report, including its recommendation to the chairperson of the Wexner medical center board within fourteen days of the final vote by the medical staff administrative committee. An adverse action which must be reported to the state medical board or the federal government, including the national practitioner data bank, shall entitle an affected medical staff member to the procedures of this rule. The affected member of the medical staff shall be notified of the decision of the medical staff administrative committee by the chief medical officer.

(11) The decision and record of the medical staff administrative committee shall be transmitted to the quality and professional affairs committee of the Wexner medical center board, which shall, subject to the affected member's right to appeal and implementation of paragraph (E) of this rule, consider the matter at its next scheduled meeting, or at a special meeting to be held no less than thirty days following receipt of the transmittal. The quality and professional affairs committee may accept, reject, or modify the decision of the medical staff administrative committee. The quality and professional affairs committee may remand that matter back to the medical staff administrative committee for further action as directed.

(12) The recommendation of the quality and professional affairs committee shall be promptly considered by the Wexner medical center board, at its next scheduled meeting. The Wexner medical center board may accept, reject, or modify the recommendation of the quality and

professional affairs committee. The Wexner medical center board may remand the matter back to the medical staff administrative committee for further action as directed.

(13) A copy of the Wexner medical center board decision shall be sent certified return receipt mail to the affected medical staff member at the member's last known address as determined by university records.

(E) Appeal process.

(1) Within thirty days after receipt of a notice by an affected medical staff member of the decision of the medical staff administrative committee, the member may, by written notice to the chairperson of the Ohio state university Wexner medical center board, request an appeal. The appeal shall only be held on the record before the medical staff administrative committee.

(2) If an appeal is not requested within thirty days, the affected medical staff member shall be deemed to have:

(a) Waived the member's right to appeal, and

(b) Accepted the adverse decision.

(3) The appeal shall be conducted by the quality and professional affairs committee of the Wexner medical center board.

(4) The affected medical staff member shall have access to the reports and records, including transcripts, if any, of the hearing committee and of the medical staff administrative committee and all other material, favorable or unfavorable, that has been considered by the medical staff administrative committee. The staff member shall then submit a written statement indicating those factual and procedural matters with which the member disagrees, specifying the reasons for such disagreement. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the quality and professional affairs committee no later than seven days following the date of the affected member's notice of appeal.

(5) New or additional matters not raised during the hearing or in the medical staff administrative committee hearings shall only be considered on appeal at the sole discretion of the quality and professional affairs committee.

(6) Within fourteen days following submission of the written statement by the affected medical staff member, the quality and professional affairs committee shall recommend to the Ohio state university Wexner medical center board that the adverse decision be affirmed, modified or rejected, or to refer the matter back to the medical staff administrative committee for further review and recommendation. Such referral to the medical staff administrative committee may include a request for further investigation.

(7) Any final decision by the Wexner medical center board shall be communicated by the chief medical officer and by certified return receipt mail to the affected medical staff member at that member's last known address as determined by university records. The chief medical officer shall also notify in writing the executive vice president for health sciences, the dean of the college of medicine, the chief executive officer of the Ohio state university hospitals and the vice president for health services, chief of staff, the chief of the clinical department, and the person(s) who initiated the request for formal peer review. The chief medical officer shall take immediate steps to implement the final decision.

(Board approval dates: 6/7/2002, 5/6/2005, 2/1/2008, 9/19/2008, 9/18/2009, 5/14/2010, 4/8/2011, 11/7/2014, 11/6/2015, 4/6/2018)

**3335-43-07 Categories of the medical staff.**

The medical staff of the Ohio state university hospitals shall be divided into ~~seven~~ nine categories:; attending; ~~medical staff; courtesy A medical staff~~community affiliate A; community affiliate B; community affiliate C; community affiliate D; consulting ~~medical staff~~; contracted; ~~medical staff; community affiliate medical staff; and~~ physician scholar ~~medical staff~~and limited staff. Medical staff members who do not wish to obtain any clinical privileges shall be exempt from the requirements of medical malpractice liability insurance, DEA registration, demonstration of recent active clinical practice during the last two years and specific annual education requirements ~~as outlined in the list maintained in the chief medical officer's office,~~ but are otherwise subject to the provisions of these bylaws.

(A) Attending

(1) Qualifications: The attending medical staff shall consist of those faculty members of the colleges of medicine and dentistry to whom clinical teaching responsibilities are assigned in the Ohio state university hospitals and who satisfy the requirements and qualifications for membership set forth in rule 3335-43-04 of the Administrative Code. The assignment of teaching responsibility is the prerogative of the chief of the clinical department or the chief's designee.

(2) Prerogatives:

An attending medical staff member may:

(a) Admit patients consistent with their clinical privileges and the balanced teaching and patient care responsibilities of the Ohio state university hospitals. When, in the judgment of the chief of the clinical department, a balanced teaching program is jeopardized, following consultation with the dean of the college of medicine and the

(b) Ohio state university hospitals' chief executive officer, and with the concurrence of a majority of the medical staff administrative committee, the chief of the clinical department may restrict an attending medical staff member's ability to admit patients. Imposition of such restrictions shall not entitle the attending medical staff member to a hearing or appeal pursuant to rule 3335-43-06 of the Administrative Code.

(c) Be free to exercise such clinical privileges as are granted pursuant to these bylaws.

(d) Vote on all matters presented at general and special meetings of the medical staff and of the department and committees of which he or she is a member unless otherwise provided by resolution of the medical staff, clinical department, or committee and approved by the medical staff administrative committee.

(e) Hold office in the medical staff organization and in the clinical department and committees of which he or she is a member, unless otherwise provided by resolution of the medical staff, clinical department, or committee and approved by the medical staff administrative committee.

(3) Responsibilities:

Each member of the attending medical staff with clinical privileges shall:

(a) Meet the basic responsibilities set forth in rules 3335-43-02 and 3335-43-03 of the Administrative Code.

(b) Retain responsibility within the member's area of professional competence for the continuous care and supervision of each patient in the Ohio state university hospitals

for whom the member is providing care or arrange a suitable alternative for such care and supervision.

(c) Actively participate in such quality evaluation and monitoring activities as required by the medical staff and discharge such medical staff functions as may be required from time to time.

(d) Satisfy the requirements set forth in rule 3335-43-11 of the Administrative Code for attendance at staff and departmental meetings and meetings of those committees of which he or she is a member and for payment of membership dues.

(e) Supervise members of the limited staff in the provision of patient care in accordance with accreditation standards and policies and procedures of approved clinical training programs. It is the responsibility of the attending physician to authorize each member

of the limited staff to perform only those services which the limited staff member is competent to perform under supervision.

(f) Supervise other licensed healthcare professionals as necessary in accordance with accreditation standards and state law. It is the responsibility of the attending physician to authorize each licensed healthcare professional to perform only those services which the licensed healthcare professional is privileged to perform.

(g) Take call as assigned by the chief of the clinical department.

(B) Community affiliate A ~~Courtesy A medical staff.~~

(1) Qualifications: The community affiliate A ~~courtesy A~~ medical staff shall consist of physicians and other licensed healthcare professionals ~~those faculty members of the colleges of medicine and dentistry~~ who do not ~~qualify~~ meet the criteria for attending medical staff appointment. This category includes community physicians and physicians employed by an affiliate entity who have clinical activity required for membership and actively participate in teaching programs. ~~routinely admit patients to the Ohio state university hospitals and who actively participate in teaching programs.~~

(2) Prerogatives:

The community affiliate A ~~courtesy A~~ medical staff may:

(a) Exercise such clinical privileges as are granted pursuant to these bylaws.

(b) Admit, consistent with their clinical privileges, patients who complement the clinical teaching program.

(c) Attend meetings as a member of the medical staff and the clinical department of which he or she is a member and any medical staff or the Ohio state university hospitals education programs. The ~~courtesy A~~community affiliate A medical staff member may vote on medicals staff policies, bylaws, rules and regulations and for elected officials of the medical staff. ~~for and be eligible to hold a position on the medical staff administrative committee reserved for the representative of the courtesy A or community affiliate medical staff as set forth in paragraph (D) of rule 3335-43-09 and paragraph (C) of rule 3335-43-10 of the Administrative Code.~~ Members of the ~~courtesy A~~ community affiliate A medical staff may be appointed to serve on ~~non-elected~~ medical staff committees as provided by these bylaws.

(3) Responsibilities: Each member of the ~~courtesy A~~community affiliate A medical staff with clinical privileges shall be required to have a faculty appointment and discharge the basic responsibilities specified in paragraph (B)(3) of this rule.

(C) Community affiliate B

(1) Qualifications: The community affiliate B medical staff shall consist of those doctors of medicine, osteopathic medicine, dentists and practitioners of podiatry or psychology who are employed by an affiliate entity, do not have patient activity at university hospitals but who are enrolled under institutional managed care contracts or other contractual arrangements and who work at facilities not owned by the Wexner medical center. Community affiliate B medical staff members shall not be required to obtain appointment to the faculty of the Ohio state university and will not possess clinical privileges. Community affiliate B medical staff shall not be eligible to hold office or required to pay medical staff dues and shall not be eligible to vote on medical staff policies, rules and regulations, or bylaws.

(D) Community affiliate C~~Courtesy B medical staff.~~

(1) Qualifications: The community affiliate C ~~courtesy B~~ medical staff shall consist of those ~~faculty members of the colleges of medicine and dentistry who do not qualify for~~physicians and other licensed healthcare professionals who do not quality for attending medical staff appointment and shall not possess clinical privileges. This category is comprised of referring physicians who desire to be associated with the Ohio state university hospitals to refer and follow patients. ~~Courtesy~~ Community affiliate C medical staff members ~~B medical staff members shall not possess clinical privileges,~~ shall not be eligible to vote on medical staff policies, rules and regulations, or bylaws, ~~and~~ shall not be eligible to hold office and are not required to pay medical staff dues.

(2) Prerogatives:

Community affiliate C~~Courtesy B~~ medical staff members may:

(a) Have access to the Ohio state university hospitals and shall be given notice of all medical staff activities and meetings.

(b) Attend meetings as a member of the medical staff and the clinical departments of which he or she is a member and any medical staff or the Ohio state university hospitals education programs.

(c) The grant of community affiliate **C**~~courtesy B~~ medical staff appointment to physicians is a courtesy only and may be terminated by the Wexner medical center board upon recommendation of the medical staff administrative committee without the right to a hearing or appeal.

(E) Community affiliate D~~medical staff~~

This is a closed medical staff category that was created as a one-time grandfathering category for medical staff members of the Ohio state university hospitals east prior to July 1, 2007.

(1) Qualifications: Community affiliate D medical staff shall consist of those doctors of medicine, osteopathic medicine, dentists and practitioners of podiatry or psychology who:

(a) Do not qualify for an attending medical staff appointment; and

(b) Are community affiliate D members seeking reappointment; and

(c) Satisfy the requirements and qualifications set forth in rule 3335-43-04 of the Administrative Code and are already appointed to the community affiliate D medical staff pursuant to these bylaws.

(3) A community affiliate D medical staff member shall meet and maintain the same standards for quality patient care applicable to all members of the medical staff. Community affiliate D medical staff members shall be subject to these bylaws and the rules and regulations of the medical staff except as provided in this paragraph. The community affiliate D medical staff member shall not be required to obtain appointment to the faculty of the Ohio state university. The community affiliate D medical staff member shall not be subject to the requirement for board certification within the community affiliate D medical staff member's respective area of practice if that requirement was waived when he or she became a member of the Ohio state university east medical staff. Teaching and research accomplishments shall not be required in determining the qualifications of applicants to this category of the medical staff.

(4) To optimize the clinical organization, resource utilization, and planning of the hospitals, the chief of the clinical department may require that the applicant for community affiliate D medical staff membership to identify categories of diagnosis, extent of anticipated patient activity, and service areas to be utilized and may prepare a statement of participation for the applicant which will be made a part of the application for appointment.

(5) Prerogatives:

A community affiliate D medical staff member may:

(a) Admit patients consistent with the limitations of bed and service allocations established by the medical directors and approved by the medical staff administrative committee, and the Wexner medical center board. If, in the judgment of the medical directors, a balanced teaching program is jeopardized, following consultation with the chief of the clinical department, and with the concurrence of a majority of the medical staff administrative committee, the medical director may restrict admissions of members of the community affiliate D medical staff. Patients admitted under the care of the community affiliate D medical staff will not be required to participate in the educational mission of the Ohio state university hospitals. Ordinarily, no

coverage by the limited medical staff will be afforded, with the exception of emergency medical services.

(b) Exercise the clinical privileges granted, have access to all medical records, and be entitled to utilize the facilities of the Ohio state university hospitals incidental to the clinical privileges granted pursuant to these bylaws.

(c) Attend teaching and educational conferences approved by the Ohio state university, attend medical staff social functions, and participate as providers in the Ohio state university or the Ohio state university hospitals affiliated health plans.

(6) Responsibilities:

Each member of the community affiliate D medical staff shall:

(a) Participate in the management of and represent the interests of the clinical department for which he or she is granted clinical privileges. The community affiliate D medical staff member shall comply with all provisions of these bylaws and rules and regulations of the medical staff, unless expressly exempted under this rule.

(b) The community affiliate D medical staff member shall comply with all the Ohio state university hospitals' policies and accreditation standards, and shall be subject to the same quality evaluation, monitoring, and resource management requirements as other members of the medical staff.

(c) Be responsible within the member's area of professional competence for the continuous care and supervision of each patient in the Ohio state university hospitals for whom the member is providing care or arrange a suitable alternative for such care and supervision.

(d) Not be eligible to vote on medical staff policies, rules and regulations, or bylaws or to hold office. Members of the community affiliate D medical staff may serve on non-elected medical staff committees as provided by these bylaws.

(e) Be subject to payment of medical staff dues or assessments as approved by the medical staff.

(F) Consulting

(1) Qualifications. The consulting medical staff shall consist of those faculty members of the colleges of medicine and dentistry who:

(a) Satisfy the requirements and qualifications for membership set forth in rule 3335-43-04 of the Administrative Code.

(b) Are consultants of recognized professional ability and expertise who provide a service not readily available from the attending medical staff. These practitioners provide services at the Ohio state university hospitals only at the request of attending or community affiliate A ~~courtesy A~~ members of the medical staff.

(c) Demonstrate participation on the active medical staff at another accredited hospital requiring performance improvement/quality assessment activities similar to those of the Ohio state university hospitals. The practitioner shall also hold at such other hospital the same privileges, without restriction, that he/she is requesting at the Ohio state university hospitals. An exception to this qualification may be made by the Wexner medical center board provided the practitioner is otherwise qualified by

education, training and experience to provide the requested service.

(2) Prerogatives:

Consulting medical staff members may:

(a) Exercise the clinical privileges granted for consultation purposes on an occasional basis when requested by an attending or community affiliate A ~~courtesy A~~ medical staff member.

(b) Have access to all medical records and be entitled to utilize the facilities of the Ohio state university hospitals incidental to the clinical privileges granted pursuant to these bylaws.

(c) Not admit patients to the Ohio state university hospitals.

(d) Not vote on medical staff policies, rules and regulations, or bylaws, and may not hold office.

(e) Must actively participate in such quality evaluation and monitoring activities as required by the medical staff and as outlined in the medical staff policy entitled "Consulting medical staff member policy."

(f) Attend medical staff meetings but shall not be entitled to vote at such meetings or hold office.

(g) Attend department meetings but shall not be entitled to vote at such meetings or serve as chief of a clinical department.

(h) Serve as a non-voting member of a medical staff committee; provided, however, that he/she may not serve as a committee chair or as a member of the medical staff administrative committee.

(3) Responsibilities.

Each member of the consulting medical staff shall:

(a) Meet the basic responsibilities set forth in rules 3335-43-02 and 3335-43-03 of the Administrative Code.

(b) Be exempt from all medical staff dues.

(G) Contracted

(1) Qualifications: contracted medical staff shall consist of those members who meet the requirements for medical staff membership and are providing services to Wexner medical center patients exclusively through a contract with the Wexner medical center. Contracted medical staff members shall meet and maintain the same standards for quality patient care applicable to all members of the medical staff and shall be subject to these bylaws and the rules and regulations of the medical staff except as provided in this paragraph.

Contracted medical staff shall not be required to obtain appointment to the faculty of the Ohio state university. Contracted medical staff shall not be eligible to vote on medical staff policies, rules and regulations, or bylaws, shall not be eligible to hold office or required to pay medical staff dues.

(2) Prerogatives:

Contracted medical staff may:

(a) Exercise such clinical privileges as are granted pursuant to these bylaws.

(3) Any contracted medical staff member whose membership has been terminated due to loss of contract and/or clinical privileges shall not be entitled to request a hearing and appeal in accordance with rule 3335-43-06 of the Administrative Code.

(H) Physician scholar

(1) Qualifications: The physician scholar medical staff shall be composed of those faculty members of the colleges of medicine and dentistry who are recognized for outstanding reputation, notable scientific and professional contributions, and high professional stature. This medical staff category includes but is not limited to emeritus faculty members. Nominations may be made to the chair of the credentialing committee who shall present the candidate to the medical staff administrative committee for approval.

(2) Prerogatives: Members of the physician scholar medical staff shall have access to the Ohio state university hospitals and shall be given notice of all medical staff activities and meetings. Members of the physician scholar medical staff shall enjoy all rights of an attending medical staff member except physician scholar members shall not possess clinical privileges.

(3) Physician scholar medical staff must have either a full license or an emeritus registration by the State Medical Board of Ohio.

(I) Limited staff

Limited staff are not considered full members of the medical staff, do not have delineated clinical privileges and do not have the right to vote in general medical staff elections. Except where expressly stated, members of the limited staff are bound by the terms of these bylaws, the rules and regulations of the medical staff, and the limited staff agreement.

(1) Qualifications:

(a) The limited staff shall consist of doctors of medicine, osteopathic medicine, dentists and practitioners of podiatry or psychology who are accepted in good standing by a program director into a post-doctoral graduate medical education program and appointed to the limited staff in accordance with these bylaws.

(b) The limited staff shall maintain compliance with the requirements of state law, including regulations adopted by the Ohio state university Wexner medical center board, or the limited staff member's respective licensing board.

(c) Members of the limited staff shall possess a valid training certificate or an unrestricted Ohio license from the applicable state board based on eligibility criteria defined by that state board. All members of the limited staff shall be required to successfully obtain an Ohio training certificate prior to beginning training within a program.

(2) Responsibilities:

Each member of the limited staff shall:

(a) Be responsible to respond to all questions and to complete all forms as may be required by the credentials committee.

(b) Participate fully in the teaching programs, conferences, and seminars of the clinical department in which he or she is appointed in accordance with accreditation standards and policies and procedures of the graduate medical education committee and approved clinical training programs.

(c) Participate in the care of all patients assigned to the limited staff member under the appropriate supervision of a designated member of the attending or community affiliate A ~~courtesy A~~ medical staff in accordance with accreditation standards and policies and procedures of the clinical training programs. The clinical activities of the limited staff shall be determined by the program director appropriate for the level of education and training. Limited staff shall be permitted to perform only those services that they are authorized to perform by the member of the attending or community affiliate A ~~courtesy A~~ medical staff based on the competence of the limited staff to perform such services. The limited staff may admit or discharge patients only when acting on behalf of the attending or community affiliate A~~courtesy A~~ medical staff. The limited staff member shall follow all rules and regulations of the service to which the limited staff member is assigned, as well as the general rules of the Ohio state university hospitals pertaining to limited staff. Specifically, a limited staff member shall consult with the attending or community affiliate A ~~courtesy A~~ member of the medical staff responsible for the care of the patient before the limited staff member undertakes a procedure or treatment that carries a significant, material- risk to the patient unless the consultation would cause a delay that would jeopardize the life or health of the patient.

(d) Serve as a member of various medical staff committees in accordance with established committee composition as described in these bylaws and/or the rules and regulations of the medical staff. The limited staff member shall not be eligible to vote or hold elected office in the medical staff organization but may vote on committees to which the limited staff member is assigned.

(e) Be expected to make regular satisfactory professional progress including anticipated certification by the respective specialty or sub-specialty program of post-doctoral training in which the limited staff member is enrolled. Evaluation of professional growth and appropriate humanistic qualities shall be made on a regular schedule by the clinical departmental chief, program director, teaching faculty or evaluation committee in accordance with accreditation standards and policies and procedures of the approved training programs.

(f) Appeal by a member of the limited staff of probation, lack of promotion, suspension or termination for failure to meet expectations for professional growth or failure to display appropriate humanistic qualities or failure to successfully complete any other competency as required by the accreditation standards of an approved training program will be conducted and limited in accordance with written guidelines established by the respective department or training program and approved by the program director and the Ohio state university hospitals graduate medical education committee as delineated in the limited staff agreement and by the graduate medical education policies. Alleged misconduct by a member of the limited staff, for reasons other than failure to meet expectations of professional growth as outlined above, shall be handled in accordance with rules 3335-43-05 and 3335-43-06 of the Administrative Code.

(3) Failure to meet reasonable expectations.

Termination of employment from the limited staff member's residency or fellowship training program shall result in automatic termination of the limited staff member's appointment pursuant to these bylaws.

(4) Temporary appointments.

(a) Limited staff members who are Ohio state university faculty may be granted an early commencement or an extension of appointment upon the recommendation of the chief of the clinical department, with prior concurrence of the associate dean for graduate medical education, when it is necessary for the limited staff member to begin his or her training program prior to or extend his or her training program beyond a regular appointment period. These appointments shall not exceed sixty days.

(b) Temporary appointments may be granted upon the recommendation of the chief of the clinical department, with prior concurrence of the medical directors, for limited staff members who are not Ohio state university faculty but who, pursuant to education affiliate agreements approved by the university, need to satisfy approved graduate medical education clinical rotation requirements. These appointments shall not exceed a total of one hundred twenty days in any given post-graduate year. In such cases, the mandatory requirement for a faculty appointment may be waived. All other requirements for limited staff member appointment must be satisfied.

(5) Supervision.

Limited staff members shall be under the supervision of an attending or community affiliate A ~~courtesy A~~ medical staff member. Limited staff members shall have no privileges as such but shall be able to care for patients under the supervision and responsibility of their attending or community affiliate A ~~courtesy A~~ medical staff member. The care they extend will be governed by these bylaws and the general rules and regulations of each clinical department. The practice of care shall be limited by the scope of privileges of their attending or community affiliate A ~~courtesy A~~ medical staff member. Any concerns or problems that arise in the limited staff member's performance should be directed to the attending or community affiliate A ~~courtesy A~~ medical staff member or the director of the training program.

(a) Limited staff members may write admission, discharge and other orders for the care of patients under the supervision of the attending or community affiliate A ~~courtesy A~~ medical staff member.

(b) All records of limited staff member cases must document involvement of the attending or community affiliate A ~~courtesy A~~ medical staff member in the supervision of the patient's care to include co-signature of the admission order, history and physical, operative report, and discharge summary.

(J) Temporary medical staff appointment.

(1) External peer review. When peer review activities are being conducted by someone other than a current member of the medical staff, the chief medical officer may admit a practitioner to the medical staff for a limited period of time. Such membership is solely for the purpose of conducting peer review in a particular evaluation and this temporary membership automatically expires upon the member's completion of duties in connection with such peer review. Such appointment does not include clinical privileges and is for a limited purpose.

(2) Proctoring. Temporary privileges may be extended to visiting medical faculty for special clinical or educational activities as provided by the Ohio state medical or dental board. When medical staff members require proctoring for the purposes of gaining experience to become credentialed to perform a procedure, a visiting physician may apply for temporary privileges per the prescribed medical staff proctoring policy.

(K) Clinical privileges.

(1) Delineation of clinical privileges:

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Updated February 8, 2022

(a) Every person practicing at the Ohio state university hospitals by virtue of medical staff membership, faculty appointment, contract or under authority granted in these bylaws shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically applied for and granted to the staff member or other licensed health care professional by the Ohio state university Wexner medical center board after recommendation from the medical staff administrative committee.

Each clinical department shall develop specific clinical criteria and standards for the evaluation of clinical privileges with emphasis on invasive or therapeutic procedures or treatment which present significant risk to the patient or for which specific professional training or experience is required. Such criteria and standards are subject to the approval of the medical staff administrative committee and the Wexner medical center board.

(b) Requests for the exercise and delineation of clinical privileges must be made as part of each application for appointment or reappointment to the medical staff on the forms prescribed by the medical staff administrative committee. Every person in an administrative position who desires clinical privileges shall be subject to the same procedure as all other applicants. Requests for clinical privileges must be submitted to the chief of the clinical department in which the clinical privileges will be exercised. Clinical privileges requested other than during appointment or reappointment to the medical staff shall be submitted to the chief of the clinical department and such request must include documentation of relevant training or experience supportive of the request.

(c) The chief of the clinical department shall review each applicant's request for clinical privileges and shall make a recommendation regarding clinical privileges to the chief medical officer. Requests for clinical privileges shall be evaluated based upon the applicant's education, training, experience, demonstrated competence, references, and other relevant information, including the direct observation and review of records of the applicant's performance by the clinical department in which the clinical privileges are exercised. Whenever possible the review should be of primary source information.

(d) The applicant shall have the burden of establishing the applicant’s qualifications and competency in clinical privileges requested and shall have the burden of production of adequate information for the proper evaluation of qualifications.

(e) The applicant's request for clinical privileges and the recommendation of the chief of the clinical department shall be forwarded to the credentials committee and shall be processed in the same manner as applications for appointment and reappointment pursuant to rule 3335-43-04 of the Administrative Code.

(f) Medical staff members who are granted new or initial privileges are subject to FPPE, which is a six-month period of focused monitoring and evaluation of practitioners’ professional performance. Following FPPE medical staff members with clinical privileges are subject to ongoing professional practice evaluation (OPPE), which information is factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal. FPPE and OPPE are fully detailed in medical staff policies that were approved by the medical staff administrative committee and the Wexner medical center board.

(g) Upon resignation, termination or expiration of the medical staff member’s faculty appointment or employment with the university for any reason, such medical staff appointment and clinical privileges of the medical staff member shall automatically expire.

(h) Medical staff members authorize the Ohio state university hospitals and clinics to share credentialing, quality and peer review information pertaining to the medical staff member's clinical competence and/or professional conduct. Such information may be shared at initial appointment and/or reappointment and at any time during the medical staff member's medical staff appointment to the medical staff of the Ohio state university hospitals.

(i) Medical staff members authorize the Ohio state university hospitals to release information, in good faith and without malice, to managed care organizations, regulating agencies, accreditation bodies and other health care entities for the purposes of evaluating the medical staff member's qualifications pursuant to a request for appointment, clinical privileges, participation or other credentialing or quality matters.

(2) Temporary privileges:

(a) Temporary privileges may be extended to a doctor of medicine, osteopathic medicine, dental surgery, psychologist, podiatry or to a licensed health care professional upon completion of an application prescribed by the medical staff administrative committee, upon recommendation of the chief of the clinical department. All temporary privileges are granted by the chief executive officer or authorized designee. The temporary privileges granted shall be consistent with the applicant's training and experience and with clinical department guidelines.

Prior to granting temporary privileges, primary source verification of licensure and current competence shall be required. Temporary privileges shall be limited to situations which fulfill an important patient-care need and shall be granted for a period not to exceed one hundred twenty days.

(b) Temporary privileges may be extended to visiting medical faculty or for special activity as provided by the Ohio state medical or dental board.

(c) Temporary privileges granted for locum tenens may be exercised for a maximum of ninety days, consecutive or not, any time during the ~~twenty-four month~~thirty-six-month period following the date they are granted.

(d) Practitioners granted temporary privileges will be restricted to the specific delineations for which the temporary privileges are granted. The practitioner will be under the supervision of the chair of the clinical department while exercising any temporary privileges granted.

(e) Special privileges. Upon receipt of a written request for specific temporary privileges and the approval of the clinical department chief and the chief medical officer, an appropriately licensed practitioner of documented competence, who is not an applicant for medical staff membership, may be granted special privileges for the care of one or more specific patients. Such privileges shall be exercised in accordance with the conditions specified in these bylaws.

(f) Practitioners exercising temporary privileges shall abide by these medical staff bylaws, rules and regulations, and hospital and medical staff policies.

(g) The temporary and special privileges must be in conformity with accrediting bodies' standards and the rules and regulations of the professional boards of Ohio.

(3) Expedited privileges.

If the Wexner medical center board is not scheduled to convene in a timeframe that permits the timely consideration of the recommendation of a complete application by the medical staff

administrative committee, applicants may be granted expedited privileges by the quality and professional affairs committee of the Wexner medical center board. Certain restrictions apply to the appointment and granting of clinical privileges via the expedited process. These include but are not limited to: an involuntary termination of medical staff membership at another hospital, involuntary termination of medical staff membership at another hospital, involuntary limitation, or reduction, denial or loss of clinical privileges, a history of professional liability actions resulting in a final judgement against the applicant or a challenge by a state licensing board.

(4) Podiatric privileges:

(a) Practitioners of podiatry may admit patients to the Ohio state university hospitals if such patients are being admitted solely to receive care that a podiatrist may provide without medical assistance, pursuant to the scope of the professional license of the podiatrist. Practitioners of podiatry must, in all other circumstances, co-admit patients with a member of the medical staff who is a doctor of medicine or osteopathic medicine. A member of the medical staff who is a doctor of medicine or osteopathy shall be responsible for any medical problems that the patient has while an inpatient of the Ohio state university hospitals.

(b) A member of the medical staff who is a doctor of medicine or osteopathy:

i. Shall be responsible for any medical problems that the patient has while an inpatient of the Ohio state university hospitals; and

ii. Shall confirm the findings, conclusions and assessment of risk prior to high- risk diagnosis or therapeutic interventions defined by the medical staff.

(c) Practitioners of podiatry shall be responsible for the podiatric care of the patient including the podiatric history and physical examination and all appropriate elements of the patient's record.

(d) The podiatrist shall be responsible to the chief of the department of orthopaedics.

(5) Psychology privileges.

(a) Psychologists shall be granted clinical privileges based upon their training, experience and demonstrated competence and judgment consistent with their license to practice. Psychologists shall not prescribe drugs, or perform surgical procedures, or in any other way practice outside the area of their approved clinical privileges or expertise, unless otherwise authorized by law.

(b) Psychologists may not admit patients to the Ohio state university hospitals but may diagnose and treat a patient's psychological illness as part of the patient's comprehensive care while hospitalized. All patients admitted for psychological care shall receive the same medical appraisal as all other hospitalized patients. A member of the medical staff who is a doctor of medicine or osteopathic medicine shall admit the patient and shall be responsible for the history and physical and any medical care that may be required during the hospitalization and shall determine the appropriateness of any psychological therapy based on the total health status of the patient. Psychologists may provide consultation within their area of expertise on the care of patients within the Ohio state university hospitals.

In outpatient settings, psychologists shall diagnose and treat their patients' psychological illness. Psychologists shall ensure that their patients receive referral for appropriate medical care.

(c) Psychologists shall be responsible to the chief of the clinical department in which they are appointed.

(6) Dental privileges.

(a) Practitioners of dentistry, who have not been granted clinical privileges as oral and maxillofacial surgeons, may admit patients to the Ohio state university hospitals if such patients are being admitted solely to receive care which a dentist may provide without medical assistance, pursuant to the scope of the professional license of the dentist. Practitioners of dentistry must, in all other circumstances co-admit patients with a member of the medical staff who is a doctor of medicine or osteopathic medicine. A member of the medical staff who is a doctor of medicine or osteopathy shall be responsible for any medical problems that the patient has while an inpatient of the Ohio state university hospitals.

(b) A member of the medical staff who is a doctor of medicine or osteopathy:

i. Shall be responsible for any medical problems that the patient has while an inpatient of the Ohio state university hospitals; and

ii. Shall confirm the findings, conclusions and assessment of risk prior to high- risk diagnosis or therapeutic interventions defined by the medical staff.

(c) Practitioners of dentistry shall be responsible for the dental care of the patient including the dental history and physical examination and all appropriate elements of the patient's record.

(7) Oral and maxillofacial surgical privileges.

All patients admitted to the Ohio state university hospitals for oral and maxillofacial surgical care shall receive the same medical appraisal as all other hospitalized patients. Qualified oral and maxillofacial surgeons shall admit patients, shall be responsible for the plan of care for the patients, shall perform the medical history and physical examination, if they have such privileges, in order to assess the medical, surgical, and anesthetic risks of the proposed operative and other procedure(s) and shall be responsible for the medical care that may be required at the time of admission or that may arise during hospitalization.

(8) Other licensed health care professionals.

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

i. Members of the faculty of the Ohio state university, or

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

iii. Employees or members of the medical staff.

(b) A licensed health care professional as used herein, shall not be eligible for medical staff membership but shall be eligible to exercise those clinical privileges granted pursuant to these bylaws and in accordance with applicable Ohio state law. If granted such privileges under this rule and in accordance with applicable Ohio state law,

(c) other licensed health care professionals may perform all or part of the medical history and physical examination of a patient. Licensed health care professionals with privileges are subject to FPPE and OPPE.

(d) Licensed health care professionals shall apply and re-apply for clinical privileges on forms prescribed by the medical staff administrative committee and shall be processed in the same manner as provided in rule 3335-43-04 of the Administrative Code subject to the provisions of paragraph (G)(8) of this rule.

(e) Licensed health care professionals are not members of the medical staff, but may write admitting orders for patients of the Ohio state university hospitals when granted such privileges under this rule and in accordance with applicable Ohio state law. If such privileges are granted, the patient will be admitted under the medical supervision of the responsible medical staff member. Licensed health care professionals and shall not be eligible to hold office, to vote on medical staff affairs, or serve on standing committees of the medical staff unless specifically authorized by the medical staff administrative committee.

(f) Each licensed health care professional shall be individually assigned to a clinical department and shall be sponsored by one or more members of the medical staff. The licensed health care professional's clinical privileges are contingent upon the sponsoring medical staff member's privileges. In the event that the sponsoring medical staff member loses privileges or resigns, the licensed health care professionals whom he or she has sponsored shall be placed on administrative hold until another sponsoring medical staff member is assigned. The new sponsoring medical staff member must be assigned in less than thirty days.

(g) Licensed health care professionals must comply with all limitations and restrictions imposed by their respective licenses, certifications, or legal credentials as required by Ohio law, and may only exercise those clinical privileges granted in accordance with provisions relating to their respective professions.

(h) Only applicants who can document the following shall be qualified for clinical privileges as a licensed health care professional:

i. Current license, certification, or other legal credential required by Ohio law.

ii. Certificate of authority, standard care agreement, or utilization plan.

iii. Education, training, professional background and experience, and professional competence.

iv. Patient care quality indicators definition for initial appointment. This data will be in a format determined by the licensed health care professional subcommittee and the quality management department.

v. Adherence to the ethics of the profession for which an individual holds a license, certification, or other legal credential required by Ohio law.

vi. Evidence of required immunization.

vii. Evidence of good personal and professional reputation as established by peer recommendations.

viii. Satisfactory physical and mental health to perform requested clinical privileges.

xi. Ability to work with members of the medical staff and the Ohio state university hospitals employees.

(i) The applicant shall have the burden to produce documentation with sufficient adequacy to assure the medical staff and the Ohio state university hospitals that any patient cared for by the licensed health care professional seeking clinical privileges shall be given quality care, and that the efficient operation of the Ohio state university hospitals will not be disrupted by the applicant's care of patients in the Ohio state university hospitals.

(j) By applying for clinical privileges as a licensed health care professional, the applicant agrees to the following terms and conditions:

i. The applicant has read the bylaws and rules and regulations of the medical staff of the Ohio state university hospitals and agrees to abide by all applicable terms of such bylaws and any applicable rules and regulations, including any subsequent amendments thereto, and any applicable Ohio state university hospitals policies that the Ohio state university hospitals may from time to time put into effect.

ii. The applicant releases from liability all individuals and organizations who provide information to the Ohio state university hospitals regarding the applicant and all members of the medical staff, the Ohio state university hospitals staff, the Ohio state university Wexner medical center board and the Ohio state university board of trustees for all acts in connection with investigating and evaluating the applicant.

iii. The applicant shall not deceive a patient as to the identity of any practitioner providing treatment or service in the Ohio state university hospitals.

iv. The applicant shall not make any statement or take any action that might cause a patient to believe that the licensed health care professional is a member of the medical staff.

v. The applicant shall not perform any patient care in the Ohio state university hospitals that is not permitted under the applicant's license, certification, or other legal credential required under Ohio law.

vi. The applicant shall obtain and continue to maintain professional liability insurance in such amounts required by the medical staff.

(k) Licensed health care professionals shall be subject to quality review and corrective action as outlined in this paragraph for violation of these bylaws, their certificate of authority, standard of care agreement, utilization plan, or the provisions of their licensure, including professional ethics. Review may be requested by any member of the medical staff, a chief of the clinical department, or by the chief quality officer or his or her designee. All requests shall be in writing and shall be submitted to the chief quality officer. The chief quality officer shall appoint a three-person committee to review and make recommendations concerning appropriate action. The committee shall consist of at least one licensed health care professional and one medical staff member. The committee shall make a written recommendation to the chief quality officer, who may accept, reject, or modify the recommendation. The chief quality officer forwards his or her recommendation to the chief medical officer for final determination.

(l) Appeal process.

i. A licensed health care professional may submit a notice of appeal to the chairperson of the quality and professional affairs committee within thirty days of receipt of written notice of any adverse corrective action pursuant to these bylaws.

ii. If an appeal is not so requested within the thirty-day period, the licensed health care professional shall be deemed to have waived the right to appeal and to have conclusively accepted the decision of the chief medical officer.

iii. The appellate review shall be conducted by the chief of staff, the chair of the Licensed health care professionals subcommittee and one medical staff member from the same discipline as the licensed health care professional under review. The licensed health care professional under review shall have the opportunity to present any additional information deemed relevant to the review and appeal of the decision.

iv. The affected licensed health care professional shall have access to the reports and records, including transcripts, if any, of the hearing committee and of the medical staff administrative committee and all other material, favorable or unfavorable, that has been considered by the chief quality officer. The licensed health care professional shall submit a written statement indicating those factual and procedural matters with which the member disagrees, specifying the reasons for such disagreement. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the review committee no later than seven days following the date of the licensed health care professional's notice of appeal.

v. New or additional matters shall only be considered on appeal at the sole discretion of the quality and professional affairs committee.

vi. Within thirty days following submission of the written statement by the licensed health care professional, the chief of staff shall make a final recommendation to the chair of the quality and professional affairs committee of the Wexner medical center board. The quality and professional affairs committee of the Wexner medical center board shall determine whether the adverse decision will stand or be modified and shall recommend to the Ohio state university Wexner medical center board that the adverse decision be affirmed, modified or rejected, or to refer the matter back to the review committee for further review and recommendation. Such referral to the review committee may include a request for further investigation.

vii. Any final decision by the Wexner medical center board shall be communicated by the chief quality officer and by certified return receipt mail to the last known address of the licensed health care professional as determined by university records. The chief quality officer shall also notify in writing the executive vice president for health sciences, the dean of the college of medicine, the chief executive officer of the Ohio state university hospitals and the vice president for health services and the chief of the applicable clinical department or departments. The chief medical officer shall take immediate steps to implement the final decision.

(9) Emergency privileges.

In case of an emergency, any member of the medical staff to the degree permitted by the member's license or certification and regardless of department or medical staff status shall be permitted to do everything possible to save the life of a patient using every facility of the Ohio state university hospitals necessary, including the calling for any consultation necessary or desirable. After the emergency situation resolves, the patient shall be assigned to an appropriate member of the medical staff. For the purposes of this paragraph, an "emergency" is defined as a condition which would result in serious permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

(10) Disaster privileges.

Disaster privileges may be granted in order to provide voluntary services during a local, state, or national disaster in accordance with hospital/medical staff policy and only when the following two conditions are present: the emergency management plan has been activated and the hospital is unable to meet immediate patient needs. Such privileges may be granted by the chief medical officer or his or her designee to fully licensed or certified, qualified individuals who at the time of the disaster are not members of the medical staff. These privileges will be limited in scope and will terminate once the disaster situation subsides or at the discretion of the chief medical officer.

(Board approval dates: 6/7/2002, 9/6/2002, 5/30/2003, 6/4/2004, 5/6/2005, 11/4/2005, 2/2/2007, 2/1/2008, 9/19/2008, 9/18/2009, 5/14/2010, 4/8/2011, 8/31/2012, 2/1/2013, 11/07/2014, 11/6/2015, 4/6/2018, 2/8/2022)

**3335-43-08 Organization of the medical staff.**

(A) Each member of the attending ~~medical~~, ~~courtesy A and B medical~~, community affiliate A, community affiliate B, ~~medical,~~ community affiliate C, community affiliate D, limited, and physician scholar medical staff shall be assigned to a clinical department and division, if applicable, upon the recommendation of the applicable chief of the clinical department.

(B) Names of clinical departments.

(1) Anesthesiology.

(2) Dermatology.

(3) Emergency medicine.

(4) Family and community medicine.

(5) Internal medicine.

(6) Neurological surgery.

(7) Neurology.

(8) Obstetrics and gynecology.

(9) Ophthalmology and visual science.

(10) Orthopaedics.

(11) Otolaryngology- head and neck surgery.

(12) Pathology.

(13) Pediatrics.

(14) Physical medicine and rehabilitation.

(15) Plastic and reconstructive surgery.

(16) Psychiatry and behavioral health.

(17) Radiation oncology.

(18) Radiology.

(19) Surgery.

(20) Urology.

(21) Dentistry.

(C) The directors of the divisions in the Ohio state university hospitals shall be appointed by the chiefs of the clinical departments in the Ohio state university hospitals in which the divisions are included. ~~Clinical divisions may be added or deleted upon the recommendation of the chief of the clinical department with the concurrence of a majority of the medical staff administrative committee.~~

(D) Qualifications and responsibilities of the chief of the clinical department.

The academic department chairperson shall ordinarily serve also as the chief of the clinical department. Each chief of the clinical department shall be qualified by education and experience appropriate to the discharge of the responsibilities of the position. Each chief of the clinical department must be board certified by an appropriate specialty board or must establish comparable competence. The chief of the clinical department must be a medical staff member at the Ohio state university hospitals. Such qualifications shall be judged by the respective dean of the college of medicine or dentistry. Qualifications for chief of the clinical department generally shall include: recognized clinical competence, sound judgment and well-developed administrative skills.

(1) Procedure for appointment and reappointment of the chief of the clinical department.

Appointment or reappointment of chief of the clinical department shall be made by the dean of the respective college of medicine or dentistry in consultation with elected representatives of the medical staff and the chief medical officer.

(2) Term of appointment of the chief of the clinical department.

The term of appointment of the chief of the clinical department shall be concurrent with the chief's academic appointment but shall be no longer than four years. Prior to the end of said four-year term, a review shall be conducted by the dean of the college of medicine and such review shall serve as the basis for the recommendation for reappointment pursuant to paragraph (D)(1) of this rule.

(3) Duties of the chief of the clinical department.

Each chief of the clinical department is responsible for the following:

(a) Clinically related activities of the department;

(b) Administratively related activities of the department, unless otherwise provided by the hospital;

(c) Continuing surveillance of the professional performance of all practitioners in the department who have delineated clinical privileges;

(d) Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department;

(e) Recommending clinical privileges for each practitioner of the department based on relevant training and experience, current appraised competence, health status that does not present a risk to patients, and evidence of satisfactory performance with existing privileges;

(f) Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the hospital;

(g) The integration of the department or service into the primary functions of the hospital, developing services that complement the medical center's mission and plan for clinical program development;

(h) The coordination and integration of interdepartment and intradepartmental services;

(i) The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services. This includes the development, implementation, enforcement and updating of departmental policies and procedures that are consistent with the hospital's mission. The clinical department chief shall make such policies and procedures available to the medical staff;

(j) The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services, including ensuring that call coverage provides for continuous high quality and safe care;

(k) The determination of the qualifications and competence of department or service personnel who are not licensed ~~independent~~ practitioners and who provide patient care, treatment, and services;

(l) The continuous assessment and improvement of the quality of care, treatment, and services;

(m) The maintenance of quality control programs, as appropriate;

(n) The orientation and continuing education of all persons in the department or service;

(o) Recommending space and other resources needed by the department or service; and hold regular clinical department meetings and ensure open lines of communication are maintained in the clinical department. The agenda for the meetings shall include, but not be limited to, a discussion of the clinical activities of the department and communication of the decisions of the medical staff

administrative committee. Minutes of departmental meetings, including a record of attendance, shall be electronically available and/or distributed to all medical staff members in the clinical department, and such minutes shall be kept in the clinical department.

(Board approval dates: 6/7/2002, 7/6/2002, 3/5/2003, 6/4/2004, 5/6/2005, 11/4/2005, 2/1/2006, 2/2/2007, 9/21/2007, 9/19/2008, 9/18/2009, 10/29/2009, 9/17/2010, 4/8/2011, 8/31/2012, 1/31/2014, 5/18/2021)

**3335-43-09 Elected officers of the medical staff of the Ohio state university hospitals.**

(A) Chief of staff.

The chief of staff shall:

(1) Serve on those committees of the Ohio state university Wexner medical center board as appointed by the chairperson of that board.

(2) Serve as vice chairperson of the medical staff administrative committee.

(3) Provide for communication between the medical staff and the Ohio state university Wexner medical center board or its committees in matters of quality of care, education, and research.

(4) Serve as liaison between the Ohio state university hospitals administration, medical administration, and the medical staff in all matters of mutual concern within the Ohio state university hospitals.

~~(4)~~(5) In consultation with the medical directors and the chief medical officer, seek to ensure that the medical staff is represented and participates as appropriate in any Ohio state university hospitals deliberation which affects the discharge of medical staff responsibilities.

~~(5)~~(6) Call, preside, and be responsible for the agenda of all general medical staff meetings.

~~(6)~~(7) Make medical staff committee appointments jointly with the medical directors and chief of staff-elect in consultation with the chief executive officer of the Ohio state health system and the Wexner medical center board.

~~(7)~~(8) Be spokesperson for the medical staff in its external professional and public relations.

~~(8)~~(9) Serve as chairperson of the nominating committee of the medical staff.

~~(9)~~(10) ~~Hold meetings of the elected medical staff officers, representatives from medical staff committees, hospital administrative leadership and medical directors.~~

(B) Chief of staff-elect.

The chief of staff-elect shall:

(1) Serve on those committees of the Ohio state university Wexner medical center board as appointed by the chairperson of the Wexner medical center board.

(2) Carry out all the duties of the chief of staff when the chief of staff is unable to do so.

(3) Oversee the inclusion of changes in the bylaws, rules and regulations of the medical staff.

(4) Assist the Chief of Staff with duties outlined above in Section A (1)- (9).

(C) Representatives of the medical staff elected at-large.

There shall be three medical staff representatives elected at-large. Each representative shall be a member of the medical staff administrative committee and shall serve on those committees of the Ohio state university Wexner medical center board as appointed by the chairperson of the Wexner medical center board.

(D) Qualifications of officers.

(1) Officers must be members of the attending staff at the time of their nomination and election and must remain members in good standing during the term of their office. Failure to maintain such status shall immediately create a vacancy in the office involved.

(2) Chiefs of the clinical departments shall not be eligible to serve as chief of staff or chief of staff-elect unless they are replaced in their Ohio state university hospitals administrative role during the period of their term of office.

(E) Election of officers.

(1) All officers (other than at-large officers) shall be elected by a majority of those voting by ~~written or~~ electronic ballot of the attending staff.

(2) The nominating committee shall be composed of five members. The chief of staff shall serve on the committee and shall select four other members for the committee. The chief of staff shall be its chairperson.

(3) Nominations for officers shall be accepted from any member of the medical staff and shall be submitted either electronically or in writing to the nominating committee.

(4) The committee's nominees shall be submitted to all voting members of the attending staff no later than May first of the election year.

(5) Candidates for the office of chief of staff-elect shall be listed and each attending staff member shall be entitled to cast one vote. Candidates for the at-large positions shall be voted upon as a group. Each voting member of the attending staff shall be entitled to vote for three at-large candidates. The three candidates with the highest number of votes shall be elected. A majority of the votes shall not be necessary.

(6) Automatic removal shall be for failure to meet those responsibilities assigned within these bylaws, failure to comply with medical staff rules and regulations, policies and procedures of the medical staff, for conduct or statements that damage the reputation of the Ohio state university Wexner medical center, its goals and missions, or programs, or an automatic termination or suspension of clinical privileges that lasts more than thirty days.

(F) Term of office.

(1) The chief of staff and chief of staff-elect shall each serve two years in office beginning on July first. The chief of staff-elect shall be elected in the odd numbered years. A former chief of staff may not succeed the immediately preceding chief of staff-elect.

(2) The at-large representatives shall each serve two years, beginning July first. The at-large representatives may succeed themselves for three successive terms (six years total), if so elected. Upon completion of the three successive terms, the representative may not serve again without a period of two years out of office as an at-large representative. The representative may be elected chief of staff-elect at any time.

(G) Vacancies in office.

(1) A vacancy in the office of chief of staff shall be filled by the chief of staff-elect. If the unexpired term is one year or less, the new chief of staff shall serve out the remaining term in office and shall then serve as chief of staff for the term for which elected. If the unexpired term is more than one year, the new chief of staff shall serve out the remaining term only.

(2) Vacancies in the office of chief of staff-elect shall be filled by a special election held within sixty days of the vacancy by the nominating and election process set forth in paragraph (F) of this rule. The new chief of staff-elect shall become chief of staff at the end of the term of the incumbent.

(3) Vacancies in the at-large representatives medical staff positions shall be filled by appointment by the chief of staff.

(Board approval dates: 6/7/2002, 3/5/2003, 5/30/2003, 11/4/2005, 2/2/2007, 9/19/2008, 9/18/2009, 4/8/2011, 8/31/2012, 11/7/2014, 9/2/2016, 4/6/2018, 5/18/2021)

**3335-43-10 Administration of the medical staff of the Ohio state university hospitals**

(A) Chief medical officer.

The chief clinical officer functions as the chief medical officer as referred to herein these bylaws. The chief medical officer is the senior medical officer for the medical center with the responsibility and authority for all health and medical care delivered at the medical center. The chief medical officer is responsible for overall quality improvement and clinical leadership throughout the medical center, physician alignment, patient safety and medical staff development. The appointment, scope of authority, and responsibilities of the chief medical officer shall be as outlined in the Ohio state university Wexner medical center board bylaws.

(B) Chief quality officer.

The chief quality and patient safety officer of the Ohio state university Wexner medical center is referred to herein these bylaws as the chief quality officer. The chief quality officer reports to the chief medical officer. The chief quality officer works collaboratively with clinical leadership of the medical center, including the director of medical affairs for the James cancer hospital, nursing leadership and hospital administration. The chief quality officer provides leadership in the development and measurement of the medical center's approach to quality, patient safety and reduction of adverse events. The chief quality officer communicates and implements strategic, operational and programmatic plans and policies to promote a culture where patient safety is an important priority for medical and hospital staff.

(C) Medical directors.

The medical directors of the hospitals of the Ohio state university report to the chief executive officer or the executive director of the respective hospital and chief medical officer. Each medical director will collaborate with the chief quality officer, the chief medical officer and the clinical department chiefs to develop, execute and monitor the quality and safety programs of the hospital. The appointment, scope of authority, and responsibilities of the medical directors for the Ohio state university hospitals shall be further outlined in the Ohio state university Wexner medical center board bylaws.

(D) Medical staff committees.

(1) Appointments:

Appointments to all medical staff committees except the medical staff administrative committee and nominating committee and all health system committees, shall be made jointly by the chief of staff, chief of staff-elect, and the hospital medical directors with medical staff administrative committee ratification. Representatives from the Ohio state university hospitals to health system committees shall be appointed jointly by the chief medical officer of the health system and the medical director. Unless otherwise provided by these bylaws, all appointments to medical staff committees shall be for two years and may be renewed. The chief of staff, chief medical officer, medical director, and the chief executive officer of the Ohio state university hospitals may serve on any medical staff committee as an ex-officio member without vote.

(2) Meetings:

Each medical staff committee shall meet at the call of its chairperson and at least quarterly. Committees shall maintain records of proceedings and minutes of meetings and shall forward all recommendations and actions to the chief medical officer who shall promptly communicate them to the medical staff administrative committee. The chairperson shall control the committee agenda, attendance of staff and guests, and conduct of the proceedings. A simple majority of appointed voting members shall constitute a quorum.

(3) Peer review committees:

The medical staff as a whole and each committee provided for by these medical staff bylaws is hereby designated as a peer review committee in accordance with the laws of the state of Ohio. The medical staff through its committees shall be responsible for evaluating, maintaining and/or monitoring the quality and utilization of patient care services provided by the Ohio state university hospitals.

(E) Medical staff administrative committee.

(1) Composition.

(a) This committee shall consist of the following voting members: chief of staff, chief of staff-elect, chiefs of the clinical departments, three medical staff representatives elected at large, the chief medical officer, and the chief executive officer of the Ohio state university hospitals. Additional members may be appointed to the medical staff administrative committee at the recommendation of the dean or the chief medical officer of the medical center subject to the approval of the medical staff administrative committee and subject to review/renewal on a biennial basis. Any members may be removed from the medical staff administrative committee at the recommendation of the dean, the executive vice president for health sciences or the chief medical officer of the medical center and subject to the review and approval of the medical staff administrative committee. A replacement will be appointed as outlined above to maintain the medical staff administrative committee's constituency. The chief medical officer shall be the chairperson and the chief of staff shall be vice-chairperson.

(b) Any member of the committee who anticipates absence from a meeting of the committee may appoint as a temporary substitute another member of the same category of the medical staff to represent him or her at the meeting. The temporary substitute shall have all the rights of the absent member. The chief executive officer of the Ohio state university hospitals may invite any member of the chief executive

officer's staff to represent him or her at a meeting or to attend any meeting.

(c) All members of the committee shall attend, either in person or by proxy, a minimum of two-thirds of all committee meetings.

(2) Duties.

(a) To represent and to act on behalf of the medical staff, subject to such limitations as may be imposed by these bylaws, by the bylaws of the Ohio state university Wexner medical center board, the bylaws or rules of the board of trustees of the Ohio state university.

(b) To have primary authority for activities related to self-governance of the medical staff. Action approved by the medical staff administrative committee can be reviewed by the quality and professional affairs committee pursuant to section 3335-43-13 of these bylaws.

(c) To receive and act upon committee reports

(d) To delegate appropriate staff business to committees while retaining the right of executive responsibility and authority over all medical staff committees. This shall include but is not limited to review of and action upon medical staff appointments and reappointments whenever timely action is necessary.

(e) To approve and implement policies of the medical staff.

(f) To provide a liaison between the medical staff, medical director, chief executive officer, and the Wexner medical center board.

(g) To recommend action to the medical directors and chief executive officer of the Ohio state university hospitals on matters of medical-administrative nature.

(h) To fulfill the medical staff's accountability to the Wexner medical center board and the board of trustees of the Ohio state university for medical care rendered to patients in the Ohio state university hospitals, and for the professional conduct and activities of the medical staff, including recommendations concerning:

i. Medical staff structure;

ii. The mechanism to review credentials and to delineate clinical privileges;

iii. The mechanism by which medical staff membership may be terminated;

iv. Participation in the Ohio state university hospitals' performance improvement activities; and

v. Corrective action and hearing procedures applicable to medical staff members and other licensed health care professionals granted clinical privileges.

vi. To ensure the medical staff is kept abreast of the accreditation process and informed of the accreditation status of the Ohio state university hospitals.

(i) To review and act on medical staff appointments, reappointments, and requests for delineation of clinical privileges. Whenever there is doubt of an applicant's ability to perform the privileges requested, the medical staff administrative committee shall have the authority to request an evaluation of the applicant's clinical activities

relevant to requested privileges.

(j) To report to the medical staff all actions affecting the medical staff.

(k) To inform the medical staff of all changes in committees, and the elimination of such committees as circumstances shall require.

(l) To create committees (for which membership is subsequently appointed pursuant to rule 3335-43-09 of the Administrative Code) to meet the needs of the medical staff and comply with the requirements of accrediting agencies.

(m) To establish and maintain rules and regulations governing the medical staff.

(n) To perform other functions as are appropriate.

(3) Executive session.

(a) Upon the recommendation of the credentialing committee, the medical staff administrative committee may vote to hold a portion of a regular, special or emergency meeting in executive session with participation limited to voting members of the medical staff administrative committee. Other individuals may be invited to attend any or all portions of an executive session as deemed necessary by the committee chair.

(4) Meetings. The committee shall meet monthly and shall keep detailed minutes which shall be distributed to each committee member and to the Wexner medical center board through the quality and professional affairs committee.

(5) Voting. At a properly constituted meeting, voting shall be by a simple majority of members present except in the case of termination or non-reappointment of medical staff membership or permanent suspension of clinical privileges, wherein a two-thirds vote of members present shall be required.

(F) Credentialing committee of the hospitals of the Ohio state university:

(1) Composition:

The credentialing responsibilities of medical staff are delegated to the credentialing committee of the hospitals of the Ohio state university, the composition of which shall include representation from the medical staff of each health system hospital.

The credentialing committee of the hospitals of the Ohio state university shall be appointed by the chief medical officer of the health system. The chief of staff, director of medical affairs and medical directors of each hospital shall make recommendations to the chief medical officer for representation on the credentialing committee of the hospitals of the Ohio state university.

The credentialing committee of the hospitals of the Ohio state university shall meet at the call of its chair, who shall be appointed by the chief medical officer of the health system.

(2) Duties:

(a) To review all applications for medical staff and licensed health care professional appointment and reappointment, as well as all requests for delineation, renewal, or amendment of clinical privileges in the manner provided in these medical staff bylaws, including applicable time limits. During its evaluation, the credentialing

committee of the hospitals of the Ohio state university will take into consideration the appropriateness of the setting where the requested privileges are to be conducted;

(b) To review ~~biennially~~ triennially all applications for reappointment or renewal of clinical privileges;

(c) To review all requests for changes in medical staff membership;

(d) To assure, through the chairperson of the committee, that all records of formal peer review activity taken by the committee, including committee minutes, are maintained

in the strictest of confidence in accordance with the laws of the state of Ohio. The committee may conduct investigations and interview applicants as needed to discharge its duties. The committee may refer issues and receive issues as appropriate from other medical staff committees;

(e) To make recommendations to the medical staff administrative committee through the chairperson of the credentialing committee regarding appointment applications and initial requests for clinical privileges. Such recommendations shall include the name, status, department (division), medical school and year of graduation, residency and fellowships, medical-related employment since graduation, board certification and recertification, licensure status as well as all other relevant information concerning the applicant's current competence, experience, qualifications, and ability to perform the clinical privileges requested;

(f) To recommend to the medical staff administrative committee that certain applications for appointment be reviewed in executive session;

(g) The committee, after review and investigation, may make recommendations to the chief medical officer, chief of staff or the chief of a clinical department, regarding the restriction or limitation of a member's clinical privileges for noncompliance or any other matter related to its responsibilities;

(h) To review all grants of special or temporary privileges; and

(i) To review requests made for clinical privileges by other licensed health care professionals as set forth in these bylaws.

(j) To recommend eligibility criteria for the granting of medical staff membership and privileges.

(k) To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities.

(l) To review, and where appropriate take action on, reports that are referred to it from other medical staff committees and medical staff members.

(m) To perform such other functions as requested by the medical staff administrative committee, the quality and professional affairs committee or Wexner medical center board.

(3) Licensed health care professionals subcommittee.

(a) Composition:

This subcommittee shall consist of other licensed health care professionals who have been appointed in accordance with paragraph (A)(6) of rule 3335-43-09 of the Administrative Code. The subcommittee shall be chaired by a director of nursing who shall serve as chair of the subcommittee.

(b) Duties:

i. To review, within thirty days of receipt, all completed applications as may be referred by the credentialing committee of the hospitals of the Ohio state university.

ii. To review and investigate the character, qualifications and professional competence of the applicant.

iii. To review the applicant's patient care quality indicator definitions on initial granting of clinical privileges and the performance-based profile at the time of renewal.

iv. To verify the accuracy of the information contained in the application.

v. To request a personal interview with the applicant if deemed appropriate.

vi. To forward, following review of the application, a written recommendation for clinical privileges to the credentialing committee of the hospitals of the Ohio state university for review at its next regularly scheduled meeting

vii. To develop relevant policies and procedures regarding the scope of service and scope of practice to be granted to each licensed health care professional specialty. These policies and procedures shall be ratified by the credentialing committee and medical staff administrative committee and be approved by the Wexner medical center board.

(G) Committee for practitioner health.

(1) Composition:

The committee shall consist of medical staff members appointed in accordance with paragraph (A)(6) of rule 3335-43-09 of the Administrative Code.

(2) Duties:

(a) To consider issues of licensed ~~independent~~ practitioner health or impairment whenever a self-referral or referral is requested by an affected member or another member or committee of the medical staff, the Ohio state university hospitals staff, or any other individual.

(b) To educate the medical staff and the Ohio state university hospitals staff about illness and impairment recognition issues, including at-risk criteria, specific to licensed ~~independent~~ practitioners.

(c) To provide appropriate counsel, referral and monitoring until the rehabilitation is complete and periodically thereafter, if required, to enable the medical staff member to obtain appropriate diagnosis and treatment, and to provide appropriate standards

of care.

(d) To consult regularly with the chief of staff, chief medical officer and medical director of the Ohio state university hospitals.

(e) To advise credentials or other appropriate medical staff committees on the credibility of any complaint, allegation or concern, including those affecting the quality and safety of patient care.

(f) To assure, through the chairperson of the committee, that all proceedings and records, including the identity of the person referring the case, are handled and maintained in the strictest confidence in accordance with the laws of the state of Ohio.

(g) To initiate appropriate actions when a licensed practitioner fails to complete the required rehabilitation program.

(H) Medical staff bylaws committee.

(1) Composition:

The committee shall consist of those members appointed in accordance with paragraph (A)(6) of rule 3335-43-09 of the Administrative Code. The chairperson shall always be the chief of staff-elect.

(2) Duties:

(a) To review and recommend amendments, as appropriate, to these medical staff bylaws to the medical staff administrative committee at least every two years.

(b) To receive from members of the medical staff or the medical staff administrative committee any suggestions that may necessitate amendment of these bylaws.

(I) Infection prevention committee.

(1) Composition:

The medical staff members of the committee shall consist of those members appointed in accordance with paragraph (A)(6) of rule 3335-43-09 of the Administrative Code. The committee shall also include representatives of nursing, environmental services, and hospital administration as may be invited from time to time by the chief of staff. The chairperson shall be a physician member of the medical staff with experience or training in infectious diseases.

(2) Duties:

(a) To oversee surveillance and institute any recommendations necessary for the investigation, prevention, containment of nosocomial and clinical infectious diseases of both patients and staff at all facilities owned, operated, or controlled by the Ohio state university hospitals and subject to accreditation standards.

(b) To take necessary action through the chairperson of the committee, and the Ohio state university hospitals' epidemiologist, in consultation with the medical director of the Ohio state university hospitals, to prevent and control emerging spread or outbreaks of infections; isolate communicable and infectious patients as indicated; and obtain all necessary cultures in emergent situations when the responsible medical staff member is unavailable.

(J) Ethics committee.

(1) Composition:

The committee shall consist of members of the medical staff, nursing, hospital administration, and other persons who by reason of training, vocation, or interest may make a contribution. Members shall be appointed as provided in these bylaws. The chairperson shall be a medical staff member who is a clinically active physician.

(a) To make recommendations for the review and development of guidelines or policies regarding ethical issues.

(b) To provide ethical guidelines and information in response to requests from members of the medical staff, patients, patient's family or other representative, and staff members of the Ohio state university hospitals.

(c) To provide a support mechanism for primary decision makers at the Ohio state university hospitals.

(d) To provide educational resources on ethics to all health care providers at the Ohio state university hospitals.

(e) To provide and enhance interaction between hospitals administration and staff, departmental ethics committees, pastoral care services, and members of the medical staff.

(K) Practitioner evaluation committee.

(1) Composition.

This multi-disciplinary peer review committee is composed of clinically-active practitioners. If additional expertise is needed, the practitioner evaluation committee may request the assistance from any medical staff member or recommend to the chief medical officer an external review.

(2) Duties:

(a) To meet and keep minutes, which describe issues, opportunities to improve patient care, recommendations and actions to the chief quality officer and chair of the clinical department, responsible parties, and expected completion dates. The minutes are maintained in the quality and operations improvement office.

(b) To ensure that ongoing and systematic monitoring, evaluation, and process improvement is performed in each clinical department.

(c) To develop and utilize objective criteria in practitioner peer review activities.

(d) To ensure that the medical staff peer review process is effective.

(e) To maintain confidentiality of its proceedings. These issues are not to be handled outside of PEC by any individual, clinical department, division, or committee.

(L) Quality Leadership Council

(1) Composition:

The quality leadership council shall consist of members appointed in accordance with paragraph (A)(6) of rule 3335-43-09 of the Administrative Code and shall include the executive vice president for health sciences, the dean of the college of medicine and the chairperson of the quality and professional affairs committee of the Wexner medical center board as ex-officio members without a vote. The chief quality officer shall be the chairperson of the quality leadership council.

(a) To design and implement systems and initiatives to enhance clinical care and outcomes throughout the integrated health care delivery system.

(b) To serve as the oversight council for the clinical quality management and patient safety plan.

(c) To establish goals and priorities for clinical quality, safety and service on an annual basis.

(M) Clinical quality and patient safety committee.

(1) Composition:

The members of this group shall be appointed pursuant to these bylaws and shall include medical staff members from various clinical departments and support services and shall include the director of the clinical quality management policy group, and representatives of nursing and hospitals administration. The chairperson of the policy group shall be a physician member of the medical staff.

(a) Duties:

i. To coordinate the quality management related activities of the clinical departments, the medical information management department, utilization review, infection control, pharmacy and therapeutics and drug utilization committee, transfusion and isoimmunization, and other medical staff and the Ohio state university hospitals committees.

ii. To implement clinical improvement programs to achieve the goals of the Ohio state university hospitals quality management plan, as well as assure optimal compliance with accreditation standards and governmental regulations concerning performance improvement.

iii. To review, analyze, and evaluate on a continuing basis the performance of the medical staff and other health care providers; and advise the clinical department clinical quality sub-committees in defining, monitoring, and evaluating quality indicators of patient care and services.

iv. To serve as liaison between the Ohio state university and the Ohio peer review organizations through the chairperson of the policy group and the director of clinical quality.

v. To make recommendations to the medical staff administrative committee on the establishment of and the adherence to standards of care designed to improve the quality of patient care delivered in the Ohio state university hospitals.

vi. To hear and determine issues concerning the quality of patient care rendered by members of the medical staff and the Ohio state university hospitals staff and make appropriate recommendations and evaluate action plans when appropriate to the chief medical officer, the medical director, the chief of a clinical department, or the Ohio state university hospitals administration.

vii. To appoint ad-hoc interdisciplinary teams to address the Ohio state university hospitals-wide quality management plan.

viii. To annually review and revise as necessary the Ohio state university hospitals-wide clinical quality management plan.

ix. To report and coordinate with the quality leadership council all quality improvement initiatives.

(N) Clinical resource utilization policy group.

(1) Composition:

The members shall be appointed in accordance with paragraph (A)(6) of rule 3335- 43-09 of the Administrative Code and shall include medical staff members from various clinical departments and support services the directors of clinical quality and case management, and representatives of nursing and hospitals administration. The chairperson of the policy group shall be a physician member of the medical staff.

(a) Duties:

i. To promote the most efficient and effective use of the hospitals of the Ohio state university health system facilities and services by participating in the review process and continued stay reviews on all hospitalized patients.

ii. To formulate and maintain a written resource management review plan for the hospitals of the Ohio state university health system consistent with applicable governmental regulations and accreditation requirements.

iii. To conduct resource management studies by clinical department or divisions, or by disease entity as requested or in response to variation from benchmark data would indicate.

iv. To report and recommend to the quality leadership council changes in clinical practice patterns in compliance with applicable governmental regulations and accreditation requirements, and when the opportunity exists to improve the resource management.

v. To oversee evaluation and cost-effective utilization of clinical technology.

vi. To oversee the activities of the utilization management committee of the hospitals of the Ohio state university health system. This oversight will include the annual review and approval of the utilization management plan.

(O) Clinical practice guideline committee.

(1) Composition

The members shall be appointed in accordance with paragraph (A)(6) of rule 3335-43-09 of the Administrative Code, and shall include medical staff members from various clinical departments and support services, representatives of nursing, pharmacy, information systems, hospitals administration, and the chair of the clinical quality and management policy group. The chairperson of the policy group shall be a physician member of the medical staff.

(2) Duties:

(a) To oversee the planning, development, approval, implementation and periodic review of evidence-based medicine resources (i.e., clinical practice guidelines, quick reference guides, clinical pathways, and clinical algorithms) for use within the Ohio state university hospitals and its affiliated institutions. Planning should be based on the prioritization criteria approved by the quality leadership council and review should focus on incorporating recent medical practice, literature or developments. Annual review should be done in cooperation with members of the medical staff with specialized knowledge in the field of medicine related to the guideline.

(b) To report and recommend to quality leadership council specific process and outcomes measures for each evidence-based medicine resource.

(c) To oversee ongoing education of medical staff (including specifically limited staff) and other appropriate Ohio state university hospitals staff regarding the fundamental concepts and value of evidence-based practice and outcomes measurement and its relation to quality improvement.

(d) To initiate and support research projects when appropriate in support of the objectives of the quality leadership council.

(e) To oversee the development, approval and periodic review of the clinical elements of ordersets and clinical rules to be used within the information system of the Ohio state university hospitals and its affiliated institutions. ordersets and clinical rules related to specific practice guidelines should be forwarded to quality leadership council for approval. All other ordersets and clinical rules should be forwarded to the quality leadership council for information.

(f) To regularly report a summary of all actions to the quality leadership council.

(P) Professionalism consultation committee.

(1) Composition.

This multi-disciplinary peer review committee is composed of clinically-active practitioners and other individuals with expertise in professionalism.

(2) Duties.

(a) Receive and review validity of complaints regarding concerns about professionalism of credentialed practitioners;

(b) Treat, counsel and coach practitioners in a firm, fair and equitable manner;

(c) Maintain confidentiality of the individual who files a report unless the person who submitted the report authorizes disclosure or disclosure is necessary to fulfill the institution's legal responsibility;

(d) Ensure that all activities be treated as confidential and protected under applicable peer review and quality improvement standards in the Ohio Revised Code;

(e) Forward all recommendations to the clinical department chief, the chief medical officer or his/her designee and, if applicable, to the chief nursing officer.

(Board approval dates: 4/7/2000, 10/5/2001, 6/7/2002, 5/30/2003, 6/4/2004, 5/6/2005, 11/4/2005, 2/2/2007, 2/1/2008, 9/19/2008, 9/18/2009, 10/29/2009, 4/8/2011, 8/31/2012, 2/01/2013, 1/31/2014, 11/7/2014, 11/6/2015, 9/2/2016, 4/6/2018, 5/18/2021)

**3335-43-11 History and physical**

(A) History and physical examination.

(1) A history and physical appropriate to the patient and/or the procedure to be completed shall be documented in the medical record of all patients either:

(a) Admitted to the hospital

(b) Undergoing outpatient/ambulatory procedures

(c) Undergoing outpatient/ambulatory surgery

(d) In a hospital-based ambulatory clinic

(2) For patients admitted to the hospital, the history and physical examination shall include at a minimum:

(a) Date of admission

(b) History of present illness, including chief complaint

(c) Past medical and surgical history

(d) Relevant past social and family history

(e) Medications and allergies

(f) Review of systems

(g) Physical examination

(h) Test results

(i) Assessment or impression

(j) Plan of care

(3) For patients undergoing outpatient/ambulatory procedures or outpatient/ambulatory surgery, the history and physical examination shall include at a minimum:

(a) Indications for procedure or surgery

(b) Relevant medical and surgical history

(c) Medications and allergies or reference to current listing in the chart or electronic medical record

(d) Focused review of systems, as appropriate for the procedure or surgery

(e) Pre-procedure assessment and physical examination

(f) Assessment/impression and treatment plan

(4) For patients seen in a hospital-based ambulatory clinic, the history and physical shall include at a minimum:

(a) Chief complaint

(b) History of present illness

(c) Medications and allergies

(d) Problem-focused physical examination

(e) Assessment or impression

(f) Plan of care

(5) Deadlines and sanctions.

(a) A history and physical examination must be performed by a member of the medical staff, his/her designee or other licensed health care professional, who is appropriately credentialed by the hospital, and be signed, timed and dated.

(b) Patients admitted to the hospital: If the history and physical is performed by the medical staff member's designee or other licensed health care professional who is appropriately credentialed by the hospital, the history and physical must be countersigned by the responsible medical staff member.

(c) The complete history and physical examination shall be dictated, written or updated no later than twenty-four hours after admission for all inpatients.

(d) Admitted patients or patients undergoing a procedure or surgery, the history and physical examination may be performed or updated up to thirty days prior to admission or the procedure/surgery. If completed before admission or the procedure/surgery, there must be a notation documenting an examination for any changes in the patient's condition since the history and physical was completed. The updated examination must be completed and documented in the patient's medical record within twenty-four hours after admission or before the procedure/surgery, whichever occurs first. It must be performed by a member of the medical staff, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital, and be signed, timed and dated. In the event the history

and physical update is performed by the medical staff member's designee or other licensed health care professional who is appropriately credentialed by the hospital, it shall be countersigned, timed and dated by the responsible medical staff member.

i. For patients undergoing an outpatient procedure or surgery, regardless of whether the treatment, procedure or surgery is high or low risk, a history and physical examination must be performed by a member of the medical staff, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital and must be signed or countersigned when required, timed and dated.

ii. If a licensed health care professional is appropriately credentialed by the hospital to perform a procedure or surgery independently, a history and physical performed by the licensed health care professional prior to the procedure or surgery is not required to be countersigned.

Hospital-based ambulatory clinic: If a history and physical examination is performed by licensed health care professional who is appropriately credentialed by the hospital to see patients independently, the history and physical is not required to be countersigned.

(e) When the history and physical examination, including the results of indicated laboratory studies and x-rays, is not recorded in the medical record before the time stated for a procedure or surgery, the procedure or surgery cannot proceed until the history, and physical is signed or countersigned when required, by the responsible medical staff member, and indicated test results are entered into the medical record. In cases where such a delay would likely cause harm to the patient, this condition shall be entered into the medical record by the responsible medical staff member, his/her designee or other licensed health care professional, who is appropriately credentialed by the hospital, and the procedure or surgery may begin. When there is a disagreement concerning the urgency of the procedure, it shall be adjudicated by the medical director or the medical director's designee. (B/T 10, 29/2009, 8/31/12)

(f) Ambulatory patients must have a history and physical at the initial visit as outlined in paragraph (A)(4) of this rule.

(g) For psychology, psychiatric and substance abuse ambulatory sites, if no other acute or medical condition is present on the initial visit, a history and physical examination may be performed either:

i. within the past six months prior to the initial visit,

ii. at the initial visit, or

iii. within 30 days following the initial visit.

(Board approval dates: 10/29/2009, 8/31/2012, 1/31/2014, 11/7/2014, 11/6/2015)

**Chapter 3335-43 - *Bylaws of the Medical Staff* of The Ohio State University Hospitals**
Updated February 8, 2022

**3335-43-12 Meetings and dues.**

(A) Meetings.

The medical staff of the Ohio state university hospitals shall conduct scheduled meetings at least annually ~~twice yearly~~. Notice of the meeting shall be sent to all medical staff at least two weeks prior to the meeting. Attendance is encouraged, but shall not be a requirement for continued medical staff membership and clinical privileges. Special and/or electronic meetings of the medical staff may be called at the option of the medical staff administrative committee.

(B) Dues.

The medical staff, by two-thirds vote of those in attendance at a regularly scheduled meeting, may establish dues. Payment of dues is a requirement for continued staff membership.

(Board approval date: 10/29/2009, 4/6/2018)

**3335-43-13 Amendments and adoption.**

(A) Medical staff responsibility.

The medical staff bylaws committee shall have the initial responsibility to formulate, review at least biennially, and recommend to the quality and professional affairs committee of the Wexner medical center board any medical staff bylaws, rules, regulations, policies, procedures, and amendments as needed. Amendments to the bylaws shall be effective when approved by the university board of trustees. Amendments to the rules and regulations shall be effective when approved by the Wexner medical center board.

Such responsibility shall be exercised in good faith, in a timely manner and in accordance with applicable laws and regulatory standards. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these bylaws.

The organized medical staff shall also have the ability to propose amendments to the medical staff bylaws, rules and regulations, and policies and procedures and propose them directly to the quality and professional affairs committee of the Wexner medical center board.

If the voting members of the organized medical staff propose to adopt amendments to the bylaws, rules and regulations or policies, they must first communicate the proposal to the medical staff administrative committee. When the medical staff administrative committee proposes to adopt amendments to the bylaws, rules and regulations or policies, it communicates the proposal to the organized medical staff.

Conflict between the organized medical staff and the medical staff administrative committee will be managed by allowing communication directly from the medical staff to the quality and professional affairs committee of the Wexner medical center board on issues including, but not limited to amendments to the bylaws and the adoption of new rules and regulations or policies. Medical staff members may communicate with the quality and professional affairs committee of the Wexner medical center board by submitting their communication in writing to the chief of staff, who shall then communicate on their behalf to the quality and professional affairs committee of the Wexner medical center board at its next regularly scheduled meeting for final determination.

In cases of urgent need to update the medical staff bylaws or rules and regulations in order to comply with law, statute, federal regulation, or accreditation standard, the medical staff administrative committee and the quality and professional affairs committee of the Wexner medical center board may provisionally approve an urgent amendment without prior notification to the medical staff. The medical staff shall be immediately notified by the medical staff administrative committee. The medical staff shall have the opportunity for review of and vote on the provisional amendment.

If the medical staff votes in favor of the provisional amendment, it shall stand. If there is conflict over the provisional amendment, process for resolving conflict between the organized medical staff and the medical staff administrative committee shall be implemented.

(B) Methods of adoption and amendment to these bylaws.

Proposed amendments to these bylaws may be originated by the medical staff bylaws committee, medical staff administrative committee or by a petition signed by twenty-five per cent of attending medical staff members.

Each attending medical staff member will be eligible to vote on the proposed amendment via ~~printed or~~ secure ~~electronic~~ ballot in a manner determined by the medical staff administrative committee. All attending medical staff members shall receive at least ~~thirty~~ fourteen days advance notice of the changes to be adopted:

(1) The medical staff receives a simple majority of the votes cast by those members eligible to vote.

(2) Amendments so adopted shall be effective when approved by the university board of trustees.

(C) Methods of adoption and amendment to medical staff rules, regulations and policies.

The medical staff may adopt additional rules, regulations and policies as necessary to carry out its functions and meet its responsibilities under these bylaws.

Proposed amendments to the rules, regulations and policies may be originated by the medical staff bylaws committee or the medical staff administrative committee.

The medical staff administrative committee shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the medical staff administrative committee, rules and regulations may be adopted, amended or repealed, in whole or in part and such changes shall be effective when approved by the organized medical staff, and the Wexner medical center board. Policies and procedures will become effective upon approval of the medical staff administrative committee.

In addition to the process described above, the organized medical staff itself may recommend directly to the quality and professional affairs committee of the Wexner medical center board an amendment to any rule, regulation, or policy by submitting a petition signed by twenty-five percent of the members of the attending medical staff category. Upon presentation of such petition, the adoption process outlined above will be followed.

(D) The medical staff administrative committee may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the committee's judgment, administrative, technical or legal modifications or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Wexner medical center board but must be approved by the vice president of health services. Neither the organized medical staff nor the Wexner medical center board may unilaterally amend the medical staff bylaws or rules and regulations.

**Chapter 3335-43 - *Bylaws of the Medical Staff* of The Ohio State University Hospitals**
Updated February 8, 2022

The medical staff bylaws, rules and regulations, Wexner medical center board bylaws, and relevant policies shall not conflict. The medical staff bylaws committee shall assure that there is no conflict.

**3335-43-14 Rules of construction.**

(A) "Shall" as used herein is to be construed as mandatory.

(B) These bylaws should be construed to be gender neutral.

(Effective 6/14/2011 no board date given; was not 4/8/2011)

**Chapter 3335-43 - *Bylaws of the Medical Staff* of The Ohio State University Hospitals**
Updated February 8, 2022

APPENDICES

APPENDIX I. COAT OF ARMS OF
THE OHIO STATE UNIVERSITY HOSPITALS

The official coat of arms of The Ohio State University Hospitals shall be as follows:

The blazon of the arms of University Hospitals is a shield, 16th century style, on a field of gray surrounded by an "O" in scarlet with the words, "The Ohio State University Hospitals" in black.

The shield is embattled above the chief, with three azure towers. The shield is divided "fesse cotised," through the "fesse point" by three bars, "gemels of or" (gold), separated each by bars, "gemels of argent" (silver). The chief is "gules" (scarlet), impaled by a charge, "The Ohio State University Crest." The "O" is argent, the center is gules, impaled by a charge with the "or" book of knowledge, and the base of the "O" is impaled by a charge of a "buckeye leaf vert" (green).

The base is quartered per pale.

The dexter base is vertical with a charge, the staff of Aesculapius.

The sinistra base is azure with a charge, the Hospitalier's cross, gules.

The scroll contains the Latin motto: "Hospitale-Academia-Investigatus."

The use of the coat of arms of The Ohio State University Hospitals will be by all who are connected with University Hospitals.

**Chapter 3335-43 - *Bylaws of the Medical Staff* of The Ohio State University Hospitals**
Updated February 8, 2022

APPENDIX II.

COAT OF ARMS OF THE MEDICAL STAFF
OF THE OHIO STATE UNIVERSITY HOSPITALS

The official coat of arms of the medical staff of The Ohio State University Hospitals shall be as follows: The shield on vertical narrow stripes, alternating silver and white, is square, parted per green (medicine) chevron. The dexter chief contains the golden oak leaf surmounted by the silver acorn representing the practice of medicine; the sinistra chief contains the multiple atomis circles representing research; the center base contains the golden book of knowledge encircled by the gray "O" from the crest of The Ohio State University and represents the teaching obligation of our staff. The scroll is gold, with the black lettering of the motto, "Eruditio A Scientia Exornata Miliorem Valetudinem Mortalibus Praestat" (knowledge enhanced by science assures better health for mankind).

Encircling the achievement are the words, "The Medical Staff" joined by a green buckeye leaf (symbol of the State of Ohio) to the words, "The Ohio State University Hospitals." Impaled in this "coat of arms" are the heritage of the State of Ohio and The Ohio State University with the obligation of teaching and research to provide and improve medical care. The use of this coat of arms of the medical staff shall be limited to duly appointed members of the medical staff and the staff organization.

**James Medical Staff Bylaws**
*Redline Summary*
*5.31.23*

**111-04 Membership**

**(A) Qualifications**

**(3)** (Pg 3)

- changes to annual education requirement; allows MSAC or CHRI to approve and assign elearnings to the medical staff with clinical privileges
- med center assigned eLearnings include those required for all faculty and staff, regardless of role or work location for regulatory, accreditation and/or patient safety reasons

**(5)** (Pg 4)

- Remove waiver language (rewritten in A (7))

**(7) (e), (f)** (pg 5)

- Update waiver request to permit request of a waiver for physicians who have voluntarily opted out of government healthcare programs. (ie community oral Surgeons providing call coverage)
- Confirms that waiver requests from providers who are on the federal government exclusion list will not be considered.
- Add language to prohibit waivers for requirements that are mandated by external bodies such as governmental agencies, accrediting bodies, etc.

**(C)** (pg 6)

- Changed reappointment cycle from 24 to 36 months in all applicable sections in accordance with joint commission changes
- WMC Board bylaws will be updated also

**(E) Procedure for appointment**

**(3)** (pg 8,9)

- permit remote background checks that meet the minimum requirements of OSUWMC
- permit remote drug screens that meet the minimum requirements of OSUWMC
- require competency specific elearnings prior to application but others can be completed within 60 days in alignment with deadlines for staff

**111-08 Organization of the medical staff**

(k) (pg 42)

- Removed independent from licensed independent practitioners per Joint Commission change. (also in (F) Committee for Practitioner Health (2) (a) and (f) (Pg 50)

**111-10 Administration of the medical staff of the CHRI**

**(C) Medical staff administrative committee**

**(1) (a) Composition**

- Added Department Chair of Dermatology

**(3) (a) Executive Session** (pg 47)

- Add section to clarify how and when MSAC can call Executive Session.

**111-12 Amendments and adoption.**

**(B) Methods of adoption** (Pg 56)

- Change timeline for medical staff to vote on bylaws and rules and regulations from 30 days to 14 days since votes are submitted electronically.

**111-13 Meetings and Dues**

**(A)**

- Update language to state that meetings will occur at least annually, instead of biannually, under the purview of the chief of staff.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

**Chapter 3335-111 - *Bylaws of the Medical Staff* of the**
**Arthur G. James Cancer Hospital and Richard J. Solove Research Institute**

Updated February 8, 2022

**3335-111-01 Medical staff name.**

The board of trustees of the Ohio state university, by official action, established "the Arthur G. James cancer hospital and Richard J. Solove research institute (CHRI)." Hereinafter, the abbreviation "CHRI" shall mean the Arthur G. James cancer hospital and Richard J. Solove research institute; the term "medical staff" shall refer to the medical staff of the cancer hospital and research institute. "The medical staff of the Arthur G. James cancer hospital and Richard J. Solove research institute" shall be the name of the hospital's medical staff organization. In accordance with rules 3335-109-01 to 3335-109-20 and 3335-104-07 of the Administrative Code, the Ohio state university Wexner medical center board (herein called "Wexner medical center board") has delegated to the medical staff of the CHRI the responsibility to prepare and recommend adoption of these bylaws.

(Board approval dates: 9/1/1993, 2/5/1999, 9/6/2002, 2/6/2004, 11/4/2005, 2/11/2011, 11/7/2014)

**3335-111-02 Purpose.**

The purpose of the self-governing, democratically organized medical staff, which is accountable to the Ohio state medical center board for the quality of care provided to the patients of the CHRI shall be:

(A) To maintain exemplary standards of medical care for all patients at the CHRI. To assure continuity of care and treatment for the individual patient throughout the course of his or her illness, and to assure ongoing support and care for cancer survivors. To commit to being responsive to the needs of all CHRI patients and to communicate compassionately and effectively concerning matters of patient care.

(B) To support and encourage research, with an emphasis on the prevention and treatment of cancer; to actively encourage patients to participate in clinical trials and other research, and to foster research programs to enhance and advance the educational and patient care programs.

(C) To support educational programs for health care and other professionals, patients and families, and the community, with an emphasis on cancer-related education; to elevate and advance the educational standards of our professions, including pre and post medical or osteopathic students, nursing students, students of the allied medical professions, and students of other health professional colleges.

(D) To provide a means to identify and review medical problems, assure adherence to regulatory and accreditation standards, review and revise policies and procedures; and to provide a means for establishing and maintaining standards of professional, medical and educational performance, evaluation and discipline within the medical staff, and harmonious cooperation and understanding among the units comprising the CHRI.

(E) To govern medical staff credentialed practitioners and these Bylaws are not intended to and shall not create any contractual rights between the Ohio state university Wexner medical center and any practitioner. Any and all contracts of affiliation, association or employment shall control contractual and financial relationships between the Ohio state university Wexner medical center and such practitioners.

(Board approval dates: 9/1/1993, 12/6/1996, 9/1/1999, 12/3/1999, 6/2/2000, 11/4/2005, 9/18/2009, 10/29/2011, 4/8/2011, 4/6/2018)

**Chapter 3335-111 - *Bylaws of the Medical Staff* of the**
**Arthur G. James Cancer Hospital and Richard J. Solove Research Institute**
Updated February 8, 2022

**3335-111-03 Patients.**

(A) The continuous care and treatment of individual patients is the medical responsibility of the member of the attending, associate attending, clinical attending or community associate attending medical staff to whose care the patient is treated at or transferred to the CHRI, and to an allied health professional being granted clinical privileges under these bylaws.

(B) There shall be only one category or classification of patients in the CHRI, and those patients are the patients of the medical staff under whose care they are treated. Patients treated at the CHRI who, prior to treatment, have not requested or selected a member of the medical staff to attend them shall be assigned for their care and treatment to a member of the medical staff for their care and treatment.

(C) All patients treated at the CHRI should cooperate in, and, whenever applicable, participate in an approved cancer related protocol and knowingly participate in the teaching program of the college of medicine. Should a patient, or on the behalf of the patient, the patient's representative, refuse to participate or cooperate in the teaching program of the CHRI or the college of medicine, the medical staff member responsible for the care and treatment of the patient will encourage participation in the Ohio state university's teaching programs, but will simultaneously inform patients, or when appropriate, the patients representative, of their right to refuse participation.

(D) Students, including pre and post medical or osteopathic, but not limited thereto, shall be under the direction and control of the members of the medical staff to whom the patient is assigned for treatment within the CHRI. The CHRI respects the patient's right to participate in decisions about his or her care, treatment and services, and further respects the patient's rights to refuse care, treatment and services, in accordance with law and regulation.

(Board approval dates: 9/1/1993, 12/6/1996, 12/3/1999, 9/6/2002, 2/6/2004, 11/4/2005, 9/18/2009, 4/8/2011)

**3335-111-04 Membership.**

(A) Qualifications.

(1) Membership on the medical staff of the CHRI is a privilege extended to doctors of medicine, osteopathic medicine, dentistry, and to practitioners of psychology and podiatry who consistently meet the qualifications, standards, and requirements set forth in the bylaws, rules and regulations of the medical staff, and the board of trustees of the Ohio state university. Membership on the medical staff is available on an equal opportunity basis without regard to race, color, creed, religion, sexual orientation, national origin, gender, age, handicap, genetic information or veteran/military status. Doctors of medicine, osteopathic medicine, dentistry, and practitioners of psychology and podiatry in faculty and administrative positions who desire medical staff membership shall be subject to the same policies and procedures as all other applicants for the medical staff.

(2) All members of the medical staff of the CHRI, except physician scholar medical staff, shall be members of the faculty of the Ohio state university college of medicine, or in the case of dentists, of the Ohio state university college of dentistry, and shall be duly licensed or certified to practice in the state of Ohio. Members of the limited staff shall possess a valid training certificate, or an unrestricted license from the applicable state board based on the eligibility criteria defined by that board. All members of the medical staff and limited staff and licensed health care professionals with clinical privileges shall comply with provisions of state law and the regulations of the respective state medical board or other state licensing board if applicable. Only those physicians, dentists, and practitioners of psychology and podiatry who can document their education, training, experience, competence, adherence to the ethics of

their profession, dedication to educational and research goals and ability to work with others with sufficient adequacy to assure the Wexner medical center board and the board of trustees of the Ohio state university that any patient treated by them at the CHRI will be given high quality medical care provided at CHRI, shall be qualified for eligibility for membership on the medical staff of the CHRI. CHRI medical staff members shall also hold appointments to the medical staff of the Ohio state university hospitals for consulting purposes. Loss of such appointment shall result in immediate termination of membership on the CHRI medical staff and immediate termination of clinical privileges as of the effective date of the Ohio state university hospitals appointment termination. This consequence does not apply to an individual's suspension for completion of medical records. If the medical staff member regains an appointment to the Ohio state university hospitals medical staff, the affected medical staff member shall be eligible to apply for CHRI medical staff membership at that time. All applicants for membership, clinical privileges, and members of the medical staff must provide basic health information to fully demonstrate that the applicant or member has, and maintains, the ability to perform requested clinical privileges. The director of medical affairs of the CHRI, the medical director of credentialing, the department chairperson, the credentialing committee, the medical staff administrative committee, the quality and professional affairs committee of the Ohio state university Wexner medical center board, or the Ohio state university Wexner medical center board may initiate and request a physical or mental health evaluation of an applicant or member. Such request shall be in writing to the applicant.

(3) All members of the medical staff and licensed health care professionals will comply with medical staff and the CHRI policies regarding employee and medical staff health and safety, provision of uncompensated care, and will comply with appropriate administrative directives and policies which, if not followed, could adversely impact overall patient care or may adversely impact the ability of the CHRI employees or staff to effectively and efficiently fulfill their responsibilities. All members of the medical staff and licensed health care professionals shall agree to comply with bylaws, rules and regulations, and policies and procedures adopted by the medical staff administrative committee and the Wexner medical center board, including but not limited to policies on professionalism, behaviors that undermine a culture of safety. Aannual education and training approved by the medical staff administrative committee or as required by the CHRI to meet accreditation standards, federal regulations, or quality and safety goals is required for medical staff members with clinical privileges in addition to conflict of interest disclosure. ~~(list approved by the medical staff administrative committee and maintained in the chief medical officer's office), conflict of interest, HIPAA compliance and access and communication guidelines.~~ Medical staff members and licensed health care professionals must also comply with the university integrity program requirements including but not limited to billing, self-referral, ethical conduct and annual education. Medical staff members and licensed health care professionals with clinical privileges must immediately disclose to the chief medical officer and the department chairperson the occurrence of any of the following events: a licensure action in any state, any malpractice claims filed in any state or an arrest by law enforcement.

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(4) All members of the medical staff and credentialed providers must maintain continuous uninterrupted enrollment with all governmental healthcare programs. This includes any federal and state government programs.

(a) It shall be the duty of all medical staff members and credentialed providers to promptly inform the chief medical officer and the corporate credentialing office of any investigation, action taken, or the initiation of any process which could lead to an action taken by any governmental program.

(b) Exclusion of any medical staff member or credentialed provider from participation in any federal or state government program or suspension from participation, in whole or in part, in any federal or state government reimbursement program, shall result in immediate lapse of membership on the medical staff of the CHRI and the immediate

lapse of clinical privileges at the CHRI as of the effective date of the exclusion or suspension. Medical staff members may submit a request to resign their medical staff membership to the Chief Medical Officer in lieu of automatic termination. The resignation in lieu of automatic termination shall be discussed at the next credentialing committee and medical staff administrative committee in order to provide recommendations to the Quality and Professional Affairs Committee of the Wexner Medical Center Board. A final determination should be decided by the Quality and Professional Affairs Committee at its next regular meeting.

(c) If the medical staff member's or credentialed provider's participation in all governmental programs is fully reinstated, the affected medical staff member or credentialed provider shall be eligible to apply for membership and clinical privileges at that time.

(5) Board certification.

An applicant for membership shall at the time of appointment or reappointment, be board certified in his or her specialty. This board certification must be approved by the American board of medical specialties, or other applicable certifying boards for doctors of osteopathy, podiatry, psychology, and dentistry. All applicants must be certified within the specific areas for which they have requested clinical privileges. Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years will be eligible for medical staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training. Applicants must maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirement. Recertification will be assessed at reappointment. Failure to meet or maintain board certification shall result in termination of membership on the medical staff of the CHRI. ~~Waiver of these eligibility criteria is as follows:~~

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~~(a) A request for a waiver will only be considered if the applicant provides information sufficient to satisfy his or her burden to demonstrate that his or her qualifications are equivalent to or exceed the criterion in question and that there are exceptional circumstances that warrant a waiver. The clinical department chief must endorse the request for waiver in writing to the credentialing committee.~~

~~(b) The credentialing committee may consider supporting documentation submitted by the prospective applicant, any relevant information from third parties, input from the relevant clinical department chiefs, and the best interests of the hospital and the communities it serves. The credentialing committee will forward its recommendation, including the basis for such, to the medical staff administrative committee.~~

~~(c) The medical staff administrative committee will review the recommendation of the credentialing committee and make a recommendation to the Wexner medical center board regarding whether to grant or deny the request for a waiver and the basis for its recommendation.~~

~~(d) The Wexner medical center board determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a denial of appointment or clinical privileges and does not give rise to a right to a hearing. The prospective applicant who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent for any other applicant. A determination to grant a waiver does not mean that an appointment will be granted.~~

**Chapter 3335-111 - *Bylaws of the Medical Staff* of the**
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Updated February 8, 2022

~~Waivers of threshold eligibility criteria will not be granted routinely. No applicant is entitled to a waiver or to a hearing if a waiver is not granted.~~

(6) All applicants must demonstrate recent clinical activity in their primary area of practice during the last two years to satisfy minimum threshold criteria for privileges within their clinical departments.

(7) Waiver requests for the threshold eligibility requirements listed in paragraphs (A)(4) through (A)(6) may be requested and considered as follows:

(a) A request for a waiver will only be considered if the applicant provides information sufficient to satisfy his or her burden to demonstrate that his or her qualifications are equivalent to or exceed the criterion in question and that there are exceptional circumstances that warrant a waiver. The clinical department chief must endorse the request for waiver in writing to the credentialing committee.

(b) The credentialing committee may consider supporting documentation submitted by the prospective applicant, any relevant information from third parties, input from the relevant clinical department chiefs, and the best interests of the hospital and the communities it serves. The credentialing committee will forward its recommendation, including the basis for such, to the medical staff administrative committee.

(c) The medical staff administrative committee will review the recommendation of the credentialing committee and make a recommendation to the Wexner medical center board regarding whether to grant or deny the request for a waiver and the basis for its recommendation.

(d) The Wexner medical center board determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a denial of appointment or clinical privileges and does not give rise to a right to a hearing. The prospective applicant who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent for any other applicant. A determination to grant a waiver does not mean that an appointment will be granted.

(e) Waivers of threshold eligibility criteria will not be granted routinely. No applicant is entitled to a waiver or to a hearing if a waiver is not granted.

(f) Waivers to requirements prescribed by regulatory, accrediting, or other external agencies will not be granted.

~~(6)~~

(8) Resignation, termination or non-reappointment to the faculty of the Ohio state university shall result in immediate termination of membership on the medical staff of the CHRI for attending, associate attending and clinical attending staff members.

(9) Any staff member whose membership has been terminated pursuant to paragraph (A)(4) or, (A)(5) ~~or (A)(7)~~ of this rule shall not be entitled to request a hearing and appeal in accordance with rule 3335-111-06 of the Administrative Code. Any allied health professional whose clinical privileges have been terminated pursuant to paragraph (A)(4) of this rule may not request an appeal in accordance with paragraph ~~(F)~~(J)(6)(8)(i) of rule 3335-111-07 of the Administrative Code.

(10) No applicant shall be entitled to medical staff membership and or clinical privileges merely by the virtue of fulfilling the above qualifications or holding a previous appointment to the medical staff.

(B) Application for membership.

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**Chapter 3335-111 - *Bylaws of the Medical Staff* of the**
**Arthur G. James Cancer Hospital and Richard J. Solove Research Institute**

Updated February 8, 2022

Initial application for all categories of medical staff membership shall be made by the applicant to the clinical department chief or designee on forms prescribed by the medical staff administrative committee, stating the qualifications and references of the applicant and giving an account of the applicant's current licensure, relevant professional training and experience, current competence and ability to perform the clinical privileges requested. All applications for appointment must specify the clinical privileges requested. Applications may be made only if the qualifications are fulfilled as outlined in paragraph (A) of this rule. See paragraph (E)(1) of rule 3335-111-07 of the Administrative Code for exceptions to signature requirements. The application shall include written statements by the applicant that commit the applicant to abide by the bylaws, rules and regulations and policies and procedures of the medical staff, the Wexner medical center board, and the board of trustees of the Ohio state university. The applicant shall produce a government issued photo identification to verify his/her identity pursuant to hospital/medical staff policy. The applicant for medical staff membership shall agree that membership requires participation in and cooperation with the peer review processes of evaluating credentials, medical staff membership and clinical privileges, and that a condition for membership requires mutual covenants between all members of the medical staff to release one another from civil liability in these review processes as long as the peer review is not conducted in bad faith, with malice, or without reasonable effort to ascertain the accuracy of information being disclosed or relied upon. A separate record shall be maintained for each applicant requesting appointment to the medical staff.

(C) Terms of appointment.

Initial appointment to the medical staff, except for the honorary category, shall be for a period not to exceed ~~twenty-four months~~thirty-six months. An appointment or grant of privileges for a period of less than twenty- four months shall not be deemed an adverse action. During the first six months of the initial appointment, except medical staff appointments without clinical privileges, appointees shall be subject to focused professional practice evaluation (FPPE) in order to evaluate the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization pursuant to these bylaws. FPPE requires the evaluation by the clinical department chief with oversight by the credentials committee and the medical staff administrative committee. The provisional appointee iIdentifies the primary hospital. Following the six month FPPE period, the clinical department chief may:

(1) ~~(1)~~ recommend the initial appointee to transition to ongoing professional practice evaluation (OPPE), which is described later in these bylaws to the medical staff administrative committee.

(2) ~~:(2)~~ extend the FPPE period, which is not considered an adverse action, for an additional six months not to exceed a total of twelve months for purposes of further monitoring and evaluation; or

(3) ~~(3)~~ terminate the initial appointee's medical staff membership and clinical privileges. In the event that the medical staff administrative committee recommends that an adverse action be taken against an initial appointee, the initial appointee shall be entitled to the provisions of due process as outlined in these bylaws.

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(D) Professional ethics.

The code of ethics as adopted, or as may be amended, by the American medical association, the American dental association, the American osteopathic association, the American psychological association, the American college of surgeons, or the American podiatric medical association shall usually govern the professional ethical conduct of the respective members of the medical staff.

(E) Procedure for appointment.

(1) The completed and signed application for membership of all categories of the medical staff as defined in rule 3335-111-07 of the Administrative Code, shall be presented to the clinical department chief or designee. The applicant shall include in the application a signed statement indicating the following:

(a) If the applicant should be appointed to a category of the CHRI medical staff, the

applicant agrees to be governed by the bylaws, rules and regulations of the medical staff, the Wexner medical center board, and the board of the trustees of the Ohio state university.

(b) The applicant consents to be interviewed in regard to the application.

(c) The applicant authorizes the CHRI to consult with members of the medical staffs of other hospitals with which the applicant has been or has attempted to be associated, and with others who may have information bearing on the applicant's competence, character and ethical qualifications.

(d) The applicant consents to the CHRI's inspection of all records and documents that may be material to the evaluation of the applicant's professional qualifications and competence to carry out the clinical and educational privileges which the applicant is seeking as well as the applicant's professional and ethical qualifications for medical staff membership.

(e) The applicant releases from any liability:

(i) All representatives of the CHRI for acts performed in connections with evaluating the applicant's credentials or releasing information to other institutions for the purpose of evaluating the applicant's credentials in compliance with these bylaws performed in good faith and without malice; and

(ii) All third parties who provide information, including otherwise privileged and confidential information, to members of the medical staff, the CHRI staff, the medical center board members, and members of the Ohio state university board of trustees concerning the applicant's credentials performed in good faith and without malice.

(f) The applicant has an affirmative duty to disclose any prior termination, voluntary or involuntary, current loss, restriction, denial, or the voluntary or involuntary relinquishment of any of the following: professional licensure, board certification, DEA registration, membership in any professional organization or medical staff membership or privileges at any other hospital or health care facility.

(g) The applicant further agrees to disclose to the director of medical affairs or the medical director of credentialing the initiation of any process which could lead to such loss or restriction of the applicant's professional licensure, board certification, DEA registration, membership in any professional organization or medical staff membership or privileges at any other hospital or health care facility.

(h) The applicant agrees that acceptance of an appointment to any category of the CHRI medical staff authorizes the CHRI to conduct any appropriate health assessment including, but not limited to, drug or alcohol screens on a practitioner before granting of privileges and at any time during the normal pursuit of medical staff duties, based upon reasonable cause as determined by the chief of the practitioner's clinical department or the director of medical affairs of the CHRI or their authorized designees.

(2) The purpose of the health assessment shall be to ensure that the applicant or appointee to the CHRI medical staff is able to fully perform and discharge the clinical, educational, administrative and research responsibilities which the applicant or appointee would or is permitted to exercise by reason of medical staff appointment. If, at the time of the initial request for a health assessment, and at any time an appointee refuses to participate as needed in a health assessment, including, but not limited to, a drug or alcohol screening, this shall result in automatic lapse of membership, privileges, and prerogatives until remedied by

compliance with the requested health assessment. Upon request of the medical staff administrative committee or the Wexner medical center board, the applicant or appointee will provide documentation of their physical/mental status with sufficient adequacy to demonstrate that any patient treated by the applicant or appointee will receive efficient and quality care at a professionally recognized level of quality and efficiency. The conditions of this paragraph shall be deemed continuing and may be applicable to issues of continued good standing as an appointee to the medical staff.

(3) An application for membership on the medical staff shall be considered complete when all the information requested on the application form is provided, the applicant signs the application and the information is verified. A completed application must contain:

(a) Peer recommendations from at least three individuals with first hand knowledge about the applicant's clinical and professional skills within the last year;

(b) Evidence of required immunizations;

(c) Evidence of current professional medical malpractice liability coverage required for the exercise of clinical privileges;

(d) Satisfaction of ECFMG requirements, if applicable. If an individual receives a conceded eminence certificate or a clinical research faculty certificate from the state medical board of Ohio, the requirement for ECFMG certification may be waived at the discretion of the Wexner medical center board.

(e) Verification by primary source documentation of:

(i) Current and previous state licensure, and

(ii) Faculty appointment, when applicable.

~~(f)~~(iii) DEA registrations, when required for the exercise of requested clinical privileges;

~~(g)~~(iv) Graduation from an accredited professional school, when applicable;

~~(h)~~(v) Successful completion or record of post professional graduate medical education;

~~(i)~~(vi) Board certification or, active candidacy for board certification or applicant qualifies for a waiver pursuant to paragraph (A)(5) of this rule.

~~(j)~~(f) Information from the national practitioner data bank and other JCAHO approved sources;

~~(k)~~(g) Verification that the applicant has not been excluded from any federally funded health care program; and

~~(l)~~(h) Complete disclosure by the applicant of all past and current claims, suits, verdicts, and settlements, if any.

~~(m)~~(i) Completion of a criminal ~~history check by the Ohio state university medical center security department.~~background investigation that meets the requirements of the Wexner Medical Center.

~~(n)~~(j) Completion of ~~the Ohio state university medical center~~ drug testing for substances required for individuals applying for clinical privileges and in accordance with Wexner Medical Center approved testing protocols.

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~~(o)~~(k) Verification of completion of specific competencies required for clinical privileges, as approved by the Medical Staff Administrative Committee and maintained in the provider's credentials files.~~annual educational requirements approved by the medical staff administrative committee and maintained in the chief medical officer's office.~~All other required annual online learnings must be completed within sixty days of employment.

~~(p)~~(l) Demonstration of recent active clinical practice during the last two years required for exercise of clinical privileges.

~~(q)~~(m) Attestation of current Ohio automated Rx reporting system ("OARRS") account for all applicants who have a DEA registration.

(4) The clinical department chief shall be responsible for investigating and verifying the character, qualifications and professional standing of the applicants by making inquiry of the primary source of such information and shall within thirty days of receipt of the completed application, submit a report of those findings along with a recommendation on medical staff membership and clinical privileges to the applicant's respective CHRI department chairperson and/or division director. Licensed allied health professional applicants will have their clinical department chief's report submitted to the subcommittee of the credentials committee charged with review of applications for associates to the medical staff.

(5) The department chairperson and/or division director shall receive all initial signed and verified applications from the appropriate clinical department chief and shall make a recommendation to the medical director of credentialing on each application. The medical director of credentialing shall make an initial determination as to whether the application is complete. The credentials committee, the medical staff administrative committee, the quality and professional affairs committee, and the Wexner medical center board have the right to render an application incomplete, and therefore not able to be processed, if the need arises for additional or clarifying information. The medical director of credentialing shall forward all completed applications to the credentials committee.

(6) The applicants shall have the burden of producing information for an adequate evaluation of his/her qualifications for membership and for the clinical privileges requested. If the applicant fails to complete the prescribed forms or fails to provide the information requested within sixty days of receipt of the signed application, processing of the application shall cease and the application shall be deemed to have been voluntarily withdrawn, action which is not subject to hearing or appeal pursuant to rule 3335-111-06 of the Administrative Code.

(7) If the clinical department chief does not submit a report and recommendation on a timely basis, the completed application shall be forwarded to the medical director of credentialing for presentation to the credentials committee on the same basis as other applicants.

(8) Completed applications shall be acted upon as follows:

(a) By the credentials committee within thirty days after receipt of a completed application from the medical director of credentialing;

(b) By the medical staff administrative committee within thirty days after receipt of a completed application and the report of the recommendation of the credentials committee;

(c) By the quality and professional affairs committee of the Wexner medical center board;

(d) By the Wexner medical center board within one hundred twenty days after receipt of a completed application and the report and recommendation of the medical staff

administrative committee; and

(e) By the Wexner medical center board, or a subcommittee of the Wexner medical center board if eligible for expedited credentialing, within one hundred twenty days after receipt of a completed application and the report and recommendation of the medical staff administrative committee.

(9) These time periods are deemed guidelines only and do not periods. These periods may be stayed or altered pending receipt and verification of further information requested from the applicant, or if the application is deemed incomplete at any time. If the procedural rights create any right to have an application processed within these precise specified in rule 3335-111-06 of the Administrative Code are activated, the time requirements provided therein govern the continued processing of the application.

(10) The credentials committee shall review the application, evaluate and verify the supporting documentation, references, licensure, the clinical department chief's report and recommendation, and other relevant information. The credentials committee shall examine the character, professional competence, professional conduct, qualifications, and ethical standing of the applicant and shall determine, through information contained in the personal references and from other sources available, whether the applicant established and met all of the necessary qualifications for the category of the medical staff and clinical privileges requested.

(11) The credentials committee shall, within thirty days from receipt of a completed application, make a recommendation to the medical director of credentialing that the application be accepted, rejected or modified. The medical director of credentialing shall forward the recommendation of the credentials committee to the medical staff administrative committee. The credentials committee or the medical director of credentialing may recommend to themedical staff administrative committee that certain applications for appointment be reviewed in executive session.

(12) The recommendation of the medical staff administrative committee regarding an appointment decision shall be made within thirty days of receipt of the credentials committee recommendation and shall be communicated by the medical director of credentialing, along with the recommendation of the director of medical affairs, to the quality and professional affairs committee of the Wexner medical center board, and thereafter to the Wexner medical center board. When the Wexner medical center board has acted, the chair of the Wexner medical center board shall instruct the director of medical affairs to transmit the final decision to the clinical department chief, the applicant, and the respective department chairperson and/or division director.

(13) At any time, the medical staff administrative committee first recommends non-appointment of an initial applicant for any category of the medical staff or recommends denial of any clinical privileges requested by the applicant, the medical staff administrative committee shall require the medical director of credentialing to notify the applicant by certified return receipt mail that applicant may request an evidentiary hearing as provided in paragraph (D) of rule 3335-111-06 of the Administrative Code. The applicant shall be notified of the requirement to request a hearing as provided by paragraph (B) of rule 3335-111-06 of the Administrative Code. If a hearing is properly requested, the applicant shall be subject to the rights and responsibilities of rule 3335-111-06 of the Administrative Code. If an applicant fails to properly request a hearing, the medical staff administrative committee shall accept, reject, or modify the application for appointment to membership and clinical privileges.

(14) The director of medical affairs, who may make a separate recommendation to the Wexner medical center board, shall directly communicate the final recommendation of the medical staff administrative committee to the Wexner medical center board. When the Wexner medical center board has acted, the director of medical affairs will transmit the final decision to the clinical department chief, the applicant, the respective department chairperson and/or

division director, and the Ohio state university board of trustees.

(F) Procedure for reappointment.

(1) Reappointment for all categories of the medical staff shall be for a period not to exceed ~~twenty-four~~thirty-six months. An appointment or grant of privileges for a period of less than ~~twenty- four~~thirty-six months shall not be deemed an adverse action. At least ninety days prior to the end of the medical staff member' or licensed allied health professional's appointment period, the clinical department chief shall provide each individual with an application for reappointment to the medical staff on forms prescribed by the medical staff administrative committee.

(2) The reappointment application shall include all information necessary to update and evaluate the qualification of the applicant. The clinical department chief shall review the information available on each applicant for reappointment and shall make recommendations regarding reappointment to the medical staff and for granting of privileges for the ensuing appointment period. The clinical department chief's recommendation shall be transmitted in writing along with the signed and completed reappointment forms to the appropriate department chairperson and/or division director at least forty-five days prior to the end of the individual's appointment. The terms of paragraphs (A), (B), (C), (D), (E)(1), and (E)(2) of this rule shall apply to all applicants for reappointment. Only completed applications for reappointment shall be considered by the credentials committee.

(3) An application for reappointment is complete when all the information requested on the reappointment application is provided, the reappointment form is signed by the applicant, and the information is verified, and no need for additional or clarifying information is identified. A completed reappointment application must contain:

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(a) Evidence of current professional medical malpractice liability insurance required for the exercise of clinical privileges;

(b) Verification by primary source documentation of state licensure;

(c) DEA registration when required for clinical privileges as requested;

(d) Successful completion or record of any additional post graduate medical or professional education not submitted since initial or last appointment;

(e) Board certification, recertification, or continued active candidacy for certification or applicant qualifies for a waiver pursuant to paragraph (A)(5) of this rule.

(f) Information from the national practitioner data bank;

(g) Verification that the applicant has not been excluded from any federally funded health care program;

(h) Specific requests for any changes in clinical privileges sought at reappointment with supporting documentation as required by credentialing guidelines;

(i) Specific requests for any changes in medical staff category;

(j) A summary of the member's clinical activity during the previous appointment period;

(k) Verification of completion of any annual education requirements approved by the medical staff administrative committee and maintained in the chief medical officer's office;

(l) Complete disclosure by individuals of claims, suits, verdicts and settlements, if any

since last appointment; and

(m) Continuing medical education and applicable continuing professional education activities: documentation of category one CME that, at least in part, relates to the individual medical staff member's specialty or subspecialty area and is consistent with the licensing requirements of the applicable Ohio state licensing board shall be required.

(n) Attending physicians only: submit information summarizing clinical research activities with each application.

(o) Attestation of current OARRS account for all applicants who have a DEA registration.

(4) The applicant for reappointment shall be required to submit any reasonable evidence of current ability to perform the clinical privileges requested. The clinical department chief shall review and evaluate the reappointment application and the supporting documentation. The clinical department chief shall evaluate all matters relevant to recommendation, including: the applicant's professional competence; clinical judgment; clinical or technical skills; ethical conduct; participation in medical staff affairs, if applicable; compliance with the bylaws, rules and regulations of the medical staff, the Wexner medical center board, and the board of trustees of the Ohio state university; cooperation with the CHRI hospitals personnel and the use of the CHRI hospital's facilities for patients; relations with other physicians other health professionals or other staff; maintenance of a professional attitude toward patients; and the responsibility to the CHRI and the public.

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(5) The clinical department chief shall submit a report of those findings along with a recommendation on reappointment to the applicant's respective CHRI department chairperson and/or division director. Licensed allied health professional applicants will have their clinical department chief's report submitted to the subcommittee of the credentials committee charged with review of application for associates to the medical staff. The department chairperson and/or division director shall review the reappointment application and forward to the medical director of credentialing with a recommendation for reappointment. The medical director of credentialing shall forward the reappointment forms and the recommendations of the clinical department chief and department chairperson and/or division director to the credentials committee. The credentials committee shall review the request for reappointment in the same manner, and with the same authority, as an original application for medical staff membership. The credentials committee shall review all aspects of the reappointment application including source verification of the member's quality assurance record for continuing membership qualifications and for continuing clinical privileges. The credentials committee shall review each member's performance-based profile to ensure that all medical staff members deliver the same level of quality of care with similar delineated clinical privileges across all clinical departments and across all categories of medical staff membership.

(6) The credentials committee shall forward its recommendations to the medical director of credentialing at least thirty days prior to the end of the period of appointment for the individual. The medical director of credentialing shall transmit the completed reappointment application and recommendation of the credentials committee to the medical staff administrative committee.

(7) Failure of the member to submit a reappointment application shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership and all clinical privileges at the end of the medical staff member's current appointment period, action which shall not be subject to a hearing or appeal pursuant to rule 3335-111-06 of the Administrative Code. A request for reappointment subsequently received from a member who has been automatically terminated shall be processed as a new appointment.

(8) Failure of the clinical department chief to act in a timely manner on an application for

reappointment shall be the same as provided in paragraph (E)(7) of this rule.

(9) The medical staff administrative committee shall review each request for reappointment in the same manner and with the same authority as an original application for appointment to the medical staff and shall accept, reject, or modify the request for reappointment in the same manner and with the same authority as an original application. The recommendation of the medical staff administrative committee regarding reappointment shall be communicated by the medical director of credentialing, along with the recommendation of the director of medical affairs, to the quality and professional affairs committee of the Wexner medical center board, and thereafter to the Wexner medical center board. When the Wexner medical center board has acted, the chair of the Wexner medical center board shall instruct the director of medical affairs to transmit the final decision to the clinical department chief, the applicant, and the department chairperson and/or division director.

(10) When the decision of the medical staff administrative committee results in a decision of non-reappointment or reduction, suspension, or revocation of clinical privileges, the medical staff administrative committee shall instruct the medical director of credentialing to give written notice to the affected member of the decision, the stated reason for the decision, and the member's right to a hearing pursuant to rule 3335-111-06 of the Administrative Code. This notification and an opportunity to exhaust the appeal process shall occur prior to an adverse decision unless the provisions outlined in paragraph (C) of rule 3335-111-06 of the Administrative Code apply. The notice by the medical director of credentialing shall be sent certified return receipt mail to the affected member's last known address as determined by the Ohio state university records.

(11) If the affected member of the medical staff does not make a written request for a hearing to the director of medical affairs within thirty-one days after receipt of the adverse decision, it shall be deemed a waiver of the right to any hearing or appeal as provided in rule 3335-111-06 of the Administrative Code to which the staff member might otherwise have been entitled on the matter. If a timely, written request for hearing is made, the procedures set forth in rule 3335-111-06 of the Administrative Code shall apply.

(G) Resumption of clinical activities following a leave of absence:

(1) A member of the medical staff or credentialed provider shall request a leave of absence in writing for good cause shown such as medical reasons, educational and research reasons or military service to the chief of clinical service and the director of medical affairs. Such leave of absence shall be granted at the discretion of the chief of the clinical service and the director of medical affairs provided, however, such leave shall not extend beyond the term of the member's or credentialed provider's current appointment. A member of the medical staff or credentialed provider who is experiencing health problems that may impair his or her ability to care for patients has the duty to disclose such impairment to his or her chief of clinical department and the director of medical affairs and the member or credentialed provider shall be placed on immediate medical leave of absence until such time the member or credentialed provider can demonstrate to the satisfaction of the director of medical affairs that the impairment has been sufficiently resolved and can request for reinstatement of clinical activities. During any leave of absence, the member or credentialed provider shall not exercise his or her clinical privileges, and medical staff responsibilities and prerogatives shall be inactive.

(2) The member or credentialed provider must submit a written request for the reinstatement of clinical privileges to the chief of the clinical service. The chief of the clinical service shall forward his recommendation to the credentialing committee which, after review and consideration of all relevant information, shall forward its recommendation to the medical staff administrative committee and the quality and professional affairs committee of the Wexner medical center board. The credentials committee, the director of medical affairs, the medical director of credentialing, the chief of the clinical service or the medical staff administrative

committee shall have the authority to require any documentation, including advice and consultation from the member's or credentialed provider's treating physician or the committee for practitioner health that might have a bearing on the medical staff member's or credentialed provider's ability to carry out the clinical and educational responsibilities for which the medical staff is seeking privileges. Upon return from a leave of absence for medical reasons the medical staff member or credentialed provider must demonstrate his or her ability to exercise his or her clinical privileges upon return to clinical activity.

(3) All members or credentialed providers of the medical staff who take a leave of absence for medical or non-medical reasons must be in good standing on the medical staff upon resumption of clinical activities. No member shall be granted leave of absence in excess of his or her current appointment and the usual procedure for appointment and reappointment, including deadlines for submission of application as set forth in this rule will apply irrespective of the nature of the leave. Absence extending beyond his or her current term of failure to request reinstatement of clinical privileges shall be deemed a voluntary resignation from the medical staff and of clinical privileges, and in such event, the member or credentialed provider shall not be entitled to a hearing or appeal.

(Board approval dates: 9/1/1993, 3/3/1995, 4/3/1996, 12/6/1996, 9/1/1999, 12/3/1999, 6/2/2000, 4/5/2002, 2/6/2004, 11/4/2005, 8/6/2007, 2/6/2009, 9/18/2009, 5/14/2010, 10/29/2011, 4/8/2011, 8/31/2012, 2/1/2013, 6/6/2014, 11/7/2014, 11/6/2015, 9/2/2016, 4/6/2018)

**3335-111-05 Peer review and corrective action**

(A) Informal peer review.

(1) All medical staff members agree to cooperate in informal peer review activities that are solely intended to improve the quality of medical care provided to patients at the CHRI.

(2) Information indicating a need for informal review, including patient complaints, disagreements, questions of clinical competence, inappropriate conduct and variations in clinical practice identified by the clinical departments or divisions and medical staff committees shall be referred to the chair of the practitioner evaluation committee.

(3) The practitioner evaluation committee chair or his or her designee may obtain information or opinions from medical staff members or credentialed providers as well as external peer review consultants pursuant to criteria outlined in these bylaws. The information or opinions from the informal peer review may be presented to the practitioner evaluation committee or another designated peer review committee.

(4) Following the assessment by the practitioner evaluation committee chair or his or her designee, the practitioner evaluation committee may make recommendations for educational actions of additional training, sharing of comparative data or monitoring or provide other forms of guidance to the medical staff member to assist him or her in improving the quality of patient care. Such actions are not regarded as adverse, do not require reporting to any governmental or other agency, and do not invoke a right to any hearing.

(5) At the conclusion of the evaluation, the practitioner evaluation committee chair or his or her designee submits a report to the applicable clinical department chief and the director of medical affairs. The clinical department chief and the director of medical affairs shall evaluate the matter to determine the appropriate course of action. They shall make an initial written determination on whether:

(a) The matter warrants no further action;

(b) Informal resolution under this paragraph is appropriate. The clinical department chief and the director of medical affairs shall determine whether to include documentation of the

informal resolution in the medical staff member's file. If documentation is included in the member's file, the affected member shall have an opportunity to review it and may make a written response which shall also be placed in the file. Informal review under this paragraph is not a procedural prerequisite to the initiation of formal peer review under paragraph (B) of this rule; or

(c) Formal peer review under paragraph (B) of this rule is warranted. In cases where the clinical department chief and director of medical affairs cannot agree, the matter shall be submitted and determined as set forth in paragraph (B) of this rule.

(B) Formal peer review.

(1) Formal peer review may be requested in more serious situations or where informal review has not resolved an issue or whenever the activities or professional conduct of a member of the medical staff of the CHRI:

(a) Violates the standards or aims of the medical staff or standards of professional conduct;

(b) Is considered to be disruptive to the operation of the CHRI;

(c) Violates the bylaws, rules and regulations of the medical staff, the Wexner medical center board, or the board of trustees of the Ohio state university;

(d) Violates state or federal law; or

(e) Is detrimental to patient safety or to the delivery of patient care within the CHRI.

(2) Formal peer review may be initiated by the clinical department chief, the department chairperson and/or division director, the director of medical affairs, any member of the medical staff, the chief executive officer of the CHRI, the dean of the college of medicine, any member of the Wexner medical center board, or the vice president for health services. All requests for formal peer review shall be in writing, shall be submitted to the director of medical affairs, and shall be supported by reference to the specific activities or conduct which constitute grounds for the requested action.

(3) The director of medical affairs shall promptly notify the affected member of the medical staff, in a confidential manner, that a request for formal peer review has been made, and inform the member of the specific activities or conduct which constitute grounds for the requested action. The director of medical affairs shall verify the facts related to the request for formal peer review, and within thirty days, make a written determination. If the director of medical affairs decides that no further action is warranted, the director of medical affairs shall notify the person(s) who filed the request for formal peer review and the member accused, in writing, that no further action would be taken.

(4) Whenever the director of medical affairs determines that formal peer review is warranted and that a reduction, suspension or revocation of clinical privileges could result, the director of medical affairs shall refer the request for formal peer review to the formal peer review committee. The affected member of the medical staff shall be notified of the referral to the formal peer review committee, and be informed that these medical staff bylaws shall govern all further proceedings. The executive vice president for health sciences or designee shall exercise any or all duties or responsibilities assigned to the director of medical affairs under these rules for implementing corrective action and appellate procedure only if:

(a) The director of medical affairs is the medical staff member charged;

(b) The director of medical affairs is responsible for having the charges brought against another medical staff member; or

(c) There is an obvious conflict of interest.

(5) The formal peer review committee shall investigate every request and shall report in writing its findings and recommendations for action to the appropriate clinical department chief and notice given to the division director. In making its recommendation the formal peer review committee may consider as appropriate, relevant literature and clinical practice guidelines, all the opinions and views expressed throughout the review process, and any information or explanations provided by the member under review. Prior to making its report, the medical staff member against whom the action has been requested shall be afforded an opportunity for an interview with the formal peer review committee. At such interview, the medical staff member shall be informed of the specific activities alleged to constitute grounds for formal peer review, and shall be afforded the opportunity to discuss, explain or refute the allegations against the medical staff member. The medical staff member may furnish written or oral information to the formal peer review committee at this time. However, such interview shall not constitute a hearing, but shall be investigative in nature. The medical staff member shall not be represented by an attorney at this interview. The written findings and recommendations for action is expected to be submitted within 90 days, unless an extension is deemed necessary by the committee.

(6) Upon receipt of the written report from the formal peer review committee, the appropriate clinical department chief shall make his or her own written determination and forward that determination along with the findings and recommendations of the formal peer review committee to the director of medical affairs, or if required by paragraph (B)(3) of this rule, to the executive vice president for health sciences or designee.

(7) Following receipt of the recommendation from the clinical department chief and the report from the formal peer review committee, the director of medical affairs, or the executive vice president for health sciences or designee, shall approve or modify the determination of the clinical department chief. Following receipt of the report of the clinical department chief, the director of medical affairs or executive vice president for health sciences or designee shall decide whether the grounds for the requested corrective action are such as should result in a reduction, suspension or revocation of clinical privileges. If the director of medical affairs, or executive vice president for health sciences or designee, decides the grounds are not substantiated, the director of medical affairs will notify the formal peer review committee; clinical department chief and if applicable, the academic department chairperson; division director; person(s) who filed the complaint and the affected medical staff member, in writing, that no further action will be taken.

In the event the director of medical affairs or executive vice president for health sciences or designee finds the grounds for the requested corrective action are substantiated, the director of medical affairs shall promptly notify the affected medical staff member of that decision and of the affected medical staff member's right to request a hearing before the medical staff administrative committee pursuant to rule 3335-111-06 of the Administrative Code. The written notice shall also include a statement that the medical staff member's failure to request a hearing in the timeframe prescribed in rule 3335-111-06 of the Administrative Code shall constitute a waiver of rights to a hearing and to an appeal on the matter; a statement that the affected medical staff member shall have the procedural rights found in rule 3335-111-06 of the Administrative Code; and a copy of the rule 3335-111-06 of the Administrative Code. This notification and an opportunity to exhaust the administrative hearing and appeal process shall occur prior to the imposition of the proposed corrective action unless the emergency provisions outlined in paragraph (D) of this rule apply. This written notice by the director of medical affairs shall be sent certified return receipt mail to the affected medical staff member's last known address as determined by university records.

(8) If the affected member of the medical staff does not make a written request for a hearing to the director of medical affairs within thirty-one days after receipt of the adverse decision, it

shall be deemed a waiver of the right to any review by the medical staff administrative committee to which the staff member might otherwise have been entitled on the matter.

(9) If a timely, written request for hearing is made, the procedures set forth in rule 3335-111-06 of the Administrative Code shall apply.

(C) Composition of the formal peer review committee.

(1) When the determination that formal peer review is warranted is made, the clinical department chief shall select three members of the medical staff to serve on a formal peer review committee.

(2) Whenever the questions raised concern the clinical competence of the member under review, the clinical department chief shall select members of the medical staff to serve on the formal peer review committee who shall have similar levels of training and qualifications as the member who is subject to formal peer review.

(3) An external review consultant may serve as a member of the formal peer review whenever:

(a) A determination is made by the clinical department chief and the director of medical affairs that the clinical expertise needed to conduct the review is not available on the medical staff;

(b) The objectivity of the review may be compromised due to economic considerations; or

(c) Whenever the director of medical affairs determines that an external review is otherwise advisable.

If an external reviewer is recommended, the clinical department chief shall make a written recommendation to the director of medical affairs for selection of an external reviewer. The director of medical affairs shall make the final selection of an external reviewer.

(D) Summary suspension.

(1) Notwithstanding the provisions of this rule, a member of the medical staff shall have all or any portion of clinical privileges immediately suspended or appointment terminated by the chief executive officer or department chairperson and/or division director, whenever such action must be taken when there is imminent danger to patients or to the patient care operations. Such summary suspension shall become effective immediately upon imposition and the chief executive officer will subsequently notify the medical staff member in writing of the suspension. Such notice shall be by certified return receipt mail to the affected medical staff member's last known address as determined by university records.

(2) A medical staff member whose privileges have been summarily suspended or whose appointment has been terminated shall be entitled to appeal the suspension pursuant to rule 3335-111-06 of the Administrative Code. If the affected member of the medical staff does not make a written request for a hearing to the chief executive officer within thirty-one days after receipt of the adverse decision, it shall be deemed a waiver of the affected member's right to any review by the medical staff administrative committee of which the member might otherwise been entitled. If a timely, written request for a hearing is made, the procedures set forth in rule 3335-111-06 of the Administrative Code shall apply.

(3) Immediately upon the imposition of a summary suspension, the chief executive officer in consultation with the appropriate department chairperson and/or division director, shall have the authority to provide for alternative medical coverage for the patients of the suspended medical staff member who remain in the hospital at the time of suspension. The wishes of

the patient shall be considered in the selection of such alternative medical coverage. While a summary suspension is in effect, the member of the medical staff is ineligible for reappointment to the medical staff. Medical staff and hospital administrative duties and prerogatives are suspended during the summary suspension.

(E) Automatic suspension and termination.

(1) Notwithstanding the provisions of this rule, a temporary lapse of a medical staff member's admitting privileges, effective until medical records are completed, may be imposed automatically by the chief executive officer after a warning, in writing, of delinquency for failure to complete medical records as defined by the rules and regulations of the medical staff.

(2) Action by the state boards of licensure revoking or suspending a medical staff member's licensure or placing the member on probation shall automatically impose the same restrictions to that member's CHRI medical staff privileges.

(3) Failure to maintain the minimum required type and amount of professional liability insurance with an approved insurer, shall result in immediate and automatic suspension of a medical staff member's appointment and privileges until such time as proof of appropriate insurance coverage is furnished. In the event such proof is not provided within ten days of notice of such suspension, the medical staff member or credentialed provider shall be deemed to no longer comply with medical staff requirements under 3335-111-04 and automatically relinquish his or her appointment and privileges.

(4) Upon exclusion, debarment, or other prohibition from participation in any state or federal health care reimbursement program, or a federal procurement or non-procurement program, the medical staff member's appointment and privileges shall immediately and automatically terminate, unless resignation in lieu of automatic termination is permitted pursuant to rule 3335-43-04(A)(4).

(5) If a medical staff member pleads guilty to or is found guilty of a felony which involves violence or abuse upon a person, conversion, embezzlement, or misappropriation of property; fraud, bribery, evidence tampering, or perjury; or a drug offense, the medical staff member's appointment and privileges shall be immediately and automatically terminated.

(6) Whenever a medical staff member's drug enforcement administration (DEA) or other controlled substances number is revoked, he or she shall be immediately and automatically divested of his or her right to prescribe medications covered by the number.

(7) When a medical staff member's DEA or other controlled substances number is suspended or restricted in any manner, his or her right to prescribe medications covered by the number is similarly automatically suspended or restricted during the term of the suspension or restriction.

(8) No medical staff member shall be entitled to the procedural rights set forth in rule 3335-111-06 of the Administrative Code as a result of an automatic suspension or termination. As soon as practicable after the imposition of an automatic suspension, the medical staff administrative committee shall convene to determine if further corrective action is necessary. Any further action with respect to an automatic suspension must be taken in accordance with this rule.

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**Chapter 3335-111 - *Bylaws of the Medical Staff* of the**
**Arthur G. James Cancer Hospital and Richard J. Solove Research Institute**
Updated February 8, 2022

**3335-111-06 Hearing and appellate review procedure.**

(A) Right to hearing before the medical staff administrative committee and to appellate review.

(1) When a member of the medical staff has exhausted remedies under paragraph (F) of rule 3335-111-04 of the Administrative Code on reappointments; or under rule 3335-111-05 of the Administrative Code for corrective action; or who has been summarily suspended under paragraph (D) of rule 3335-111-05 of the Administrative Code, the staff member shall be entitled to an adjudicatory hearing.

(2) A medical staff member shall not be entitled to a hearing under the following circumstances:

(a) Denial of the Wexner medical center board to grant a waiver of board certification for a medical staff member.

(b) Termination of a medical staff member because of exclusion from participation in any government reimbursement program.

(c) Voluntary withdrawal of a medical staff application.

(d) Failure to submit a reappointment application.

(e) A leave of absences extending beyond current appointment or failure to request reinstatement of clinical privileges following a leave of absence.

(f) Actions or recommendations resulting from an informal peer review.

~~(g) Termination of courtesy B medical staff appointments upon approval by the Wexner medical center board.~~

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(3) All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this rule to assure that the affected medical staff member is accorded all rights to which the member is entitled.

(B) Request for hearing.

(1) The request for a hearing shall be submitted in writing by the affected medical staff member to the chief executive officer within thirty days of notifications by the chief executive officer of the intended action. The chief executive officer shall forward the request to the medical staff administrative committee along with instructions to convene a hearing.

(2) The failure of a medical staff member to request a hearing to which the member is entitled by these bylaws within the time and in the manner herein provided, shall be deemed a waiver of the member's right to any review by the medical staff administrative committee to which the member might otherwise been entitled. The chief executive officer shall then implement the decision and that action shall become and remain effective against the medical staff member in the same manner as a final decision of the Wexner medical center board as provided for in paragraph (E) of this rule. The chief executive officer shall promptly inform the affected medical staff member that the proposed decision, which had entitled the medical staff member to a hearing, has now become final.

(C) Notice of hearing.

(1) After receipt of a timely request for hearing by the chief executive officer from a medical staff member entitled to such hearing, the medical staff administrative committee shall be notified of the request for hearing by the chief executive officer, and shall at the next scheduled meeting take the following action:

(a) Instruct the director of medical affairs and chief of staff to jointly appoint within seven days a hearing committee, consisting of three to five members of the medical staff who are not members of the medical staff administrative committee, are not direct competitors, do not have a conflict of interest, and who have not previously participated in the peer review of the matter under consideration.

(b) Instruct the hearing committee to schedule and arrange for a hearing which hearing shall be conducted not less than thirty nor more than sixty days from the date of the receipt of the request for a hearing by the chief executive officer. However, an initial hearing or meeting for a medical staff member who is under summary suspension, which is then in effect, shall be held as soon as arrangements may be reasonably made.

(2) The medical staff member shall be given at least ten days prior notice of the scheduled hearing, provided that the medical staff member may waive this notice in writing. Notice shall be by certified return receipt mail to the staff member at the staff member's last known address as reflected by university records. The notice of hearing shall state in concise language the acts or omissions with which the medical staff member is charged; a list of representative medical records or documents being used; names of potential witnesses to be called; and any other reason or evidence that may be considered by the hearing committee during the hearing.

(D) Conduct of hearing.

(1) The hearing committee shall select a chairperson from the committee to preside over the hearing. The chairperson may require a representative for the individual and for the medical staff administrative committee (or the Wexner medical center board) to participate in a pre-hearing conference. At the pre-hearing conference, the chairperson shall resolve all procedural questions, including any objections to exhibits or witnesses, the role of legal counsel, and determine the time to be allotted to each witness's testimony and cross-examination. The hearing committee shall have benefit of Ohio state university legal counsel. The hearing committee may grant continuances, recesses, and the chairperson may excuse a member of the hearing committee from attendance temporarily for good cause, provided that there shall be at no time less than two members of the hearing committee present unless the affected staff member waives this requirement.

All members of the hearing committee must be present to deliberate and vote. No member may vote by proxy. The person who has taken the action from which the affected staff member has requested the hearing shall not participate in the deliberation or voting of the hearing committee. The hearing shall be a de novo hearing, although evidence of the prior recommendations and decisions may be presented.

(2) An accurate record of the hearing shall be kept. The record shall be done by the use of a professional stenographer. This record shall be available to the affected member of the medical staff upon request at the affected member's expense.

(3) The personal presence of the medical staff member for whom the hearing has been scheduled shall be required. A medical staff member who fails without good cause to appear

and proceed at such hearing shall be deemed to have waived the right to appear and to have a hearing before the medical staff administrative committee in the same manner as provided in paragraph (B) of this rule, and to have accepted the adverse recommendation or decision involved and the same shall therein become and remain in effect as provided in paragraph (B) of this rule. The hearing committee may, at its own discretion, proceed with the hearing without the medical staff member and impose a sanction.

(4) Postponements of hearings beyond the time set forth in this chapter shall be made only with the approval of the medical staff administrative committee. Granting of such postponement shall be only for good cause shown.

(5) The hearing need not be conducted strictly according to the rules of law related to the examination of witnesses or presentation of evidence. Any relevant matters upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The member of the medical staff for whom the hearing is being held shall, prior to, or during the hearing, be entitled to submit memoranda concerning any issues of procedure or of fact and such memoranda shall become a part of the hearing record.

(6) The affected medical staff member shall have the following rights: to be represented by an attorney at law and to call and examine witnesses; to introduce evidence; to cross-examine any witnesses on any matter relevant to the issue of the hearing; and to challenge any witness and to rebut any evidence. If the medical staff member does not testify in his/her own behalf, the member may be called and examined as if under cross-examination.

(7) The hearing committee shall request the person who has taken the action from which the affected medical staff member has requested the hearing to present evidence to the hearing committee in support of the adverse recommendation. The hearing committee may proceed to hear evidence and testimony from either party in whatever order the hearing committee deems appropriate. The hearing committee may call its own witnesses, may recall any party's witnesses, and may question witnesses as it deems appropriate. All parties shall be responsible to secure the attendance of their own witnesses. All witnesses and evidence received by the hearing committee shall be open to challenge and cross-examination by the parties. Witnesses shall not be placed under oath. At the close of the evidence the hearing committee may request each party to make summary statements, either oral or written.

(8) The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. The hearing committee shall make its best effort to expeditiously determine the issues presented. The hearing committee may limit its proceedings when sufficient material has been received. The parties may be required to provide evidence in oral or written form. Upon conclusion of the presentation of evidence the hearing shall be closed. The hearing committee may there upon, at a time convenient to itself, conduct its deliberations outside the presence of the medical staff member for whom the hearing was convened.

(9) Within sixty days after its appointment, unless otherwise extended by the medical staff administrative committee, the hearing committee shall forward its written report and recommendation together with the transcript of the hearing and all other documentation presented by the parties to the medical staff administrative committee. The affected member shall be notified of the recommendation of the hearing committee including a statement of the basis for the recommendation. The medical staff administrative committee shall accept, reject, or modify the recommendation of the hearing committee. The medical staff administrative committee may conduct further hearings as it deems necessary or may

remand the matter back to the hearing committee for further action as directed. The medical staff administrative committee may impose a greater or lesser sanction than that recommended by the hearing committee.

(10) Within fourteen days after the conclusion of the taking of all evidence and of all hearings, the medical staff administrative committee shall make a written report of its findings and its recommendation and shall forward the same together with the hearings record and all other documentation to the chairperson of the Wexner medical center board. Notice of that decision shall be sent certified return receipt mail to the affected medical staff member at the member's last known address as determined by university records by the director.

(11) The decision and record of the medical staff administrative committee shall be transmitted to the quality and professional affairs committee of the Wexner medical center board, which shall, subject to the affected member's right to appeal and implementation of paragraph (E) of this rule, consider the matter at its next scheduled meeting, or at a special meeting to be held no less than thirty days following receipt of the transmittal. The quality and professional affairs committee of the Wexner medical center board may accept, reject, or modify the decision of the medical staff administrative committee.

(12) The recommendation of the quality and professional affairs committee of the Wexner medical center board shall be promptly considered by the Wexner medical center board at its next scheduled meeting. The Wexner medical center board may accept, reject, or modify the recommendation of the quality and professional affairs committee of the Wexner medical center board.

(13) A copy of the Wexner medical center board decision shall be sent by certified return receipt mail to the affected medical staff member at the member's last known address as determined by university records.

(E) Appeal process.

(1) Within thirty days after receipt of a notice by an affected medical staff member of the action of the medical staff administrative committee the staff member may, by written notice to the chairperson of the Wexner medical center board, request an appeal. Such appeal shall only be held on the record before the medical staff administrative committee.

(2) If an appeal is not requested within the thirty-day period, the affected medical staff member shall be deemed to have waived the right to an appeal, and to have accepted such adverse decision.

(3) The appeal shall be conducted by the quality and professional affairs committee of the Wexner medical center board.

(4) The affected medical staff member shall have access to the reports and records, including transcripts, if any, of the medical staff administrative committee and all other material, favorable or unfavorable, that have been considered by that committee. The member shall then submit a written factual statement specifying those factual and procedural matters with which the member disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the quality and professional affairs committee of the Wexner medical center board no later than seven days following the date of the affected member's notice of appeal.

(5) New or additional matters not raised during the hearing procedure or in the medical staff administrative committee hearings shall only be introduced on appeal at the sole discretion of the quality and professional affairs committee of the Wexner medical center board.

(6) Within fourteen days following submission of the written statement by the affected medical staff member, the quality and professional affairs committee shall recommend to the Wexner medical center board that the adverse decision be affirmed, modified or rejected, or to refer the matter back to the medical staff administrative committee for further review and recommendation. Such referral to the medical staff administrative committee may include a request for further investigation.

(7) Any final decision by the Wexner medical center board shall be communicated by the chief executive officer by certified return receipt mail to the affected medical staff member at the member's last known address as determined by university records. The chief executive officer shall also notify in writing the executive vice president for health sciences, the dean of the college of medicine, the chief medical officer of OSU medical center, the vice president for health services, the director of medical affairs, chief of staff, the department chairperson and/or division director, clinical department chief and the academic department chairperson and the person(s) who initiated the request for formal peer review. The chief executive officer shall take immediate steps to implement the final decision.

(Board approval dates: 9/1/1993, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 2/6/2009, 9/18/2009, 10/29/2010, 4/8/2011, 11/7/2014, 11/6/2015, 4/6/2018)

**3335-111-07 Categories of the medical staff.**

The medical staff of the CHRI shall be divided into honorary, physician scholar, attending, associate attending, clinical attending, consulting medical staff and limited designations. All medical staff members with admitting privileges may admit patients in accordance with state law and criteria for standards of care established by the medical staff. Medical staff members who do not wish to obtain any clinical privileges shall be exempt from the requirements of medical malpractice liability insurance, DEA registration, demonstration of recent active clinical practice during the last two years and specific annual education ~~requirements as outlined in the list maintained in the chief medical officer's office,~~ but are otherwise subject to the provisions of these bylaws.

(A) Honorary staff.

The honorary staff will be composed of those individuals who are recognized for outstanding reputation, notable scientific and professional contributions, and high professional stature in an oncology field of interest. The honorary staff designation is awarded by the Wexner medical center board on the recommendation of the chief executive officer of the CHRI, executive vice president for health sciences, department chairperson and/or division director, or the credentials committee after approval by the medical staff administrative committee. This is a lifetime appointment. Honorary staff are not entitled to patient care privileges.

(B) Physician scholar medical staff.

(1) Qualifications: The physician scholar medical staff shall be composed of those faculty members of the colleges of medicine and dentistry who are recognized for outstanding reputation, notable scientific and professional contributions, and high professional stature. This medical staff category includes but is not limited to emeritus faculty members. Nominations may be made to the chair of the credentialing committee who shall present the candidate to the medical staff administrative committee for approval.

(2) Prerogatives: Members of the physician scholar medical staff shall have access to the CHRI and shall be given notice of all medical staff activities and meetings. Members of the physician scholar medical staff shall enjoy all rights of an attending medical staff member except physician scholar members shall not possess clinical privileges.

(3) Physician scholar medical staff must have either a full license or an emeritus registration by the State Medical Board of Ohio.

(C) Attending medical staff.

(1) Qualifications:

The attending staff shall consist of those regular faculty members of the colleges of medicine and dentistry who are licensed or certified in the state of Ohio, whose practice is at least seventy-five percent oncology and with a proven career commitment to oncology as demonstrated by the majority of the following:

Training, current board certification (as specified in paragraph (A)(5) of rule 3335-111-04 of the Administrative Code), publications, grant funding, other funding and experience (as deemed appropriate by the chief executive officer and the department chairperson and/or division director); and who satisfy the requirements and qualifications for membership set forth in rule 3335-111-04 of the Administrative Code.

(2) Prerogatives:

Attending staff members may:

(a) Admit patients consistent with the balanced teaching and patient care responsibilities of the CHRI. When, in the judgment of the director of medical affairs, a balanced teaching program is jeopardized, following consultation with the chief executive officer, the clinical department chief and with the concurrence of a majority of the medical staff administrative committee, the director of medical affairs may restrict admissions. Imposition of such restrictions shall not entitle the attending staff member to a hearing or appeal pursuant to rule 3335-111-06 of the Administrative Code.

(b) Be free to exercise such clinical privileges as are granted pursuant to these bylaws.

(c) Vote on all matters presented at general and special meetings of the medical staff and committees of which he or she is a member unless otherwise provided by resolution of the medical staff, clinical department or committee and approved by the medical staff administrative committee.

(d) Hold office in the medical staff organization, clinical departments and committees of which they are a member, unless otherwise provided by resolution of the medical staff, clinical department or committee and approved by the medical staff administrative committee.

(3) Responsibilities:

An attending staff member shall:

(a) Meet the basic responsibilities set forth in rules 3335-111-02 and 3335-111-03 of the Administrative Code.

(b) Retain responsibility within the member's area of professional competence for the continuous care and supervision of each patient in the CHRI for whom he or she is providing care, or arrange a suitable alternative for such care and supervision.

(c) Actively participate in such quality evaluation and monitoring activities as required by the medical staff, and discharge such staff functions as may be required from time to time.

(d) Satisfy the requirements set forth in rule 3335-111-13 of the Administrative Code for attendance at medical staff meetings and meetings of those committees of which they are a member.

(e) Supervise members of the limited staff in the provision of patient care in accordance with accreditation standards and policies and procedures of approved clinical training programs. It is the responsibility of the attending physician to authorize each member of the limited staff to perform only those services that the limited staff member is competent to perform under supervision.

(f) Supervise other licensed allied health professionals as necessary in accordance with accreditation standards and state law. It is the responsibility of the attending physician to authorize each licensed allied health professional to perform only those services which the licensed allied health professional is privileged to perform.

(g) Take call as assigned by the clinical department chief.

(D) Associate attending staff.

(1) Qualifications:

The associate attending staff shall consist of those regular faculty members of the colleges of medicine and dentistry who do not qualify for attending staff appointment.

(2) Prerogatives:

The associate attending staff may:

(a) Admit patients consistent with the balanced teaching and patient care responsibilities of the institution. When, in the judgment of the director of medical affairs, a balanced teaching program is jeopardized, following consultation with the chief executive officer, the clinical department chief and with the concurrence of a majority of the medical staff administrative committee, the director of medical affairs may restrict admissions. Imposition of such restrictions shall not entitle the associate attending staff member to a hearing or appeal pursuant to rule 3335-111-06 of the Administrative Code.

(b) Be free to exercise such clinical privileges as are granted pursuant to the bylaws.

(c) Vote on all matters presented at general and special meetings of the medical staff and at committees of which he or she is a member unless otherwise prohibited by these bylaws or by resolution approved by the medical staff administrative committee.

(d) The associate attending staff member may not vote on amendments to the bylaws.

(3) Responsibilities:

Associate attending staff members shall:

(a) Meet the basic responsibilities set forth in rules 3335-111-02 and 3335-111-03 of the Administrative Code.

(b) Retain responsibility within the member's care area of professional competence for the continuous care and supervision of each patient in the CHRI for whom the member is providing care, or arrange a suitable alternative for such care and supervision including the supervision of interns, residents and fellows assigned to their service.

(c) Actively participate in such quality evaluation and monitoring activities as required by the staff and discharge such staff functions as may be required from time to time.

(d) Satisfy the requirements set forth in rule 3335-111-13 of the Administrative Code for attendance at medical staff meetings and meetings of those committees of which they are a member.

(E) Clinical attending staff.

(1) Qualifications:

The clinical attending staff shall consist of those clinical faculty members of the colleges of medicine and dentistry who have training, expertise, and experience in oncology, as determined by the chief executive officer in consultation with the department chairperson and/or division director and who satisfy the requirements and qualifications for membership set forth in rule 3335-111-04 of the Administrative Code.

(2) Prerogatives:

The clinical attending staff may:

(a) Admit patients which complement the research and clinical teaching program. At times when hospital beds or other resources are in short supply, patient admissions of clinical staff shall be subordinate to those of attending or associate attending staff.

(b) Be free to exercise such clinical privileges as are granted pursuant to these bylaws.

(c) Attend meetings as non-voting members of the medical staff and any medical staff or hospital education programs. The clinical attending staff may not hold elected office in the medical staff organization.

(3) Responsibilities:

(a) Meet the basic responsibilities set forth in rules 3335-111-02 and 3335-111-03 of the Administrative Code.

(b) Retain responsibility within the member's area of professional competence for the continuous care and supervision of each patient in the CHRI for whom the member is providing care, or arrange a suitable alternative for such care and supervision including the supervision of interns, residents and fellows assigned to their service.

(c) Actively participate in such quality evaluation and monitoring activities as required by the staff and discharge such staff functions as may be required from time to time.

(d) Satisfy the requirements set forth in rule 3335-111-13 of the Administrative Code for attendance at medical staff meetings and meetings of those committees of which they are a member.

(e) Supervise members of the limited staff in the provision of patient care in accordance with accreditation standards and policies and procedures of approved clinical training programs. It is the responsibility of the attending physician to authorize each member of the limited staff to perform only those services which the limited staff member is competent to perform under supervision.

(f) Supervise other licensed allied health professionals as necessary in accordance with accreditation standards and state law. It is the responsibility of the attending physician to authorize each licensed allied health professional to perform only those services which the licensed allied health professional is privileged to perform.

(F) Consulting medical staff.

(1) Qualifications.

The consulting medical staff shall consist of those faculty members of the colleges of medicine and dentistry who:

(a) Satisfy the requirements and qualifications for membership set forth in rule 3335-111-04 of the Administrative Code.

(b) Are consultants of recognized professional ability and expertise who provide a service not readily available from the attending medical staff. These practitioners provide services to James patients only at the request of attending or associate attending members of the medical staff.

(c) Demonstrate participation on the active medical staff at another accredited hospital requiring performance improvement/quality assessment activities similar to those of the hospitals of the Ohio state university. The practitioner shall also hold at such other hospital the same privileges, without restriction, that he/she is requesting at the James cancer hospital. An exception to this qualification may be made by the Wexner medical center board provided the practitioner is otherwise qualified by education, training and experience to provide the requested service.

(2) Prerogatives:

Consulting medical staff members may:

(a) Exercise the clinical privileges granted for consultation purposes on an occasional basis when requested by an attending or associate attending medical staff member.

(b) Have access to all medical records and be entitled to utilize the facilities of the Ohio state university hospitals and James cancer hospital incidental to the clinical privileges granted pursuant to these bylaws.

(c) Not admit patients to the Ohio state university hospitals or James cancer hospital.

(d) Not vote on medical staff policies, rules and regulations, or bylaws, and may not hold office.

(e) Must actively participate in such quality evaluation and monitoring activities as required by the medical staff and as outlined in the medical staff policy entitled "consulting medical staff member policy."

(f) Attend medical staff meetings, but shall not be entitled to vote at such meetings or hold office.

(g) Attend department meetings, but shall not be entitled to vote at such meetings or serve as clinical department chief.

(h) Serve as a non-voting member of a medical staff committee; provided, however, that he/she may not serve as a committee chair or as a member of the medical staff administrative committee.

(3) Responsibilities.

Each member of the consulting medical staff shall:

(a) Meet the basic responsibilities set forth in rules 3335-111-02 and 3335-111-03 of the Administrative Code.

(b) Be exempt from all medical staff dues.

(G) Limited staff.

Limited staff are not considered members of the medical staff, do not have delineated clinical privileges, and do not have the right to vote in general medical staff elections. Except where expressly stated, limited staff are bound by the terms of these bylaws, rules and regulations of the medical staff and the limited staff agreement.

(1) Qualifications:

The limited staff shall consist of doctors of medicine, osteopathic physicians, dentists and practitioners of podiatry or psychology who are accepted in good standing by a program director into a postdoctoral graduate medical education program and appointed to the limited staff in accordance with these bylaws. The limited staff shall maintain compliance with the requirements of state law, including regulations adopted by the Ohio state medical board, or the limited staff member's respective licensing board.

Members of the limited staff shall possess a valid training certificate or an unrestricted Ohio license from the applicable state board based on eligibility criteria defined by that state board. All members of the limited staff shall be required to successfully obtain an Ohio training certificate prior to beginning training within a program.

(2) Responsibilities:

The limited staff shall:

(a) Be responsible to respond to all questions and complete all forms as may be required by the credentials committee.

(b) Participate fully in the teaching programs, conferences, and seminars of the clinical department in which he or she is appointed in accordance with accreditation standards and policies and procedures of the graduate medical education committee and approved clinical training programs.

(c) Participate in the care of all patients assigned to the limited staff member under the appropriate supervision of a designated member of the attending medical staff in accordance with accreditation standards and policies and procedures of the clinical training programs. The clinical activities of the limited staff shall be determined by the program director appropriate for the level of education and training. Limited staff shall be permitted to perform only those services that they are authorized to perform by the member of the attending medical staff based on the competence of the limited staff to perform such services. The limited staff may admit or discharge patients only when acting on behalf of the attending, associate attending or clinical attending medical staff. The limited staff member shall follow all rules and regulations of the service to which he or she is assigned, as well as the general rules of the CHRI pertaining to limited staff.

(d) Serve as full members of the various medical staff committees in accordance with established committee composition as described in these bylaws and/or rules and regulations of the medical staff. The limited staff member shall not be eligible to vote or hold elected office in the medical staff organization, but may vote on committees to which the limited staff member is assigned.

(e) Be expected to make regular satisfactory professional progress including anticipated certification by the respective specialty or subspecialty program of post-doctoral training in which the limited staff member is enrolled. Evaluation of professional growth and appropriate humanistic qualities shall be made on a regular schedule by the clinical department chief, program director, teaching faculty or evaluation committee in accordance with accreditation standards and policies and procedures of the approved training programs.

(f) Appeal by a member of the limited staff of probation, lack of promotion, suspension or termination for failure to meet expectations for professional growth or failure to display appropriate humanistic qualities or failure to successfully complete any other competency as required by the accreditation standards of an approved training program will be conducted and limited in accordance with written guidelines established by the respective academic department or training program and approved by the program director and the Ohio state university's graduate medical education committee as delineated in the limited staff agreement and by the graduate medical education policies.

Alleged misconduct by a member of the limited staff, for reasons other than failure to meet expectations of professional growth as outlined above, shall be handled in accordance with rules 3335-111-05 and 3335-111-06 of the Administrative Code.

(3) Failure to meet reasonable expectations:

Termination of employment from the limited staff member's residency or fellowship training program shall result in automatic termination of the limited staff member's appointment pursuant to these bylaws.

(4) Temporary appointments:

(a) Limited staff members who are Ohio state university faculty may be granted an early commencement or an extension of appointment upon the recommendation of the chief of the clinical department, with prior concurrence of the associate dean for graduate medical education, when it is necessary for the limited staff member to begin his or her training program prior to or extend his or her training program beyond a regular appointment period. The appointment shall not exceed sixty days.

(b) Temporary appointments may be granted upon the recommendation of the chief of the clinical department, with prior concurrence of the associate dean for graduate medical education, for limited staff members who are not Ohio state university faculty but who, pursuant to education affiliate agreements approved by the university, need to satisfy approved graduate medical education clinical rotation requirements. These appointments shall not exceed a total of one hundred twenty days in any given post-graduate year. In such cases, the mandatory requirement for a faculty appointment may be waived. All other requirements for limited staff member appointment must be satisfied.

(5) Supervision:

Limited staff members shall be under the supervision of an attending, associate attending or clinical attending medical staff member. Limited staff members shall have no privileges as such but shall be able to care for patients under the supervision and responsibility of their attending, associate attending or clinical attending medical staff member. The care they extend will be governed by these bylaws and the general rules and regulations of each clinical department. The practice of care shall be limited by the scope of privileges of their attending, associate attending or clinical attending medical staff member. Any concerns or problems that arise in the limited staff member's performance should be directed to the attending, associate attending or clinical attending medical staff member or the director of the training program.

(a) Limited staff members may write admission, discharge or other orders for the care of patients under the supervision of the attending, associate attending or clinical attending medical staff member.

(b) All records of limited staff member cases must document involvement of the attending, associate attending or clinical attending medical staff member in the supervision of the patient's care to include co-signature of the admission order, history and physical, operative report, and discharge summary.

(H) Associates to the medical staff.

(1) Qualifications:

Licensed health care professionals are those professionals who possess a license, certificate or other legal credential required by Ohio law to provide direct patient care in a hospital setting, but who are not acting as licensed independent practitioners.

(2) Due process:

Licensed health care professionals are subject to corrective action for violation of these rules, their certificate of authority, standard care agreement, utilization plan or the provisions of their licensure, including professional ethics. Corrective action may be requested by any member of the medical staff, the clinical department chief, the chairperson of an academic

department, the section chief, the medical director of credentialing or the director of medical affairs. All requests shall be in writing and be submitted to the director of medical affairs.

The director of medical affairs shall appoint a three-person committee to review the situation and recommend appropriate corrective action, including termination or suspension of clinical privileges. The committee shall consist of at least one licensed health care professional licensed in the same field as the individual being reviewed, if available, and one medical staff member. The committee shall make a written recommendation to the director of medical affairs, who may accept, reject or modify the recommendation. The decision of the director of medical affairs shall be final.

(I) Temporary medical staff appointment.

(1) External peer review. When peer review activities are being conducted by someone other than a current member of the medical staff, the chief medical officer or director of medical affairs may admit a practitioner to the medical staff for a limited period of time. Such membership is solely for the purpose of conducting peer review in a particular evaluation and this temporary membership automatically expires upon the member's completion of duties in connection with such peer review. Such appointment does not include clinical privileges, and is for a limited purpose.

(2) Proctoring. Temporary privileges may be extended to visiting physician or visiting medical faculty for special clinical or educational activities as permitted by the Ohio state medical or dental board. When medical staff members require proctoring for the purposes of gaining experience to become credentialed to perform a procedure, a visiting medical faculty or visiting physician may apply for temporary privileges pursuant to the medical staff proctoring policy.

(J) Clinical privileges.

(1) Delineation of clinical privileges:

(a) Every person practicing at the CHRI by virtue of medical staff membership, faculty appointment, contract or under authority granted in these bylaws shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically applied for and granted to the staff member or other licensed allied health professional by the Wexner medical center board after recommendation from the medical staff administrative committee.

(b) Each clinical department and CHRI department and/or division shall develop specific clinical criteria and standards for the evaluation of privileges with emphasis on invasive or therapeutic procedures or treatment which represent significant risk to the patient or for which specific professional training or experience is required. Such criteria and standards are subject to the approval of the medical staff administrative committee and the Wexner medical center board.

(c) Requests for the exercise and delineation of clinical privileges must be made as part of each application for appointment or reappointment to the medical staff on the forms prescribed by the medical staff administrative committee. Every person in an administrative position who desires clinical privileges shall be subject to the same procedure as all other applicants. Requests for clinical privileges must be submitted to the chief of the clinical department in which the clinical privileges will be exercised. Clinical privileges requested other than during appointment or reappointment to the medical staff shall be submitted to the chief of the clinical department and such

request must include documentation of relevant training or experience supportive of the request.

(d) The chief of the clinical department shall review each applicant's request for clinical privileges and shall make a recommendation regarding clinical privileges to the medical director of credentialing. Requests for clinical privileges shall be evaluated based upon the applicant's education, training, experience, demonstrated competence, references, and other relevant information including the direct observation and review of records of the applicant's performance by the clinical department in which the clinical privileges are exercised. Whenever possible, the review should be of primary source information. The applicant shall have the burden of establishing qualifications and competence in the clinical privileges requested and shall have the burden of production of adequate information for the proper evaluation of qualifications.

(e) The applicant's request for clinical privileges and the recommendation of the clinical department chief shall be forwarded to the credentials committee and shall be processed in the same manner as applications for appointment and reappointment pursuant to rule 3335-111-04 of the Administrative Code.

(f) Medical staff members who are granted new or initial privileges are subject to FPPE, which is a six-month period of focused monitoring and evaluation of practitioner's professional performance. Following FPPE medical staff members with clinical privileges are subject to ongoing professional practice evaluation (OPPE), which information is factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal. FPPE and OPPE are fully detailed in medical staff policies that were approved by the medical staff administrative committee and the Wexner medical center board.

(g) Upon resignation, termination or expiration of the medical staff member's faculty appointment or employment with the university for any reason, such medical staff appointment and clinical privileges of the medical staff member shall automatically expire.

(h) Medical staff members authorize the CHRI and clinics to share amongst themselves credentialing, quality and peer review information pertaining to the medical staff member's clinical competence and/or professional conduct. Such information may be shared at initial appointment and/or reappointment and at any time during the medical staff member's medical staff appointment to the medical staff of the CHRI.

(i) Medical staff members authorize the CHRI to release, in good faith and without malice, information to managed care organizations, regulating agencies, accreditation bodies and other health care entities for the purposes of evaluating the medical staff member's qualifications pursuant to a request for appointment, clinical privileges, participation or other credentialing or quality matters.

(2) Temporary and special privileges:

(a) Temporary privileges may be extended to a doctor of medicine, osteopathic medicine, dental surgery, psychologist, podiatry or to a licensed allied health professional upon completion of an application prescribed by the medical staff administrative committee, upon recommendation of the chief of the clinical department. All temporary privileges are granted by the chief executive officer or authorized designee. The temporary privileges granted shall be consistent with the applicant's training and experience and with clinical department guidelines. Prior to

granting temporary privileges, primary source verification of licensure and current competence shall be required. Temporary privileges shall be limited to situations which fulfill an important patient care need and shall not be granted for a period not to exceed one hundred twenty days.

(b) Temporary privileges may be extended to visiting medical faculty or for special activity as provided by the Ohio state medical or dental boards.

(c) Temporary privileges granted for locum tenens may be exercised for a maximum of one hundred twenty days, consecutive or not, any time during the thirty-sixtwenty-four month period following the date they are granted.

(d) Practitioners granted temporary privileges will be restricted to the specific delineations for which the temporary privileges are granted. The practitioner will be under the supervision of the chair of the clinical department while exercising any temporary privileges granted.

(e) Practitioners exercising temporary privileges shall abide by these medical staff bylaws, rules and regulations, and hospital and medical staff policies.

(f) Special privileges -- upon receipt of a written request for specific temporary clinical privileges and the approval of the clinical department chief, the chairperson of the academic department and the director of medical affairs, an appropriately licensed or certified practitioner of documented competence, who is not an applicant for medical staff membership, may be granted special clinical privileges for the care of one or more specific patients. Such privileges shall be exercised in accordance with the conditions specified in rule 3335-111-04 of the Administrative Code.

(g) The temporary and special privileges must also be in conformity with accrediting bodies' standards and the rules and regulations of professional boards of Ohio.

(3) Expedited privileges:

If the Wexner medical center board is not scheduled to convene in a timeframe that permits the timely consideration of the recommendation of a complete application by the medical staff administrative committee, eligible applicants may be granted expedited privileges by the quality and professional affairs committee of the Wexner medical center board. Certain restrictions apply to the appointment and granting of clinical privileges via the expedited process. These include but are not limited to: an involuntary termination of medical staff membership at another hospital, involuntary limitation, or reduction, denial or loss of clinical privileges, a history of professional liability actions resulting in a final judgment against the applicant, or a challenge by a state licensing board.

(4) Podiatric privileges:

(a) Practitioners of podiatry may admit patients to the CHRI if such patients are being admitted solely to receive care that a podiatrist may provide without medical assistance, pursuant to the scope of the professional license of the podiatrist. Practitioners of podiatry must, in all other circumstances co-admit patients with a member of the medical staff who is a doctor of medicine or osteopathic medicine.

(a)(b) A member of the medical staff who is a doctor of medicine or osteopathy shall:

(i) Shall Bbe responsible for any medical problems that the patient has while an inpatient of the CHRI; and

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(ii) Shall confirm the findings, conclusions and assessment of risk prior to high-risk diagnosis or therapeutic interventions defined by the medical staff.

~~(b)~~(c) Practitioners of podiatry shall be responsible for the podiatric care of the patient including the podiatric history and physical examination and all appropriate elements of the patient's record.

~~(c)~~(d) The podiatrist shall be responsible to the chief of the department of orthopaedics.

(5) Psychology privileges:

(a) Psychologists shall be granted clinical privileges based upon their training, experience and demonstrated competence and judgment consistent with their license to practice. Psychologists shall not prescribe drugs, or perform surgical procedures, or in any other way practice outside the area of their approved clinical privileges or expertise unless otherwise authorized by law.

(b) Psychologists may not admit patients to the CHRI, but may diagnose and treat a patient's psychological illness as part of the patient's comprehensive care while hospitalized. All patients admitted for psychological care shall receive the same medical appraisal as all other hospitalized patients. A member of the medical staff who is a doctor of medicine or osteopathic medicine shall admit the patient and shall be responsible for the history and physical and any medical care that may be required during the hospitalization, and shall determine the appropriateness of any psychological therapy based on the total health status of the patient. Psychologists may provide consultation within their area of expertise on the care of patients within the CHRI. In ambulatory settings, psychologists shall diagnose and treat their patient's psychological illness. Psychologists shall ensure that their patients receive referral for appropriate medical care.

(c) Psychologists shall be responsible to the chief of the clinical department in which they are appointed.

(6) Dental privileges:

(a) Practitioners of dentistry, who have not been granted clinical privileges as oral and maxillofacial surgeons, may admit patients to the CHRI if such patients are being admitted solely to receive care which a dentist may provide without medical assistance, pursuant to the scope of the professional license of the dentist. Practitioners of dentistry must, in all other circumstances, co-admit patients with a member of the medical staff who is a doctor of medicine or osteopathic medicine.

(b) A member of the medical staff who is a doctor of medicine or osteopathy:

(i) Shall be responsible for any medical problems that the patient has while an inpatient of the CHRI; and

(ii) Shall confirm the findings, conclusions and assessment of risk prior to high-risk diagnoses or therapeutic interventions defined by the medical staff.

(c) Practitioners of dentistry shall be responsible for the dental care of the patient including the dental history and physical examination and all appropriate elements of the patient's record.

(7) Oral and maxillofacial surgical privileges:

All patients admitted to the CHRI for oral and maxillofacial surgical care shall receive the same medical appraisal as all other hospitalized patients. Qualified oral and maxillofacial surgeons shall admit patients, shall be responsible for the plan of care for the patients, shall perform the medical history and physical examination, if they have such privileges, in order to assess the medical, surgical, and anesthetic risks of the proposed operative and other procedure(s), and shall be responsible for the medical care that may be required at the time of admission or that may arise during hospitalization.

(8) Licensed allied health professionals:

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

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

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

(iii) Employees of members of the medical staff.

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

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

(d) Licensed allied health professionals are not members of the medical staff, but may write admitting orders for; patients of the CHRI when granted such privileges under tis rule and in accordance with applicable Ohio state law. If such privileges are granted, the patient will be admitted under the medical supervision of the responsible medical staff member. Licensed allied health professionals are not members of the medical staff and shall not be eligible to hold office, to vote on medical staff affairs, or to serve on standing committees of the medical staff unless specifically authorized by the medical staff administrative committee.

(e) Each licensed allied health professional shall be individually assigned to a clinical department and shall be supervised by or collaborate with one or more members of the medical staff as required by Ohio law. The licensed health care professional's clinical privileges are contingent upon the collaborating/supervising medical staff member's privileges. In the event that the collaborating/supervising medical staff member loses privileges or resigns, the licensed allied health care professionals whom he or she has supervised shall be placed on administrative hold until another collaborating/ supervising medical staff member is assigned. The new collaborating/supervising medical staff member shall be assigned in less than thirty days.

(f) Licensed allied health professionals must comply with all limitations and restrictions imposed by their respective licenses, certifications, or legal credentials as required by Ohio law, and may only exercise those clinical privileges granted in accordance with provisions relating to their respective professions.

(g) Only applicants who can document the following shall be qualified for clinical privileges as a licensed allied health professional:

(i) Current license, certification, or other legal credential required by Ohio law;

(ii) Certificate of authority, standard care arrangement/agreement, or utilization plan;

(iii) Education, training, professional background and experience, and professional competence;

(iv) Patient care quality indicators definition for initial appointment. This data will be in a format determined by the licensed allied health professional subcommittee and the quality management department of the Ohio state university medical center;

(v) Adherence to the ethics of the profession for which an individual holds a license, certification, or other legal credential required by Ohio law;

(vi) Evidence of required immunization;

(vii) Evidence of good personal and professional reputation as established by peer recommendations;

(viii) Satisfactory physical and mental health to perform requested clinical privileges; and

(ix) Ability to work with members of the medical staff and the CHRI employees.

(h) The applicant shall have the burden to produce documentation with sufficient adequacy to assure the medical staff and the CHRI that any patient cared for by the licensed allied health professional seeking clinical privileges shall be given quality care, and that the efficient operation of the CHRI will not be disrupted by the applicant's care of patients in the CHRI.

(i) By applying for clinical privileges as a licensed allied health professional, the applicant agrees to the following terms and conditions:

(i) The applicant has read the bylaws and rules and regulations of the medical staff of the CHRI and agrees to abide by all applicable terms of such bylaws and any applicable rules and regulations, including any subsequent amendments thereto, and any applicable CHRI policies that the CHRI may from time to time put into effect;

(ii) The applicant releases from liability all individuals and organizations who provide information to the CHRI regarding the applicant and all members of the medical staff, the CHRI staff and the Wexner medical center board and the Ohio state university board of trustees for all acts in connection with investigating and evaluating the applicant;

(iii) The applicant shall not deceive a patient as to the identity of any practitioner providing treatment or service in the CHRI;

(iv) The applicant shall not make any statement or take any action that might cause a patient to believe that the licensed allied health professional is a member of the medical staff; and

(v) The applicant shall obtain and continue to maintain professional liability insurance in such amounts required by the medical staff.

(j) Licensed allied health care professionals shall be subject to quality review and corrective action as outlined in this paragraph for violation of these bylaws, their certificate of authority, standard of care agreement, utilization plan, or the provisions of their licensure, including professional ethics. Review may be requested by any member of the medical staff, a chief of the clinical department, or by the medical director of quality or the chief quality officer. All requests shall be in writing and shall be submitted to the chief quality officer. The chief quality officer, unless delegated to the medical director of quality, shall appoint a three-person committee to review and make recommendations concerning appropriate action. The committee shall consist of at least one licensed allied health care professional and one medical staff member. The committee shall make a written recommendation to the chief quality officer, unless delegated to the medical director of quality, who may accept, reject, or modify the recommendation. The chief quality officer, unless delegated to the medical director of quality shall forward his or her recommendation to the director of medical affairs for final determination.

(k) Appeal process.

(i) A licensed allied health care professional may submit a notice of appeal to the chairperson of the quality and professional affairs committee within thirty days of receipt of written notice of any adverse corrective action pursuant to these bylaws.

(ii) If an appeal is not so requested within the thirty-day period, the licensed allied health care professional shall be deemed to have waived the right to appeal and to have conclusively accepted the decision of the director of medical affairs.

(iii) The appellate review shall be conducted by the chief of staff, the chair of the licensed health care professionals subcommittee and one medical staff member from the same discipline as the licensed allied health care professional under review. The licensed allied health care professional under review shall have the opportunity to present any additional information deemed relevant to the review and appeal of the decision.

(iv) The affected licensed allied health care professional shall have access to the reports and records, including transcripts, if any, of the hearing committee and of the medical staff administrative committee and all other material, favorable or unfavorable, that has been considered by the chief quality officer. The licensed allied health care professional shall submit a written statement indicating those factual and procedural matters with which the member disagrees, specifying the reasons for such disagreement. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the review

committee no later than seven days following the date of the licensed allied health care professional's notice of appeal.

(v) New or additional matters shall only be considered on appeal at the sole discretion of the quality and professional affairs committee.

(vi) Within thirty days following submission of the written statement by the licensed allied health care professional, the chief of staff shall make a final recommendation to the chair of the quality and professional affairs committee of the Wexner medical center board. The quality and professional affairs committee of the Wexner medical center board shall determine whether the adverse decision will stand or be modified and shall recommend to the Ohio state university Wexner medical center board that the adverse decision be affirmed, modified or rejected, or to refer the matter back to the review committee for further review and recommendation. Such referral to the review committee may include a request for further investigation.

(vii) Any final decision by the Wexner medical center board shall be communicated by the chief quality officer and by certified return receipt mail to the last known address of the licensed allied health care professional as determined by university records. The chief quality officer shall also notify in writing the senior vice president for health sciences, the dean of the college of medicine, the chief executive officer of the CHRI and the vice president for health services and the chief of the applicable clinical department or departments. The chief quality officer, unless delegated to the medical director of quality, shall take immediate steps to implement the final decision.

(9) Emergency privileges:

In the case of an emergency, any member of the medical staff to the degree permitted by the member's license or certification and regardless of department or medical staff status shall be permitted to do everything possible to save the life of a patient using every facility of the CHRI necessary, including the calling for any consultation necessary or desirable. After the emergency situation resolves, the patient shall be assigned to an appropriate member of the medical staff. For the purposes of this paragraph, an "emergency" is defined as a condition that would result in serious permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

(10) Disaster privileges:

Disaster privileges may be granted in order to provide voluntary services during a local, state or national disaster in accordance with hospital/medical staff policy and only when the following two conditions are present: the emergency management plan has been activated and the hospital is unable to meet immediate patient needs. Such privileges may be granted by the director of medical affairs or the medical director of credentialing to fully licensed or certified, qualified individuals who at the time of the disaster are not members of the medical staff. These privileges will be limited in scope and will terminate once the disaster situation subsides or at the discretion of the director of medical affairs temporary privileges are granted thereafter.

(11) Telemedicine:

Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Diagnosis and treatment of a patient may now be performed via telemedicine link.

(a) A member of the medical staff who wishes to utilize electronic technologies (telemedicine) to render care must so indicate on the application for clinical privileges form.

(b) A member of the medical staff may request to exercise via telemedicine the same clinical privileges he or she has already been granted. The credentials committee, the chief of the clinical service, medical director of credentialing, the director of medical affairs or the medical staff administrative committee, and the Wexner medical center board shall have the prerogative of requiring documentation or making a determination of the appropriateness of the exercise of a particular specialty/subspecialty via telemedicine.

~~(b)~~

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**3335-111-08 Organization of the CHRI medical staff.**

(A) The chief executive officer.

(1) Method of appointment:

The chief executive officer shall be appointed by the board of trustees of the Ohio state university upon recommendation of the president, executive vice president for health sciences, and the vice president for health services following consultation with the medical center board in accordance with university bylaws, rules and regulations. The chief executive officer shall be a member of the attending medical staff of the CHRI.

(2) Responsibilities:

The chief executive officer shall be responsible for the conduct of teaching, research, and CHRI service activities of the facility, including continuing compliance with all appropriate quality assurance standards, ethical codes, or other monitoring or regulatory requirements. The chief executive officer shall be a member of all committees of the CHRI.

(B) The director of medical affairs (physician-in-chief/chief medical officer of the James cancer hospital).

(1) Method of appointment:

The director of medical affairs shall be appointed by the executive vice president for health sciences upon recommendation by the chief executive officer of the James Cancer Hospital. The director of medical affairs is the physician-in-chief and shall be the chief medical officer of the CHRI and must be a member of the attending medical staff of the CHRI.

(2) Responsibilities:

The director of medical affairs shall report to the chief executive officer and the Wexner medical center board for the quality of patient care provided in the CHRI. The director of medical affairs shall assist the chief executive officer in the administration of medical affairs including quality assurance and credentialing. In addition, the director of medical affairs determines initial medical staff category appointments, reappointments and any changes in categories of the medical staff.

(C) The chief medical officer of the Ohio state university medical center.

The chief medical officer of the Ohio state university medical center is the senior medical officer for the medical center with the responsibility and authority for all health and medical care delivered at the medical center. The chief medical officer is responsible for overall quality improvement and clinical leadership throughout the medical center, physician alignment, patient safety and medical staff development. The appointment, scope of authority, and responsibilities of the chief medical officer shall be as outlined in the Ohio state medical center board bylaws. The director of medical affairs will work collaboratively with the chief medical officer and medical directors of each hospital of the medical center for the: coordination and supervision of patient care and clinical activities; responsibility for the clinical organization of his or her respective hospital; and to establish priorities, jointly with the chief executive officer or executive director of his or her respective hospital, for capital medical equipment, clinical space, and the establishment of new clinical programs, or the revision of existing clinical programs.

(D) The chief quality officer of the Ohio state university medical center.

The chief quality and patient safety officer of the Ohio state university medical center is referred to herein these bylaws as the chief quality officer. The chief quality officer reports to the chief medical officer. The chief quality officer works collaboratively with clinical leadership of the medical center, including medical director of quality for the CHRI, director of medical affairs for the CHRI, nursing leadership and hospital administration. The chief quality officer provides leadership in the development and measurement of the medical center's approach to quality, patient safety and reduction of adverse events. The chief quality officer communicates and implements strategic, operational and programmatic plans and policies to promote a culture where patient safety is an important priority for medical and hospital staff.

(E) Medical director of credentialing.

The medical director of credentialing for the James cancer hospital oversees the process for the credentialing of practitioners applying for membership and/or clinical privileges at the James cancer hospital. The medical director of credentialing shall provide guidance on specific practitioner application or privileging concerns as raised pursuant to these bylaws and shall recommend practitioners for membership and/or privileges at the James cancer hospital and facilitate the process for approving such membership and granting of clinical privileges.

(F) Medical director, James surgical services.

The medical director, James surgical services has oversight of all James designated perioperative services and procedural suites. Working collaboratively with the administrator of perioperative services, the medical director, James surgical services facilitates the timely sharing of OR resources (including personnel and equipment) across the medical center in order to maximize the efficiency of OR services. The medical director, James surgical services works with clinical service lines and clinical leadership to coordinate OR services in a manner that enhances the quality of care and safety of services for patients. The medical director, James surgical services reports to the director of medical affairs of the James.

(G) Professional assignments.

Each member of the attending, associate attending, clinical, limited, physician scholar and honorary staff shall be assigned to a CHRI division and/or department by the chief executive officer upon the recommendation of the appropriate academic department chairperson and the credentials committee.

**Chapter 3335-111 - *Bylaws of the Medical Staff* of the**
**Arthur G. James Cancer Hospital and Richard J. Solove Research Institute**
Updated February 8, 2022

Appointment to a specific department and/or division is based on the clinical specialty of the applicant for medical staff membership. Each department and/or division is headed by a department chairperson or division director who has the responsibility to oversee all research and clinical activities conducted by members of the department and/or division. Specifically, the department chairperson or division director shall be responsible for the following: the development and implementation of policies and procedures that guide and support the provision of service; recommendations re: staffing needs and clinical privileges for all members appointed to the department and/or division; the orientation and continuing surveillance of the professional performance of all department and/or division members; recommendation for space and other resources needed.

(H) Clinical department chief.

(1) Qualifications and responsibilities of the chief of the clinical department. The academic department chair shall ordinarily serve also as the chief of the clinical department. Each clinical department chief shall be qualified by education and experience appropriate to the discharge of the responsibilities of the position. Each clinical department chief must be board certified by an appropriate specialty board or must establish comparable competence. The chief of the clinical department must be a medical staff member at the Ohio state university hospitals. Such qualifications shall be judged by the respective dean of the colleges of medicine or dentistry. Qualifications for chief of the clinical department generally shall include recognized clinical competence, sound judgment and well-developed administrative skills.

(2) Procedure for appointment. Appointment or reappointment of chief of the clinical department shall be made by the dean of the respective colleges of medicine or dentistry in consultation with elected representatives of the medical staff and the chief medical officer of the Ohio state university medical center.

(3) Term of appointment of the chief of the clinical department. The term of the appointment of the chief of the clinical department shall be concurrent with the chief's academic appointment but shall be no longer than four years. Prior to the end of said four-year term, a review shall be conducted by the dean of the college of medicine and such review shall serve as the basis for the recommendation for reappointment pursuant to paragraph (D)(2) of this rule.

(4) Duties of the chief of the clinical department:

Each clinical department chief is responsible for the following:

(a) Clinically related activities of the department;

(b) Administratively related activities of the department, unless otherwise provided by the hospital;

(c) Continuing surveillance of the professional performance of all practitioners in the department who have delineated clinical privileges;

(d) Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department;

(e) Recommending clinical privileges for each practitioner of the department based on relevant training and experience, current appraised competence, health status that does not present a risk to patients, and evidence of satisfactory performance with existing privileges;

(f) Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the hospital;

(g) The integration of the department or service into the primary functions of the hospital, developing services that complement the medical center's mission and plan for clinical program development;

(h) The coordination and integration of interdepartmental and intradepartmental services;

(i) The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services. This includes the development, implementation, enforcement and updating of departmental policies and procedures that are consistent with the hospital's mission. The clinical department chief shall make such policies and procedures available to the medical staff;

(j) The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services, including call coverage for continuous high quality and safe care;

(k) The determination of the qualifications and competence of department or service personnel who are not licensed ~~independent~~ practitioners and who provide patient care, treatment, and services;

(l) The continuous assessment and improvement of the quality of care, treatment, and services;

(m) The maintenance of quality control programs, as appropriate;

(n) The orientation and continuing education of all persons in the department or service;

(o) Recommending space and other resources needed by the department or service; and

(p) Hold regular clinical department meetings and ensure open lines of communication are maintained in the clinical department. The agenda for the meetings shall include, but not be limited to, a discussion of the clinical activities of the department and communication of the decisions of the medical staff administrative committee. Minutes of the departmental meetings, including a record of attendance, shall be kept in the clinical department.

(Board approval dates: 9/1/1993, 3/3/1995, 12/6/1996, 12/3/1999, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 7/7/2006, 2/6/2009, 9/18/2009, 5/14/2010, 2/11/2011, 4/8/2011, 8/31/2012, 2/01/2013, 6/6/2014, 11/6/2015, 4/6/2018)

**3335-111-09 Elected officers of the medical staff of the CHRI.**

(A) Chief of staff.

The chief of staff shall:

(1) Serve on those committees of the Ohio state medical center board as appointed by the chairperson of the medical center board.

(2) Be a vice chairperson of the medical staff administrative committee and serve as liaison between university administration, CHRI administration, and the medical staff in all matters of mutual concern within the CHRI.

(3) Call, preside, and be responsible for the agenda of all general staff meetings.

(4) Make medical staff committee appointments jointly with the director of medical affairs and chief of staff-elect for approval by the CHRI medical staff administrative committee.

(5) Be a spokesperson for the medical staff in its external professional and public relations.

(6) Serve as chairperson of the nominating committee of the medical staff.

(B) Chief of staff-elect.

The chief of staff-elect shall:

(1) Serve on those committees of the Ohio state medical center board as appointed by the chairperson of the medical center board.

(2) Serve as the chairperson of the bylaws committee of the CHRI.

(3) Carry out all the duties of the chief of staff when the chief of staff is unable to do so.

(4) Oversee the inclusion of changes in the bylaws, rules and regulations of the medical staff.

(5) Assist the Chief of Staff with duties outlined above in section (A) 1-6.

(C) Delegates at-large.

Up to two additional at-large member(s) may be appointed to the medical staff administrative committee at the recommendation of the chief executive officer of the CHRI, subject to the approval of the medical staff administrative committee and subject to review and renewal every two years.

(D) Qualifications of officers.

(1) Officers must be members of the attending staff at the time of their nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

(2) The chief executive officer and director of medical affairs, chiefs of the clinical departments, and division directors are not eligible to serve as chief of staff or chief of staff-elect unless they are replaced in their CHRI administrative role during the period of their term of office.

(E) Election of officers.

(1) All officers (other than at-large officers) will be elected by a majority of those voting by ~~written or~~ electronic ballot after the April meeting of the medical staff. If one candidate does not achieve a majority vote, there will be an election on a second ballot between the two receiving the greatest number of votes.

(2) The nominating committee will be composed of five members. The chief of staff and the chief of staff-elect will serve on the committee and the chief of staff will be its chairperson. The chief of staff will appoint the three other members of the committee.

(3) Nominations for officers will be accepted from the floor at the March meeting.

(4) The committee's nominees will be submitted by electronic or written ballot to all voting members of the medical staff no later than May.

(5) Candidates for the office of chief of staff-elect will be listed and each attending staff member may vote for one.

(6) Automatic removal shall be for failure to meet those responsibilities assigned within these bylaws, failure to comply with medical staff rules and regulations, policies and procedures of the medical staff, for conduct or statements that damage the reputation of the CHRI, its goal and missions, or programs, or an automatic termination or suspension of clinical privileges that lasts more than thirty days.

(F) Term of office.

(1) The chief of staff and chief of staff-elect will each serve two years in office beginning on the first of July. The chief of staff-elect will be elected in the odd years. The chief of staff may not be elected chief of staff-elect within one year of the end of the chief of staff's term in office.

(2) The at-large representatives shall serve two years, beginning on the first of July. The delegate at large may succeed themselves for three successive terms (six years, total), if so elected. They may not serve again without a period of two years out of office as a delegate at large. The delegate at large may be elected chief of staff-elect at any time if they are members of the attending staff.

(G) Vacancies in office.

(1) Vacancies in the office of chief of staff during the chief's term will be automatically succeeded and performed by the chief of staff-elect. When the unexpired term is one year or less, the new chief of staff will continue in office until the completion of the expected term in that office. When the unexpired term is more than one year, the new chief of staff will serve out the remaining term only.

(2) Vacancies in the office of chief of staff-elect shall be filled by a special election held within sixty days of establishing the vacancy by the nominating and election process set forth in paragraph (F) of this rule. The nominating committee will make nominations and a special meeting of the voting members of the medical staff will be called to add nominations and elect the replacement. The new chief of staff-elect will become chief of staff at the end of the term of the incumbent.

(3) Vacancies in the at-large representatives' positions will be filled by appointment by the chief executive officer.

(Board approval dates: 9/1/1993, 3/3/1995, 12/6/1996, 9/1/1999, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 2/6/2009, 9/18/2009, 2/11/2011, 4/8/2011, 6/6/2014, 9/2/2016, 4/6/2018, 5/18/2021)

**Chapter 3335-111 - *Bylaws of the Medical Staff* of the**
**Arthur G. James Cancer Hospital and Richard J. Solove Research Institute**
Updated February 8, 2022

**3335-111-10 Administration of the medical staff of the CHRI.**

Medical staff committees.

(A) Appointments: Appointments to all medical staff committees except the medical staff administrative committee (MSAC) and the nominating committee will be made jointly by the chief of staff, chief of staff-elect, and the director of medical affairs with medical staff administrative committee ratification. Unless otherwise provided by the bylaws, all appointments to medical staff committees are for two years and may be renewed. The chairperson shall control the committee agenda, attendance of staff and guests and conduct the proceedings. A simple majority of appointed voting members shall constitute a quorum. All committee members appointed or elected to serve on a medical staff committee are expected to participate fully in the activities of those committees. The chief of staff, director of medical affairs and the chief executive officer of the CHRI may serve on any medical staff committee as an ex-officio member without vote.

(B) The medical staff as a whole and each committee provided for by these medical staff bylaws is hereby designated as a peer review committee in accordance with the laws of the state of Ohio. The medical staff through its committees shall be responsible for evaluating, maintaining and monitoring the quality and utilization of patient care services provided by CHRI.

(C) Medical staff administrative committee:

(1) Composition:

(a) Voting membership includes: chief of staff, chief of staff-elect, immediate past chief of staff, clinical department chief or division director of medical oncology, radiation oncology, anatomic pathology and molecular pathology; department chairperson or division director of hematology, gynecologic oncology, otolaryngology/head and neck, hospital medicine, human genetics, infectious diseases, surgical oncology, thoracic surgery, neurological oncology, orthopaedic oncology/sarcoma pulmonary, critical care, sleep medicine, and urology; medical director of James emergency services; clinical department chiefs of anesthesia, dermatology, physical medicine and rehabilitation, plastic surgery, psychiatry, and radiology; CHRI medical director of quality, CHRI medical director of credentialing, CHRI chief executive officer, CHRI director of medical affairs, director of the division of palliative medicine, chairperson of the cancer subcommittee, CCC director for clinical research, CCC director for cancer control, and medical director of the James surgical services. Up to two additional at-large member(s) may be appointed to the MSAC at the recommendation of the chief executive officer of the CHRI, subject to the approval of the medical staff administrative committee and subject to review and renewal on a yearly basis. If a division director is a member by leadership position, he or she will also fulfill the role of division director appointment. The director of medical affairs shall be the chairperson and the chief of staff shall be the vice-chairperson.

(b) Ex-officio non-voting membership includes: the CHRI executive director, the CHRI chief nursing officer, the CHRI executive director of patient services, the medical director of university hospital and/or the chief medical officer of the medical center, the dean of the Ohio state university college of medicine and the executive vice president for health sciences.

(c) Any member of the committee who anticipates absence from a meeting of the committee may appoint a temporary substitute as a representative at the meeting. The temporary substitute will have all the rights of the absent member. The chief executive officer may invite any member of staff as the chief executive officer's representative at a meeting or to attend any meeting with the chief executive officer.

(d) All members of the committee shall attend, either in person or by proxy, a minimum of two-thirds of all committee meetings.

(e) Any members may be removed from the medical staff administrative committee at the recommendation of the dean of the college of medicine, the director of medical affairs or the executive vice president for health sciences and subject to the review and approval of the medical staff administrative committee. A replacement will be appointed as outlined above to maintain the medical staff administrative committee's composition as stated in this paragraph.

(2) Duties:

(a) To represent and to act on behalf of the medical staff, subject to such limitations as may be imposed by this chapter, and the bylaws or rules of the Ohio state university.

(b) To have primary authority for activities related to self-governance of the medical staff. Action approved by the medical staff administrative committee can be reviewed by the quality and professional affairs committee pursuant to rule 3335-43-13 of the Administrative Code.

(c) To receive and act upon commission and committee reports. To delegate appropriate staff business to committees while retaining the right of executive responsibility and authority over all medical staff committees. This shall include but is not limited to review of and action upon medical staff appointments and reappointments whenever timely action is necessary.

(d) To approve and implement policies of the medical staff.

(e) To recommend action to the chief executive officer on matters of medico-administrative nature.

(f) To fulfill the medical staff's accountability to the Wexner medical center board for medical care rendered to patients in the CHRI, and for professional conduct and activities of the medical staff, including recommendations concerning;

(i) Medical staff structure;

(ii) The mechanism to review credentials and to delineate clinical privileges;

(iii) The mechanism by which medical staff membership may be terminated or suspended;

(iv) Participation in the CHRI's performance improvement, quality and patient safety activities; and

(v) Corrective action and hearing procedures applicable to medical staff members and other licensed allied health professionals granted clinical privileges.

(g) To ensure the medical staff is kept abreast of the accreditation process and informed of the accreditation status of the CHRI.

(h) To review and act on medical staff appointments and reappointments.

(i) To report to the medical staff all actions affecting the medical staff.

(j) To inform the medical staff of all changes in committees, and the creation or elimination of such committees as circumstances shall require.

(k) To create committees (for which membership is subsequently appointed pursuant to rule 3335-111-10 of the Administrative Code) to meet the needs of the medical staff and comply with the requirements of accrediting agencies.

(l) To establish and maintain rules and regulations governing the medical staff.

(m) To oversee functions related to performance improvement of professional services provided by individuals with clinical privileges.

(n) To perform other functions as are appropriate.

(3) Executive Session

(a) Upon the recommendation of the credentialing committee, the medical staff administrative committee may vote to hold a portion of a regular, special or emergency meeting in executive session with participation limited to voting members of the medical staff administrative committee. Other individuals may be invited to attend any or all portions of an executive session as deemed necessary by the committee chair.

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~~(3)~~(4) Meetings:

The committee shall meet monthly and keep detailed minutes, which shall be distributed to each committee member before or at the next meeting of the committee.

~~(4)~~(5) Voting:

At a properly constituted meeting, voting shall be by a simple majority of members present except in the case of termination or non-reappointment of medical staff membership or permanent suspension of clinical privileges, wherein two-thirds of members present shall be required.

(D) Credentialing committee of the hospitals of the Ohio state university:

(1) Composition:

The credentialing responsibilities of the medical staff are delegated to the credentialing committee of the hospitals of the Ohio state university, the composition of which shall include representation from the medical staff of each hospital.

The chief medical officer of the medical center shall appoint the credentialing committee of the hospitals of the Ohio state university. The director of medical affairs and medical director of credentialing shall make recommendation to the chief medical officer for representation on the credentialing committee of the hospitals of the Ohio state university.

The credentialing committee of the hospitals of the Ohio state university shall meet at the call of its chair, whom shall be appointed by the chief medical officer of the medical center.

(2) Duties:

(a) To review all applications for medical staff and licensed allied health professional appointment and reappointment, as well as all requests for delineation, renewal, or amendment of clinical privileges in the manner provided in these medical staff

bylaws, including applicable time limits. During its evaluation, the credentialing committee of the hospitals of the Ohio state university will take into consideration the appropriateness of the setting where the requested privileges are to be conducted;

(b) To review ~~biennially~~ triennially all applications for reappointment or renewal of clinical privileges;

(c) To review all requests for changes in medical staff membership;

(d) To assure, through the chairperson of the committee, that all records of peer review activity taken by the committee, including committee minutes, are maintained in the strictest of confidence in accordance with the laws of the state of Ohio. The committee may conduct investigations and interview applicants as needed to discharge its duties. The committee may refer issues and receive issues as appropriate from other medical staff committees;

(e) To make recommendations to the medical staff administrative committee through the medical director of credentialing regarding appointment applications and initial requests for clinical privileges. Such recommendations shall include the name, status, department (division and/or department), medical school and year of graduation, residency and fellowships, medical-related employment since graduation, board certification and recertification, licensure status as well as all other relevant information concerning the applicant's current competence, experience, qualifications, and ability to perform the clinical privileges requested;

(f) To recommend to the medical staff administrative committee that certain applications for appointment be reviewed in executive session;

(g) The committee, after review and investigation, may make recommendations to the director of medical affairs, chief of staff, or the chief of a clinical department, regarding the restriction or limitation of any medical staff member's clinical privileges, noncompliance with the credentialing process, or any other matter related to its responsibilities;

(h) To review requests made for clinical privileges by other licensed allied health professionals as set forth in this chapter.

(i) To recommend eligibility criteria for the granting of medical staff membership and privileges.

(j) To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities.

(k) To review, and where appropriate take action on, reports that are referred to it from other medical staff committees and medical staff members.

(l) To perform such other functions as requested by the medical staff administrative committee, quality and professional affairs committee or Wexner medical center board.

(3) Licensed health care professionals subcommittee:

(a) This subcommittee shall consist of other licensed health care professionals who have been appointed in accordance with paragraph (A)(3) of rule 3335-111-09 of the Administrative Code. This subcommittee shall be chaired by a director of nursing.

(b) Duties:

(i) To review, within thirty days of receipt, all completed applications as may be referred by the credentialing committee of the hospitals of the Ohio state university;

(ii) To review and investigate the character, qualifications and professional competence of the applicant;

(iii) To review the applicant's patient care quality indicator definitions on initial granting of clinical privileges and the performance based profile at the time of renewal;

(iv) To verify the accuracy of the information contained in the application; and

(v) To forward, following review of the application, a written recommendation for clinical privileges to the credentialing committee of the hospitals of the Ohio state university for review at its next regularly scheduled meeting.

(vi) To develop relevant policies and procedures regarding the scope of service and scope of practice to be granted to each licensed allied health care professional specialty. These policies and procedures shall be ratified by the credentialing committee, and medical staff administrative committee and be approved by the Wexner medical center board.

(E) Medical staff bylaws committee:

(1) Composition.

The committee shall be composed of at least four members of the attending staff pursuant to paragraph (A)(3) of rule 3335-111-09 of the Administrative Code. The chairperson shall always be the chief of staff-elect.

(2) Duties.

To review and recommend amendments to the medical staff administrative committee as necessary to maintain bylaws that reflect the structure and functions of the medical staff but not less than every two years. This committee will recommend changes to the medical staff administrative committee.

(F) Committee for practitioner health.

(1) Composition:

The committee shall consist of medical staff members appointed in accordance with paragraph (A)(3) of rule 3335-111-09 of the Administrative Code.

(2) Duties:

(a) To consider issues of licensed ~~independent~~ practitioner health or impairment whenever a self-referral or referral is requested by an affected member or another member or committee of the medical staff, CHRI hospital staff, or any other individual.

(b) To provide appropriate counsel, referral, and monitoring until the rehabilitation is complete and periodically thereafter, if required, to enable the medical staff member to obtain appropriate diagnosis and treatment, and to provide appropriate standards of care.

(c) To consult regularly with the chief of staff, medical director of credentialing and director of medical affairs of the CHRI.

(d) To advise credentials and/or other appropriate medical staff committees on the credibility of a complaint, allegation or concern, including those affecting the quality and safety of patient care.

(e) It will be the responsibility of the chairperson of the committee to assure that all proceedings and records, including the identity of the person referring the case, are handled and maintained in the strictest of confidence in accordance with the laws of the state of Ohio.

(f) To educate CHRI hospital and the medical staff about illness and impairment recognition issues, including at risk criteria specific to licensed ~~independent~~ practitioners.

~~(f)~~

(G) Cancer subcommittee:

(1) Composition:

Required to be included as members of the cancer subcommittee are physician representatives from surgery, medical oncology, radiology, radiation oncology, anesthesia, plastic surgery, urology, otolaryngology/head and neck, hematology, gynecologic oncology, thoracic surgery, orthopaedic oncology, neurological oncology, emergency medicine, palliative medicine and pathology, the cancer liaison physician and non-physician representatives from the cancer registry, administration, nursing, social services, and quality assurance. Other disciplines should be included as appropriate for the institution. The chairperson is appointed at the recommendation of the chief executive officer of the CHRI and the director of medical affairs, subject to the approval of the medical staff administrative committee and subject to review and renewal on a yearly basis.

(2) Duties:

(a) Develop and evaluate the annual goals and objectives for the clinical, educational, and programmatic activities related to cancer.

(b) Promote a coordinated, multidisciplinary approach to patient management.

(c) Ensure that educational and consultative cancer conferences cover all major site and related issues.

(d) Ensure that an active supportive care system is in place for patients, families, and staff.

(e) Monitor quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes.

(f) Promote clinical research.

(g) Supervise the cancer registry and ensure accurate and timely abstracting, staging, and follow-up reporting.

(h) Perform quality control of registry data.

(i) Encourage data usage and regular reporting.

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(j) Ensure content of the annual report meets requirements.

(k) Publishes the annual report by November first of the following year.

(l) Upholds medical ethical standards.

(m) Serve as cancer committee for commission on cancer program of the American college of surgeons.

(3) Meetings:

(a) The subcommittee shall meet in collaboration with the medical staff administrative committee as a policy-advisory and administrative body with documentation of activities and specialties in attendance.

(b) Any member anticipating an absence from the meeting should designate a representative to attend in their place.

(H) Ethics committee.

(1) Composition.

The committee is a joint committee and shall consist of members of the medical staff, nursing, hospital administration, and other persons representing both the CHRI and UH who, by reason of training, vocation, or interest, may make a contribution. Appointments will be made as provided by in this chapter. The chairperson shall be a physician who is a clinically active member of the medical staff of UH or the CHRI.

(2) Duties

(a) To make recommendations for the review and development of guidelines or policies regarding ethical issues.

(b) To provide ethical guidelines and information in response to requests from members of the medical staff, patients, patient's family or other representative, and staff members of the CHRI.

(c) To provide a support mechanism for primary decision makers at the CHRI.

(d) To provide educational resources on ethics to all health care providers at the CHRI.

(e) To provide and enhance interaction between CHRI administration and staff, departmental ethics committees, pastoral care services, and members of the medical staff.

(I) Practitioner evaluation committee.

(1) Composition.

This multi-disciplinary peer review committee is composed of clinically-active practitioners. If additional expertise is needed, the practitioner evaluation committee may request the assistance from any medical staff member or recommend to the director of medical affairs an external review.

(2) Duties:

(a) To meet regularly and keep minutes, which describe issues, opportunities to improve patient care, recommendations and actions to the chief quality officer, unless delegated to the medical director of quality and the chair of the clinical department, responsible parties, and expected completion dates. The minutes are maintained in the quality and patient safety office.

(b) To ensure that ongoing and systematic monitoring, evaluation and process improvement is performed in each clinical department.

(c) To develop and utilize objective criteria in practitioner peer review activities.

(d) To ensure that the medical staff peer review process is effective.

(e) To maintain confidentiality of its proceedings. These issues are not to be handled outside of the practitioner evaluation committee by any individual, clinical department, division, or committee.

(J) Professionalism consultation committee.

(1) Composition.

This multi-disciplinary peer review committee is composed of clinically-active practitioners and other individuals with expertise in professionalism.

(2) Duties.

(a) Receive and review validity of complaints regarding concerns about professionalism of credentialed practitioners;

(b) Treat, counsel and coach practitioners in a firm, fair and equitable manner;

(c) Maintain confidentiality of the individual who files a report unless the person who submitted the report authorizes disclosure or disclosure is necessary to fulfill the institution's legal responsibility;

(d) Ensure that all activities be treated as confidential and protected under applicable peer review and quality improvement standards in the Ohio Revised Code;

(e) Forward all recommendations to the clinical department chief, director of medical affairs or his/her designee and, if applicable, to the chief nursing officer.

(Board approval dates: 9/1/1993, 3/3/1995, 12/6/1996, 9/1/1999, 10/1/1999, 12/3/1999, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 7/7/2006, 2/6/2009, 9/18/2009, 5/14/2010, 2/11/2011, 4/8/2011, 8/31/2012, 2/1/2013, 11/7/2014, 11/6/2015, 9/2/2016, 4/6/2018, 5/18/2021)

**3335-111-11 History and physical**.

(A) History and physical examination.

(1) A history and physical appropriate to the patient and/or the procedure to be completed shall be documented in the medical record of all patients either:

(a) Admitted to the hospital

(b) Undergoing outpatient/ambulatory procedures

(b) Undergoing outpatient/ambulatory surgery

(d) In a hospital-based ambulatory clinic

(2) For patients admitted to the hospital, the history and physical examination shall include at a minimum:

(a) Date of admission

(b) Chief complaint and/or indication for procedure

(c) History of present illness

(d) Past medical and surgical history

(e) Relevant past social and family history

(f) Medications and allergies

(g) Review of systems

(h) Physical examinations

(i) Test results

(j) Assessment or impression

(k) Plan of care

(3) For patients undergoing outpatient/ambulatory procedures or outpatients/ambulatory surgery, the history and physical examination shall include at a minimum:

(a) Indication for procedure/surgery

(b) Relevant medical or surgical history

(c) Medications and allergies or reference to current listing in the electronic medical record

(d) Focused review of systems, as appropriate

(e) Pre-procedure assessment and physical examination

(f) Assessment/impression and treatment plan

(4) For patients seen in a hospital-based ambulatory clinic, the history and physical shall include at a minimum:

(a) Chief complaint

(b) History of present illness

(c) Medications and allergies

(d) Problem-focused physical examination

(e) Assessment or impression

(f) Plan of care

(B) Deadlines and sanctions

(1) A history and physical examination must be performed by a member of the medical staff, his/her designee or other licensed healthcare professional, who is appropriately credentialed by the hospital, and be signed, dated and timed.

(2) Patients admitted to the hospital: If the history and physical is performed by the medical staff member's designee or other licensed healthcare professional who is appropriately credentialed by the hospital, the history and physical must be countersigned by the responsible medical staff member.

(3) The complete history and physical examination shall be dictated, written or updated no later than twenty-four hours after admission for all inpatients.

(4) Admitted patients or patients undergoing a procedure or surgery, the history and physical examination may be performed or updated up to thirty days prior to admission, or the procedure/surgery. If completed before admission or the procedure, there must be a notation documenting an examination for any changes in the patient's condition since the history and physical was completed. The updated examination must be completed and documented in the patient's medical record within twenty-four hours after admission, or before the procedure/surgery, whichever occurs first. It must be performed by a member of the medical staff, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital, and be signed, dated and timed. In the event the history and physical update is performed by the medical staff member's designee or other licensed health care professional who is appropriately credentialed by the hospital, it shall be countersigned, dated and timed by the responsible medical staff member.

(a) For patients undergoing an outpatient procedure or surgery, regardless of whether the treatment, procedure or surgery is high or low risk, a history and physical examination must be performed by a member of the medical staff, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital and must be signed or countersigned when required, timed and dated.

(b) If a licensed health care professional is appropriately credentialed by the hospital to perform a procedure or surgery independently, a history and physical performed by the licensed health care professional prior to the procedure or surgery is not required to be countersigned.

(5) Hospital-based ambulatory clinic: If a history and physical examination is performed by a licensed health care professional who is appropriately credentialed by the hospital to see patients independently, the history and physical is not required to be countersigned.

(6) When the history and physical examination including the results of indicated laboratory studies and x-rays is not recorded in the medical record before the times stated for a procedure or surgery, the procedure or surgery cannot proceed until the history and physical is signed or countersigned, when required, by the responsible medical staff member, and

indicated test results are entered into the medical record. In cases where such a delay would likely cause harm to the patient, this condition shall be entered into the medical record by the responsible medical staff member, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital, and the procedure or surgery may begin. When there is disagreement concerning the urgency of the procedure, it shall be adjudicated by the medical director or the medical director's designee.

(7) Ambulatory patients must have a history and physical at the initial visit.

(8) For psychology, psychiatric and substance abuse ambulatory sites, if no other acute or medical condition is present on the initial visit, a history and physical examination may be performed either:

(a) Within the past six months prior to the initial visit,

(b) At the initial visit, or

(c) Within thirty days following the initial visit.

(Board approval dates: 5/14/2010, 6/6/2014, 11/7/2014, 11/6/2015)

**3335-111-12 Amendments and adoption.**

(A) Medical staff responsibility.

The medical staff bylaws committee shall have the initial responsibility to formulate, review at least biennially, and recommend to the quality and professional affairs committee of the Wexner medical center board any medical staff bylaws, rules, regulations, policies, procedures, and amendments as needed. Amendments to the bylaws shall be effective when approved by the university board of trustees. Amendments to the rules and regulations shall be effective when approved by the Wexner medical center board.

Such responsibility shall be exercised in good faith, in a timely manner and in accordance with applicable laws and regulatory standards. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these bylaws.

The organized medical staff shall also have the ability to propose amendments to the medical staff bylaws, rules and regulations and policies and procedures and propose them directly to the quality and professional affairs committee of the Wexner medical center board.

If the voting members of the organized medical staff propose to adopt amendments to the bylaws, rules and regulations or policies, they must first communicate the proposal to the medical staff administrative committee. When the medical staff administrative committee proposes to adopt amendments to the bylaws, rules and regulations or policies, it communicates the proposal to the organized medical staff.

Conflict between the organized medical staff and the medical staff administrative committee will be managed by allowing communication directly from the medical staff to the quality and professional affairs committee of the Wexner medical center board on issues including, but not limited to: amendments to the bylaws and the adoption of new rules and regulations or policies. Medical staff members may communicate with the quality and professional affairs committee of the Wexner medical center board by submitting their communication in writing to the chief of staff, who shall then

communicate on their behalf to the quality and professional affairs committee of the Wexner medical center board at its next regularly scheduled meeting for final determination.

In cases of urgent need to update the medical staff bylaws or rules and regulations in order to comply with law, statute, federal regulation, or accreditation standard, the medical staff administrative committee and the quality and professional affairs committee of the Wexner medical center board may provisionally approve an urgent amendment without prior notification to the medical staff. The medical staff shall be immediately notified by the medical staff administrative committee. The medical staff shall have the opportunity for review of and vote on the provisional amendment. If the medical staff votes in favor of the provisional amendment it shall stand. If there is conflict over the provisional amendment, process for resolving conflict between the organized medical staff and the medical staff administrative committee shall be implemented.

(B) Methods of adoption and amendment to these bylaws.

Proposed amendments to these bylaws may be originated by the medical staff bylaws committee, medical staff administrative committee or by a petition signed by twenty-five percent (25%) of attending medical staff members.

Each attending medical staff member will be eligible to vote on the proposed amendment via ~~printed or~~ secure ~~electronic~~ ballot in a manner determined by the medical staff administrative committee. All attending medical staff members shall receive at least ~~thirty~~ fourteen days advance notice of the changes to be adopted:

(1) The medical staff receives a simple majority of the votes cast by those members eligible to vote.

(2) Amendments so adopted shall be effective when approved by the university board of trustees.

(C) Methods of adoption and amendment to medical staff rules, regulations and policies.

The medical staff may adopt additional rules, regulations and policies as necessary to carry out its functions and meet its responsibilities under these bylaws.

Proposed amendments to the rules, regulations and policies may be originated by the medical staff bylaws committee or the medical staff administrative committee.

The medical staff administrative committee shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the medical staff administrative committee, rules and regulations may be adopted, amended or repealed, in whole or in part and such changes shall be effective when approved by the organized medical staff, and the Wexner medical center board. Policies and procedures will become effective upon approval of the medical staff administrative committee.

In addition to the process described above, the organized medical staff itself may recommend directly to the quality and professional affairs committee of the Wexner medical center board an amendment to any rules, regulation, or policy by submitting a petition signed by twenty-five per cent of the members of the attending medical staff category. Upon presentation of such petition, the adoption process outlined above will be followed.

(D) The medical staff administrative committee may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the committee's judgment, administrative, technical or legal modifications or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression. Such amendments need not be

approved by the entire Wexner medical center board but must be approved by the vice president of health services. Neither the organized medical staff nor the Wexner medical center board may unilaterally amend the medical staff bylaws or rules and regulations.

The medical staff bylaws, rules and regulations, Wexner medical center board bylaws, and relevant policies shall not conflict. The medical staff bylaws committee shall assure that there is no conflict.

(Board approval dates: 9/1/1993, 3/3/1995, 12/3/1999, 9/6/2002, 2/6/2004, 9/18/2009, 5/14/2010, 2/11/2011, 4/8/2011, 11/7/2014)

**3335-111-13 Meetings and dues.**

(A) Meetings.

The medical staff of the CHRI shall conduct scheduled meetings semi-annually. Notice of the meetings will be sent to all medical staff at least two weeks prior to the meeting. Attendance is encouraged, but shall not be a requirement for continued medical staff membership and clinical privileges. Special or electronic meetings may be called at the option of the medical staff administrative committee.

(B) Dues. The medical staff, by two-thirds vote of those in attendance at a regularly scheduled meeting, may establish dues. Payment of dues is a requirement for continued medical staff membership except honorary, clinical, and limited staff.

(Board approval date: 4/8/2011)

**3335-111-14 Rules of construction.**

(A) "Shall" as used herein is to be construed as mandatory.

(B) These bylaws should be construed to be gender neutral.

(Board approval dates: 9/1/1993, 12/6/1996, 9/1/1999, 9/6/2002, 5/14/2010, 4/8/2011)

**Approved:**
UH Bylaws Committee *5/31/23*
UH MSAC *6/14/23*
UH Medical Staff Vote *6/22/23*
Quality & Professional Affairs Committee
Wexner Medical Center Board
Ohio State University Board of Trustees

**University Hospital Rules & Regulations**
***Summary of proposed changes***

**84-14 Pharmacy and Therapeutics committee**

- Removes specific names of P&T subcommittees
- Adds language to permit P&T to establish subcommittees as needed

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

**84-14 Pharmacy and therapeutics committee**

The pharmacy and ~~t~~therapeutics ~~and drug utilization C~~ committee shall be appointed in conformity with these bylaws and have representation from medical staff, nursing, pharmacy department, and hospital administration. The majority of members shall be members of the medical staff. The committee shall meet at least quarterly and carry out the following duties:

(A) Review the appropriateness, safety, and effectiveness of the prophylactic, empiric, and therapeutic use of drugs, including antibiotics, through the analysis of individual or aggregate patterns of drug practice.

(B) Provide the medical and hospitals staff with information and advice concerning the proper use of drugs and related products. Monitor and evaluate those drugs which are most prescribed, known to present problems or risks to patients, and which constitute a critical part of a patient's specific diagnosis, condition or procedure.

(C) Consider the welfare of patients as well as education, research and economic factors when analyzing the utilization of drugs and related products.

(D) Advise on the use and control of experimental drugs.

(E) Develop or approve policies and procedures relating to the selection, distribution, use, handling, and administration of drugs and diagnostic testing materials.

(F) Review all significant untoward drug reactions.

(G) Maintain the Formulary of Accepted Drugs with review of proposed additions and deletions and review of use of non-formulary drugs within the institution.

(H) Maintain written reports of conclusions, recommendations, actions taken, and the results of actions taken, and report these at least quarterly to the medical staff administrative committee.

(I) Create sub-committees with defined responsibilities and scope and appoint members with expertise in specified areas.~~, as follows: pharmacy and therapeutic and drug utilization executive sub-committee; formulary sub-committee; antibiotic usage sub-committee; medication safety and policy sub-committee; hematology-oncology subcommittee;, antithrombotic, thrombosis, and & hemostasis subcommittee; glycemic management subcommittee, and the therapeutic drug monitoring sub-committeeopioid and & analgesic subcommittee~~.

(J~~) The therapeutic drug utilization monitoring sub-committee shall:~~

~~1. Establish methods by which serum blood levels may be used to improve the therapeutic activity of drugs.~~

~~2. Establish programs to educate health care providers to the appropriate methods of monitoring the therapeutic effect in drugs via serum drug assays.~~

~~3. Provide guidance to the therapeutic drug monitoring service at university hospitals.~~

~~4. Recommend the development of policies and procedures to the pharmacy and therapeutic and drug utilization executive sub-committee.~~

(Board approval dates: 4/7/2000, 9/6/2002, 4/6/2016)

**James Medical Staff Rules and Regulations**
*Redline Summary*
*5.31.23*

## James Rules & Regulations

### 11 Committees

Pharmacy and therapeutics committee (p. 14)

- Removes specific names of P&T subcommittees
- Adds language to permit P&T to establish subcommittees as needed

**Quality Leadership Council**

(B) Clinical Quality and Patient Safety Committee (p.16)

- Name changed from Clinical Quality and Patient Safety Committee to "James Quality, Safety, and Experience Council" (Q-SEC).

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**MEDICAL STAFF RULES AND REGULATIONS**
**Arthur G. James Cancer Hospital and Richard J. Solove Research Institute**
**as of February 8, 2022**

**01 Ethical pledge.**

(A) Each member of the medical staff and health care providers with clinical privileges shall pledge adherence to standard medical ethics, including:

(1) Refraining from fee splitting or other inducements relating to patient referral;

(2) Providing for continuity of patient care;

(3) Refraining from delegating the responsibility for diagnosis or care of hospitalized patients to a medical or dental practitioner or other licensed healthcare professional who is not qualified to undertake this responsibility or who is not adequately supervised;

(4) Seeking consultation whenever necessary; and

(5) Never substituting physicians without the patient's knowledge or appropriate consent.

(Board approval dates: 7/7/2006, 8/31/2012, 4/6/2016)

**02 Admission procedures.**

(A) Except in an emergency, in the interest of assignment to the appropriate service, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated by the patient's attending physician a member of the attending staff, limited staff member or other licensed healthcare professional who is appropriately credentialed by the hospital and under the supervision of the responsible medical staff member. The request for admission shall also include the following information:

(1) Any facts essential for the protection of the general hospital population against unnecessary exposure to infectious and other communicable diseases.

(2) Any information which will warn responsible hospital personnel of any tendency of any patient to commit suicide or to injure others because of mental disturbance.

(3) Any information concerning physical condition or personality idiosyncrasy which might be objectionable to other patients who might be occupying the same or adjoining rooms.

(B) It shall be the responsibility of the attending physician to notify hospital or medical staff personnel of the existence of mental or substance disorders and to order such precautionary measures as may be necessary to assure protection of the patient and the protection of others whenever a patient might be a source of danger. The attending physician is responsible to provide a comprehensive plan of care, including emergency care.

(Board approval dates: 9/18/2009, 4/6/2016)

**MEDICAL STAFF RULES AND REGULATIONS**
**Arthur G. James Cancer Hospital and Richard J. Solove Research Institute**
Updated February 8, 2022

**03 Attending assignment.**

(A) All patients entering the Arthur G. James cancer hospital and Richard J. Solove research institute (CHRI) who have not requested the services of a member of the medical staff to be responsible for their care and treatment while a patient therein shall be assigned to a member of the attending staff of the service concerned with the treatment of the disease, injury, or condition which necessitated the admission of the patient to the CHRI. This shall also apply to the transfer of patients within the services of the CHRI.

(B) Alternative attending medical staff member coverage.

Each division shall have a plan for medical coverage. Each member of the medical staff shall designate on his or her medical staff application one or more members of the attending or limited medical staff who have accepted this responsibility and who shall be called to attend his or her patients if the responsible attending medical staff member is not available, the director of medical affairs, section chiefs, department chair or his designee shall have authority to contact any member of the medical staff and arrange for coverage should the attending medical staff member and the alternate be unavailable.

(C) In the case of a medical or psychiatric emergency involving a patient, visitor or CHRI staff member in an inpatient or outpatient setting, any individual who is a member of the medical staff or who has been delineated privileges is permitted to do everything possible to save the life or prevent serious harm regardless of the individual's staff status or clinical privileges.

(Board approval dates: 11/4/2005, 2/11/2011, 4/6/2016)

**04 Consultations.**

(A) Consultation requirements.

When a patient care problem is identified that requires intervention during the hospital stay that is outside the medical staff member's area of training and experience, it is the responsibility of the medical staff member or his or her designee (with appropriate credentials) to obtain consultation by the appropriate specialist. The consultation may be ordered by the responsible medical practitioner, a member of the limited staff, or another licensed healthcare professional with appropriate clinical privileges as designated in these rules and regulations. If a consultation is ordered prior to 10:00 a.m., the consult shall occur on the same business day. If a consultation is ordered after 10:00 a.m., the consult shall occur within twenty-four hours. Each patient is continuously assessed and his or her plan for care if modified as necessary.

(B) Responsibility to monitor consultations.

It is the duty of the medical staff, through its clinical section chief and the medical staff administrative committee, to assure that members of the staff comply in the matter of requesting consultations as needed.

(C) Consultation contents.

A satisfactory consultation shall be rendered within one day of the request and shall include examination of the patient, examination of the medical record, and a written opinion signed by the consultant that is made a part of such record. If operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

(Board approval dates: 11/4/2005, 7/7/2006, 2/6/2009, 9/18/2009, 4/8/2011, 4/6/2016)

**MEDICAL STAFF RULES AND REGULATIONS**
**Arthur G. James Cancer Hospital and Richard J. Solove Research Institute**
Updated February 8, 2022

**05 Order writing privileges.**

(A) Definition of "patient orders".

(1) A patient order(s) is a prescription for care or treatment of patients. An order can be given verbally, electronically or in writing to qualified personnel identified by category in paragraph (C) of this rule and shall be authenticated by the licensed medical practitioner, a member of the limited staff, or another licensed healthcare professional with appropriate clinical privileges. Patient orders may be given initially, renewed, discontinued or cancelled. Throughout these rules and regulations, the word “written” and its grammatical derivatives, as used to describe a nonverbal order, refer to both written and electronically entered orders.

(2) Electronic orders are equivalent and have the same authority as written orders. Electronic orders have been expressly structured to mirror these rules and regulations and all policy guidelines adopted by the medical staff and hospital administration.

(B) Responsible medical practitioner.

All patient care is the responsibility of the attending, associate attending, clinical attending, or community associate attending staff. Coverage may be provided by the limited staff or another licensed healthcare professional with appropriate clinical privileges under supervision. The licensed physician, dentist, podiatrist, or psychologist (under medical doctor supervision) with appropriate clinical privileges responsible for the hospitalization or outpatient care, and treatment of the patient is responsible for all orders for the patient. Attending, associate attending and clinical medical staff may designate members of the limited staff, or other licensed healthcare professionals with appropriate clinical privileges to write or electronically enter orders under their direction. The attending staff member may also designate members of the pre-M.D. medical student group to write or electronically enter orders, but in all cases these orders shall be signed by the physician, dentist, psychologist, podiatrist, or designated limited staff member who has the right to practice medicine, dentistry, psychology, or podiatry and who is responsible for that patient's care prior to the execution of the order. Supervising physicians may delegate to a medical staff member (who is appropriately credentialed) the ability to relay, enter, transcribe or write orders for routine laboratory, radiologic and diagnostic studies under their direction, but, in all cases, the order shall be co-signed by the supervising physician within twenty-four hours of the order being written. Community associate staff coverage may be provided by the limited staff under supervision.

(C) Telephone and verbal orders may be given by the responsible attending physician, dentist, podiatrist, psychologist, member of the limited medical staff, or other licensed healthcare professionals with appropriate clinical privileges only to health care providers who have been approved in writing by title or category by the director of medical affairs and each chief of the clinical service where they will exercise clinical privileges, and only where said health care provider is exercising responsibilities which have been approved and delineated by job description for employees of the hospital, or by the customary medical staff credentialing process when the provider is not an employee of the hospital. Lists of the approved titles or categories of providers shall be maintained by the director of medical affairs. Verbal orders should be utilized infrequently. The individual giving the verbal or telephone order must verify the complete order by having the person receiving the information record and “read back” the complete order to assure the quality and safety of patient care. The job description or delineated privileges for each provider must indicate each provider’s authority to receive telephone or verbal orders, including but not limited to the authority to receive orders for medications. The order is to be recorded and authenticated by approved health care provider to whom it is given as “verbal order by _____,” or “V.O. or T.O. by _____,” giving the licensed healthcare practitioner’s name and the time of the order, followed by the approved health care provider’s signature and date, and read back in its entirety to the ordering physician, dentist, psychologist, podiatrist, designated limited staff member, or other licensed healthcare professionals with appropriate clinical privileges. All verbal orders for DEA schedule II controlled substances, patient seclusion, or patient restraint must be

authenticated within twenty-four hours by signature of a licensed physician, dentist, podiatrist, psychologist, or designated limited staff member or other licensed healthcare professionals with appropriate clinical privileges. Verbal orders for directives of urgent issues that cannot be addressed by the prescriber's order entry are encouraged to be signed electronically within forty-eight hours, but must be authenticated within twenty-one days by signature by a licensed physician, dentist, podiatrist, psychologist, limited staff member, or other licensed healthcare professionals with appropriate clinical privileges.

(D) Standing orders.

Standing orders for medications are only approved in emergency situations. All other standing orders must be developed, approved, used and monitored in strict compliance with the standing orders medical staff policy approved by the medical staff administrative committee and hospital administration.

(E) Preprinted orders.

Preprinted order forms for patients must be reviewed, dated, timed and signed by a responsible medical practitioner, a limited staff member, or other licensed healthcare professionals with appropriate clinical privileges before becoming effective.

(F) Investigational drug orders.

Evidence of informed patient consent must be available to a nurse or pharmacist before an investigational agent is ordered and administered. Investigational drugs may be ordered only upon authorization of the principal or co-investigator or other delegated physician, dentist, or podiatrist named in FDA forms 1572 or 1573. Registered nurses or pharmacists who are knowledgeable about the investigational agents may administer the drugs to patients.

(G) Change of nursing service.

Level of care is defined as the type and frequency of medical and nursing interventions required to appropriately manage the medical and nursing care requirements of the patient. "Change of level of care" means official and physical movement (transfer) of a patient from an inpatient or observation care unit providing one level of care to another providing a different level of care, with or without change in attending physician, dentist, psychologist or podiatrist or clinical service. Orders effective before transfer must be reviewed, renewed or rewritten upon transfer by signature of a responsible medical practitioner. The new or renewed orders may be written or electronically entered before or when the patient arrives on the receiving unit and may become effective immediately.

In each case of "change of nursing service," it is the responsibility of the receiving nurse to establish the availability of renewed or new written or electronically entered orders. Prior orders will remain in effect until new orders are available. This should be done within eight hours of transfer.

(H) "Transfer of clinical service" means transfer of full patient responsibility from one attending physician, dentist, psychologist or podiatrist to another; the patient may remain on the same unit or a change in patient care area may also occur. Admission of a patient from an emergency service to the hospital as an inpatient involves "transfer of clinical service."

For the purposes of order writing or electronically entering orders, two essentials of "transfer of clinical service" are necessary:

(1) The initial transfer order must indicate the release of responsibility and control of the patient, pending acceptance by the receiving service. The order may read "transfer (or admit) to Dr., head and neck service."

(2) Transfer of service may be completed only by the receiving service writing an order to the effect "accept in transfer (or admission) to Dr., head and neck service."

Orders effective before the transfer must be renewed or rewritten upon transfer by signature of a responsible medical practitioner, a limited staff member, or other licensed healthcare professionals with appropriate clinical privileges. The new or renewed orders may be written or electronically entered before or at the time of transfer, and may become effective immediately. It is the responsibility of the receiving nurse to establish the availability of new or renewed orders. If new orders are unavailable, then the nurse may continue previous orders and immediately notify the responsible medical practitioner, a limited staff member, or other licensed healthcare professionals with appropriate clinical privileges.

(I) Patient orders and the "covering" medical practitioner.

"Coverage" of patient responsibilities for another physician, dentist or podiatrist for a brief period of time does not constitute or require "transfer of clinical service" unless so desired and agreed upon by the physician, dentist, or podiatrist and patient.

(J) Hospital discharge/readmission orders.

Hospital discharge from standard inpatient units or day care unit to outpatient status requires appropriate discharge orders. Readmission to any inpatient unit requires new, rewritten/reentered or renewed orders by signature of the responsible medical practitioner, limited staff member, or other licensed healthcare professional with appropriate privileges and under the supervision of the responsible medical staff member.

(K) Do not resuscitate orders.

The order for do not resuscitate indicating that the patient should not undergo cardiopulmonary resuscitation may be written only by the attending physician or his delegate. Verbal orders for do not resuscitate will not be accepted under any circumstances. The order for do not resuscitate may be rescinded only by the attending physician or delegate and an order must be written to annul said order. Please refer to hospital policy 03-24 do not resuscitate orders for further details.

(L) Hospital admission/observation orders.

Hospital admission/observation requires an appropriate level of care (ALOC) order designating the patient as inpatient or outpatient (observation). The appropriate level of care (ALOC) order may be written a signed by the attending physician. If the ALOC order for inpatient admission is written by a member of the limited staff or other licensed healthcare practitioner with appropriate clinical privilege, it must be co-signed by the attending physician prior to the patient being discharged from the hospital. Admission to any inpatient unit or placing a patient in observation status requires new, rewritten/reentered or renewed orders by the responsible medical practitioner or limited staff member or other licensed healthcare professional with appropriate privileges and under the supervision of the responsible medical staff member.

(Board approval dates: 4/6/2016, 9/2/2016)

**06 Death procedures.**

(A) Every member of the medical staff shall be actively interested in securing necropsies in every death on their service. No autopsy shall be performed without written consent, permission, or direction as prescribed by the laws of Ohio.

(B) The death of a patient in the hospital within twenty-four hours of admission must be reported to the proper legal authorities under the laws of Ohio.

(C) When a necropsy is performed, provisional anatomic diagnosis should be recorded in the medical record within three days and the complete protocol should be made a part of the record within sixty days.

(D) Criteria for autopsy requests include the following:

(1) Coroner's cases when the coroner elects not to perform an autopsy. The county coroner has jurisdiction for performing an autopsy when death is the result of violence, casualty, or suicide, or occurs suddenly in a suspicious or unusual manner. Deaths occurring during surgery or within twenty-four hours of admission to the hospital are also coroner's cases, and the decision whether to autopsy is the coroner's responsibility. When the coroner elects not to perform an autopsy, a request of an autopsy shall be made pursuant to paragraph (A) of this rule.

(2) Unexpected or unexplained deaths, where apparently due to natural causes or due to those occurring during or following any surgical, medical, or dental diagnostic procedures or therapies.

(3) Undiagnosed infections disease where results may be of value in treating close contacts.

(4) All deaths in which the cause of death is not known with certainty on clinical grounds.

(5) Cases where there is question of disease related to occupational exposure.

(6) Organ donors (to rule out neoplastic or infectious disease).

(7) Cases in which autopsy may help to allay the concerns of the family or public regarding the death and to provide assurance to them regarding the same.

(8) Deaths in which autopsy may help to explain unknown or unanticipated medical complications to the attending.

(9) Deaths of patients who have participated in investigational therapy protocols.

(10) Deaths in which there is a need to enhance the education and knowledge of the medical staff and house staff. The attending practitioner shall be notified of the autopsies performed by the pathology department.

(E) When an autopsy is performed, provisional anatomic diagnosis should be recorded in the medical record within three days and the complete protocol should be made a part of the record within sixty days.

(Board approval dates: 11/4/2005, 4/6/2016)

**07 Emergency preparedness.**

(A) Emergency care.

Emergency care is considered to be treatment rendered to stabilize the patient prior to transport to the Ohio state university hospital's emergency department or other appropriate facility as the patient's condition dictates.

(B) Disaster preparedness.

In case of a civil, military, natural emergency or disaster, patients may be discharged from the CHRI, moved to other community hospitals, or moved to other facilities made available for the care and treatment of patients, by the order of the director of medical affairs of the CHRI or the director of medical affairs designated agent, to preserve life and health, to make room for more critically ill or injured patients sent to the hospitals from a disaster area or for the purpose of saving lives and to provide adequate medical care and treatment.

(Board approval dates: 11/4/2005, 2/6/2009, 4/6/2016)

**08 Surgical case review (tissue committees).**

Surgical case review shall be performed on an on-going basis by each department regularly doing surgical procedures in conjunction with the clinical quality management committee. The review shall include indications for surgery and all cases in which there is a major discrepancy between preoperative and postoperative (including pathologic) diagnoses. Discrepancies between the clinical impression and tissue removed during a surgical procedure are identified by pathology and then referred to the appropriate department for review. A screening mechanism based on predetermined criteria may be established for cases involving no specimens. Written records of the evaluations and any action taken shall be maintained in the quality and operations improvement department, and be available to the director of medical affairs, the CHRI section chief, department chairperson or their designees.

(Board approval dates: 11/4/2005, 4/6/2016)

**09 Tissue disposition.**

All tissue and foreign bodies removed during a surgical procedure shall be sent to the pathology laboratory for examination except for the following categories. These exceptions may be invoked by the attending surgeon only when the quality of care is not compromised by the exception when another suitable means of verification of the removal is routinely employed and when there is an authenticated operative or other official report that documents the removal. The categories of specimens that may be exempted from pathological examination are the following:

(A) Specimens that by their nature or condition do not permit fruitful examination, such as cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure;

(B) Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements;

(C) Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary;

(D) Foreign bodies (for example bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives.

(E) Specimens known to rarely if ever show pathological change, and removal of which is highly visible postoperatively.

(F) Teeth, provided the number including fragments is recorded in the medical record.

(G) Specimens for gross only examination.

(H) Medical devices. Soft tissue accompanying medical devices may be submitted for microscopic examination if deemed appropriate by the pathologist.

(I) Foreign bodies that are hard and cannot be decalcified. Accompanying soft tissue may be submitted for microscopic examination if deemed appropriate by the pathologist.

(J) Portions of bone removed from feet for bunions/hammer toes, if microscopic exam deemed unnecessary by pathology.

(K) Portions of rib removed for operative exposure only and not designated "disposal only." At the pathologist's discretion, marrow samples from such ribs may be submitted for microscopic examination.

(L) Nasal bone and cartilage removed for deviated septum (does not apply if deviation due to neoplastic or inflammatory process). If soft tissue accompanies nasal bone and cartilage, it may be examined at pathologist's discretion.

(Board approval dates: 11/4/2005, 4/6/2016)

**10 Medical records.**

(A) Each member of the medical staff shall conform to the following medical information management department policies:

(1) Medical record contents.

(a) The attending physician is ultimately responsible for the preparation of a complete medical record for each patient. The medical record may contain information collected and maintained by members of the medical staff, limited staff, other licensed healthcare professionals, medical students or providers who participate in the care of the patient. This record shall including the following elements as it applies to the patient encounter:

(i) Identification demographic data including the patient’s race and ethnicity.

(ii) The patient’s language and communication needs.

(iii) Emergency care provided to the patient prior to arrival, if any.

(iv) The legal status of patients receiving mental health services.

(v) Evidence of known advance directives.

(vi) Statement of present complaint.

(vii) History and physical examination.

(viii) Any patient generated information.

(ix) Provisional diagnosis.

(x) Documentation of informed consent when required.

(xi) Any and all orders related to the patient’s care.

(xii) Special reports, as those from:

(a) The clinical laboratory, including examination of tissues and autopsy findings, when applicable.

(b) Signed and dated reports of nuclear medicine interpretations, consultations, and procedures.

(c) The radiology department.

(d) Consultants as verified by the attending medical staff member's signature.

(xiii) Medical and surgical treatments.

(xiv) Progress notes.

(xv) Pre-sedation or pre-anesthesia assessment and plans of care for patients receiving anesthesia.

(xvi) An intra-operative anesthesia record.

(xvii) Postoperative documentation records, the patient's vital signs and level of consciousness; medications, including IV fluids, blood and blood components; any unusual events or postoperative complications; and management of such events.

(xviii) Postoperative documentation of the patient's discharge from the post-sedation or post-anesthesia care area by the responsible licensed independent practitioner or according to discharge criteria.

(xix) A post anesthesia follow-up report written within forty-eight hours after surgery by the individual who administers the anesthesia.

(xx) All reassessments and any revisions of the treatment plan.

(xxi) Every dose of medication administered and any adverse drug reaction.

(xxii) Every medication dispensed to an inpatient at discharge.

(xxiii) Summary and final diagnosis as verified by the attending physician's signature.

(xxiv) Discharge disposition, condition of patient at discharge, instructions given at that time and the plan for follow up care.

(xxv) Any referrals and communications made to external or internal providers and to community agencies.

(xxvi) Any records of communication with the patient made by telephone or email or patient electronic portal.

(xxvii) Memorandum copy of the death certificate when applicable.

(2) Deadlines and sanctions.

(a) A procedure note shall be entered in the record by the responsible attending medical staff member or the medical staff member's designee (who is appropriately credentialed) immediately upon completion of an invasive procedure. Procedure notes must be written for any surgical or medical procedures, irrespective of their repetitive nature, which involve material risk to the patient. Notes for procedures performed in the operating rooms must be finalized in the operating room information system by the attending surgeon. For any formal operative procedures, a note shall include pre-operative and post-operative diagnoses, procedure(s) performed and description of each procedure, surgeon(s), resident(s), anesthesiologist(s), surgical service, type of anesthesia (general or local), complications, estimated blood loss, any pertinent information not included on the O.R./anesthesia record, preliminary surgical findings, and specimens removed and disposition of each specimen. Where a formal operative procedure report is appropriate, the report must be completed immediately following the procedure. The operative/procedure report must be signed by the attending medical staff member. Any operative/procedure report not completed or any procedure note for procedures completed in the operating rooms not completed in the operating room information system by 10:00 a.m. the day following the procedure shall be deemed delinquent and the attending medical staff member responsible shall lose operating/procedure room and medical staff privileges the following day. The operating rooms and procedure rooms will not cancel cases scheduled before the suspension occurred. Effective with the suspension, the attending medical staff member will lose all privileges to schedule elective cases. Affected medical staff members shall receive telephone calls from the medical information management department indicating the delinquent operative/procedure reports.

(b) Progress notes must provide a pertinent chronological report of the patient's course in the hospital and reflect any change in condition or results of treatment. A progress note must be completed by the attending medical staff member or his or her designated member of the limited medical staff or practitioner with appropriate privileges at least once every day. Each medical student or other licensed health care professional progress note in the medical records should be signed or counter-signed by a member of the attending, courtesy, or limited staff.

(c) Medical staff members with more than twenty-five verbal orders that remain unsigned greater than twenty-one days after the date of the order will be subject to corrective action including administrative suspension which may include suspension of admitting and operating room scheduling privileges until the orders are signed. Medical staff members shall be notified electronically prior to suspension for unsigned verbal orders.

(d) Birth certificates must be signed by the medical staff member who delivers the baby within one week of completion of the certificate. Fetal death certificates and death certificates must be signed and the cause of death must be recorded by the medical staff member with a permanent Ohio license within twenty-four hours of death.

(e) Office visit encounters shall be closed within ten days of the patient’s visit.

(f) All entries not previously defined must be signed within ten days of completion.

(g) Queries by clinical documentation specialists requesting clarification of a patient’s diagnoses and procedures will be resolved within five business days of confirmed notification of request.

(3) Discharges.

(a) Patients may not be discharged without a written or electronically entered discharge order from the appropriately credentialed, responsible medical staff member, a limited staff member or other licensed healthcare professional.

(b) At the time of discharge, the appropriately credentialed attending medical staff member, limited staff member, or other licensed healthcare professional is responsible for certifying the principal diagnosis, secondary diagnosis, the principal procedure, if any, and any other significant invasive procedures that were performed during the hospitalization. If a principal diagnosis has not yet been determined, then a "provisional" principal diagnosis should be used instead.

(c) The discharge summary must be available to any facility receiving the patient before the patient arrives at the facility. Similarly, the discharge summary must be available to the care provider before the patient arrives at any outpatient care visit subsequent to discharge. The discharge summary should be available within forty-eight hours of discharge for all patients. The discharge summary should be signed by the responsible attending medical staff member within forty-eight hours of availability.

(d) The discharge summaries must contain the following elements:

i. hospital course including reason for hospitalization and significant findings upon admission;

ii. principal and secondary diagnoses or provisional diagnosis;

iii. relevant diagnostic test results;

iv. procedures performed and care, treatment and services provided;

v. condition on discharge;

vi. medication list and medication instructions;

vii. plan for follow-up of tests and studies for which results are pending at discharge;

viii. coordination and planning for follow-up testing and physician appointments;

ix. plans for follow-up care and communication, and the instructions provided to the patient.

(e) All medical records must be completed by the attending medical staff member or, when applicable, the limited staff member or other licensed healthcare professional who is appropriately credentialed by the hospital, within twenty-one days of discharge of the patient.

(f) Attending medical staff members shall be notified prior to suspension for all incomplete records. After notification, attending medial staff members shall have their admitting and operative scheduling privileges suspended until all records are completed. Attending medical staff members shall receive electronic notification of delinquent records. If an attempt is made by the attending medical staff member, or the attending medical staff member’s designee, who is appropriately credentialed by

the hospital, when applicable, to complete the record, and the record is not available electronically for completion, the record shall not be counted against the attending medical staff member. Medical staff members who are suspended for a period of longer than one hundred twenty consecutive days are required to appear before the practitioner evaluation committee.

(g) Records which are incomplete greater than twenty-one days after discharge or the patient's visit are defined as delinquent.

(4) Confidentiality.

Access to medical records is limited to use in the treatment of patients, research, and teaching. All medical staff members are required to maintain the confidentiality of medical records. Improper use or disclosure of patient information is subject to disciplinary action.

(5) Ownership.

Medical records of hospital sponsored care are the property of the hospital and shall not be removed from the hospital's jurisdiction and safekeeping except in accordance with a court order, subpoena, or statute.

(6) Records storage, security, and accessibility.

All patient's records, pathological examinations, slides, radiological films, photographic records, cardiographic records, laboratory reports, statistical evaluations, etc., are the property of the CHRI and shall not be taken from the CHRI except on court order, subpoena or statute duly filed with the medical record administrator or the hospital administration. The hospital administration may, under certain conditions, arrange for copies or reproductions of the above records to be made. Such copies may be removed from the hospital after the medical record administrator or the proper administrative authority has received a written receipt thereof. In the case of readmission of the patient, all previous records or copies thereof shall be available for the use of the attending medical staff member.

In general, medical records shall be maintained by the hospital. Records on microfilms, paper, electronic tape recordings, magnetic media, optical disks, and such other acceptable storage techniques shall be used to maintain patient records for twenty-one years for minors and ten years for adults. In the case of readmission of the patient, all records or copies thereof from the past ten/twenty-one years shall be available for the use of the attending medical staff member or other health care providers.

(7) Informed consent documentation.

(a) Where informed consent is required for a special procedure (such as surgical operation), documentation that such consent has been obtained must be made in the hospital record prior to the initiation of the procedure.

(b) In the case of limb amputation, a limb disposition form, in duplicate, must be signed prior to the operation.

(8) Sterilization consent.

Prior to the performance of an operative procedure for the expressed purpose of sterilization of a (male or female) patient, the attending medical staff member shall be responsible for the completion of the legal forms provided by the hospital and signed by the patient. Patients who are enrolled in the Medicaid program must have their forms signed at least thirty days

prior to the procedure. Informed consent must also be obtained from one of the parents or the guardian of an unmarried minor.

(9) Criteria changes.

The medical information management department shall make recommendations for changes in the criteria for record completion with approval of the medical staff.

(10) Entries and authentication.

(a) Entries in the medical record can only be made by staff recommended by the medical information management department subject to the approval of the medical staff.

(b) All entries must be legible and complete and must be authenticated, dated and timed promptly by the person, identified by name and credentials, who is responsible for ordering, providing, or evaluating the service furnished.

(c) The electronic signature of medical record documents requires a signing password. At the time the password is issued, the individual is required to sign a statement that she/he will be the only person using the password. This statement will be maintained in the department responsible for the electronic signature.

(d) Signature stamps may not be used in the medical record.

(11) Abbreviations.

Abbreviations, acronyms and symbols appearing on the non-approved abbreviations list may not be used in the medical record.

(Board approval dates: 9/18/2009, 4/8/2011, 8/31/2012, 4/6/2016, 9/2/2016, 4/6/2018, 5/31/2019, 2/8/2022)

**11 Committees.**

In addition to the medical staff committees, the medical staff shall participate in the following hospital and monitoring functions: infection control, clinical quality management, safety, and disaster planning and in other quality leadership council policy groups.

Operating Room Committee

(A) The operating room committee shall have representation from all clinical departments utilizing the operating room. Representation will include: medical director of the CHRI operating room, the section or division chief, or their designee, of: surgery, gynecologic oncology, urology, otolaryngology, radiation oncology, thoracic surgery, surgical oncology, neurological surgery, orthopedic surgery, anesthesia, and plastic surgery; epidemiology/infection control, the medical director of perioperative services for the Ohio state university, the CHRI medical director of quality, the director of perioperative services of the CHRI operating room, the manager of perioperative services, the director of admitting, the operating room coordinator, and the CHRI director of operations. The committee chair will be a CHRI surgeon selected by the nominating committee and shall serve a two-year term beginning on the first of July. The committee shall meet monthly and carry out the following duties:

(1) Develop written policies and procedures concerning the scope and provision of care in the surgical suite in cooperation with the departments and services concerned, including allocation of operating room resources. Allocation of operating room time will be done by the director of medical affairs and approved by the operating room committee.

(2) Monitor quality concerns and consider problems and improvements in operating room functions brought to its attention by any of its members.

(3) Monitor medical staff compliance with operating room policies established for patient safety, infection control, access and throughput, and smooth functioning of the operating rooms.

(4) Maintain written records of actions taken, and results of those actions, and make these available to each committee member, the vice president of health services, the director of medical affairs, and the executive director of the CHRI.

(B) Each member of the medical staff shall conform to the policies established by the operating room committee, including the following:

A member of the surgical attending staff and a member of the anesthesiology staff shall be present in person for crucial periods of surgical procedures and anesthetization, shall be familiar with the progress of the procedure, and be immediately available at all times during the procedure.

Pharmacy and Therapeutics Committee (P & T Committee)

The P & T committee shall be appointed in conformity with the medical staff bylaws and have representation from medical staff, nursing, pharmacy department, and the hospital administration. The majority of members shall be members of the medical staff. The committee shall meet at least quarterly and carry out the following duties:

(A) Review the appropriateness, safety, and effectiveness of the prophylactic empiric and therapeutic use of drugs, including antibiotics, through the analysis of individual or aggregate patterns of drug practice.

(B) Consider the welfare of patients as well as education, research and economic factors when analyzing the utilization of drugs and related products.

(C) Advise on the use and control of experimental drugs.

(D) Develop or approve policies and procedures relating to the selection, distribution, use, handling, and administration of drugs and diagnostic testing materials.

(E) Review all significant untoward drug reactions.

(F) Maintain the Formulary of Accepted Drugs with review of proposed additions and deletions and review of use of non-formulary drugs within the institution.

(G) Maintain written reports of conclusions, recommendations, actions taken, and the results of actions taken, and report these at least quarterly to the medical staff administrative committee.

Create sub-committees with defined responsibilities and scope and appoint members with expertise in
(A) specified areas. ~~as follows: pharmacy and therapeutic and drug utilization executive sub-committee; formulatory sub-committee; antibiotic usage sub-committee; medication safety and policy sub-committee; and the therapeutic drug monitoring sub-committee.~~

~~(B) Establish methods by which serum blood levels may be used to improve the therapeutic activity of drugs.~~

~~(C) Establish programs to educate health care providers to the appropriate methods of monitoring the therapeutic effect in drugs via serum drug assays.~~

~~(D) Provide guidance to the therapeutic drug monitoring service at the CHRI.~~

~~(E) Recommend the development of policies and procedures to the pharmacy and therapeutic and drug utilization executive subcommittee.~~

Transfusion and Isoimmunization Committee

(A) The transfusion and isoimmunization committee has representation from physicians of the clinical departments frequently using blood products, nursing, transfusion service, and hospital administration. The majority of members shall be members of the medical staff. The committee shall meet at least quarterly and carry out the following duties:

(1) Evaluate the appropriateness of all transfusions, including the use of whole blood and blood components.

(2) Evaluate all confirmed or suspected transfusion reactions.

(3) Develop and recommend to the medical staff administrative committee policies and procedures relating to the distribution, use, handling, and administration of blood and blood components.

(4) Review the adequacy of transfusion services to meet the needs of patients.

(5) Review ordering practices for blood and blood products.

(6) Provide a liaison between the clinical departments, nursing services, hospital administration, and the transfusion service.

(7) Use clinically valid criteria for screening and more intensive evaluation of known or suspected problems in blood usage.

(8) Keep written records of meetings, conclusions, recommendations, and actions taken, and the results of actions taken, and make these available to each committee member and to the medical staff administrative committee.

(B) Each member of the medical staff shall conform to the policies established by the transfusion committee, including the following:

(1) All pregnant patients admitted for delivery or abortion shall be tested for Rh antigen.

(2) No medication may be added to blood or blood products.

Infection Control Committee

(A) The committee members shall be appointed and shall also include representation from nursing, environmental services, and hospital administration. The chairperson will be a physician with experience and/or training in infectious diseases and carry out the following duties.

(1) Oversee surveillance and institute any recommendations necessary for investigation, prevention, and containment of nosocomial and clinical infectious diseases of both patients and staff at all facilities operated by CHRI and subject to TJC standards.

(2) The chairperson of the committee and the hospital epidemiologist, in consultation with the director of medical affairs of the CHRI, will take necessary actions to prevent and control emerging spread or outbreaks of infections; isolate communicable and infectious patients as

indicated; and obtain all necessary cultures in emergent situations when the responsible medical staff member is unavailable.

Quality Leadership Council

The quality leadership council shall consist of members appointed pursuant to the university hospital's medical staff bylaws, and shall include the senior vice president for health sciences, the dean of the college of medicine and the chairperson of the professional affairs committee of the Wexner medical center board as ex officio members without a vote, and the director of medical affairs and chief of staff as voting members. The chief quality officer shall be the chairperson of the quality leadership council. The quality leadership council shall authorize policy groups to be formed to accomplish necessary hospital and medical staff functions on behalf of the CHRI and university hospitals.

CHRI representatives on the quality leadership council shall be appointed as provided in the CHRI bylaws.

(A) Duties include:

(1) To design and implement systems and initiatives to enhance clinical care and outcomes throughout the integrated health care delivery systems.

(2) To serve as the oversight council for the clinical quality management and patient safety plan.

(3) To establish goals and priorities for clinical quality, safety and service on an annual basis.

(B) ~~Clinical quality and patient safety committee.~~James Quality, Safety and Experience Council (Q-SEC).

(1) Composition.

The members shall include physicians from various clinical areas and support services, the director of clinical quality management policy group, and representation from nursing and hospitals administration. The chairperson of the policy group will be a physician.

(2) Duties.

(a) Coordinate the quality management related activities of the clinical sections or departments, the medical information management department, utilization review, infection control, pharmacy and therapeutics and drug utilization committee, transfusion and immunization, and other medical staff and hospital committees.

(b) Implement clinical improvement programs to achieve the goals of the CHRI quality management plan, as well as assure optimal compliance with accreditation standards and governmental regulations concerning performance improvement.

(c) Review, analyze, and evaluate on a continuing basis the performance of the medical staff and other health care providers; and advise the clinical section or department clinical quality sub-committees in defining, monitoring, and evaluating quality indicators of patient care and services.

(d) Serve as liaison between the CHRI and the Ohio peer review organizations through the chairperson of the policy group and the director of clinical quality.

(e) Make recommendations to the medical staff administrative committee on the establishment of and the adherence to standards of care designed to improve the quality of patient care delivered in the CHRI.

(f) Hear and determine issues concerning the quality of patient care rendered by members of the medical staff and hospitals staff, make appropriate recommendations and evaluate action plans when appropriate to the director of medical affairs, the chief of a clinical section or department, or hospitals administration.

(g) Appoint ad-hoc interdisciplinary teams to address hospital-wide quality management plan.

(h) Annually review and revise as necessary the hospital-wide clinical quality management plan.

(i) Report and coordinate with the quality leadership council all quality improvement initiatives.

(C) Clinical resource utilization policy group.

(1) Composition.

The members shall include physicians from various areas and support services, the director of clinical resource utilization policy group, and representation from nursing and hospitals administration. The chairperson of the policy group will be a physician.

(2) Duties.

(a) Promote the most efficient and effective use of hospital facilities and services by participating in the review process and continued stay reviews on all hospitalized patients.

(b) Formulate and maintain a written resource management review plan for hospitals consistent with applicable governmental regulations and accreditation requirements.

(c) Conduct resource management studies by clinical service or by disease entity as requested or in response to variation from benchmark data would indicate.

(d) Report and recommend to the quality leadership council changes in clinical practice patterns in compliance with applicable governmental regulations and accreditation requirements when the opportunity exists to improve the resource management.

(D) Clinical Practice Guideline Committee.

(1) Composition.

The members shall include physicians from various areas and support services, the director of the practice guidelines policy group, and representation from nursing and hospitals administration. The chairperson of the policy group will be a physician.

(2) Duties.

(a) Oversee the planning, development, approval, implementation and periodic review of evidence-based medicine resources (i.e. clinical practice guidelines, quick reference guides, clinical pathways, and clinical algorithms) for use within the CHRI. Planning should be based on the prioritization criteria approved by the leadership council and review should focus on incorporating recent medical practice, literature or developments. Annual review should be done in cooperation with members of the

medical staff with specialized knowledge in the field of medicine related to the guidelines.

(b) To report regularly to the quality leadership council for approval of all new and periodically reviewed evidence-based medicine resources for use within the CHRI.

(c) Oversee the development, approval and periodic review of the clinical elements of computerized ordersets and clinical rules to be used within the information system of the CHRI. Computerized ordersets and clinical rules related to specific practice guidelines should be forwarded to the quality leadership council for approval. All other computerized value enhancement for approval. All other computerized ordersets and clinical rules should be forwarded to the quality leadership council for information.

(d) To initiate and support research projects when appropriate in support of the objectives of the quality leadership council.

(e) Oversee ongoing education of the medical staff (including specifically limited staff) and other appropriate hospital staff on the fundamental concepts and value of evidence-based practice and outcomes measurement and its relation to quality improvement.

(f) Regularly report a summary of all actions to the quality leadership council.

(Board approval dates: 11/4/2005, 7/7/2006, 2/6/2009, 9/18/2009, 5/14/2010, 2/11/2011, 4/8/2011, 4/6/2016, 5/18/2021)

**12 Standards of practice.**

(A) Surgical schedules shall be reviewed by the attending surgeon prior to the day of surgery. Attending surgeons must notify the operating room prior to the first scheduled case that they are physically present in the hospital and immediately available to participate in the case. Attending surgeons may accomplish this by being physically present in the operating room or by calling the operating room to notify the staff of such immediate availability. The operating room must be informed of the attending surgeon's availability prior to anesthetizing the patient. The only exception is an emergency situation, where waiting might compromise the patient's safety.

(B) All medical staff members must abide by the quality and safety protocols that may be defined by the medical staff administrative committee and the Wexner medical center board.

(C) Inpatients must be seen daily by an attending physician, with no exceptions, to provide the opportunity of answering patient and family questions.

(Board approval dates: 4/8/2011, 4/6/2016)

**13 Mechanism for changing rules and regulations.**

(A) These rules and regulations may be amended pursuant to rule 3335-111-12 of the Administrative Code.

(B) Amendments so accepted shall become effective when approved by the Ohio state university Wexner medical center board.

(C) These rules and regulations shall not conflict with the rules and regulations of the board of trustees of the Ohio state university.

(D) Each member of the medical staff and those having delineated clinical privileges shall have access to an electronic copy of the rules and regulations upon finalization of the approved amendment changes.

(Board approval dates: 11/4/2005, 9/18/2009, 2/11/2011, 4/8/2011, 4/6/2016)

**14 Adoption of the rules and regulations.**

These rules and regulations shall be adopted by the medical staff administrative committee and forwarded for approval in successive order to the following: the professional affairs committee of the Wexner medical center board if it meets prior to the next scheduled Wexner medical center board meeting, and the Wexner medical center board.

(Board approval dates: 7/7/2006, 9/18/2009, 2/11/2011, 4/8/2011, 4/6/2016)

**15 Sanctions.**

Each member of the medical staff shall abide by policies approved by the medical staff administrative committee of the CHRI. Failure to abide may result in suspension of some or all hospital privileges.

(Board approval dates: 9/18/2009, 2/11/2011, 4/8/2011, 4/6/2016)

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Approvals:
MSAC- 05/10/2023
QPAC- 06/27/2023
Wexner Medical Center Board –

**TITLE: THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER (INCLUDING UNIVERSITY HOSPITAL, RICHARD M. ROSS HEART HOSPITAL, BRAIN AND SPINE HOSPITAL, DODD REHABILITATION HOSPITAL, HARDING HOSPITAL, AND EAST HOSPITAL) HOSPITAL PLAN FOR PROVIDING PATIENT CARE**

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

**OHIO STATE UNIVERSTY WEXNER MEDICAL CENTER (OSUWMC) MISSION, VISION AND VALUES**

**Mission Statement:**
To improve health in Ohio and across the world through innovations and transformation in research, education, patient care, and community engagement.

**Vision Statement:**
By pushing the boundaries of discovery and knowledge, we will solve significant health problems and deliver unparalleled care.

**Values:**
Inclusiveness, Determination, Empathy, Sincerity, Ownership and Innovation

The mission, vision and values statements, developed by our staff members, physicians, governing body members and administration team members, complements and reflects the unique role the hospitals fulfill within The Ohio State University.

**PHILOSOPHY OF PATIENT CARE SERVICES**

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

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

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

**THE HOSPITAL LEADERSHIP**

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

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

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

Other leadership responsibilities include:

a) Communication of the organization's mission, vision, goals, objectives and strategic plans across the organization;
b) Ensuring appropriate and competent direction, management and leadership of all services and/or departments;
c) Collaborating with community leaders and organizations to ensure services are designed to be appropriate for the scope and level of care required by the patients and communities served;
d) Supporting the patient's continuum of care by integrating systems and services to improve efficiencies and care from the patient's viewpoint and diversity, equity and inclusion;
e) Ensuring staffing resources are available to appropriately and effectively meet the needs of the patients served and to provide a comparable level of care to patients in all areas where patient care is provided;
f) Ensuring the provision of a uniform standard of patient care throughout the organization;
g) Providing appropriate job enrichment, employee development and continuing education opportunities which serve to promote retention of staff and to foster excellence in care delivery and support services;
h) Establishing standards of care that all patients can expect and which can be monitored through the hospital's quality assurance and performance improvement (QAPI) process;

i) Approving the organizational plan to prioritize areas for improvement, developing mechanisms to provide appropriate follow up actions and/or reprioritizing in response to untoward and unexpected events;
j) Implementing an effective and continuous program to improve patient safety;
k) Appointing appropriate committees, task forces, and other forums to ensure interdepartmental collaboration on issues of mutual concerns and requiring interdisciplinary input; and,
l) Supporting patient rights and ethical considerations.

**ROLE OF THE CHIEF NURSING OFFICER**

The Chief Nursing Officer is responsible for the practice of nursing by ensuring consistency in the standard of nursing practice across the clinical settings. The CNO supports and facilitates an interdisciplinary team approach to the overall delivery of care to patients, families, and the community. This includes creating an environment in which collaboration is valued and excellence in clinical care, education, and research is promoted and achieved. The CNO leads quality, safety, and innovation initiatives in partnership with the Hospital Executive Directors.

The CNO is responsible for developing and driving the nursing strategic plan to deliver excellent patient care. The role will include responsibility for nursing performance improvement, program management, business operations, budgets, resource utilization, financial stewardship and maintenance of the professional contract with the Ohio State University Nursing Organization. The CNO ensures the vision, strategic direction, and the advancement of the profession of nursing at OSUWMC.

**ROLE OF THE ASSOCIATE CHIEF NURSING OFFICER**

The Associate Chief Nursing Officer (ACNO) is a member of the Nursing Executive Leadership team. The ACNO works collaboratively with both the CNO and Executive Director of their business entities. The ACNO has the authority and responsibility for directing the activities related to the provision of nursing care in those departments defined as providing nursing care to patients.

The ACNO is responsible to plan, develop, implement, and oversee programs and projects designed to evaluate and improve clinical quality, safety, resource utilization and operations in all areas staffed by nurses. The role includes implementation of patient care services strategies to support efficiency, clinical effectiveness, clinical operations and quality improvement with interdisciplinary team members. The ACNO works with teams to develop projects, programs and implement system changes that promote care coordination across the health care continuum.

**FUNCTIONS OF NURSING LEADERSHIP**

The Chief Nursing Officer and ACNOs ensure the following functions are addressed:

a) Evaluating patient care programs, policies, and procedures describing how patients' nursing care needs are assessed, evaluated and met throughout the organization;
b) Developing and implementing the plan for the provision of patient care through evidence-based practice and nursing research;
c) Participating with leaders from the governing body, management, medical staff and clinical areas in organizational decision-making, strategic planning and in planning and conducting performance improvement activities throughout the organization;
d) Implementing an effective, ongoing program to assess, measure and improve the quality of nursing care delivered to patients; developing, approving, and implementing standards of nursing practice,

standards of patient care, and patient care policies and procedures that include current research/ literature findings that are evidence based;

e) Participating with organizational leaders to ensure that resources are allocated to provide a sufficient number of qualified nursing staff to provide patient care;

f) Ensuring that nursing services are available to patients on a continuous, timely basis.

**DEFINITION OF PATIENT SERVICES, PATIENT CARE AND PATIENT SUPPORT**

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

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

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

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

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

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

**SCOPE OF SERVICES / STAFFING PLANS**

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

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

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

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

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

**STANDARDS OF CARE**

Patients of the Hospitals can expect that:

1) Staff will do the correct procedures, treatments, interventions, and care following the policies, procedures, and protocols that have been established. Efficacy and appropriateness of procedures, treatment, interventions and care provided will be demonstrated based on patient assessments/reassessments, standard practice, and with respect for patient's rights and confidentiality.
2) Staff will provide a uniform standard of care and services throughout the organization.
3) Staff will design, implement and evaluate systems and services for care delivery (assessments, procedures, treatments, interventions) which are consistent with a personalized health care focus and which will be delivered:

a. With compassion, courtesy, respect and dignity for each individual without bias using a patient centered approach;
b. In a manner that best meets the individualized needs of the patient;
c. Coordinated through interdisciplinary collaboration, to ensure continuity and seamless delivery of care to the greatest extent possible; and,
d. In a manner that maximizes the efficient use of financial and human resources, streamlines processes, decentralizes services, enhances communication, supports technological advancements and maintains patient safety.

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

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

**STANDARDS OF COMPETENT PERFORMANCE/STAFF EDUCATION**

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

**CARE DELIVERY MODEL**

The care delivery model is guided by the following goals:

- The patient and family will experience the benefits of the AACN Synergy model for patient care. This model is driven by the core concept that the patient and family needs influence the competencies and characteristics of the nursing care provided. The benefits include enhanced quality of care, improved service, appropriate length of hospitalization and minimized cost.
- Hospital employees will demonstrate values and behaviors consistent with the OSUWMC Buckeye Spirit set of core values. The philosophical foundation reflects a culture of inclusiveness, sincerity, determination, ownership, empathy and innovation.
- Effective communication will impact patient care by ensuring timeliness of services, utilizing staff resources appropriately, and maximizing the patient's involvement in his/her own plan of care.
- Configuring departmental and physician services to accommodate the care needs of the patient in a timely manner will maximize quality of patient care and patient satisfaction.
- The Synergy professional nursing practice model is a framework which reflects our underlying philosophy and vision of providing care to patients based on their unique needs and characteristics. Aspects of the professional model support:

(1) matching nurses with specific skills to patients with specific needs to ensure "safe passage" to achieve the optimal outcome of their hospital stay;
(2) the ability of the nurse to establish and maintain a therapeutic relationship with their patients;
(3) the presence of an interdisciplinary team approach to patient care delivery. The knowledge and expertise of all caregivers is utilized to restore a patient to the optimal level of wellness based on the patient's definition;
(4) physicians, nurses, pharmacists, respiratory therapists, case managers, dietitians and many other disciplines collaborate and provide input to patient care.

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

**PATIENT RIGHTS AND ORGANIZATIONAL ETHICS**

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

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

- Services and capabilities offered meet identified patient and community needs and are fairly and accurately represented to the public.
- Adherence to a uniform standard of care throughout the organization, providing services only to those patients for whom we can safely care for within this organization. The Hospitals do not discriminate based age, ancestry, color, disability, gender identity or expression, genetic information, HIV/AIDS status, military status, national origin, race, religion, sex, gender, sexual orientation, pregnancy, protected veteran status or any other basis under the law.
- Patients will be billed only for care and services provided.

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

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

**INTEGRATION OF PATIENT CARE, ANCILLARY AND SUPPORT SERVICES**

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

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

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

**CONSULTATIONS AND REFERRALS FOR PATIENT SERVICES**

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

**INFORMATION MANAGEMENT PLAN**

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

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

**PATIENT CARE ORGANIZATIONAL IMPROVEMENT ACTIVITIES**

All departments are responsible for following the Hospitals' Quality Assurance and Performance Improvement (QAPI) plan. Departments utilize the QAPI plan and cascade the hospital's goals to service line quality plans to ensure proper alignment to support the overall hospital quality goals.

**PLAN REVIEW**

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

**Appendix A: Scope of Services: Patient Ancillary and Support Services**

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

| DEPARTMENT | SERVICE |
|---|---|
| BEHAVIORAL EMERGENCY RESPONSE TEAM (BERT) | Expert team that provides innovative and quality care to patients with complex behavioral symptoms while working collaboratively with staff through consultation, education, and early intervention |
| CARDIAC PROCEDURAL | Cardiac procedural areas include both cardiac catheterization and electrophysiology. Procedures may be diagnostic or interventional. |
| CARDIOVASCULAR IMAGING SERVICES | Diagnostic and therapeutic procedures in cardiac MR/CT, Nuclear Medicine, Echocardiography, Vascular Imaging Stress Test. Cardiovascular Imaging Services can be provided at inpatient, outpatient, and emergency locations. |
| CASE MANAGEMENT | As part of the health care team, provides personalized care coordination and resource management with patients and families. |
| CENTRAL STERILE SUPPLY (CSS) | Responsible for supporting all instrument cleaning and sterilization needs across the Health System. In addition, CSS is responsible for providing case carts to the operating rooms which contain all of the instrumentation and disposable supply needs for each surgical case. |
| CHAPLAINCY AND CLINICAL PASTORAL EDUCATION | Assists patients, their families and hospital personnel in meeting spiritual needs through professional pastoral and spiritual care and education. |
| CLINICAL ENGINEERING | Routine equipment evaluation, maintenance, and repair of electronic equipment owned or used by the hospital; evaluation of patient owned equipment. |
| CLINICAL INFORMATICS | A subset of IT services that focuses on appropriately integrating the clinical care provided to the patient into the Electronic Health Record (EHR) through the specialized knowledge of clinical care and informatics. Additionally, direct work with the clinicians occurs through this team to ensure the EHR is adopted and aligns with the clinical work occurring in the organization and provides an accurate depiction of the patients' clinical course while being cared for in the organization. |
| CLINICAL LABORATORY | Responsible for pre-analytic, analytic and post-analytic functions on clinical specimens in order to obtain information about the health of a patient as pertaining to the diagnosis, treatment, and prevention of disease; assisting care providers with clinical information related to patient care, education, and research. |
| COMMUNICATIONS AND MARKETING | Responsible for developing strategies and programs to promote the organization's overall image and specific products and services to targeted internal and external audiences. Handles all media relations, advertising, internal communications, special events and publications. |
| DECEDENT AFFAIRS | Provide support to families of patients who died & assist them with completing required disposition decisions. Ensure notification of the CMS designated Organ Procurement Agency (OPO) – Lifeline of Ohio (Lifeline). Promote & facilitate organ/eye/tissue donation by serving as the OSU hospital Lifeline Liaison. Analyze data provided by Lifeline regarding organ/tissue/eye donation. |
| DIAGNOSTIC TRANSPORTATION | Provision of on-site transportation services for patients requiring diagnostic, operative or other ancillary services. |
| DIALYSIS | Dialysis is provided for inpatients of the medical center within a dedicated unit unless the patient cannot be moved. In those instances, bedside dialysis will be administered. |

| DEPARTMENT | SERVICE |
|---|---|
| EARLY RESPONSE TEAM (ERT) | Provides timely diagnostic and therapeutic intervention before there is a cardiac or respiratory arrest or an unplanned transfer to the Intensive Care Unit. Consists of a Critical Care RN and Respiratory Therapist who are trained to help patient care staff when there are signs that a patient's health is declining. |
| EDUCATION, DEVELOPMENT & RESOURCES | Provides and promotes ongoing development and training experiences to all member of the OSUWMC community; provides staff enrichment programs, organizational development, leadership development, orientation and training, skills training, continuing education, competency assessment and development, literacy programs and student affiliations. |
| ENDOSCOPY | Provides services to patients requiring a nonsurgical review of their digestive tract. |
| ENVIRONMENTAL SERVICES | Provides routine housekeeping and quality monitoring of such. Additional services upon request: extermination, wall cleaning, etc. |
| EPIDEMIOLOGY | Enhance the quality of patient care and the work environment by minimizing the risk of acquiring infection within the hospital setting. |
| FACILITIES OPERATIONS | Provide oversight, maintenance and repair of the building's life safety, fire safety, and utility systems. Provide preventative, repair and routine maintenance in all areas of all buildings serving patients, guests, and staff. This would include items such as electrical, heating and ventilation, plumbing, and other such items. Also providing maintenance and repair to basic building components such as walls, floors, roofs, and building envelope. Additional services available upon request. |
| FISCAL SERVICES | Works with departments/units to prepare capital and operational budgets. Monitors and reports on financial performance monthly. |
| HUMAN RESOURCES | Serves as a liaison for managers regarding all Human Resources information and services; assists departments with restructuring efforts; provides proactive strategies for managing planned change within the Health System; assists with Employee/Labor Relations issues; assists with performance management process; develops compensation strategies; develops hiring strategies and coordinates process for placements; provides strategies to facilitate sensitivity to issues of cultural diversity; provides HR information to employees, and establishes equity for payroll. |
| INFORMATION SYSTEMS | Work as a team assisting departments to explore, deploy and integrate reliable, state of the art Information Systems technology solutions to manage change. |
| MATERIALS MANAGEMENT | Routinely stocks supplies in patient care areas, distributes linen. Sterile Central Supply, Storeroom - upon request, distributes supplies/equipment not stocked on units. |
| MEDICAL INFORMATION MANAGEMENT | Maintains patient records serving the needs of the patient, provider, institution, and various third parties to health care. |
| NUTRITION SERVICES | Provides nutrition care and food service for Medical Center patients, staff, students, and visitors. Clinical nutrition assessment, care plan development, and consultation are available in both inpatient and outpatient settings. The Department provides food service to inpatients and selected outpatient settings in addition to operating a variety of retail café locations and acts as a liaison for vending and sub-contracted food services providers. Serve as dietetic education preceptors. |
| PATIENT ACCESS SERVICES | Coordinates registration/admissions with nursing management. |
| PATIENT EXPERIENCE | Develops programs for support of patient relations and customer service, and includes front-line services such as information desks. |
| PATIENT FINANCIAL SERVICES | Provides financial assistance upon request from patient/family. Also responsible for posting payments from patients and insurance companies among others to a patient's bill for services. |

| DEPARTMENT | SERVICE |
|---|---|
| PATIENT FLOW DEPARTMENT | Monitors and supports all admissions, discharges, and transfers across OSUWMC. Ensures timely, safe, and individualized access to all patients and families through collaboration with the healthcare team. |
| PERIOPERATIVE SERVICES | Perioperative Services include preoperative, intraoperative and postoperative care. |
| PHARMACY | Provides comprehensive pharmaceutical care through operational and clinical services. Responsible for medication distribution via central and satellite pharmacies, as well as 797 compliant IV compounding room and automated dispensing cabinets. Some of the many clinical services include pharmacokinetic monitoring, renal and hepatic dose adjustments, and patient educational. Specialist pharmacists also round with patient care teams to optimize medication regimens and serve as the team's primary medication information resource. |
| QUALITY AND OPERATIONS IMPROVEMENT | Provides an integrated quality management program and facilitates continuous quality improvement efforts throughout the medical center. |
| RADIOLOGIC SERVICES | Diagnostic and therapeutic procedures in MR, CT, X-ray, Fluoroscopy, Interventional Radiology, Ultrasonography. Radiologic Services can be provided at inpatient, outpatient, and emergency locations. |
| RESPIRATORY THERAPY | Provide all types of respiratory therapeutic interventions and diagnostic testing, by physician order, mainly to critically ill adults and neonates, requiring some type of ventilator support, bronchodilator therapy, or pulmonary hygiene, due to chronic lung disease, multiple trauma, pneumonia, surgical intervention, or prematurity. Provides pulmonary function testing and diagnostic inpatient and outpatient testing to assess the functional status of the respiratory system. Bronchoscopy and other diagnostic/interventional pulmonology procedures are performed to diagnose and/or treat abnormalities that exist in the airways, lung parenchyma or pleural space. |
| REHABILITATION SERVICES | Physical therapists, occupational therapists, speech and language pathologists, and recreational therapists evaluate and develop a plan of care and provide treatment based on the physician's referral. The professional works with each patient/family/caregiver, along with the interdisciplinary medical team, to identify and provide the appropriate therapy/treatment and education needed for the established discharge plan and facilitates safe and timely movement through the continuum of care. |
| RISK MANAGEMENT | Protect resources of the hospital by performing the duties of loss prevention and claims management. Programs include: Risk Identification, Risk Analysis, Risk Control, Risk Financing, Claims Management and Medical-Legal Consultation. |
| SAFETY and EMERGENCY PREPAREDNESS | Manages programs related to general safety, life safety and emergency preparedness. Maintains compliance with regulatory agencies including, The Joint Commission, Centers for Medicare and Medicaid Services, Ohio Department of Health, State Fire Marshal, Environmental Protection Agency and other authorities having jurisdiction over hospital operations. |
| SECURITY | Provides a safe and secure environment for patients, visitors, and staff members by responding to all emergencies such as workplace violence, fires, bomb threats, visitor/staff/patient falls, Code Blues (cardiac arrests) in public places, internal and external disasters, armed aggressors, or any other incident that needs an emergency response. |
| SOCIAL WORK SERVICES | Social Work services are provided to patients/families to meet their medically related social and emotional needs as they impact on their medical condition, treatment, recovery and safe transition from one care environment to another. Social workers provide psychosocial assessment and intervention, crisis intervention, financial counseling, discharge planning, health education, provision of material resources |

| DEPARTMENT | SERVICE |
|---|---|
| | and linkage with community agencies. Consults can be requested by members of the treatment team, patients or family members. |
| VOLUNTEER SERVICES | Volunteer Services credential and place volunteers to fill departmental requests. Volunteers serve in wayfinding, host visitors in waiting areas, serve as patient / family advisors, and assist staff. |
| WOUND CARE | Wound Care includes diagnosis and management for skin impairments. |

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Approvals:
MSAC: 04/21/2023
QPAC: 06/27/2023
Wexner Medical Center Board:

**Title: Arthur G. James Cancer Hospital and Richard J.Solove Research Institute Plan for Patient Care Services**

The Plan for Providing Patient Care Services is described herein. The Plan is based on the mission, vision, values, and goals. The plan encompasses both inpatient and outpatient services delivered by the teams who provide comprehensive care, treatment, and services to patients with cancer diagnoses and their loved ones. The plan encompasses both inpatient and outpatient services of the hospital.

**The Mission, Vision, and Values:**

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

**Vision:** Create a cancer-free world, one person, and one discovery at a time.

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

At The James, no cancer is routine. Our researchers and oncologists study the unique genetic makeup of each patient's cancer, understand what drives it to develop, and then deliver the most advanced and targeted treatment for the individual patient. The James' patient centered, and relationship-based care is enhanced by our teaching and research programs. Our mission, and staff are dedicated to the fulfillment and success and distinguishes The Arthur G. James Cancer Hospital andRichard J. Solove Research Institute as one of the nation's premier comprehensive cancer centers.

**Philosophy of Patient Care Services**

The James Cancer Hospital and Solove Research Institute, in collaboration with the community, provides innovative and patient-focused multi-disciplinary cancer care through:

- Maintaining a mission which outlines the synergistic relationship between patient care, research, and teaching.
- Developing a long-range strategic plan with input from hospital leaders to determine the services and levels of care to be provided.

- Establishing annual goals and objectives consistent with the hospital mission and strategic plan, which are based on a collaborative assessment of patient/family and community needs.
- Planning and designing from the hospital leadership, involving the communities served.
- Providing individualized care, treatment, and services appropriate to the scope and level required by each patient based on professional assessments of need.
- Evaluating ongoing services provided through formalized processes such as: performance assessment and improvement activities, budgeting, and staffing plans.
- Integrating services through the following mechanisms: continuous quality improvement teams; clinical interdisciplinary quality programs; communications through management and operations meetings, Division of Nursing shared governance structure, Medical Staff Administrative Committee, administrative staff meetings, participation in Ohio State University Wexner Medical Center (OSUWMC) governance structures, special forums, leadership and employee education and professional/development.
- Maintaining competent patient care leadership and staff by providing education designed to meet identified needs.
- Respecting each patient's rights and their decisions as an essential component in theplanning and provision of care.
- Assuring every staff member demonstrates behaviors which reflect the philosophical foundation based on the values of The James Cancer Hospital and Solove Research Institute.

**Hospital Leadership**

The hospital leadership is defined as the governing Board of Trustees, the University President, Executive Vice President/Chief Executive Officer, administrative staff, faculty, physicians, nurses, clinical, and operational leaders in both appointed and elected positions. The hospital's leadership team is responsible for producing a framework to plan health care services which are to be provided by the organization, based on the hospital's mission and strategic planning. These responsibilities include developing and implementing a planning process that allows for defining timely and clear goals.

The planning process also includes an assessment of our customer and community needs. Thisprocess begins with:

- Developing a long-range strategic plan.
- Developing annual operational plans.
- Establishing annual operating and capital budgets, and monitoring compliance.

- Establishing resource allocations and policies.
- Ongoing evaluation of every plan's implementation and ongoing success.

The planning process addresses both patient care functions (patient: rights, assessment, care, safety, patient and family education, coordination of care,and discharge planning) and organizational support functions (information management, human resource management, infection control, quality, the environment of care, and the improvement of organization performance).

The hospital leadership team works collaboratively with all operational and clinical leaders to ensure integration of planning, evaluation, and communication processes within and between departments, to enhance patient care services and support. This occurs informally, daily, and formally, via multi-disciplinary leadership meetings. The leadership team works with each department manager to evaluate, plan, and recommend annual budget expenses and capital objectives, based on the expected resource needs of the department. Department leaders are accountable for managing, justifying their budgets and resource utilization. This includes, but is not limited to identifying, investigating, budgeting for modern technologies, and resources that are expected to improve the delivery of patient care and services.

Other leadership responsibilities include but are not limited to:

- Communicating the organization's mission, vision, goals, objectives, and strategic plans across the organization.
- Ensuring appropriate, competent management and leadership of all services and/or departments.
- Collaborating with community leaders and organizations to ensure services are designed to be appropriate for the scope and level of care required by the patients and communities served.
- Supporting the continuum of care by integrating systems and services to improve efficiencies and care from a patient's viewpoint.
- Ensuring staff resources are available and competent to effectively meet the needs of the patients and to provide a high level of care to patients in all clinical areas.
- Ensuring the provision of uniform standards of patient care are delivered throughout the continuum of care in accordance with each respective disciplines' approved standards of practice and organizational policy/procedure.
- Providing appropriate job enrichment, employee development, continuing education opportunities that serve to promote retention of staff and to foster excellence in care delivery and support services.
- Establishing standards of care for all patients, and which can be monitored through the hospital's performance assessment and improvement plan.
- Approving the organizational plan to prioritize areas for improvement, developing mechanisms to provide appropriate follow up actions and/or reprioritizing in response to unexpected events.

- Implementing an effective and continuous program to monitor and improve patient safety.
- Appointing appropriate committees, task forces, and other forums to ensure interdepartmental collaboration on issues of mutual concerns and requiring interdisciplinary input.
- Supporting patient rights and ethical considerations.
- Support of evidence-based practice (EBP) to drive patient care decision-making.

**Role of the Executive Director of Clinical Services, and the Chief Nursing Officer**

The Executive Director of Clinical Services, and the Chief Nursing Officer are members of the Executive Leadership Team who has the requisite authority and responsibility for directing activities related to the provision of care, treatment and services in those departments defined as providing care to patients.

The Executive Director of Clinical Services ensures the following functions are addressed:

- Evaluating patient care programs, policies, and procedures which describe how patients' care needs are assessed, evaluated, and met throughout the organization.
- Implementing the plan for the provision of patient care.
- Participating with leaders from the governing body, medical staff, and clinical areas in organizational decision-making. Strategic planning and conducting performance improvement activities through the organization.
- Implementing an effective, ongoing program to assess, measure and improve the quality of care and safe outcomes of care provided for patients.
- Participating with organizational leaders to ensure that resources are allocated to provide enough qualified and competent staff to provide patient care.
- Ensuring services are available to patients on a continuous, timely basis.
- Reviewing the plan for the providing patient care services on an annual basis.

The Chief Nursing Officer (CNO) ensures the following functions are addressed:

- Implementing standards of nursing practice, standards of patient care, patient care policies, and procedures that include current research and evidence-based practice.
- Supports and facilitates a multi-disciplinary team approach to the overall delivery of care to patients, families, and the community.
- Promotes relationship-based care (RBC), leads quality, safety, and innovation initiatives in partnership with the Executive Director of Clinical Services.
- Responsible for driving nursing strategic plan to deliver excellent patient care.
- Responsible for nursing performance improvement, program management,

business operations, budgets, resource, utilization, and maintenance of the professional contract with the Ohio State University Nursing Organization (OSUNO).

**Definition of Patient Services, Patient Care, Nursing Care, and Patient Support**

*Patient Services*
Defined as those departments and care providers with direct contact with patients. These services occur through organized and systematic through-put processes designed to ensure the delivery of appropriate, safe, effective, and timely care and treatment. The patient through-put process includes those activities designed to coordinate patient care before admission, during the admission process, in the hospital, in the ambulatory exam or treatment clinics before discharge and at discharge. This process includes:

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

*Patient Care:*
Encompasses the recognition of disease, health, and patient education, which allows the patient to participate in their care, advocacy, and spirituality. The full scope of patient care is provided by professionals who perform the functions of assessing, planning patient care based on information gathered from the assessment, as well as past medical history, social history, and other pertinent findings. Patient care and services are planned, coordinated, provided, delegated, and supervised by professional health care providers who recognize the unique physical, emotional, and spiritual (body, mind, and spirit) needs of each person. Under the auspices of the hospital medical staff, registered nurses, and allied health professionals function collaboratively as part of an interdisciplinary, patient-focused care team to achieve positive patient outcomes and personalized care.

Competency for staff resources is determined during the initial orientation period and at least annually through performance evaluations and other department specific assessment processes. Physicians direct all aspects of a patient's medical care as delineated through the clinical privileging process and in accordance with the Medical Staff By-Laws. Registered Nurses support the medical aspect of care by assessing, directing, coordinating, providing nursing care consistent with statutory requirements, according to the organization's approved Nursing Standards of Practice and hospital-wide policies and procedures. Allied health professionals provide patient care and services keeping within their licensure requirements and in collaboration with physicians and

registered nurses. Unlicensed staff may provide aspects of patient care or services at the direction of and under the supervision of licensed professionals.

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

*Patient Support:*
Provided by the rich resource of individuals and departments which may not have direct contact with patients, but which support the integration and continuity of care provided throughout the continuum of care by the direct care providers.

**Scope of Services and Staffing Plans**

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

- The type and age ranges of patients served.
- Methods used to assess and meet patient care needs (including services most frequently provided such as procedures, medication administration, surgery, etc.).
- The scope and complexity of patient care needs.
- The appropriateness, clinical necessity, and timeliness of support services provided directly or through referral contact.
- The extent to which the level of care or service meets patient needs, hours of operation if other than 24 hours a day/7days a week, and a method used to ensure hours of operation meet the needs of the patients to be served regarding availability and timeliness.
- The availability of necessary staff.
- Recognized standards or practice guidelines.

Staffing plans for patient care service departments are developed based on the level and scope of care provided, the frequency of the care to be provided, determination of the level and mix of staff that can most appropriately, competently, and confidently provide the type of care needed. Patient care units are staffed to accommodate a projected average

daily patient census based on historical data.

Unit management (including nurse manager, assistant nurse manager, charge nurse or the administrative nursing supervisor (ANS)) provide 24/7 on-site oversight and review the demand for patient care to plan for adequate staffing. Staffing can be increased or decreased to meet patient needs or changes in volume. When the census is high or the need is great, float/resource staff are available to assist in providing care.

Administrative leaders, in conjunction with budget and performance measurements, review staffing within all patient care areas and monitor ongoing regulatory requirements. Each department staffing plan is formally reviewed during the budget cycle and takes into consideration workload measures, utilization review, employee turnover, performance assessment, improvement activities, and changes in patient needs or expectations. A variety of workload measurement tools are utilized to help assess the effectiveness of staffing plan.

**Standards of Care**

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

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

- Hospital staff provide the correct procedures, treatments, interventions, and care. The efficacy and appropriateness of care will be demonstrated based on patient assessment and reassessments, evidence-based practices, and achievement of desired outcomes.
- Hospital leadership staff design, implement and evaluate care delivery systems and services which are consistently focused on patient-centered care that is delivered with compassion, respect, and dignity for everyone, without bias, and in a manner that best meets the individual needs of the patients and their loved ones.
- Staff will provide a uniform standard of care and service throughout the organization.
- Patient care is coordinated through interdisciplinary collaboration to ensure continuity and seamless delivery of care to the greatest extent possible.
- Efficient use of finances, human resources, streamlined processes, enhanced

communication, and supportive technological advancements all while focused on quality of care and patient safety.

*Patient Assessment:*
Individual patient and loved one's care requirements are determined by on-going assessments performed by qualified health professionals. Each service providing patient care within the organization has a defined scope of assessment provided. This assessment and reassessment of patient care needs continues throughout the continuum and the patient's contact.

*Coordination of Care:*
Staff provide patient discharge planning to facilitate continuity of medical care and/or other care to meet identified needs. Discharge planning is timely, addressed during initial assessment and/or upon admission, as well as during the discharge planning process, and can be initiated by any member of the multidisciplinary team. Registered nurses, patient care resource managers, advanced practice nurses, and social workers coordinate and maintain close contact with the healthcare team members to finalize a distinct discharge plan best suited for each patient.

The medical staff is assigned by clinical department or division. Each clinical department has an appointed chair responsible for a variety of administrative duties, including development and implementation of policies that support the provision of departmental services, maintaining the proper number of qualified, and competent personnel needed to provide care within the service needs of the department.

**Care Delivery Model**

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

- The patient and their loved ones will experience the benefits of individualized care that integrates skills of all care team members. These benefits include enhanced quality of care, improved service, appropriate length of hospitalization, value-based cost related to quality outcomes, and patient safety.
- Hospital employees will demonstrate behaviors consistent with the philosophy of personalized health care. This philosophical foundation reflects a culture of collaboration, enthusiasm, and mutual respect.
- Effective communication will impact patient care by ensuring timeliness of services, utilizing staff resources appropriately, and maximize the patient's involvement in their own plan of care.
- Configuring departmental and physician services to accommodate the care needs of the patient in a timely manner will maximize quality of patient care

and patient satisfaction.
- Primary nursing characteristics, such as relationship-based care, conceptual framework supporting the professional practice model are used to reflect the guiding philosophy and vision of providing individualized care.
- The patient and their loved ones will be involved in establishing the plan of care to ensure services that accommodate their needs, goals, and requests.

**Patient Rights and Organizational Ethics**

*Patient Rights:*
To promote effective and compassionate care, systems, processes, policies, and programs are designed to reflect an overall concern and commitment to each person's dignity and privacy. All hospital employees, physicians, and staff have an ethical obligation to respect and support the rights of every patient in all interactions. It is the responsibility of all employees, physicians, and staff to support the efforts of the health care team, to ensure the patient's rights are respected. Each patient (and/or loved one as appropriate) is given a list of patient rights and responsibilities upon admission and copies of this list are posted in conspicuous places throughout the hospital.

*Organizational Ethics:*
The James utilizes an ethics policy to articulate the organization's responsibility to patients,staff, physicians, and community served. General guiding principles include:
- Services and capabilities offered meet identified patient and community needs and are fairly and accurately represented to the public.
- The hospital adheres to a uniform standard of care throughout the organization, providing services to those patients for whom we can safely provide care. The James does not discriminate based upon age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity or expression, or source of payment.
- Patients are only billed for care and services received.

*Biomedical Ethics:*
A biomedical ethical issue arises when there is uncertainty or disagreement regarding medical decisions involving moral, social, or economic situations that impact human life. A mechanism is in place to provide consultation in biomedical ethics to:
- Improve patient care and ensure patient safety.
- Clarify any uncertainties regarding medical decisions.
- Explore the values and principles of underlying disagreements.
- Facilitate communication between the attending physician, the patient, members of the treatment team, and the patient's family or loved ones (as appropriate).
- Mediate and resolve disagreements.

**Integration of Patient Care and Support Services**

The importance of a collaborative, interdisciplinary team approach, that considers the unique knowledge, judgment, and skills. A variety of disciplines are involved to achieve the desired patient outcomes and serves as a foundation for integration of patient care. Continual process improvement initiatives support effective integration of hospital and health system policies, procedures, protocols, and relationships between departments. See appendix A (Page 11) for a listing of support services.

An open line of communication exists between all departments providing patient care, patient services, support services within the hospital, and as appropriate with community agencies to ensure efficient, effective, and continuous patient care. To facilitate effective interdepartmental relationships, problem solving is encouraged at the level closest to the problem. The staff is receptive to addressing one another's issues and concerns and work to achieve mutually acceptable solutions. Supervisors and managers have the responsibility and authority to mutually solve problems and seek solutions within their scope. Positive interdepartmental communications are strongly encouraged. Direct patient care services maintain open communication with each other in alignment with organizational Code of Conduct, as well as with service support departments to ensure continuity of patient care, maintenance of a safe patient environment, and positive outcomes.

**Consultations and Referrals for Patient Services**

The James provides services as identified in this plan to meet the needs of our community. Patients with assessed needs requiring services not offered at The James are transferred in a timely manner after stabilization; and/or transfers are arranged with another quality facility.

Safe transportation is provided by air or ground ambulance with staff and equipment appropriate to the required level of care. Physician consultation occurs prior to transfer to ensure continuity of care. Referrals for outpatient care occur based on patient need.

**Information Management Plan**

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

- Ensuring the integrity and security of the hospital's information resources and protect patient confidentiality.
- Developing and maintaining an integrated information, communication network linking research, academic and clinical activities.

- Developing computer-based patient records with integrated clinical management and decision support.
- Supporting administrative and business functions with information technologies that enable improved quality of services, cost effectiveness, and flexibility.
- Building an information infrastructure that supports continuous improvement of the organization.

**Patient Organization Improvement Activities**

All departments participate in the hospital's plan for improving organizational performance.

**Plan Review**

The hospital's plan for providing patient care is reviewed regularly by leadership to ensure the plan is adequate, current and compliance is maintained with the plan. Interim adjustments to the plan are made as necessary to accommodate changes in patient population, care delivery systems, processes that affect the delivery, and level of patient care required.

**Appendix A: Scope of Services for Ancillary and Support Services**

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

| Department | Service |
|---|---|
| Cancer Diagnostic Center | Offers a platform for expert evaluation and access to the appropriate diagnostic testing so that a timely and precise cancer diagnosis can be made from the beginning. The center is staffed by a team of oncology-trained advanced practice providers and nurses. Starting with initial consultation, the team will manage each patient's entire diagnostic journey. This includes identifying and prioritizing the patient's needs and concerns and coordinating the appropriate testing and evaluation. If cancer is confirmed, the team will schedule the patient with the appropriate James multidisciplinary, subspecialized cancer team based on his or her type of cancer. |
| Central Sterile Supply | Coordinates the comprehensive cleaning, decontamination, assembly and dispensing of surgical instruments, equipment, and supplies needed for regular surgical procedures in related departments. |

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| Chaplaincy and Clinical Pastoral Education | Assist patients, their loved ones, and hospital personnel in meeting spiritual needs through professional pastoral and spiritual care and education. |
| Clinical Engineering | Routine equipment evaluation, maintenance, and repair of electronic equipment, evaluation of patient owned equipment. *Refer to James Hospital Policy 04-08 "Equipment Safety for Patient Care Areas."* |
| Cell Therapy Laboratory | Responsible for the processing, cryopreservation, and storage of cells for patients undergoing bone marrow or peripheral blood stem cell transplantation or receiving CAR-T therapy. |
| Clinical Call Center | Nurse-run telephone triage department that receives and manages telephone calls regarding established James patients outside normal business hours. The hours of operation for this department are: 4:00 p.m. – 8:30 a.m. Monday through Friday and 24 hours a day on Saturday, Sunday, and all university holidays. |
| Communications and Marketing | Responsible for developing strategies and programs to promote the organization's overall image, brand, reputation, and specific products and services to targeted internal and external audiences. Manages all media relations, advertising, internal communications, special events, digital and social properties, collateral materials, and publications for the hospital. |
| Decedent Affairs | Provide support to the loved ones of patients who died and assist them with completing required disposition decisions. Ensure notification of the CMS designated Organ Procurement Agency – Lifeline of Ohio (Lifeline). Promote and facilitate organ/eye/tissue donation by serving as the OSU Hospital Lifeline Liaison. Analyze data provided by Lifeline regarding organ/tissue/eye donation. |
| Diagnostic Testing Areas | Provide tests based on verbal, electronic, or written consult requests. Final reports are included in the patient record. |
| Early Response Team (ERT) | Provide timely diagnostic and therapeutic intervention before there is a cardiac or respiratory arrest or an unplanned transfer to the Intensive Care Unit. The team is comprised of rapid response RNs trained in ACLS and Respiratory Therapist who are trained to assist patient care staff when there are signs that a patient's health is declining. |
| Educational Development and Resources | Provides and promotes ongoing development and training experiences to all members of The James Cancer Hospital community; provide staff enrichment programs, organizational development, leadership development, orientation and training, skills training, continuing education, competency assessment and development, literacy programs and student affiliations. |
| Endoscopy | Provide services to patients requiring a nonsurgical review of their digestive tract. |

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| Environmental Services (EVS) | Provide housekeeping/cleaning and disinfecting of all areas of the hospital, including ORs, patient rooms, and nursing unit environments. |
| Epidemiology | Enhance the quality of patient care and the work environment by minimizing the risk of acquiring infection within the hospital and ambulatory settings. |
| Facilities Operations | Provide oversight, maintenance and repair of the building's life safety, fire safety, and utility systems. Provides preventative, repair, and routine maintenance in all areas of all buildings serving patients, guests, and staff. |
| Financial Services | Assist managers in preparation and management of capital and operational budgets; provide comprehensive patient billing services and collaborates with patients and payers to facilitate meeting all payer requirements for payment. |
| Human Resources (HR) | Serve as a liaison for managers regarding all human resources information and services; assist departments with restructuring efforts; provide proactive strategies for managing planned change within the health system; assist with Employee/Labor Relations issues; assists with performance management process; develops compensation strategies; develop hiring strategies and coordinates process for placements; provide strategies to facilitate sensitivity to issues of cultural diversity; provide human resources information to employees, and established equity for payroll. |
| Immediate Care Center (ICC) | Patients are seen for symptom management related to their disease, or treatment of their disease, and any acute needs requiring evaluation by an advanced practice provider (APP), subsequent treatments, and/or supportive care infusion therapy. Patient visits may include diagnostic, interpretive analysis, and minor invasive procedures. Referrals to other physicians, home care and hospice agencies, dieticians etc. are made by our APPs in collaboration with the primary team. |
| Information Systems | Assist departments to explore, deploy and integrate reliable, state-of-the-art information systems technology solutions to manage change. |
| Laboratory | Provide laboratory testing of ambulatory patients with a diagnosis of malignant disease and those that require urgent medical treatment given by the emergency department. Lab Reports are included in the patient record. |
| Materials Management | Supply stock in patient care areas. |
| Medical Information Management (MIM) | Maintain patient records serving the needs of the patient, provider, institution and various third parties to health care in the inpatient and ambulatory setting. |
| Nutrition Services | Provide nutrition care and food service to The James and ambulatory site patients, staff, and visitors. Clinical nutrition assessment and consultation are available in both inpatient and outpatient settings. The department provides food service to inpatients and selected ambulatory settings. |
| Oncology Laboratories | Provide clinical laboratory support services for medical, surgical blood & marrow transplantation and radiation oncology units. |

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| Pathology | The Molecular Pathology Laboratory provides testing of inpatient and ambulatory patients with a diagnosis of malignant disease and/or genetic disease. Final Reports are included in the patient record. |
| James Patient Access Services (JPAS) | Coordinate registration/admissions with nursing management. |
| Patient Care Resource Management (PCRM) and Social Services | Provide personalized care coordination and resource management. with patients and families. Provide discharge planning, coordination of external agency contacts for patient care needs and crisis intervention and support for patients and their families. Provide services upon phone/consult request of physician, nurse or the patient or family. |
| Patient Education | Provide easy-to-understand educational resources that facilitate patient learning and encourage the patient to take an active role in their care. These resources are evidence- based, comply with national standards for health literacy/plain language/accessibility and meet Joint Commission and organizational standards. Based on their assessment, clinicians use patient education resources to assist in patient and caregiver understanding and to reinforce the learning provided during their hospital stay or clinic visit. |
| Patient Experience | Develop programs for support of patient relations and customer service and information desk. Volunteers do wayfinding, host visitors in waiting areas, serve as patient/family advisors and assist staff. Volunteer Services serves as a liaison for the Service Board auxiliary, which annually grants money to department-initiated projects, enhancing the patient and family experience. |
| Perioperative Services | Provide personalized care of the patient requiring surgical services, from pre-anesthesia through recovery, for the ambulatory and inpatient surgical patient. |
| Pharmacy | Patient care services are delivered via specialty practice pharmacists and clinical generalists. Each practitioner promotes optimal medication use and assists in achieving the therapeutic goals of the patients. Areas of service include, but are not limited to: Oncology, Breast Oncology, Hematology, Blood & Marrow Transplant, Gynecologic Oncology, Pain and Palliative Care, Anticoagulation Management, Infectious Disease, and Intensive Care. |
| Operations Improvement/Process Engineers | Operations Improvement Process Engineers utilize industrial engineering knowledge and skills, as well as LEAN and Six Sigma methods to provide internal consulting, coaching, and training services for all departments across all parts of The James Cancer Hospital to develop, implement, and monitor more efficient, cost-effective business processes and strategies. |
| Pulmonary Diagnostics Lab | Provide services to patients requiring an evaluation of the respiratory system including pulmonary function testing, bronchoscopy, and other diagnostic/interventional pulmonary procedures. |

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| Quality and Patient Safety | Provide integrated quality management and facilitate continuous quality improvement efforts throughout the Hospital. Focus on the culture of safety and work with teams to provide information on trends and improvement opportunities. |
| Radiation Oncology | Responsible for clinical care related to the application of radiation treatments. |
| Radiology Services | Provide state-of-the-art radiological diagnostic and therapeutic testing and treatment. Services offered by the Radiology Imaging Department range from general radiography and fluoroscopy to new and advanced interventional procedures, contrast imaging, which include, but not limited to CT, MRI, IVP, etc., in which contrast agents are administered by IV certified radiology technologists. |
| Rehabilitation Services | Physical therapists, occupational therapists, speech and language pathologists and recreational therapists, evaluate, formulate a plan of care, and provide treatment based on physician referral and along with the interdisciplinary medical team for appropriate treatment and education needed for the established discharge plan. |
| Respiratory Therapy (RT) | Provide respiratory therapeutic interventions and diagnostic testing, by physician order including ventilator support, bronchodilator therapy, and pulmonary hygiene. |
| Safety | Hospital safety personnel handle issues associated with licensing and regulations, such as EPA, OSHA, and fire regulations. |
| Security | Provide a safe and secure environment for patients, visitors, and staff members by responding to emergencies such as workplace violence, fires, bomb threats, internal and external disasters, armed aggressors, or any other incident that needs emergency response. |
| Social Work Services | Social Work Services are provided to patients/families to meet their medically related social and emotional needs as they impact on their medical condition, treatment, recovery, and safe transition from one care environment to another. Social workers provide psychosocial assessment and intervention, crisis intervention, financial counseling, discharge planning, health education, provision of material resources and linkage with community agencies. Members of the treatment team can request consults for patients, or their loved ones. |
| Staff Development and Education | Provide and promote ongoing employee development and training related to oncology care, provides clinical orientation, and continuing education of staff. |
| Transfer Center | Coordinate with inpatient units and ancillary departments to ensure patient flow efficiency and timely access for patients who seek care. Provide transparency real-time across the Medical Center on capacity and all ADT (Admission, Discharge, and Transfer) activity. Timely and accurate patient placement based on level of care and service line is expedited through a capacity management technology platform. |

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| Transportation | Supply patients with a secure and proficient transport within the Wexner Medical Center by transferring patients between rooms/floors within the hospitals, taking patients to and from test sites, and discharging patients to Dodd Rehabilitation Center, On-Site Hospice, and the Morgue. |
| Wound Care | Wound Care includes diagnosis and management for skin impairments. |

**Annual Contractor / Vendor Review**

| Contract Name | Contract Category | Contract Description |
|---|---|---|
| Acelis Connected Health Supplies | Direct Patient Care | VAD equipment and monitoring for VAD patients |
| Agiliti - Freedom Medical | Direct Patient Care | Medical equipment provider |
| Alternate Solutions Homecare of Columbus | Direct Patient Care | In home medical care provider |
| American Kidney Stone Management | Direct Patient Care | Provider of lithotripsy services |
| American National Red Cross | Direct Patient Care | Therapeutic Apheresis |
| AMN Healthcare | Direct Patient Care | Temporary Staffing |
| ASIST TRANSLATION SERVICE INC | Direct Patient Care | Interpreting services |
| Aya Healthcare | Direct Patient Care | Temporary Staffing |
| CRNLALOCUMS PLLC | Direct Patient Care | Locum tenens CRNA services |
| CVS Health (2002.16124C - CVS Patient Navigation for CHF Care Redesign) | Direct Patient Care | Patient navigation for OSU Congestive Heart Failure patients |
| DEAF SERVICES CENTER INC | Direct Patient Care | Interpreting services |
| DispatchHealth | Direct Patient Care | In-home medical care provider |
| Fairfield Medical Center | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| ForTec Medical, Inc | Direct Patient Care | Laser Rental and Technician Labor Services |
| Genesis Health Care System | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| Getinge | Direct Patient Care | Occasional rental of Getinge Cardiohelp perfusion systems for the purpose of increasing demand of transporting patient to OSUWMC |
| Hardin Memorial Hospital | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| Kettering Medical Center | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| Knox Community Hospital | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| Language Line Services INC | Direct Patient Care | Interpreting services |
| Laurels Healthcare | Direct Patient Care | Provide pre-certification services who have not yet received authorization from third party payor and Traditional, direct bill agreement; focused on SNF LOS and readmissions |
| Mary Rutan Hospital | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| MedCare | Direct Patient Care | Not-for-profit, air and ground critical care transportation company |

| Contract Name | Contract Category | Contract Description |
|---|---|---|
| Memorial Health System | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| Memorial Hospital | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| National Marrow Donor Program | Direct Patient Care | Blood and Marrow Transplant Program |
| Nuvasive | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| Ohio Health Marion General | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| Ohio Medical Transport Inc. (dba MedFlight of Ohio) | Direct Patient Care | Not-for-profit, air and ground air transportation company |
| One Medical | Direct Patient Care | Provide clinical care through improved access and quality, develop primary care and specialty care connections |
| Proliv Digipath N M Medical Histopathology Lab | Direct Patient Care | Telepathology consultation services agreement |
| Siemens Medical Solutions USA Inc. | Direct Patient Care | Temporary Staffing for Radiology |
| Southeastern Ohio Regional Medical Center | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| Superdimension INC | Direct Patient Care | LungGPS Patient Management Platform |
| UC Health LLC | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| University Hospitals Health System | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| Urban Zen Integrative Therapy | Direct Patient Care | Yoga Services |
| US TOGETHER INC | Direct Patient Care | Interpreting services |
| Versiti | Direct Patient Care | Blood donation center |
| Vitalent | Direct Patient Care | Collects blood from volunteer donors and provides blood, blood products and services |
| Advance Accelerator Applications | Patient Impact Service | Nuclear pharmacy drugs |
| Air Force One | Patient Impact Service | HVAC Solutions |
| Arjo | Patient Impact Service | Medical devices and solutions |
| ARUP Laboratories | Patient Impact Service | Reference lab |
| Be the Match Bio Contract No 2010.13100C | Patient Impact Service | Cell therapy product |
| Bellingham Aviation Services, LLC | Patient Impact Service | Transplant for air and ground |
| Blood Center of Wisconsin | Patient Impact Service | Reference lab |
| Buckeye Transplant | Patient Impact Service | Process of screening organ donors, providing 24/7 services |

| Contract Name | Contract Category | Contract Description |
|---|---|---|
| Building Controls Integrators LLC | Patient Impact Service | Energy Equipment and Solutions |
| Cardinal Health 414 LLC-Nuclear | Patient Impact Service | Nuclear pharmacy drugs |
| Celgene Contract | Patient Impact Service | Apheresis master service agreement; defines how team does apheresis, how to ship the product, track the product, how to infuse the product |
| Chanl Health | Patient Impact Service | Telehealth application |
| Chem Aqua Inc | Patient Impact Service | Water treatment |
| Cincinnati Children's Hospital Reference Lab | Patient Impact Service | Reference lab |
| Commercial Parts and Service of Ohio | Patient Impact Service | Service for repair and cooking equipment; ice machine cleaning and sanitizing |
| Comtex | Patient Impact Service | Linen services |
| CURIUM PHARMA | Patient Impact Service | Nuclear pharmacy drugs |
| DASCO HOME MEDICAL EQUIPMENT INC | Patient Impact Service | Provider of home medical supplies |
| Day Funeral Service | Patient Impact Service | Funeral and cremation service provider |
| DEBRA-KUEMPEL | Patient Impact Service | HVAC, preventative maintenance |
| EDM Xpress Cleaning Solutions | Patient Impact Service | Cleaning services |
| Fresenius | Patient Impact Service | Outsourcing of Dialysis Equipment Service and Supplies |
| Gamida Contract No 2010.16754C | Patient Impact Service | Cell therapy product |
| GE Health- Nuclear | Patient Impact Service | Nuclear pharmacy drugs |
| Geiger Brothers | Patient Impact Service | HVAC, preventative maintenance |
| Genedx INC | Patient Impact Service | Reference lab |
| HMPC A Joint Venture | Patient Impact Service | HVAC, preventative maintenance |
| Intuitive Surgical Inc | Patient Impact Service | Surgical device equipment and preventative maintenance |
| Iovance Contract | Patient Impact Service | Trade Agreement for manufacturer and deliver of autologous cellular immunotherapies |
| Janssen Contract | Patient Impact Service | This agreement allows OSU to expand its CAR-T program by offering a new FDA approved treatment for cell therapy. |
| Johnson Controls, Inc. | Patient Impact Service | HVAC PM and Repair |
| Jubilant Draximage | Patient Impact Service | Nuclear pharmacy drugs |
| Kite Contract No 2010.11460C | Patient Impact Service | autologous cell therapy products |
| Koffel Associates/Koffel Compliance | Patient Impact Service | Fire protection engineering and code consulting |
| Laboratory Certification Services, INC | Patient Impact Service | Testing, certification services and contamination control |

| Contract Name | Contract Category | Contract Description |
|---|---|---|
| Lantheus Medical | Patient Impact Service | Nuclear pharmacy drugs |
| LEPI Enterprises | Patient Impact Service | General contractor for environmental cleanup situations |
| Lifeline of Ohio Organ Procurement, Inc. | Patient Impact Service | Organ Procurement Organization |
| Limbach Company LLC | Patient Impact Service | Sheet metal contractor and HVAC PM/Repair |
| Lyft | Patient Impact Service | Transportation services for patients |
| Mayo Collaborative Services | Patient Impact Service | Reference lab |
| Messer (Linde) | Patient Impact Service | Medical gases |
| Mid -American Cleaning Contractors | Patient Impact Service | Custodial services for Ambulatory, Rehab |
| Midwest Elevator Company, Inc | Patient Impact Service | Elevator PMs and repair (not including ATS) |
| Milk Bank | Patient Impact Service | Donor milk bank program for Women and Infants |
| Nationwide Children's Hospital Reference Lab | Patient Impact Service | Reference lab |
| Nationwide Organ Recovery Transport (NORA) | Patient Impact Service | Transplant for air and ground |
| Novartis Contract | Patient Impact Service | Pharmaceutical products |
| OHIO Cat | Patient Impact Service | Generator services and rentals |
| Ohio Heating and Refrigeration Inc | Patient Impact Service | Commercial and residential HVAC, boilers, building automation, commercial refrigeration, fabrication and food service equipment. |
| Pro-Flow Plumbing and Drain Cleaning | Patient Impact Service | Drain Cleaning |
| PROMETHEUS LABORATORIES INC | Patient Impact Service | Reference lab |
| Rojen | Patient Impact Service | Service repair for commercial kitchen parts |
| Shoemaker Industrial Solutions | Patient Impact Service | Innovative custom engineered systems and a full range of predictive maintenance services including: Vibration Analysis, Advanced Winding Analysis, Infrared Inspection Services and Ultrasonic Inspection Services. |
| Siemens Industry INC | Patient Impact Service | Building automation systems |
| SimplexGrinnell | Patient Impact Service | HVAC PM and Repair |
| SIPS CONSULTS CORP | Patient Impact Service | Central Sterile Supply Travelers |
| States Electric / Roberts Service Group | Patient Impact Service | General contractor and electrical services |
| The Kings | Patient Impact Service | Cleaning services |
| Thomas Door Controls Inc | Patient Impact Service | Fire door certification; preventative maintenance/repair |
| TNT Services | Patient Impact Service | Fleet washing services |
| TP MECHANICAL CONTRACTORS INC | Patient Impact Service | HVAC, preventative maintenance |

| Contract Name | Contract Category | Contract Description |
|---|---|---|
| TxJet, Inc. | Patient Impact Service | Transplant for air and ground |
| University of Pittsburgh Medical Center | Patient Impact Service | Reference lab |
| US Foods | Patient Impact Service | Food supplier |
| Versiti Wisconsin reference laboratory | Patient Impact Service | Transfusion service reference laboratory |

**Services OSUWMC Purchases from The James**

| Service | Contract Category | Description |
|---|---|---|
| Apheresis Nurse Services | Direct Patient Care | On call, emergency Apheresis services for patients based on need |
| Chemotherapy Nurse Float Pool Services | Direct Patient Care | Patients receiving chemotherapy outside of The James |
| Emergency Oncology Services | Direct Patient Care | Oncology nurses, PCA, UCA, Patient Flow Coordinators, SANE nurses for ED oncology pod on 24/7 basis |
| Environmental Management Services | Patient Impact | Provides custodial/janitorial workers at Primary Care New Albany, Dodd/Davis, Harding Hospital, Primary Care Westerville, Primary Care Pickerington, Primary Care Dublin and McCampbell Hall |
| Equipment Distribution Services | Patient Impact | Maintain equipment stock, monitor inventory levels and manages all equipment needs; collaborates with purchasing and clinical engineering |
| High-Level Disinfection and Ambulatory Sterilization Services | Patient Impact | High-level disinfection and sterilization services |
| Interventional Radiology Call Services | Direct Patient Care | Radiologic services based on need outside of normal business hours |
| Interventional Radiology Technician Services | Direct Patient Care | Radiologic services based on need |
| Laboratory Services | Direct Patient Care | Lab services as defined by the Test Catalog of The James laboratories; Emergency Laboratory Services |
| Materials Management Services | Patient Impact | Supplies acquisitions and inventory control; software execution; supply rooms for Critical Care, Progressive Care and Emergency Departments. |
| Nutrition Services | Direct Patient Care | Provide meals to patients, staff, and visitors |

| Service | Contract Category | Description |
|---|---|---|
| Nursing Float Pool Services | Direct Patient Care | Nursing services through James float pool |
| Pastoral Care Services | Direct Patient Care | 0.10 FTE Chaplain and 0.40 FTE residents providing direct pastoral / spiritual support to patients and families of OSUWMC |
| Perioperative Policy and Procedure Support Services | Patient Impact | Research, edit, update and educate on perioperative policies and procedures |
| Pharmacy Services | Direct Patient Care | Administrative and operational support; clinical pharmacist support and Quality and Safety Support |
| Radiologic Services | Direct Patient Care | MR, CT, X-ray, Fluoroscopy, Interventional Radiology, Ultrasound, Nuclear Medicine at The James or Spielman Breast Center |
| Wound Ostomy Services | Direct Patient Care | Wound ostomy services |

**Services The James purchases from OSUWMC**

| Service | Contract Category | Description |
|---|---|---|
| Acute Hemodialysis Nurse Services | Direct Patient Care | As ordered by a nephrologist, Acute Hemodialysis Services are provided to The James' patients on a daily basis during normal business hours; Emergency Acute Hemodialysis Services are available, via on call |
| Central Sterile Processing Services | Patient Impact | All duties related to cleaning and decontamination of general and specialty surgical instruments, power equipment, endoscopes, as well sterilization, preparation & packaging, and delivery of surgical instruments and supplies to the James operating room |
| Clinical Engineering Services | Patient Impact | Assurance of the accuracy, safety, and proper performance of electrical and non-electrical medical equipment |
| Credentialing Services | Patient Impact | Facilitate initial appointments, reappointments, and privileging of Medical Staff, Limited Staff and Advance Practice Providers in addition to regulatory compliance. |
| Fetal and Uterine Nurse Monitoring Services | Direct Patient Care | Fetal and Uterine Monitoring Services include, but are not limited to, fetal movement assessment, auscultation, electronic fetal monitoring, non-stress test, |

| Service | Contract Category | Description |
|---|---|---|
| | | contraction stress test, fetal biophysical profile, and modified biophysical profile |
| Heart and Vascular Services | Direct Patient Care | Provide cardiovascular imaging testing, vascular studies, MRI/MRAs, CT/CTAs; TEEs; nuclear studies; stress testing |
| Interventional Radiology Call Services | Direct Patient Care | Provide a call team, consisting of one (1) IR nurse and one (1) IR Technician, to cover all of The James' after hours calls and services |
| Interventional Radiology Technician Services | Direct Patient Care | Confirm and review order from an authorized practitioner; manage supplies; assist in preparation for procedures, obtain radiographic procedural imaging for patients |
| Laboratory Services | Direct Patient Care | Laboratory tests and emergency laboratory services |
| Legal Services | Professional Service | On-call legal and risk management consultative services; provision of legal consultation and legal review of new-risk related policies and policy changes for The James. |
| Medical Information Management Services | Patient Impact | Provide storage and retrieval, document imaging, regulatory and compliance in documentation and completion of medical records, hospital coding of diagnoses and procedures, protected health information privacy, medical record forms management and electronic health record support and development |
| Nursing Float Pool Services | Direct Patient Care | Provide RNs in the event of unexpected surges in case volume or low staff numbers |
| Nutrition Services | Direct Patient Care | Responsible for daily operation of enumerated dietary services for The James and has associated responsibility for implementing The James's vision and direction for The James's Nutrition Services. |
| Occupational Health and Wellness | Professional Service | Provide new hire screening, faculty and staff injuries, manage blood and body fluid exposures, annual vaccinations |
| Pastoral Care Services | Direct Patient Care | 0.30 FTE staff member shall be dedicated to providing Pastoral Care Services |
| Pharmacy Services | Direct Patient Care | Administrative support and leadership, drug dispensing and compounding, dispensing technology and maintenance, clinical pharmacy services, cost monitoring, Epic applications, medication error reporting |
| Physician Advisor Services | Direct Patient Care | Provide second-level medical necessity of review of appropriate level of care cases |

| Service | Contract Category | Description |
|---|---|---|
| Radiologic Services | Direct Patient Care | Supply diagnostic and therapeutic radiology services to The James |
| Registration Services | Patient Impact | Provide a complete registration for The James' patients in OSUWMC's and The James' joint EMR system according to organizational guidelines |
| Rehabilitation Services | Direct Patient Care | Oversees James Acute Rehab team |
| Respiratory and Pulmonary Services | Direct Patient Care | Delivery of all inhaled respiratory therapy medications, airway clearance techniques, ventilator management, nocturnal and continuous bilevel positive airway pressure, continuous positive airway pressure, and non-invasive mechanical ventilation. |
| Security Services | Patient Impact | Provide safe and secure environment to staff, patients and visitors in all areas of The James. |

The James

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

| Contract Name | Contract Category | Contract Description |
|---|---|---|
| Acelis Connected Health Supplies | Direct Patient Care | VAD equipment and monitoring for VAD patients |
| Agiliti - Freedom Medical | Direct Patient Care | Medical equipment provider |
| Alternate Solutions Homecare of Columbus | Direct Patient Care | In home medical care provider |
| American Kidney Stone Management | Direct Patient Care | Provider of lithotripsy services |
| American National Red Cross | Direct Patient Care | Therapeutic Apheresis |
| AMN Healthcare | Direct Patient Care | Temporary Staffing |
| ASIST TRANSLATION SERVICE INC | Direct Patient Care | Interpreting services |
| Aya Healthcare | Direct Patient Care | Temporary Staffing |
| CRNLALOCUMS PLLC | Direct Patient Care | Locum tenes CRNA services |
| CVS Health (2002.16124C - CVS Patient Navigation for CHF Care Redesign) | Direct Patient Care | Patient navigation for OSU Congestive Heart Failure patients |
| DEAF SERVICES CENTER INC | Direct Patient Care | Interpreting services |
| DispatchHealth | Direct Patient Care | In-home medical care provider |
| Fairfield Medical Center | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| ForTec Medical, Inc | Direct Patient Care | Laser Rental and Technician Labor Services |
| Genesis Health Care System | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| Getinge | Direct Patient Care | Occasional rental of Getinge Cardiohelp perfusion systems for the purpose of increasing demand of transporting patient to OSUWMC |
| Hardin Memorial Hospital | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| Kettering Medical Center | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| Knox Community Hospital | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| Language Line Services INC | Direct Patient Care | Interpreting services |
| Laurels Healthcare | Direct Patient Care | Provide pre-certification services who have not yet received authorization from third party payor and Traditional, direct bill agreement; focused on SNF LOS and readmissions |
| Mary Rutan Hospital | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |

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|---|---|---|
| MedCare | Direct Patient Care | Not-for-profit, air and ground critical care transportation company |
| Memorial Health System | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| Memorial Hospital | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| National Marrow Donor Program | Direct Patient Care | Blood and Marrow Transplant Program |
| Nuvasive | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| Ohio Health Marion General | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| Ohio Medical Transport Inc. (dba MedFlight of Ohio) | Direct Patient Care | Not-for-profit, air and ground air transportation company |
| One Medical | Direct Patient Care | Provide clinical care through improved access and quality, develop primary care and specialty care connections |
| Proliv Digipath N M Medical Histopathology Lab | Direct Patient Care | Telepathology consultation services agreement |
| Siemens Medical Solutions USA Inc. | Direct Patient Care | Temporary Staffing for Radiology |
| Southeastern Ohio Regional Medical Center | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| Superdimension INC | Direct Patient Care | LungGPS Patient Management Platform |
| UC Health LLC | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| University Hospitals Health System | Direct Patient Care | Provides rehab locally for OSUWMC LVRS patients |
| Urban Zen Integrative Therapy | Direct Patient Care | Yoga Services |
| US TOGETHER INC | Direct Patient Care | Interpreting services |
| Versiti | Direct Patient Care | Blood donation center |
| Vitalent | Direct Patient Care | Collects blood from volunteer donors and provides blood, blood products and services |
| Advance Accelerator Applications | Patient Impact Service | Nuclear pharmacy drugs |
| Air Force One | Patient Impact Service | HVAC Solutions |
| Arjo | Patient Impact Service | Medical devices and solutions |
| ARUP Laboratories | Patient Impact Service | Reference lab |
| Be the Match Bio Contract No 2010.13100C | Patient Impact Service | Cell therapy product |
| Bellingham Aviation Services, LLC | Patient Impact Service | Transplant for air and ground |
| Blood Center of Wisconsin | Patient Impact Service | Reference lab |
| Buckeye Transplant | Patient Impact Service | Process of screening organ donors, providing 24/7 services |

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|---|---|---|
| Building Controls Integrators LLC | Patient Impact Service | Energy Equipment and Solutions |
| Cardinal Health 414 LLC-Nuclear | Patient Impact Service | Nuclear pharmacy drugs |
| Celgene Contract | Patient Impact Service | Apheresis master service agreement; defines how team does apheresis, how to ship the product, track the product, how to infuse the product |
| Chanl Health | Patient Impact Service | Telehealth application |
| Chem Aqua Inc | Patient Impact Service | Water treatment |
| Cincinnati Children's Hospital Reference Lab | Patient Impact Service | Reference lab |
| Commercial Parts and Service of Ohio | Patient Impact Service | Service for repair and cooking equipment; ice machine cleaning and sanitizing |
| Comtex | Patient Impact Service | Linen services |
| CURIUM PHARMA | Patient Impact Service | Nuclear pharmacy drugs |
| DASCO HOME MEDICAL EQUIPMENT INC | Patient Impact Service | Provider of home medical supplies |
| Day Funeral Service | Patient Impact Service | Funeral and cremation service provider |
| DEBRA-KUEMPEL | Patient Impact Service | HVAC, preventative maintenance |
| EDM Xpress Cleaning Solutions | Patient Impact Service | Cleaning services |
| Fresenius | Patient Impact Service | Outsourcing of Dialysis Equipment Service and Supplies |
| Gamida Contract No 2010.16754C | Patient Impact Service | Cell therapy product |
| GE Health- Nuclear | Patient Impact Service | Nuclear pharmacy drugs |
| Geiger Brothers | Patient Impact Service | HVAC, preventative maintenance |
| Genedx INC | Patient Impact Service | Reference lab |
| HMPC A Joint Venture | Patient Impact Service | HVAC, preventative maintenance |
| Intuitive Surgical Inc | Patient Impact Service | Surgical device equipment and preventative maintenance |
| Iovance Contract | Patient Impact Service | Trade Agreement for manufacturer and deliver of autologous cellular immunotherapies |
| Janssen Contract | Patient Impact Service | This agreement allows OSU to expand its CAR-T program by offering a new FDA approved treatment for cell therapy. |
| Johnson Controls, INc. | Patient Impact Service | HVAC PM and Repair |
| Jubilant Draximage | Patient Impact Service | Nuclear pharmacy drugs |
| Kite Contract No 2010.11460C | Patient Impact Service | autologous cell therapy products |
| Koffel Associates/Koffel Compliance | Patient Impact Service | Fire protection engineering and code consulting |
| Laboratory Certification Services, INC | Patient Impact Service | Testing, certification services and contamination control |
| Lantheus Medical | Patient Impact Service | Nuclear pharmacy drugs |

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| LEPI Enterprises | Patient Impact Service | General contractor for environmental cleanup situations |
| Lifeline of Ohio Organ Procurement, Inc. | Patient Impact Service | Organ Procurement Organization |
| Limbach Company LLC | Patient Impact Service | Sheet metal contractor and HVAC PM/Repair |
| Lyft | Patient Impact Service | Transportation services for patients |
| Mayo Collaborative Services | Patient Impact Service | Reference lab |
| Messer (Linde) | Patient Impact Service | Medical gases |
| Mid American Cleaning Contractors | Patient Impact Service | Custodial services for Ambulatory, Rehab |
| Midwest Elevator Company, Inc | Patient Impact Service | Elevator PMs and repair (not including ATS) |
| Milk Bank | Patient Impact Service | Donor milk bank program for Women and Infants |
| Nationwide Children's Hospital Reference Lab | Patient Impact Service | Reference lab |
| Nationwide Organ Recovery Transport (NORA) | Patient Impact Service | Transplant for air and ground |
| Novartis Contract | Patient Impact Service | Pharmaceutical products |
| OHIO Cat | Patient Impact Service | Generator services and rentals |
| Ohio Heating and Refrigeration Inc | Patient Impact Service | Commercial and residential HVAC, boilers, building automation, commercial refrigeration, fabrication and food service equipment. |
| Pro-Flow Plumbing and Drain Cleaning | Patient Impact Service | Drain Cleaning |
| PROMETHEUS LABORATORIES INC | Patient Impact Service | Reference lab |
| Rojen | Patient Impact Service | Service repair for commerical kitchen parts |
| Shoemaker Industrial Solutions | Patient Impact Service | Innovative custom engineered systems and a full range of predictive maintenance services including: Vibration Analysis, Advanced Winding Analysis, Infrared Inspection Services and Ultrasonic Inspection Services. |
| Siemens Industry INC | Patient Impact Service | Building automation systems |
| SimplexGrinnell | Patient Impact Service | HVAC PM and Repair |
| SIPS CONSULTS CORP | Patient Impact Service | Central Sterile Supply Travelers |
| States Electric / Roberts Service Group | Patient Impact Service | General contractor and electrical services |
| The Kings | Patient Impact Service | Cleaning services |
| Thomas Door Controls Inc | Patient Impact Service | Fire door certification; preventative maintenance/repair |
| TNT Services | Patient Impact Service | Fleet washing services |
| TP MECHANICAL CONTRACTORS INC | Patient Impact Service | HVAC, preventative maintenance |
| TxJet, Inc. | Patient Impact Service | Transplant for air and ground |

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|---|---|---|
| University of Pittsburgh Medical Center | Patient Impact Service | Reference lab |
| US Foods | Patient Impact Service | Food supplier |
| Versiti Wisconsin reference laboratory | Patient Impact Service | Transfusion service reference laboratory |

**Services The James purchases from OSUWMC**

| Service | Contract Category | Description |
|---|---|---|
| Acute Hemodialysis Nurse Services | Direct Patient Care | As ordered by a nephrologist, Acute Hemodialysis Services are provided to The James' patients on a daily basis during normal business hours; Emergency Acute Hemodialysis Services are available, via on call |
| Central Sterile Processing Services | Patient Impact | All duties related to cleaning and decontamination of general and specialty surgical instruments, power equipment, endoscopes, as well sterilization, preparation & packaging, and delivery of surgical instruments and supplies to the James operating room |
| Clinical Engineering Services | Patient Impact | Assurance of the accuracy, safety, and proper performance of electrical and non-electrical medical equipment |
| Credentialing Services | Patient Impact | Facilitate initial appointments, reappointments, and privileging of Medical Staff, Limited Staff and Advance Practice Providers in addition to regulatory compliance. |
| Fetal and Uterine Nurse Monitoring Services | Direct Patient Care | Fetal and Uterine Monitoring Services include, but are not limited to, fetal movement assessment, auscultation, electronic fetal monitoring, non-stress test, contraction stress test, fetal biophysical profile, and modified biophysical profile |
| Heart and Vascular Services | Direct Patient Care | Provide cardiovascular imaging testing, vascular studies, MRI/MRAs, CT/CTAs; TEEs; nuclear studies; stress testing |
| Interventional Radiology Call Services | Direct Patient Care | Provide a call team, consisting of one (1) IR nurse and one (1) IR Technician, to cover all of The James' after hours calls and services |
| Interventional Radiology Technician Services | Direct Patient Care | Confirm and review order from an authorized practitioner; manage supplies; assist in preparation for procedures, obtain radiographic procedural imaging for patients |
| Laboratory Services | Direct Patient Care | Laboratory tests and emergency laboratory services |

| | | |
|---|---|---|
| Legal Services | Professional Service | On-call legal and risk management consultative services; provision of legal consultation and legal review of new-risk related policies and policy changes for The James. |
| Medical Information Management Services | Patient Impact | Provide storage and retrieval, document imaging, regulatory and compliance in documentation and completion of medical records, hospital coding of diagnoses and procedures, protected health information privacy, medical record forms management and electronic health record support and development |
| Nursing Float Pool Services | Direct Patient Care | Provide RNs in the event of unexpected surges in case volume or low staff numbers |
| Nutrition Services | Direct Patient Care | Responsible for daily operation of enumerated dietary services for The James and has associated responsibility for implementing The James's vision and direction for The James's Nutrition Services. |
| Occupational Health and Wellness | Professional Service | Provide new hire screening, faculty and staff injuries, manage blood and body fluid exposures, annual vaccinations |
| Pastoral Care Services | Direct Patient Care | 0.30 FTE staff member shall be dedicated to providing Pastoral Care Services |
| Pharmacy Services | Direct Patient Care | Administrative support and leadership, drug dispensing and compounding, dispensing technology and maintenance, clinical pharmacy services, cost monitoring, Epic applications, medication error reporting |
| Physician Advisor Services | Direct Patient Care | Provide second-level medical necessity of review of appropriate level of care cases |
| Radiologic Services | Direct Patient Care | Supply diagnostic and therapeutic radiology services to The James |
| Registration Services | Patient Impact | Provide a complete registration for The James' patients in OSUWMC's and The James' joint EMR system according to organizational guidelines |
| Rehabilitation Services | Direct Patient Care | Oversees James Acute Rehab team |
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| Security Services | Patient Impact | Provide safe and secure environment to staff, patients and visitors in all areas of The James. |

**Services OSUWMC Purchases from The James**

| Service | Contract Category | Description |
|---|---|---|
| Apheresis Nurse Services | Direct Patient Care | On call, emergency Apheresis services for patients based on need |
| Chemotherapy Nurse Float Pool Services | Direct Patient Care | Patients receiving chemotherapy outside of The James |
| Emergency Oncology Services | Direct Patient Care | Oncology nurses, PCA, UCA, Patient Flow Coordinators, SANE nurses for ED oncology pod on 24/7 basis |
| Environmental Management Services | Patient Impact | Provides custodial/janitorial workers at Primary Care New Albany, Dodd/Davis, Harding Hospital, Primary Care Westerville, Primary Care Pickerington, Primary Care Dublin and McCampbell Hall |
| Equipment Distribution Services | Patient Impact | Maintain equipment stock, monitor inventory levels and manages all equipment needs; collaborates with purchasing and clinical engineering |
| High-Level Disinfection and Ambulatory Sterilization Services | Patient Impact | High-level disinfection and sterilization services |
| Interventional Radiology Call Services | Direct Patient Care | Radiologic services based on need outside of normal business hours |
| Interventional Radiology Technician Services | Direct Patient Care | Radiologic services based on need |
| Laboratory Services | Direct Patient Care | Lab services as defined by the Test Catalog of The James laboratories; Emergency Laboratory Services |
| Materials Management Services | Patient Impact | Supplies acquisitions and inventory control; software execution; supply rooms for Critical Care, Progressive Care and Emergency Departments. |
| Nutrition Services | Direct Patient Care | Provide meals to patients, staff, and visitors |
| Nursing Float Pool Services | Direct Patient Care | Nursing services through James float pool |
| Pastoral Care Services | Direct Patient Care | 0.10 FTE Chaplain and 0.40 FTE residents providing direct pastoral / spiritual support to patients and families of OSUWMC |
| Perioperative Policy and Procedure Support Services | Patient Impact | Research, edit, update and educate on perioperative policies and procedures |

| | | |
|---|---|---|
| Pharmacy Services | Direct Patient Care | Administrative and operational support; clinical pharmacist support and Quality and Safety Support |
| Radiologic Services | Direct Patient Care | MR, CT, X-ray, Flouroscopy, Interventional Radiology, Ultrasound, Nuclear Medicine at The James or Spielman Breast Center |
| Wound Ostomy Services | Direct Patient Care | Wound ostomy services |

THE OHIO STATE UNIVERSITY

Board of Trustees

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Columbus, OH 43201

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**SUMMARY OF ACTIONS TAKEN**

*August 16, 2023 – Talent, Compensation & Governance Committee Meeting*

**Members Present:**

John W. Zeiger
Elizabeth P. Kessler
Alan A. Stockmeister
Gary R. Heminger
Lewis Von Thaer
Jeff M.S. Kaplan
Tomislav B. Mitevski
Hiroyuki Fujita *(ex officio)*

**Members Present via Zoom: N/A**

**Members Absent: N/A**

**PUBLIC SESSION**

The Talent, Compensation & Governance Committee of The Ohio State University Board of Trustees convened on Wednesday, August 16, 2023, in person at Vitria on the Square, 14 E. 15th Avenue, Columbus, OH, 43201. Committee Chair John Zeiger called the meeting to order 8:01 a.m.

**EXECUTIVE SESSION**

It was moved by Mr. Zeiger and seconded by Mr. Heminger that the committee recess into executive session to discuss business-sensitive trade secrets required to be kept confidential by federal and state statutes, to discuss personnel matters regarding the appointment, employment and compensation of public employees, and to consult with legal counsel regarding pending or imminent litigation.

A roll-call vote was taken, and the committee voted to move into executive session with the following members present and voting: Mr. Zeiger, Ms. Kessler, Mr. Stockmeister, Mr. Heminger, Mr. Von Thaer, Mr. Kaplan, Mr. Mitevski and Dr. Fujita.

The committee entered executive session at 8:02 a.m. and reconvened in public session at 10:57 a.m. The committee adjourned at 11:06 a.m.

**PUBLIC SESSION**

***Items for Action***

1. Approval of Minutes: No changes were requested to the May 17, 2022, meeting minutes; therefore, a formal vote was not required, and the minutes were considered approved.

2. Resolution No. 2024-18, Personnel Actions: Ms. Katie Hall brought forward the personnel actions resolution that included a new hire and a severance provision that was added to two letters of offer. This adjustment was made to ensure that there are equitable contract terms across all members of President's Cabinet.

   BE IT RESOLVED, That the Board of Trustees hereby approves the personnel actions as recorded in the personnel budget records of the university since the May 18, 2023, meeting of the Board, including the following appointments and contract amendments:

New Hire

Name: Peter Mohler
Title: Executive Vice President, Enterprise for Research, Innovation and Knowledge
Unit: Office of the President
Term: August 17, 2023

Severance Update

Name: Jessica Eveland
Title: Secretary, Board of Trustees
Unit: Office of the President
Term: August 1, 2023

Name: Stacy Rastauskas
Title: Vice President, Government Affairs
Unit: Office of the President
Term: August 1, 2023

3. Resolution No. 2023-19, Ratification of Committee Appointments FY 2024-2025

BE IT RESOLVED, That the Board of Trustees hereby approves that the ratification of committee appointments for Fiscal Year 2023-2024 are as follows:

**Academic Affairs & Student Life:**
Jeff M.S. Kaplan, Chair
Elizabeth A. Harsh, Vice Chair
Elizabeth P. Kessler
Reginald A. Wilkinson
Michael Kiggin
Pierre Bigby
**JOSHUA H.B. KERNER**
Susan E. Cole (faculty member)
Hiroyuki Fujita (ex officio)

**Finance & Investment:**
Tomislav B. Mitevski, Chair
James D. Klingbeil, Vice Chair
John W. Zeiger
Gary R. Heminger
Lewis Von Thaer
Michael Kiggin
Pierre Bigby
**TAYLOR A. SCHWEIN**
Amy Chronis
Kent M. Stahl
Hiroyuki Fujita (ex officio)

**Legal, Audit, Risk & Compliance:**
Elizabeth P. Kessler, Chair
Michael Kiggin, Vice Chair
Alan A. Stockmeister
Jeff M.S. Kaplan
Elizabeth A. Harsh
Juan Jose Perez
**JOSHUA H.B. KERNER**
Amy Chronis
Hiroyuki Fujita (ex officio)

**Master Planning & Facilities:**
**ALAN A. STOCKMEISTER, CHAIR**
**REGINALD A. WILKINSON, VICE CHAIR**
Elizabeth A. Harsh
Pierre Bigby
**JOSHUA H.B. KERNER**
James D. Klingbeil
Robert H. Schottenstein
Hiroyuki Fujita (ex officio)

**Research, Innovation & Strategic Partnerships:**
Lewis Von Thaer, Chair
Reginald A. Wilkinson, Vice Chair
Juan Jose Perez
**TAYLOR A. SCHWEIN**
Phillip Popovich (faculty member)
Hiroyuki Fujita (ex officio)

**Talent, Compensation & Governance:**
John W. Zeiger, Chair
Elizabeth P. Kessler, Vice Chair
**ALAN A. STOCKMEISTER**
Gary R. Heminger
Lewis Von Thaer
Jeff M.S. Kaplan
Tomislav B. Mitevski
Hiroyuki Fujita (ex officio)

4. Resolution No. 2024-20: Recommend for Approval Amendments to the Bylaws for The Ohio State University Wexner Medical Center Board:

   Synopsis: Recommended approval of the attached amendments to the *Bylaws of The Ohio State University Wexner Medical Center Board* is proposed.

   WHEREAS pursuant to 3335-1-09 (C) of the Administrative Code, the rules and regulations for the university may be adopted, amended or repealed by a majority vote of the University Board of Trustees at any regular meeting of the board; and

   WHEREAS a periodic review of the board's bylaws is a governance best practice; and

   WHEREAS the last revisions to the *Bylaws of The Ohio State University Wexner Medical Center Board* took place in November 2022; and

   NOW THEREFORE

   BE IT RESOLVED, That the Quality and Professional Affairs Committee hereby recommends to the Wexner Medical Center Board and the University Board of Trustees the attached amendments to the *Bylaws of The Ohio State University Wexner Medical Center Board*.

   (See Appendix XIV for background information, page 716)

**Action:** Upon the motion of Mr. Zeiger, seconded by Mr. Mitevski, the foregoing resolutions were adopted by unanimous voice vote with the following members present and voting: Mr. Zeiger, Ms. Kessler, Mr. Stockmeister, Mr. Heminger, Mr. Von Thaer, Mr. Kaplan, Mr. Mitevski and Dr. Fujita.

The committee adjourned at 11:06 a.m.

THE OHIO STATE UNIVERSITY

Board of Trustees

University Square South
15 East 15th Street, 5th Floor
Columbus, OH 43201

Phone (614) 292-6359
Fax (614) 292-5903
trustees.osu.edu

**SUMMARY OF ACTIONS TAKEN**

*August 16, 2023 – Legal, Audit, Risk & Compliance Committee Meeting*

**Voting Members Present:**

Elizabeth P. Kessler
Alan A. Stockmeister
Jeff M.S. Kaplan
Elizabeth A. Harsh
Juan Jose Perez
Joshua H.B. Kerner
Hiroyuki Fujita (ex officio)

**Members Present via Zoom:**

Amy Chronis

**Members Absent:**

Michael Kiggin

The Legal, Audit, Risk & Compliance Committee of The Ohio State University Board of Trustees convened on Wednesday, August 16, 2023, in person at Vitria on the Square, 14 E. 15th Avenue, Columbus, OH, 43201, and virtually over Zoom. Committee Chair Elizabeth Kessler called the meeting to order at 11:59 a.m.

**PUBLIC SESSION**

Ms. Kessler began by welcoming new trustee Joshua Kerner to the Board and to the Legal, Audit, Risk & Compliance Committee.

***Items for Discussion:***

1. Annual Compliance Report: Gates Garrity-Rokous, vice president and chief compliance officer, joined by Chris Glaros, associate vice president for compliance operations and investigations in the Office of University Compliance and Integrity to share the university's annual compliance report. The report covered two items – overall risk trends across higher education and concern reporting. They also addressed key risk drivers for FY2023-24, which were organized into five categories: regulatory expectation and enforcement, academic excellence and research innovation, Ohio State Wexner Medical Center, athletics transformation, and economic and political environment.
(See Attachment XIV for background information, page 454)

2. Annual Government Affairs Update: Stacy Rastauskas, vice president for government affairs, was joined for this report by Trudy Bartley, associate vice president of local and community relations; Michael Rodgers, associate vice president for state relations; and Stan Skocki, associate vice president for federal relations, based in Washington D.C.; also invited guests including Angela Chapman, superintendent and CEO for Columbus City Schools; Megan Noble, executive director for strategic priorities for Columbus City Schools; and Randy Smith, vice provost for academic programs at The Ohio State University. Stacy also recognized in the audience Brendan Flynn, legislative assistant for Senator Sherrod Brown.
Ms. Rastauskas provided an overview of the Office of Government Affairs and shared highlights from 2022-23 including their efforts to secure additional investment in Ohio State and their work on responding to policy changes that affect the university.

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Ms. Bartley discussed STEAMM Rising. Last year, the university received the largest incentive package the City of Columbus had ever awarded for Carmenton. During conversations about those incentives, Mayor Ginther asked "how can Columbus City students see themselves on the campus of Carmenton?" This led to the STEAMM Rising initiative, a partnership between the City of Columbus, Columbus City Schools, Columbus State Community College and The Ohio State University.

(See Attachment XV for background information, page 463)

3. External Auditor Update: Mr. David Gagnon, partner, KPMG LLP, gave an update on the status of fiscal 2023 audits. He shared that everything is going very well, and he expects to see financial statements and other information to get to the end of the audit in October. He also shared an industry update from KPMG and highlighted two of the updates: higher education sector fundraising study done by the Council for Advancement and Support of Education (CASE), and 2022 NACUBO-TIAA Study of Endowments.

(See Attachment XVI for background information, page 473)

***Item for Action:***

4. Approval of Minutes: No changes were requested to the May 18, 2023, meeting minutes; therefore, a formal vote was not required, and the minutes were considered approved.

**EXECUTIVE SESSION**

It was moved by Ms. Kessler, and seconded by Mr. Kaplan, that the committee recess into executive session to consult with legal counsel regarding pending or imminent litigation, to consider business-sensitive trade secrets that are required to be kept confidential by federal and state statutes, and to discuss personnel matters regarding the appointment, employment and compensation of public employees.

A roll call vote was taken, and the committee voted to go into executive session with the following members present and voting: Ms. Kessler, Mr. Stockmeister, Mr. Kaplan, Mrs. Harsh, Mr. Perez, Mr. Kerner, Ms. Chronis, and Dr. Fujita.

The committee entered executive session at 12:43 p.m. and the meeting adjourned at 1:59 p.m.

ATTACHMENT XIV



# Annual Compliance Report

## Gates Garrity-Rokous

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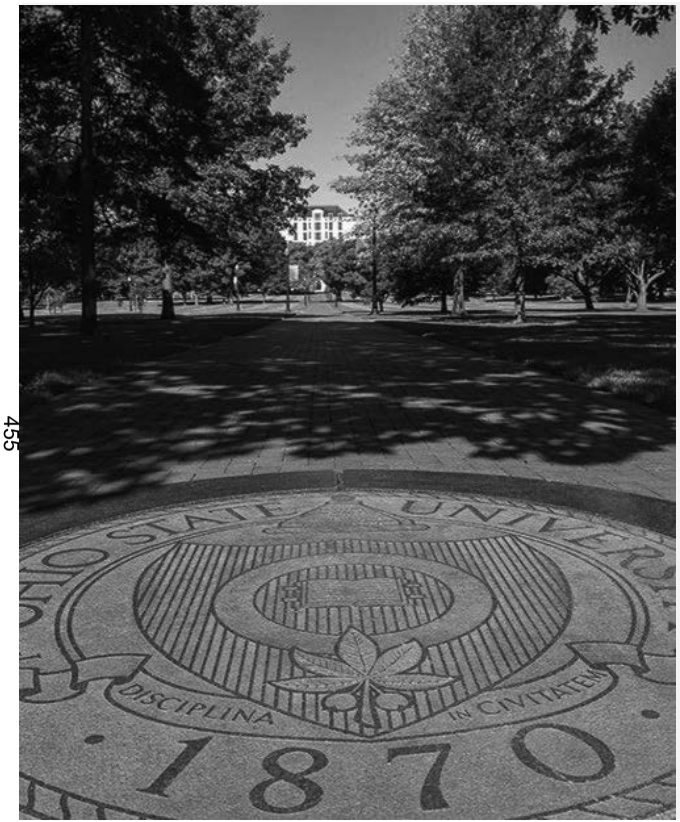



# Overview

- ✓ Risk Trends
- ✓ Focus Area: Concern Reporting

# Risk Trends: Higher Education

## *Key Risk Drivers – FY2023-24*

- Regulatory Expectations and Enforcement
- Academic Excellence and Research Innovation
- OSU Wexner Medical Center
- Athletics Transformation
- Economic and Political Environment

# Regulatory Expectations & Enforcement

*Risk Drivers*

**KNOWN RISKS**

- Continued new legislation and regulations
- Malign influence and grant repayment

**EMERGING RISKS**

- Affirmative Action and free speech
- Employment concerns

**FY2024 COMPLIANCE FOCUS**

- Continue improvements in issue response processes
- Reinforce leadership expectations
- Continue to align controls and processes

# Academic Excellence & Research Innovation

*Risk Drivers*

**KNOWN RISKS**

- Competitive pressures and key opportunities requiring increase in speed of decision-making
- New secure research regulations

**EMERGING RISKS**

- AI technologies across all operations
- Cybersecurity 3rd party risks

**FY2024 COMPLIANCE FOCUS**

- Reinforce focus on cybersecurity
- Focus on regulatory tollgates (key decision points)
- Continue to align controls and processes to obtain efficiencies and facilitate compliance

# OSU Wexner Medical Center

*Risk Drivers*

**KNOWN RISKS**

- Post-pandemic increase in enforcement
- HIPAA privacy and challenges to data sharing for research purposes

**EMERGING RISKS**

- Impact of China de-risking on sourcing
- Cybersecurity 3rd party risks

**FY2024 COMPLIANCE FOCUS**

- Maintain focus on tailored risk programs and compliance auditing
- Combine privacy and compliance investigations and auditing resources
- Continue alignment of WMC and campus information security efforts

# Athletics Transformation

*Risk Drivers*

**KNOWN RISKS**

- Fundamental change in business model
- 2022 NCAA Major Case requiring continued monitoring and reporting

**EMERGING RISKS**

- Diverse NIL recruiting strategies
- Efforts to obtain employee status or “revenue sharing” for student-athletes
- Title IX implications of any organizational changes

**FY2024 COMPLIANCE FOCUS**

- Continue rapid response to evaluate new NIL opportunities
- Maintain focus on Major Case requirements

# Economic and Political Environment

*Risk Drivers*

**KNOWN RISKS**

- Efficiency priorities and competitive employment pressures
- Need for continued simplification of operations
- Increase in student concerns of physical security

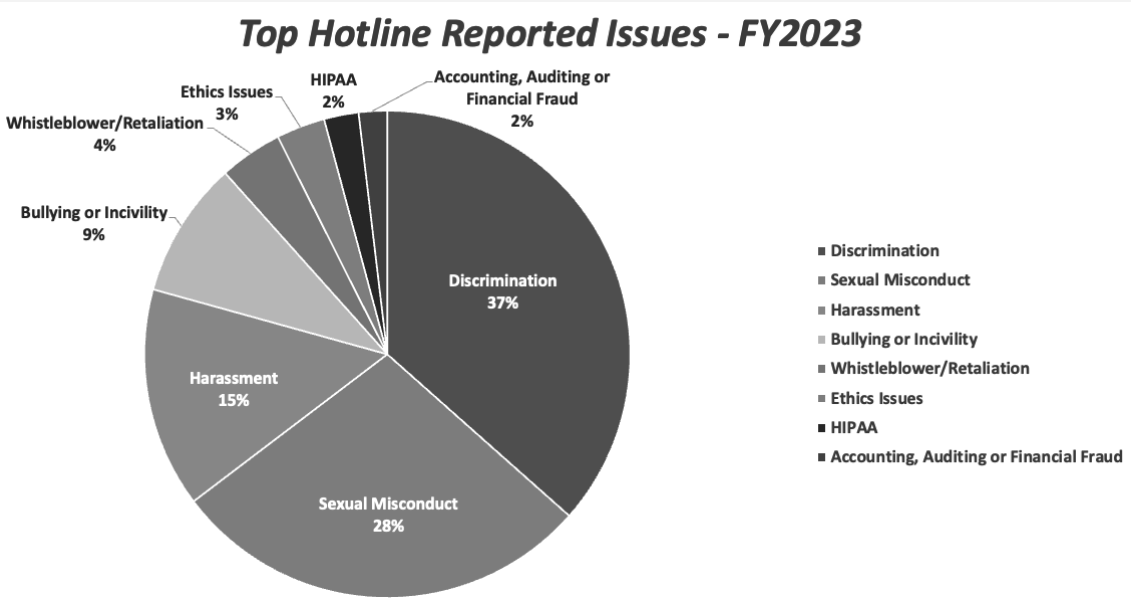
**EMERGING RISKS**

- Impact of 2024 election season

**FY2024 COMPLIANCE FOCUS**

- Assist OHR in improving compliance auditing
- Continue focus on Clery Act compliance
- Continue focus on concern reporting processes

# Focus Area: Concern Reporting




**Volume (FY22 to FY23)**

- 32% increase in employee matters (2,151 from 1,628)

**Type (FY22 to FY23)**

- Discrimination, harassment, and sexual misconduct complaints increasing
- HIPAA and bullying/ incivility concerns declining
- Proportion of anonymous complaints still declining

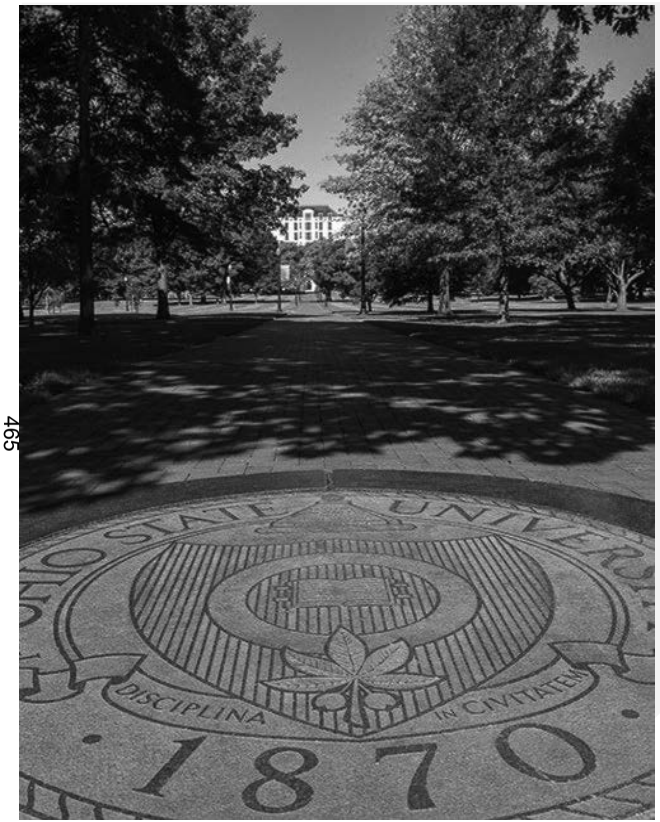
# Office of Government Affairs Annual Update

Stacy Rastauskas, Vice President for Government Affairs

**Legal, Audit, Risk, and Compliance Committee**
**Public Session**
**August 2023**

# About Government Affairs

- Federal, state, local and community, advocacy
- 20 team members focused on advancing university and medical center priorities
- Annual government investment into the university is $1.53 billion
- Worked on 57 of individual policy issues since January 2023
- Build and steward relationships between public and university officials




# 2022-2023 Highlights

- Engagement with key officials
- Advocating for investment
- Responding to policy changes affecting university

# Federal

- Federal Appropriations
  - FY23 – Signed into law on 12/29/2022
  - FY24 – In process
- Policy
  - Chips and Science Act
  - Name, Image, and Likeness (NIL)
  - Farm Bill
- Engagement
  - Legislative meetings and campus visits
  - Scarlet and Gray Congressional Breakfast and Scholarship Fundraiser, Buckeyes on the Hill

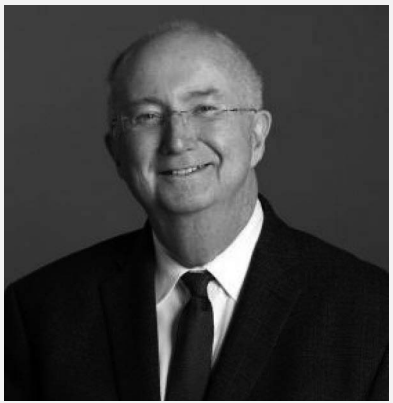
# State

- State Operating Budget
  - Funding increases
  - Policy issues
- Legislation
  - Senate Bill 83
  - Senate Bill 117
- Engagement
  - Alumni in Government Luncheon
  - Legislative meetings and campus tours
  - Ohio State Fair


# Local

- Carmenton
  - Streamlining infrastructure and construction process
- Partnership Achieving Community Transformation (PACT)
  - New Executive Director Sheldon Johnson
- Engagement with Local Stakeholders
  - November Columbus City Council elections
  - Wexner Medical Center East Side community engagement

# Columbus STEAMM Rising



**W. Randy Smith**
Vice Provost for Academic Programs
The Ohio State University

**Dr. Angela Chapman**
Superintendent and CEO
Columbus City Schools

**Megan Noble**
Executive Director, Strategic Priorities
Columbus City Schools

# Columbus STEAMM Rising - Background

- Columbus STEAMM (Science, Technology, Engineering, Art, Mathematics, and Medicine) Rising was created in response to Columbus Mayor Ginther's question: *"How can Columbus City students see themselves in STEM positions in Carmenton?"*

- STEAMM Rising was developed as a partnership between the City of Columbus, Columbus City Schools, Columbus State Community College, and Ohio State to offer a design-thinking institute for K-12 teachers to:
  - Show them the wide array of options in STEAMM education
  - Connect them with post-secondary colleagues
  - Help them begin to think about how the work fits into their own classrooms
  - Tell their students about the wide array of career options available in STEAMM

# Columbus STEAMM Rising – Implementation

- Planning began in Autumn 2021, led by the Office of Academic Affairs, and leadership in Columbus City Schools and Columbus State Community College. A commitment was made to hold 5 consecutive annual institutes through 2026.

- The first Institute was held in June 2022 at Ohio State, during which dozens of teachers from Columbus City Schools visited classrooms and labs across the Columbus campus.

- The second Institute, held in June 2023, in partnership with JPMorgan Chase hosted more than 100 Columbus City Schools educators.

# Questions?

Thank you for your time!

KPMG

# The Ohio State University




**Meeting with the**
**Legal, Audit, Risk and Compliance Committee**
**of the Board of Trustees**

August 16, 2023

The Ohio State University

# Agenda

## Status of fiscal 2023 audits (verbal update)

## Industry Update

- Higher education sector fundraising in fiscal 2022
- 2022 NACUBO-TIAA Study of Endowments
- Cryptocurrency in higher education
- ESG considerations – rating agencies

# Higher education sector fundraising in fiscal 2022

# Higher education sector fundraising in fiscal 2022

In February 2023, the Council for Advancement and Support of Education (CASE) published its annual *Voluntary Support of Education (United States)* survey. The survey gathered responses from 826 U.S. institutions, representing about 25% of the colleges and universities in the U.S. and 70% of funds raised. The survey covered various types of private and public colleges and universities and gleaned data about their philanthropic support in the 2021-2022 academic year. Following are highlighted data and our key takeaways from the survey.

## Estimated voluntary support of higher education by source[1]

(Dollars in millions)

| Donor type | 2022 amount | % of 2022 total | % increase 2021 to 2022 |
|---|---|---|---|
| Organizations[2] | $36,500 | 61.3% | 14.6% |
| Alumni | 13,500 | 22.7 | 10.2 |
| Non-alumni individuals | 9,500 | 16.0 | 8.0 |
| **Total** | **$59,500** | **100.0%** | **12.5%** |
| | | | |
| Current operations | $34,250 | 57.6% | 6.0% |
| Capital purposes | 25,250 | 42.4% | 22.6 |

[1] Source: CASE *Voluntary Support of Education (United States)*, 2022 survey.

[2] Category includes foundations, donor-advised funds (DAFs), corporations, and other organizations.

# Higher education sector fundraising in fiscal 2022 (continued)

## Key takeaways from the survey

- Following $52.9 billion of sector giving in fiscal 2021, the booming stock market through the end of calendar 2021 supported a 12.5% increase in giving in fiscal 2022, resulting in a record-high $59.5 billion of sector fundraising. By the end of the fiscal year, stock market declines may have limited total fundraising (especially major gifts, as discussed below). Still, gifts from all sources – alumni, non-alumni, and organizations – increased. Organizations, which include DAFs, foundations, corporations, and other organizations, was the single largest category of giving, comprising 61.3% of the total.
- There were seven gifts in 2022 (versus nine in 2021) of $100 million or more, totaling $1.08 billion and 1.8% of total gifts. This group of major donors included four foundations, two DAFs, and one living individual.
- Giving increases were concentrated in restricted endowment gifts, followed by restricted gifts for current operations. Once again, financial aid was the most common restricted endowment purpose (40.1% of all such gifts), and research was the most common restricted purpose for current operations (29.9% of all such gifts).
- For the 781 institutions who responded to the survey in both 2022 and 2021, support increased 11%. Of this group, approximately two-thirds saw giving totals increase, on average by 25.7%. The remaining one-third reported that giving declined, on average by 20.6%.

# Higher education sector fundraising in fiscal 2022 (continued)

## Key takeaways from the survey

- Once again, respondent private and public research/doctoral institutions generated a disproportionate share of total giving, comprising 73% of sector funds raised (versus 71% in 2020) and growing 12.1% over 2021. Mirroring this result was the group of 20 institutions – most of whom are research/doctoral institutions – who raised the most in 2022 and comprised 26.4% of all giving. Additionally, although as categories they comprise much smaller shares of total giving, respondent private and public baccalaureate institutions realized the largest overall percentage increase in giving (12.3%), whereas associate's institutions was the only category to realize a decline (15.4%).
- Several institutions responded to a new question in the 2022 survey aimed at better understanding gift distribution by size and number of gifts. The average respondent among a total of 217 reported receiving 13,165 gifts totaling $81.76 million. In terms of the sheer number of gift transactions reported, 42.1% were below $100, and the vast majority were below $1 million. As to dollars raised, the single largest distribution category–comprising 23.6% of the total dollars–was gifts from $1 million to just below $5 million. Gifts of $25 million or more constituted 13.8% of total dollars raised but less than 1% of total transactions reported.
- In 2022, the survey asked about giving from alumni by graduation cohort, with two hundred institutions responding. The data show that participation and dollars raised grow as alumni age. Participation and dollars raised for alumni out 10 years or less was 11.7% and 1.5%, respectively. The vast majority of participation and dollars raised are from alumni out 31 years or more, with the out 50+ years cohort having the highest participation (14.6%) and the most dollars raised (37.8%).

# 2022 NACUBO-TIAA Study of Endowments

Highlights of the Study

# 2022 NACUBO-TIAA Study of Endowments

## Respondent data

A total of 678 institutions–aggregating $807 billion of total endowment value–took part in the Study, which covered the fiscal year ended June 30, 2022. Endowment wealth remained sharply concentrated, with endowments over $1 billion comprising 84% of total endowment value (unchanged from 2021). Average endowment size was $1.2 billion, with the median endowment size $203.4 million.

## Fundraising

New endowment gifts in 2022 rose 22% over 2021, likely reflecting surging equity markets through the end of calendar 2021 (the first half of fiscal 2022). Responding to a question added last year, nearly two-thirds of survey respondents reported at least some giving directed toward diversity, equity, and inclusion (DEI) initiatives.

## Returns

In a staggering reversal, annualized average returns were -8.0% in 2022 versus 30.6% in 2021.Once again, larger endowment size and private market allocations correlated with better performance. The best-performing cohort–with an average return of - 4.5%–was endowments over $1 billion. The average market value decline for the three smallest cohorts was 9.6%, reflecting higher public market allocations. Post-pandemic increases in fuel and commodities prices exacerbated by the Ukraine/Russia conflict helped make private energy and infrastructure the strongest performing assets for endowments in 2022. Private equity, venture capital, and private real assets also posted strong returns, allowing the largest endowments to mitigate overall negative returns.

## Spending

Overall endowment spending in 2022 increased to $25.85 billion, even though effective spending rates were down (4.17% in 2022 versus 4.79% in 2021) due to higher market value averaging in endowment spending formulas. The median percentage of operating budget funding from endowments was 5.3%.

## ESG considerations

More endowments said they have added environmental, social, and governance (ESG) factors to their portfolios. Over 86% of endowments responding to the Study's question on investment policies include a commitment to ESG in their policies. In addition,18% of endowments include responsible investing (RI) criteria in a wide range of asset classes, and 24% plan to add or expand RI approaches to portfolios or policies given the increased focus on DEI.

# Cryptocurrency in higher education

# What is cryptocurrency?

**Cryptocurrency (crypto)** is a digital asset (i.e., property) designed to work as a medium of exchange

- Mined (i.e., formed), encrypted, and stored in secured blockchains
  - Tracking and transacting uses blockchain technologies
- Not really a security or a fiat currency
- No central authority that manages or maintains value
- Can be used as a means of payment or investment

**Blockchain** is a digital ledger that keeps record of transactions in code

- Each transaction is a "block," and the ledger is a "chain" which links the blocks together
- Does not sit on one server (decentralized tracking and validation) – no single party controls the data
- Once data is written, it cannot be deleted
- Uses technology which prevents unauthorized changes to the blockchain record through the use of a digital key

# Common cryptocurrencies

Bitcoin | Ethereum | Ripple | Litecoin | Stellar | IOTA | Dash | Bitcoin | Bitcoin

…and thousands more. Anyone can create their own form of cryptocurrency with a modified blockchain code.

# Risks and challenges

**Risk of loss**

- When holding crypto, it can be highly speculative and volatile. Recent market turmoil has resulted in value declines and bankruptcies of crypto firms.
- Losses may be direct, or indirect (e.g., crypto allocations in funds)
- Loss of keys or other access points

**Reputational risks**

- Blockchain does not disclose donor identity
- Crypto issues in endowment or operating assets
- Environmental concerns around crypto mining
- Exposure to fraud or bankruptcy from crypto firms or other third-parties

**Other challenges**

- Policies and procedures over transacting, custody, valuation, and accounting. FASB plans to extend fair value accounting currently used by NFPs to all entities.
- Use of third-party advisors and brokers and related due diligence
- Tax and other regulatory compliance

# Questions to ask

Because crypto is still speculative and volatile, engaging in transactions or holdings requires a thorough understanding of the risks, as well as the entity's crypto posture. Colleges and universities, with appropriate oversight of the board, should establish clear policies and procedures before accepting crypto or investing in these digital assets.

- Have we engaged an **outside advisor** to better understand crypto risks and opportunities?
- What **approvals** should occur prior to accepting a donation in crypto?
- How are we staying **current** on evolving tax compliance and reporting rules?
- What information will be required from donors for proper **identification**, and how can we ensure its accuracy?
- Given the potential **risk of loss** and impacts on financial reporting, will we hold or immediately liquidate such donations?
- Will we make crypto investments **directly or indirectly** (e.g., through commingled funds)?
- How will crypto payments or investments be **administered**, and by whom?
- Are **internal controls** appropriate? Consider whether a reputable custodian or broker is needed.

# ESG considerations – rating agencies

# ESG considerations – rating agencies

In its *Higher Education 2023 Outlook* (December 8, 2022), Moody's noted that ESG and nontraditional risks will have growing effects on budgets as institutions adjust to a changing environment. Moody's cited environmental challenges, including as to climate management and extreme weather, which require increased planning and higher costs (e.g., utilities and insurance); heightened social risks, including around access, affordability, student support services (e.g., mental health), and changing consumer preferences; and governance risks, including high leadership turnover, increased politicization of higher education, cybersecurity, and international campus and student risks from geopolitical realignments. Moody's and S&P have recently refined their methodologies to incorporate ESG factors–which they say increasingly influence credit drivers–and have also begun to articulate ESG risks and impacts in issuer ratings reports. Some of these risks are sector-specific, while others cut across various industries.

**Example methodology considerations**

Moody's ESG considerations result in "Issuer Profile Scores" (IPSs) and, ultimately, "Credit Impact Scores" (CISs). General IPS categories include the following:

**Environmental IPS:** Carbon transition, physical climate risks, water management, waste and pollution, and natural capital.

**Social IPS:** Customer relations, human capital, demographic and societal trends, health and safety, and responsible production.

**Governance IPS:** Financial strategy and risk management, management credibility and track record, organizational structure, compliance and reporting, and board structure and policies.

- Moody's has established general principles for assessing E, S, and G risk categories for issuers that result in the IPS, which is expressed on a five-point scale. Sector-specific risk subcategories may also be relevant to the analysis. For example, for public sector entities–including public colleges and universities–governance factors such as institutional structure and budget management may also be relevant.
- In addition, Moody's may establish a CIS to explain the impact of ESG considerations on the rating of the issuer or transaction. The CIS is based on a qualitative assessment of the impact of ESG considerations in the context of the issuer's other credit drivers that are material to a given rating. The scale ranges from CIS-1 ("Positive") to CIS-5 ("Very Highly Negative").

Some or all of the services described herein may not be permissible for KPMG audit clients and their affiliates or related entities.



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THE OHIO STATE UNIVERSITY

Board of Trustees

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Fax (614) 292-5903
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**SUMMARY OF ACTIONS TAKEN**

*August 16, 2023 – Academic Affairs and Student Life Committee Meeting*

**Members Present:**

| | | |
|---|---|---|
| Jeff M.S. Kaplan | Reginald A. Wilkinson | Susan E. Cole |
| Elizabeth A. Harsh | Pierre Bigby | Hiroyuki Fujita (ex officio) |
| Elizabeth P. Kessler | Joshua H.B. Kerner | |

**Members Present via Zoom:** N/A

**Members Absent:**

Michael Kiggin

The Academic Affairs and Student Life Committee of The Ohio State University Board of Trustees convened on Wednesday, August 16, 2023, in person at Vitria on the Square, 14 E. 15th Avenue, Columbus, OH, 43201. Committee Chair Jeff Kaplan called the meeting to order at 2:30 p.m.

**PUBLIC SESSION**

***Items for Discussion***

1. Provost's Report: Dr. Melissa Gilliam kicked off the committee's public session with her Provost's Report, featuring updates on Ohio State's Academic Plan. Highlights included updates on the new Buckeye Precollege program, the Center for Software Innovation, and sustainability education and workforce development, and new deans Karen Rose (Nursing) and Jason Lemon (Online Learning). She provided an update on the university's operational changes and processes following the U.S. Supreme Court's decision on affirmative action.

   (See Attachment XVII for background information, page 499)

2. Senior Vice President for Student Life's Report: Dr. Melissa Shivers highlighted a few key focus areas for the Office of Student Life for the 2023-24 academic year that centers around Student Life's strategic goal of investing in student well-being. She shared how Student Life, in partnership with our campus community, is helping to set students up for success.

   (See Attachment XVIII for background information, page 514)

***Items for Action***

3. Approval of Minutes: No changes were requested to the May 18, 2022, meeting minutes; therefore, a formal vote was not required, and the minutes were considered approved.

4. Resolution No. 2024-21, Approval to Establish a Doctor of Education in Teaching and Learning:

IN THE COLLEGE OF EDUCATION AND HUMAN ECOLOGY

THE OHIO STATE UNIVERSITY

Synopsis: Approval to establish a Doctor of Education in Teaching and Learning degree with a specialization in practitioner inquiry of equity-based advocacy in the College of Education and Human Ecology is proposed.

WHEREAS the need for such a program was identified through stakeholder engagement with department faculty and local educators, in addition to benchmarking programs at similar institutions; and

WHEREAS the new degree program will enhance the Department of Teaching and Learning's engagement with school districts through teaching, research, and outreach; and

WHEREAS the program will draw on the expertise of the faculty to prepare educational professionals to develop knowledge, skills, and dispositions for transforming their communities toward equity-based advocacy; and

WHEREAS the program will require a practice-based educational research project to take place in school settings where the degree candidate involves schools and districts in the design and implementation of the project, thus respecting the district's culture, strengths and assets; and

WHEREAS the program plans to focus locally within Franklin County's 19 school districts for educators with master's degrees looking to earn a doctoral degree, with the intent of expanding recruitment across the state and beyond; and

WHEREAS the proposal was reviewed and approved by the Council on Academic Affairs at its meeting on February 1, 2023; and

WHEREAS the University Senate approved this proposal on March 23, 2023:

NOW THEREFORE

BE IT RESOLVED, That the Board of Trustees hereby approves the proposal to establish a Doctor of Education in Teaching and Learning degree program in the College of Education and Human Ecology.

(See Appendix XV for background information, page 717)

5. Resolution No. 2024-22, Faculty Personnel Actions:

BE IT RESOLVED, That the Board of Trustees hereby approves the faculty personnel actions as recorded in the personnel budget records of the university since the May 17, 2023, meeting of the board, including the following appointments, appointments/reappointments of chairpersons, faculty professional leaves and emeritus titles:

Appointments

Name: SHEIKH AKBAR
Title: Professor (2023 Alumni Award for Distinguished Teaching)
College: Office of Academic Affairs
Term: N/A

Name: FLOOR BACKES
Title: Professor (The Larry J. Copeland, M.D. Professorship in Gynecologic Oncology)
College: Medicine
Term: September 1, 2023, through June 30, 2027

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Name: STEVEN BENGAL
Title: Lecturer (2023 Provost's Award for Distinguished Teaching by a Lecturer)
College: Office of Academic Affairs
Term: N/A

Name: MICAH BERMAN
Title: Professor (The Stephen F. Loebs Professorship in Health Services Management and Policy)
College: Public Health
Term: August 15, 2023, through August 14, 2028

Name: LIJUAN BI
Title: Lecturer, Newark (2023 Provost's Award for Distinguished Teaching by a Lecturer)
College: Office of Academic Affairs
Term: N/A

Name: NICHOLAS BREITBORDE
Title: Professor (The Charles F. Sinsabaugh Chair in Psychiatry)
College: Medicine
Term: August 1, 2023, through June 30, 2027

Name: STEVEN BROWN
Title: Associate Professor-Clinical (2023 Alumni Award for Distinguished Teaching)
College: Office of Academic Affairs
Term: N/A

Name: AMY BRUNELL
Title: Professor (2023 Alumni Award for Distinguished Teaching)
College: Office of Academic Affairs
Term: N/A

Name: NICK BRUNELLI
Title: Associate Professor (Ervin G. Bailey Chair in Energy Conversion)
College: Engineering
Term: July 1, 2023, through June 30, 2028

Name: CHRISTIN BURD
Title: Associate Professor (2023 Alumni Award for Distinguished Teaching)
College: Office of Academic Affairs
Term: N/A

Name: CARLOS CASTRO
Title: Professor (The Ralph W. Kurtz Chair in Mechanical Engineering)
College: Engineering
Term: July 1, 2023, through June 30, 2028

Name: NATALIA HIGUITA CASTRO
Title: Associate Professor (College of Engineering Innovation Scholar)
College: Engineering
Term: July 1, 2023, through June 30, 2028

Name: WEI-LUN (HARRY) CHAO
Title: Assistant Professor (Distinguished Assistant Professor of Engineering Inclusive Excellence)
College: Engineering
Term: August 15, 2023, through June 30, 2028

THE OHIO STATE UNIVERSITY

Name: TED CLARK
Title: Professor (2023 Provost's Award for Distinguished Teaching by a Lecturer)
College: Office of Academic Affairs
Term: N/A

Name: STUART COOPER
Title: Professor (Distinguished University Professor)
College: Office of Academic Affairs
Term: N/A

Name: GREG DAVIS
Title: Professor (The George R. and Genevieve B. Gist Endowed Chair in Ohio State University Extension)
College: Food, Agricultural, and Environmental Sciences
Term: July 1, 2023, through June 30, 2028

Name: LAURA DEETER
Title: Professor (Sandy and Andy Ross Endowed Director of the Chadwick Arboretum and Learning Gardens)
College: Food, Agricultural, and Environmental Sciences
Term: August 15, 2023, through August 14, 2028

Name: LIN DING
Title: Professor (2023 Alumni Award for Distinguished Teaching)
College: Office of Academic Affairs
Term: N/A

Name: MOLLY DOWNING
Title: Assistant Professor-Practice (2023 Provost's Award for Distinguished Teaching by a Lecturer)
College: Office of Academic Affairs
Term: N/A

Name: THEODORA DRAGOSTINOVA
Title: Professor (2023 Alumni Award for Distinguished Teaching)
College: Office of Academic Affairs
Term: N/A

Name: RACHEL GETMAN
Title: Professor (Bernice L. Claugus Endowed Chair in Chemical and Biomolecular Engineering)
College: Engineering
Term: August 15, 2023, through June 30, 2028

Name: ERIC GREEN
Title: Professor (Excellence in Veterinary Care Diagnostic Imaging Professorship in the College of Veterinary Medicine)
College: Veterinary Medicine
Term: July 1,2022, through June 30, 2027

Name: L. CAMILLE HEBERT
Title: Professor (Robert J. Lynn Chair in Law)
College: Law
Term: August 15, 2023, through August 15, 2028

THE OHIO STATE UNIVERSITY

Name: ELENA IRWIN
Title: Professor (Distinguished University Professor)
College: Office of Academic Affairs
Term: N/A

Name: JULIE JOHNSON*
Title: Professor (Dr. Samuel T. and Lois Felts Mercer Professor of Medicine and Pharmacology)
College: Medicine
Term: October 9, 2023, through October 8, 2027

Name: KAY BEA JONES
Title: Professor (2023 President and Provost's Award for Distinguished Faculty Service)
College: Office of Academic Affairs
Term: N/A

Name: JOSHUA JOSEPH
Title: Associate Professor (Endowed Professorship for Research in Internal Medicine)
College: Medicine
Term: July 1, 2023, through June 30, 2027

Name: ZAK KASSAS
Title: Professor (The Transportation Research Center, Inc. Chair in Intelligent Transportation Systems)
College: Engineering
Term: July 1, 2023, through June 30, 2028

Name: STANLEY LEMESHOW
Title: Professor (Distinguished University Professor)
College: Office of Academic Affairs
Term: N/A

Name: JASON LEMON
Title: Dean and Vice Provost for Online Learning
College: Office of Academic Affairs
Term: July 1, 2023

Name: ZAIBO LI
Title: Professor-Clinical (University Pathology Services Anatomic Pathology Professorship)
College: Medicine
Term: July 1, 2023, through June 30, 2027

Name: TREVON LOGAN
Title: Professor (ENGIE-Axium Endowed Professorship)
College: Office of Academic Affairs
Term: August 15, 2023, through May 1, 2028

Name: STEVEN LOPEZ
Title: Associate Professor (2023 President and Provost's Award for Distinguished Faculty Service)
College: Office of Academic Affairs
Term: N/A

THE OHIO STATE UNIVERSITY

Name: BERNADETTE MELNYK
Title: Professor (Vice President for Health Promotion and Chief Wellness Officer)
College: Office of Academic Affairs
Term: July 1, 2023, through June 30, 2025

Name: TODD MONROE
Title: Research Professor (Distinguished Professor of Aging Research)
College: Nursing
Term: April 24, 2023, through April 24, 2028

Name: STEVE OGHUMU
Title: Associate Professor (Excellence in Research and Education Leadership Professorship in the College of Medicine)
College: Medicine
Term: July 1, 2023, through June 30, 2027

Name: JOEL PAULSON
Title: Assistant Professor (The H.C. 'Slip' Slider Professorship in Chemical and Biomolecular Engineering)
College: Engineering
Term: September 1, 2023, through June 30, 2028

Name: ASHLEY PEREZ
Title: Assistant Professor (2023 Alumni Award for Distinguished Teaching)
College: Office of Academic Affairs
Term: N/A

Name: DANIEL GALLEGO PEREZ
Title: Associate Professor (The Edgar C. Hendrickson Designated Chair in Biomedical Engineering)
College: Engineering
Term: July 1, 2023, through June 30, 2028

Name: STEPHEN QUAYE
Title: Professor (2023 Alumni Award for Distinguished Teaching)
College: Office of Academic Affairs
Term: N/A

Name: EDUARDO REATEGUI
Title: Associate Professor (College of Engineering Innovation Scholar)
College: Engineering
Term: July 1, 2023, through June 30, 2028

Name: KATELYN SWINDLE REILLY
Title: Associate Professor (College of Engineering Innovation Scholar)
College: Engineering
Term: July 1, 2023, through June 30, 2028

Name: VINCENT ROSCIGNO
Title: Professor (2023 Alumni Award for Distinguished Teaching)
College: Office of Academic Affairs
Term: N/A

THE OHIO STATE UNIVERSITY

Name: ABDOLLAH SHAFIEEZADEH
Title: Professor (2023 Alumni Award for Distinguished Teaching)
College: Office of Academic Affairs
Term: N/A

Name: JENNY SHELDON
Title: Assistant Professor-Clinical (2023 Provost's Award for Distinguished Teaching by a Lecturer)
College: Office of Academic Affairs
Term: N/A

Name: PATRICK SOURS
Title: Senior Lecturer (2023 Provost's Award for Distinguished Teaching by a Lecturer)
College: Office of Academic Affairs
Term: N/A

Name: HUAN SUN
Title: Associate Professor (College of Engineering Innovation Scholar)
College: Engineering
Term: August 15, 2023, through June 30, 2028

Name: PIERS NORRIS TURNER
Title: Associate Professor (2023 President and Provost's Award for Distinguished Faculty Service)
College: Office of Academic Affairs
Term: N/A

Name: DEVINA PURMESSUR WALTER
Title: Associate Professor (College of Engineering Innovation Scholar)
College: Engineering
Term: July 1, 2023, through June 30, 2028

Name: KARLA ZADNIK
Title: Interim Dean
College: Public Health
Term: July 1, 2023, through June 30, 2024, or until a new Dean is appointed

Name: PATRICIA ZETTLER
Title: Professor (John W. Bricker Professorship in Law)
College: Law
Term: August 15, 2023, through August 22, 2028

Reappointments

Name: STUART COOPER
Title: Professor (Distinguished Professor of Engineering)
College: Engineering
Term: September 1, 2023, through June 30, 2028

Name: ISABELLE DESCHENES
Title: Professor and Chair (Bernie Frick Research Chair in Heart Failure and Arrhythmia)
College: Medicine
Term: August 1, 2023, through June 30, 2027

THE OHIO STATE UNIVERSITY

Name: LIANG-SHIH FAN
Title: Distinguished University Professor (The C. John Easton Professor in Engineering)
College: Engineering
Term: July 1, 2023, through June 30, 2028

Name: GERALD FRANKEL
Title: Professor (Distinguished Professor of Engineering)
College: Engineering
Term: September 1, 2023, through June 30, 2028

Name: ANDREW GLASSMAN
Title: Professor and Chair (Frank J. Kloenne Chair of Orthopaedic Surgery)
College: Medicine
Term: July 1, 2023, through June 30, 2025

Name: WILLIAM MARRAS
Title: Professor (The Honda Chair in Transportation)
College: Engineering
Term: July 1, 2023, through June 30, 2028

Name: HARVEY MILLER
Title: Professor (Bob and Mary Reusche Chair in Geography)
College: Arts and Sciences
Term: August 1, 2023, through June 30, 2028

Name: UMIT OZKAN
Title: Professor (Distinguished Professor of Engineering)
College: Engineering
Term: July 1, 2023, through June 30, 2028

Name: BOYD PANTON
Title: Professor (Lincoln Electric Company Endowed Professor)
College: Engineering
Term: September 1, 2023, through June 30, 2028

Name: MARK PARTRIDGE
Title: Professor (The C. William Swank Chair in Rural and Urban Policy Fund)
College: Food, Agricultural, and Environmental Sciences
Term: July 1, 2023, through June 30, 2024

Name: KINH LUAN PHAN
Title: Professor and Chair (Jeffrey Schottenstein Endowed Chair of Psychiatry and Resilience)
College: Medicine
Term: July 1, 2023, through June 30, 2027

Name: GIORGIO RIZZONI
Title: Professor (The Ford Motor Company Chair in Electromechanical Systems)
College: Engineering
Term: July 1, 2023, through June 30, 2028

Name: BRIAN ROE
Title: Professor (The Fred N. Van Buren Professorship in Farm Management)
College: Food, Agricultural, and Environmental Sciences
Term: July 1, 2023, through June 30, 2028

THE OHIO STATE UNIVERSITY

Name: IAN SHELDON
Title: Professor (The Andersons Endowed Chair in Agricultural Marketing, Trade and Policy)
College: Food, Agricultural, and Environmental Sciences
Term: July 1, 2023, through June 30, 2028

Name: LINDA WEAVERS
Title: Professor (John C. Geupel Chair)
College: Engineering
Term: July 1, 2023, through June 30, 2028

Name: MARCIA WORLEY
Title: Professor (Merrell Dow Professorship in Pharmaceutical Administration)
College: Pharmacy
Term: July 1, 2023, through June 30, 2026

**Extensions**

Name: WENDY FRANKEL
Title: Professor and Chair (Ralph W. and Helen Kurtz Chair in Pathology)
College: Medicine
Term: July 1, 2023, through June 30, 2024

*New Hire

Appointments/Reappointments of Chairpersons

PAUL BELLAIR**, Director, Criminal Justice Research Center, July 1, 2023, through June 30, 2027

MARTHA BELURY, Chair, Department of Food Science and Technology, July 1, 2023, through June 30, 2027

ADAM CARBERRY*, Chair, Department of Engineering Education, August 1, 2023, through May 31, 2027 (change of dates)

ISABELLE DESCHENES**, Chair, Department of Physiology and Cell Biology, August 1, 2023, through June 30, 2027

HAROLD FISK (extension), Interim Director, Center for Life Sciences Education, July 1, 2023, through June 30, 2024

BRIAN FOCHT, Interim Chair, Department of Educational Studies, August 15, 2023, through August 14, 2024

WENDY FRANKEL (extension), Chair, Department of Pathology, July 1, 2023, through June 30, 2024

MARK FULLERTON, Chair, Department of Classics, July 1, 2023, through June 30, 2027

BENNET GIVENS (extension), Secretary of the University Senate, OAA, July 1, 2023, through June 30, 2024

ANDREW GLASSMAN**, Chair, Department of Orthopaedic Surgery, July 1, 2023, through June 30, 2025

THE OHIO STATE UNIVERSITY

TIM HAAB, Interim Director, School of Environment and Natural Resources, August 15, 2023, through June 30, 2024, or until a new Director is named.

ELLY KAIZAR, Chair, Department of Statistics, July 15, 2023, through June 30, 2027

ANDREW LEBER**, Director, Center for Cognitive and Brain Sciences, July 1, 2023, through June 30, 2027

KINH LUAN PHAN**, Chair, Department of Psychiatry and Behavioral Health, July 1, 2023, through June 30, 2027

JODI MCDANIEL, Director, Center for Healthy Aging, Self-Management, and Complex Care, July 1, 2023, through June 30, 2024

HARVEY MILLER**, Director, Center for Urban and Regional Planning (CURA), July 1, 2023, through June 30, 2027

MARK PARTHUN**, Chair, Department of Biological Chemistry and Pharmacology, July 1, 2023, through June 30, 2027

PIERCE PAUL, Chair, Department of Plant Pathology, July 1, 2023, through June 30, 2027

WILLIAM SCHULER, Interim Chair, Department of Linguistics, July 1, 2023, through June 30, 2024

STEPHANIE SCHULTE, Interim Director, Prior Health Sciences Library, July 1, 2023, through June 30, 2024

SCOTT SHEARER**, Chair, Department of Food, Agricultural, and Biological Engineering, July 1, 2023, through June 30, 2027

DONGBIN XIU, Interim Chair, Department of Mathematics, July 1, 2023, through June 30, 2024

**Reappointment
*New Hire

Faculty Professional Leaves

DONNA BOBBITT-ZEHER, Associate Professor, Department of Sociology, Marion, FPL for Spring 2024

QIAN CHEN, Professor, Department of Food, Agricultural and Biological Engineering, FPL for Fall 2023, and Spring 2024

NJERI KAGOTHO, Associate Professor, College of Social Work, FPL for Fall 2023

KENNETH MADSEN, Associate Professor, Department of Geography, Newark, FPL for Spring 2024

MARK MITTON-FRY, Associate Professor, College of Pharmacy, FPL for Spring 2024

TASLEEM PADAMSEE, Associate Professor, College of Public Health, FPL for Fall 2023, and Spring 2024

KELLEY TILMON, Professor, Department of Entomology, FPL for Spring 2024

CHRISTOPHER WOLTERS, Professor, Department of Educational Studies, FPL for Spring 2024

THE OHIO STATE UNIVERSITY

Faculty Professional Leave Changes/Cancellations

HANNA CHO, Associate Professor, Department of Mechanical and Aerospace Engineering, Change of FPL from Fall 2023, and Spring 2024 to Fall 2023 only.

NOAH DORMADY, Associate Professor, John Glenn College of Public Affairs, Change of FPL from Fall 2023 to Fall 2023 and Spring 2024

KATHY FAGAN-GRANDINETTI, Professor, Department of English, FPL cancellation

KATHY NORTHERN, Associate Professor, College of Law, FPL cancellation

Emeritus Titles

DAVID APSLEY, Department of Extension, with the title of Associate Professor-Emeritus, effective September 1, 2023

BHAVIK BAKSHI, Department of Chemical and Biomolecular Engineering, with the title of Professor-Emeritus, effective July 1, 2023

CHUNSHENG BAN, Department of Mathematics, with the title of Professor-Emeritus, effective July 1, 2023

WILLIAM BENNETT, Department of Radiology, with the title of Associate Professor-Emeritus, effective August 1, 2023

DAVID CLAMPITT, School of Music, with the title of Professor-Emeritus, effective June 1, 2023

JAMES COE, JR., Department of Chemistry and Biochemistry, with the title of Professor-Emeritus, effective July 1, 2023

NENA COUCH, University Libraries, with the title of Professor-Emeritus, effective March 16, 2023

PAUL DE BOECK, Department of Psychology, with the title of Professor-Emeritus, effective August 15, 2023

ANNE DORRANCE, Department of Plant Pathology, with the title of Professor-Emeritus, effective September 1, 2023

MARTIN GOLUBITSKY, Department of Mathematics, with the title of Professor-Emeritus, effective July 1, 2023

DAVID GREENBERG, Department of Pediatrics, with the title of Professor-Emeritus, effective July 1, 2023

BARBARA KEYFITZ, Department of Mathematics, with the title of Professor-Emeritus, effective July 1, 2023

TERESA LANKER, Agricultural Technical Institute, with the title of Associate Professor-Emeritus, effective September 1, 2023

STEPHEN LESSNICK, Department of Pediatrics, with the title of Professor-Emeritus, effective July 1, 2023

KENNETH ALAN LOPER, Department of Mathematics, with the title of Professor-Emeritus, effective June 1, 2023

THE OHIO STATE UNIVERSITY

MARY ALICE MOMEYER, College of Nursing, with the title of Assistant Professor-Clinical Emeritus, effective June 1, 2023

LYNN SCHOENFIELD, Department of Pathology, with the title of Associate Professor-Clinical Emeritus, effective July 1, 2023

MICHAEL TWEEDLE, Department of Radiology, with the title of Professor-Emeritus, effective July 1, 2023

PAUL WAKELY, Department of Pathology, with the title of Professor-Emeritus, effective July 1, 2023

Promotion, Tenure, and Reappointments

**COLLEGE OF VETERINARY MEDICINE**
**CLINICAL**

REAPPOINTMENT
Lerche, Phillip, Veterinary Clinical Sciences, August 15, 2024

**Action:** Upon the motion of Mr. Kaplan, seconded by Mr. Wilkinson, the committee adopted the foregoing resolutions by voice vote with the following members present and voting: Mr. Kaplan, Mrs. Harsh, Ms. Kessler, Dr. Wilkinson, Mr. Bigby, Mr. Kerner, Dr. Cole and Dr. Fujita.

**EXECUTIVE SESSION**

It was moved by Mr. Kaplan, and seconded by Ms. Kessler, that the committee recess into executive session to discuss business-sensitive trade secrets required to be kept confidential by federal and state statutes, to consult with legal counsel regarding pending or imminent litigation, and to discuss personnel matters involving the appointment, employment and compensation of public officials, which are required to be kept confidential under Ohio law.

A roll call vote was taken, and the committee voted to go into executive session with the following members present and voting: Mr. Kaplan, Mrs. Harsh, Ms. Kessler, Dr. Wilkinson, Mr. Bigby, Mr. Kerner, Dr. Cole and Dr. Fujita.

The committee entered executive session at 3:11 p.m. and the meeting adjourned at 4:34 p.m.

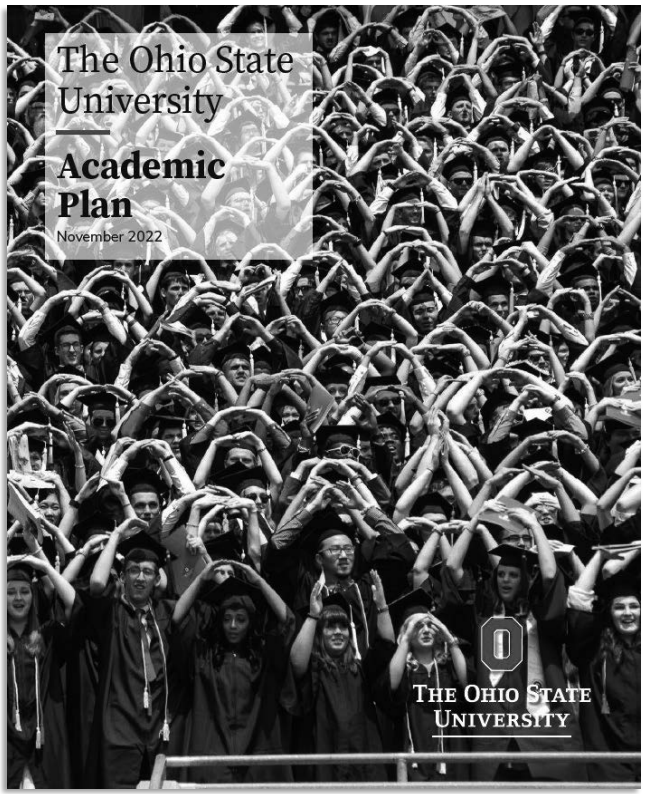
# Provost's Report

August 2023

**Melissa Gilliam**
Executive Vice President and Provost

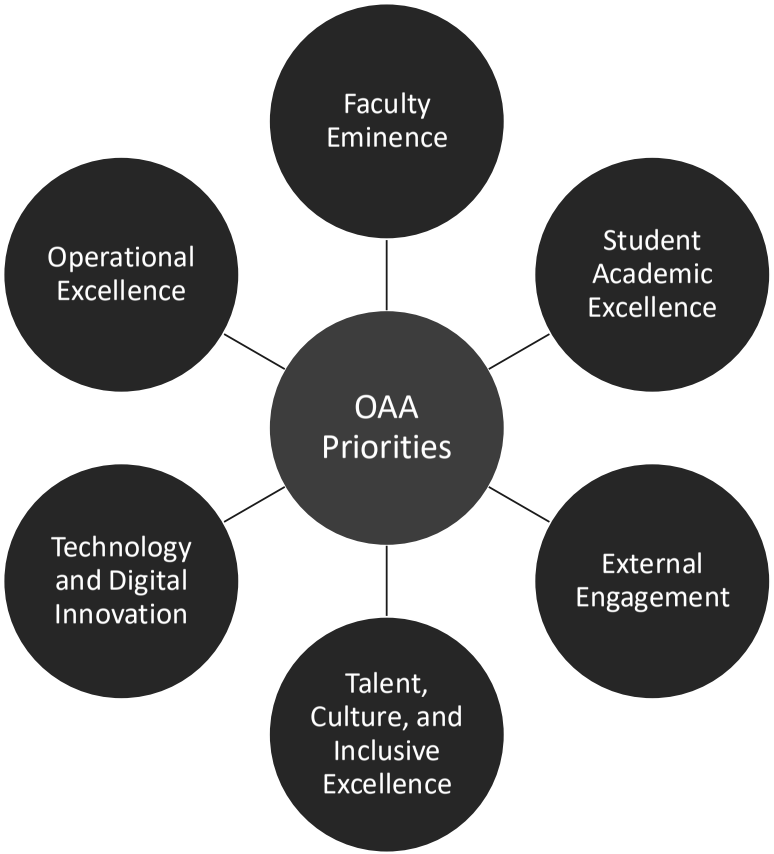
THE OHIO STATE UNIVERSITY

# A Shared Academic Vision for Ohio State



# Academic Plan

Where we will focus to achieve eminence and excellence.



# Orientation

# Visiting Stone Lab

# Sustainability Education and Workforce Development

- Data collection from employers, faculty/instructors, students, alumni, and other institutions
- Outside visiting committee, representing leaders in academia, industry, and community partners, evaluated findings and provided additional inputs

# Buckeye Precollege

**Summer Institutes** (residential)

- 95 students (rising 10th-12th graders)

**Summer Exploration** (non-residential)

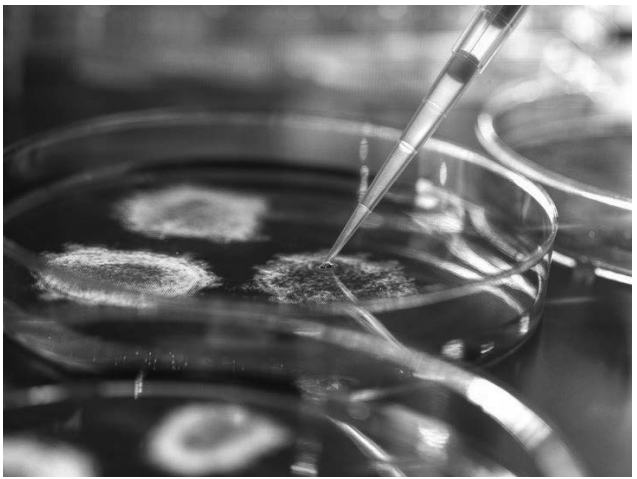
- 38 students (middle and high school)

# Center for Software Innovation

- Envisions the university and central Ohio as the new epicenter in the global digital economy, with software and innovation at the heart of it all
- Partnership with Kyiv School of Economics
- Entrepreneurial summit this fall

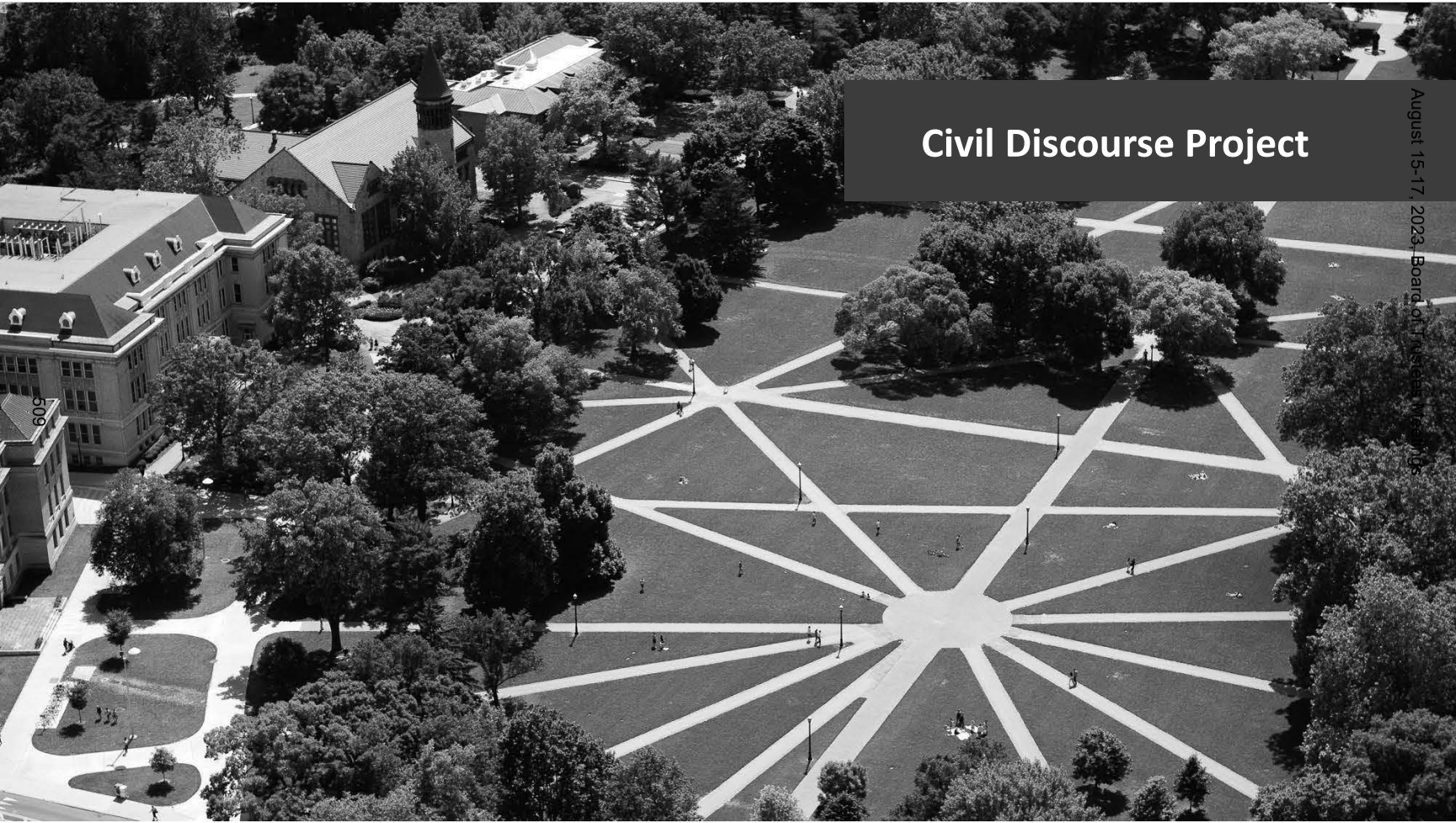
# NSF ADVANCE Program

- NSF funding award connecting Ohio State, Michigan State, and Wayne State
- Part of ADVANCE program to increase the representation and advancement of women in academic science and engineering careers
- Ohio State work will focus on leadership, culture, and developing faculty across the lifecycle



# Affirmative Action Update

- Office of Academic Affairs and Office of Legal Affairs convened working group to help the university prepare for and respond to the outcome
- Race/ethnicity removed from all documents visible to application readers, and revised evaluation tools under development for admissions/academic program reviewers
- Training will be ongoing over the coming academic year for readers and others involved in undergraduate, graduate, and professional program admissions



# Civil Discourse Project

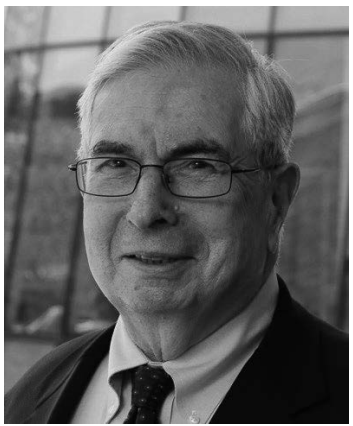
# Welcome, Karen Rose

- Dean of the College of Nursing, effective July 1
- Expert in gerontology nursing research
- Director, Center for Healthy Aging, Self-Management, and Complex Care
- Previously served as vice dean, College of Nursing

# Welcome, Jason Lemon

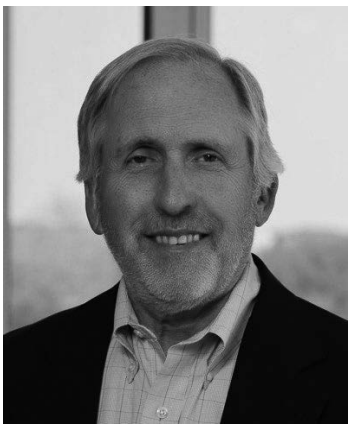
- Ohio State's first vice provost and dean for online leaning
- Providing oversight and strategic leadership for the growth and expansion of online learning programs
- Previously served as vice provost and dean of UC Online (University of Cincinnati)

# Distinguished University Professors



**Stuart Cooper**
Chemical and Biomolecular Engineering

**Elena Irwin**
Agricultural, Environmental, and Development Economics



**Stanley Lemeshow**
Public Health

# Thank you!

Engage. Learn. Thrive.

# Setting Students up for Success

Dr. Melissa S. Shivers
Senior Vice President for Student Life

THE OHIO STATE UNIVERSITY
OFFICE OF STUDENT LIFE

# Ohio State Student Well-Being

## Mental Health

**34%** of students report they have been diagnosed with anxiety

**27%** of students report they have been diagnosed with depression

**49%** of students report ever receiving mental health treatment

## Loneliness

**24%** of students report they have difficulty creating and maintaining social relationships

**53%** of students score positive for loneliness

## Alcohol and Other Drug Use

**80%** of students report using alcohol in their lifetime

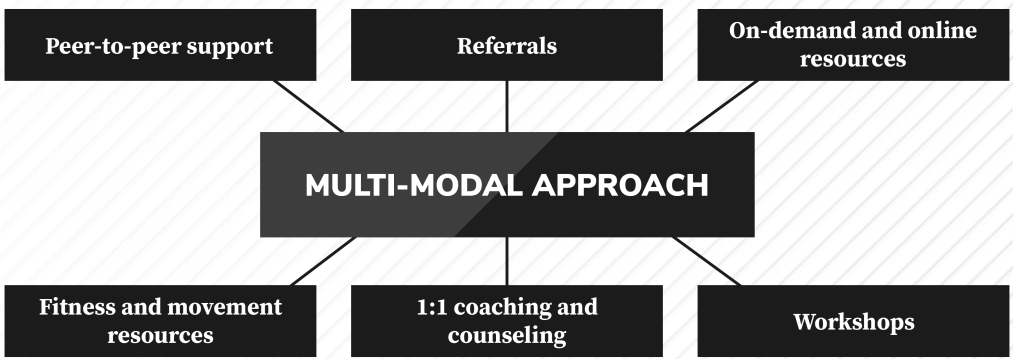
**45%** of students report using cannabis in their lifetime

**12%** of students report misusing a prescription stimulant in their lifetime

Data sources: National College Health Assessment, 2022; College Prescription Drug Study, 2022; Student Life Survey, 2023

# 10 Dimensions of Wellness

# Multi-Modal Approach



# Student Advocacy Center

**Helps students navigate Ohio State's structure to resolve issues**

**Support for wide range of needs:**

- Academic
- Enrollment
- Financial
- Health
- Personal Crisis
- Response for student death or serious injury

# Student Advocacy Center Impact

## By the numbers

- **4,199** students supported (22-23 academic year)
- **312** students received a Student Emergency Fund grant averaging $896 (22-23 academic year)
- **100%** of grant recipients reported they would go to the Student Advocacy Center for help again in the future if needed
- **93%** of students who received an emergency grant in 2021-22 either graduated or are still enrolled at Ohio State

"I would like to say thank you for how much the emergency fund helped me. I think this fund can help a lot of people in similar positions to me. It can prevent students from being homeless or having extra mental health struggles from not being able to solely focus on school without financial stressors."

**– Ohio State graduate and Student Emergency Fund grant recipient**

# Investing in a Culture of Care

# Questions?

THE OHIO STATE UNIVERSITY

Board of Trustees

University Square South
15 East 15th Avenue, 5th Floor
Columbus, OH 43201

Phone (614) 292-6359
Fax (614) 292-5903
trustees.osu.edu

**SUMMARY OF ACTIONS TAKEN**

*August 17, 2023 – Master Planning & Facilities Committee Meeting*

**Members Present:**

| | | |
|---|---|---|
| Alan A. Stockmeister | Pierre Bigby | Hiroyuki Fujita (ex officio) |
| Reginald A. Wilkinson | Joshua H.B. Kerner (8:51 am) | |
| Elizabeth A. Harsh | Robert H. Schottenstein (8:08 am) | |

**Members Present via Zoom:**

James D. Klingbeil

**Members Absent:** N/A

**PUBLIC SESSION**
The Master Planning & Facilities Committee of The Ohio State University Board of Trustees convened on Thursday, August 17, 2023, in person at Vitria on the Square, 14 E. 15th Avenue, Columbus, OH, 43201, and virtually over Zoom. Committee Chair Alan A. Stockmeister called the meeting to order at 7:59 a.m.

Mr. Stockmeister started the meeting with a thank you to Reggie Wilkinson for agreeing to serve as vice chair of the committee, and welcomed Joshua Kerner, who was recently appointed to the Board and also to this committee.

***Items for Discussion***

1. Physical Environment Scorecard: Mr. Jay Kasey, senior vice president, Office of Administration and Planning, gave an overview of the physical environment scorecard, calling the committee's attention to the safety portion. He explained the red indicator – traffic accident, non-injury – are mainly fender benders in our lots out on West campus. He also called out the yellow indicator – major on-campus crimes – which was slightly over target. These crimes are usually stolen laptops and not crimes of assault. Although the target goal was missed by 4%, we are down 25% over the past 12 months concluding June 30.

   The last indicator under safety is green – off-campus crime statistics. These monthly crime statistics are based on reports in nine crime categories occurring in the University District Area under the jurisdiction of the Columbus Division of Police. We are down almost 32% from the preceding year. The goal was to do as well as the preceding year. We are under that by 32%.

   Mr. Kasey expressed his appreciation to Monica Moll, director of public safety, and her team, the Columbus Division of Police, and Ohio State's Office of Student Life.

   (See Attachment XIX for background information, page 528)

2. Major Project Updates: Mark Conselyea, vice president, Facilities Operations and Development (FOD), shared this standard report that includes an on-time and on-budget indicator for all projects over $20M. There are a total of 13 major projects underway totaling almost $3.3B across the university and Wexner Medical Center. One project, The James Outpatient Care, was listed as "watching closely" for budget due to ongoing mediation with the contractor. Another project, the Combined Heat & Power Plant (CHP), continues to be listed as "not on track" for budget and schedule. Mr. Conselyea explained the university is working collaboratively with ENGIE to evaluate the budget and schedule. The university is focused on

THE OHIO STATE UNIVERSITY

making sure the temporary bypass plant is resilient and has the necessary capacity to support the facilities in the Carmenton area until the CHP is completed. Another focus is making sure the CHP is built efficiently and with the quality standards, so it will be a reliable source of utilities for years to come and limiting Ohio State's exposure to any additional costs to complete the project.

(See Attachment XX for background information, page 529)

3. Resource Stewardship Update: Ms. Aparna Dial, senior director of operations in Sustainability, presented an update on the university's plan to achieve the established resource stewardship goals. The plan builds on previous work and sets a course of action that solidifies Ohio State as a leader in resource stewardship.
(See Attachment XXI for background information, page 544)

4. Framework 3.0: Ms. Amanda Hoffsis, vice president, Planning, Architecture, and Real Estate, presented the final Framework 3.0 plan. This update to the university's campus master plan was developed over the past 15 months with key input from all levels of the university community. Framework 3.0 will serve as a guide, in conjunction with strategic and financial plans, for the future development of campus. Recommendations, related projects, practice and implementation principles are included as a part of the final plan.
See Attachment XXII for background information, page 559)

5. Design Reviews: Ms. Hoffsis and Mr. Kyle Albert, senior director of campus planning and design, presented the phase 2 design of the Biomedical and Materials Engineering Complex. He shared the total project budget is $90M, construction began in July 2023 and a September 2025 completion date is targeted. The next project reviewed was the renovation of Campbell Hall, originally constructed in 1916. The total project budget is $61M, construction began July 2023, with a completion target of July 2025. Mr. Albert shared the final project being reviewed today is Waterman Multi-Species Animal Learning Center (MALC). Mr. Albert shared the total project budget is $52M, construction is scheduled to begin in the first quarter of 2024, with a July 2025 target for completion.
(See Attachment XXIII for background information, page 565)

***Items for Action***

6. Approval of Minutes: No changes were requested to the May 18, 2023, meeting minutes; therefore, a formal vote was not required, and the minutes were considered approved.

7. Resolution No. 2024-23: Approval of FY24 Capital Investment Plan:

   Synopsis: Authorization and acceptance of the Capital Investment Plan for the fiscal year ending June 30, 2024, as proposed.

   WHEREAS the university has presented the recommended capital expenditures for the fiscal year ending June 30, 2024; and

   WHEREAS the recommended capital expenditures are the result of the university's comprehensive annual capital planning process; and

   WHEREAS only those projects outlined in these recommendations will be approved for funding;

   NOW THEREFORE

   BE IT RESOLVED, That the Board of Trustees hereby approves the Capital Investment Plan for the fiscal year ending June 30, 2024, as described in the accompanying documents; and

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BE IT FURTHER RESOLVED, That any request for authorization to proceed with any project contained in these recommendations must be submitted individually by the university for approval by the Board of Trustees, as provided for by Board policy.

(See Appendix XVII for background information, page 730)

8. Resolution No. 2024-24: Approval to enter into/increase professional services and enter into construction Contracts:

**APPROVAL TO ENTER INTO PROFESSIONAL SERVICES CONTRACTS**
BATTERY CELL RESEARCH & DEMONSTRATION CENTER

**APPROVAL TO ENTER INTO/INCREASE PROFESSIONAL SERVICES AND CONSTRUCTION CONTRACTS**
AIRPORT - TAXIWAY A REHABILITATION
DEPARTMENT OF ECONOMICS RELOCATION
WATERMAN - MULTI-SPECIES ANIMAL LEARNING CENTER (MALC)

Synopsis: Authorization to enter into/increase 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 contracts for the following project; and

| | Prof. Serv. Approval Requested | Total Req. | |
|---|---|---|---|
| Battery Cell Research & Demonstration Center | $2.3M | $2.3M | Grant funds (NIST)<br>Partner funds |

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

| | Prof. Serv. Approval Requested | Construction Approval Requested | Total Req. | |
|---|---|---|---|---|
| Airport - Taxiway A Rehabilitation | $1.0M | $3.5M | $4.5M | University funds<br>Grant funds (ODOT & FAA) |
| Department of Economics Relocation | $1.1M | $0.7M | $1.8M | University Funds |
| Waterman - Multi-Species Animal Learning Center (MALC) | $1.9M | $47.0M | $48.9M | University debt<br>University funds<br>Fundraising<br>State funds |

WHEREAS the Master Planning and Facilities Committee has reviewed the projects listed above for alignment with all applicable campus plans and guidelines; and

WHEREAS the Finance Committee has reviewed the projects listed above for alignment with the Capital Investment Plan and other applicable financial plans.

NOW THEREFORE

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BE IT RESOLVED, that the Board of Trustees hereby approves that the President and/or Senior Vice President for Business and Finance be authorized to enter into/increase 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.

(See Appendix XVIII for background information, page 732)

9. Resolution No. 2024-25: Approval of Framework 3.0:
SYNOPSIS: Authorization is requested to approve Framework 3.0, an update to the university's master plan, including planning principles, recommendations, and the vision for the Columbus campus.

WHEREAS Framework 3.0 builds upon the strong foundation of the previous Framework plans by reinforcing and refining previous planning ideas while establishing near and long-term concepts that strengthen the physical campus in support of academic and research excellence; and, WHEREAS the university began the planning process by completing a comprehensive assessment of existing space across campus to understand utilization and programmatic needs; and,

WHEREAS the space assessment indicated a need for additional classrooms, class laboratories, research laboratories, and amenity spaces which enhance the student and faculty experience; and,

WHEREAS robust engagement with faculty, staff and students was instrumental in developing a flexible vision for both near and long term development of campus anchored by the planning principles of stewardship, connectivity, experience and community; and

WHEREAS Framework 3.0 incorporates parallel planning efforts for Student Life facilities, the Wexner Medical Center and Carmenton: and,

WHEREAS Framework 3.0 will replace the previous Framework Plan that the Board of Trustees adopted in 2017; and,

WHEREAS Framework 3.0 lives alongside the strategic and capital plans of the university to create a shared vision for development while enabling the university to revise and re-envision as future conditions warrant:

NOW THEREFORE

BE IT RESOLVED, That the Board of Trustees hereby adopts Framework 3.0 as the guiding vision for the physical environment and directs the appropriate university offices to proceed with planning consistent with the Framework principles and long-term vision.

(See Appendix XIX for background information, page 736)

10. Resolution No. 2024-26: Approval to Enter Into Joint Use Agreement – Ohio Manufacturing and Innovation Center:

BETWEEN THE OHIO STATE UNIVERSITY
AND OHIO MANUFACTURING AND INNOVATION CENTER

Synopsis: Authorization to enter into a Joint Use Agreement (JUA) with the Ohio Manufacturing and Innovation Center (OMIC), an Ohio non-profit agency, to document the value and permit the release of funds appropriated in the State Capital Bill to expand the existing facility.

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WHEREAS The Ohio State University was allocated $500,000 in the 2023-2024 State Capital Bill that was specifically designated for use by OMIC; and

WHEREAS the OMIC will utilize the funds to partially fund design and construction of capital improvements to an existing facility, upgrading and renovating the existing structure to facilitate OMIC's mission of addressing known gaps in the Ohio technology development cycle; and

WHEREAS OMIC commits to making the facilities available for the university's use; and

WHEREAS the terms and conditions for this university use shall be more favorable than the terms and conditions of use by any other entity to a degree that reasonably reflects the magnitude of the university's investment in the OMIC facilities for the term of the agreement; and

WHEREAS except for the funds used to cover the university's reasonable administrative costs related to the project, the funds provided under this JUA shall be used by OMIC only for capital improvements or purchases and shall not be used for operating expenses; and

WHEREAS the university's use of OMIC space will further the University's mission to conduct groundbreaking research, provide unique active learning environments to students, and promote technological development and commercialization; and

WHEREAS before the state capital appropriation may be released to OMIC, the Ohio Department of Higher Education requires that a JUA between the university and the OMIC be signed to document the value of the appropriation to Ohio State and to ensure the benefits to the university will continue for a minimum period of 20 years:

NOW THEREFORE

BE IT RESOLVED, That the Board of Trustees hereby approves that the President and/or Senior Vice President for Business and Finance and/or Administration and Planning be authorized to take any action required to effect this Joint Use Agreement containing terms and conditions deemed to be in the best interest of the university.

(See Appendix XX for background information, page 742)

11. Resolution No. 2024-27: Approval to Enter Into Joint Use Agreement – City of Upper Arlington:

BETWEEN THE OHIO STATE UNIVERSITY
AND THE CITY OF UPPER ARLINGTON

Synopsis: Authorization to enter into a Joint Use Agreement (JUA) with the City of Upper Arlington, an Ohio municipal corporation, to document the value and permit the release of funds appropriated in the State Capital Bill to construct a new facility; and

WHEREAS The Ohio State University was allocated $450,000 in the 2023-2024 State Capital Bill that was specifically designated for use by the City of Upper Arlington; and

WHEREAS the City of Upper Arlington will utilize the funds to partially fund design and construction of the Upper Arlington Community Center to improve health and wellness opportunities in Central Ohio; and

WHEREAS the City of Upper Arlington commits to making the facilities available for the university's use; and

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WHEREAS the terms and conditions for this university use shall be more favorable than the terms and conditions of use by any other entity to a degree that reasonably reflects the magnitude of the university's investment in the facilities for the term of the agreement; and

WHEREAS except for the funds used to cover the university's reasonable administrative costs related to the project, the funds provided under this JUA shall be used by the City of Upper Arlington only for capital improvements or purchases and shall not be used for operating expenses; and

WHEREAS the university's use of the Community Center will promote the University's mission to improve health, wellness, and opportunity in Ohio through accessibility, innovation, and clinical excellence through our statewide network of facilities, personnel, and partnerships; and

WHEREAS before the state capital appropriation may be released to the City of Upper Arlington, the Ohio Department of Higher Education requires that a JUA between the university and the City of Upper Arlington be signed to document the value of the appropriation to the university and to ensure the benefits to the university will continue for a minimum period of 20 years:

NOW THEREFORE

BE IT RESOLVED, That the Board of Trustees hereby approves that the President and/or Senior Vice President for Business and Finance and/or Administration and Planning be authorized to take any action required to effect this Joint Use Agreement containing terms and conditions deemed to be in the best interest of the university.

(See Appendix XXI for background information, page 743)

**Action:** Upon the motion of Dr. Wilkinson, seconded by Mrs. Harsh, the committee adopted the resolutions by majority voice vote with the following members present and voting: Mr. Stockmeister, Dr. Wilkinson, Mrs. Harsh, Mr. Bigby, Mr. Kerner, Mr. Klingbeil, Mr. Schottenstein, and Dr. Fujita.

**EXECUTIVE SESSION**

It was moved by Mr. Stockmeister, and seconded by Dr. Wilkinson, that the committee recess into executive session to discuss the purchase of property, to consider business-sensitive trade secrets required to be kept confidential by federal and state statutes, and to consult with legal counsel regarding pending or imminent litigation.

A roll call vote was taken, and the committee voted to go into executive session with the following members present and voting: Mr. Stockmeister, Dr. Wilkinson, Mrs. Harsh, Mr. Bigby, Mr. Kerner, Mr. Klingbeil, Mr. Schottenstein, and Dr. Fujita.

The committee entered executive session at 9:20 a.m. The committee adjourned at 9:53 a.m.

| PHYSICAL ENVIRONMENT | Actual Prior Year Same Period (FY22 YTD) | FY23 Year-To-Date: Actual | FY23 Year-To-Date: Target (Budget) | FY23 Year-To-Date: Target %Var | FY23 Year-To-Date: Actual vs Target | FY23 Annual Target (Budget) | Comments |
|---|---|---|---|---|---|---|---|
| **A. FINANCIAL** | | | | | | | |
| 1. A&P Total Uses (General & Earnings Funds) | $161,610,724 | $204,876,427 | $201,358,990 | 1.7% | ▽ | **$201,358,990** | |
| **B. OPERATIONAL** | | | | | | | |
| 1. % Projects Completed On Time >$200K | 61.0% | 95.5% | 90.0% | 6.1% | ▬ | **90.0%** | 42 of 44 Projects completed On-Time. |
| 2. % Projects Completed On Budget >$200K | 92.7% | 100.0% | 90.0% | 11.1% | ▬ | **90.0%** | 44 of 44 Projects completed On-Budget. |
| 3. Capital Investment Program Spend* | $1,109.1 | $1,110.2 | $1,317.5 | -15.7% | ▭ | **$1,317.5** | In Millions. Spend significantly under budget since Dec. WMC down $57M, T&C projects billing slow. CNI project spend slow (Campbell Hall Renovation budgeted for $24M but only approved for Design: $2M expenditure in FY23. |
| 4. Facility Condition Index** | 0.10 | 0.11 | 0.08 | 37.5% | ▭ | **0.08** | Completed building assessments as of June 30, 2023: 225 buildings assessed, 21.3 million GSF. Not representative sample, target ranges still under review. |
| 5. CABS Riders | 2,488,181 | 2,738,308 | 2,911,000 | -5.9% | ▭ | **2,911,000** | Despite a year-over-year increase in total ridership, year-to-date ridership did not achieve projected number. |
| 6. WMC Parking Garage Peak Time Occupancy % *** | 77.7% | 81.4% | 80.0% | 1.7% | ▬ | **80.0%** | YTD (June) Occup%: Transient = 92.2%, Permit = 77.7%, Mixed= 79.8% CampusParc uses loop counters to track counts. In high demand we see counts over 100%. |
| 7. Cost of Daily Temporary Parking Space Closures | $164,189 | $196,362 | $135,965 | 44.4% | ▲ | **$135,965** | Key contributors YTD: 650 Ackerman Roof, DHC (Engie) Projects, Cannon Phase 2, the 12th Avenue Garage, & Orton Hall Envelope Project. |
| 8. WOSU Broadcast Audience (Viewers, Listeners) | 648,625 | 662,383 | 648,625 | 2.1% | ▬ | **648,625** | Average YTD Classical 101 listeners up 18.7% and TV up 8.9% compared to FY22 |
| 9. WOSU Digital Audience (Unique Visitors, Video Views, Digital Audio) | 5,721,982 | 7,227,241 | 5,721,982 | 26.3% | ▼ | **5,721,982** | Average YTD of all digital platforms up (Unique visitors 39.1%, Video views 28.4%, and Streaming 2.9%) compared to FY22 |
| **C. SAFETY** | | | | | | | |
| 1. EHS Recordable Accident Rate (CYTD): | 0.89 | 0.56 | 1.60 | -65.0% | ▼ | **1.60** | 2023 Calendar YTD |
| 2. Major On-Campus Crimes | 235 | 173 | 166 | 4.2% | ▽ | **166** | Progress in reducing crimes since earlier in the year, especially regarding Theft of Motor Vehicle Parts |
| 3. Avg Response Time to In-Progress Calls for Svc | 6:36 | 4:34 | 5:00 | -8.5% | ▲ | **5:00** | |
| 4. Traffic Accidents Injury | 26 | 17 | 26 | -34.6% | ▼ | **26** | |
| 5. Traffic Accidents Non-Injury | 95 | 113 | 95 | 18.9% | ▼ | **95** | Most common causes:"Failure to Control" and "Assured Clear Distance", occurring mostly during dayshift |
| 6. Off-Campus Crime Statistics | 1,761 | 1,201 | 1,761 | -31.8% | ▬ | **1,761** | Continued progress in reducing crimes since earlier in the year, especially regarding Motor Vehicle Theft |

*** For B3. Capital Investment Program Spend, Green = "Target %Variance" of + or - 10%, with an additional Yellow range extending 10% above and 20% below the Green range.**

**** For B4. Facility Condition Index, Green: <= 0.08; Yellow: >= 0.09, <= 0.15; Red: > 0.15. Target %Variance = Actual - Target.**

***** For B6&7. Parking Garage Peak Time Occupancy %, the target is 80% + or – 5% pts., with an additional 5% pt. Yellow range in both directions. Peak time measured on weekdays between 12:30 and 1:30 p.m.**

- Meets or surpasses Target
- Within 10% of Target
- Does not meet Target by >10%
- Data Pending
- ▲ 4-Mo Target %Var improved from Prior 4-Mo
- ▭ Within +/- 2.5% of Prior 4-Mo Target %Var
- ▽ 4-Mo Target %Var decline from Prior 4-Mo

ATTACHMENT XX



# Major Project Updates

## Projects Over $20M

AUGUST 2023




THE OHIO STATE UNIVERSITY

# **Project Status Report** - Current Projects Over $20M

| PROJECT NAME | CONSTRUCTION COMPLETION DATE | APPROVALS | | BUDGET | ON TIME | ON BUDGET |
|---|---|---|---|---|---|---|
| | | DES | CON | | | |
| The James Outpatient Care | COMPLETE | ✓ | ✓ | $356.5 M | | |
| Arts District | COMPLETE | ✓ | ✓ | $165.3 M | | |
| Jane E. Heminger Hall and Newton Renovation | COMPLETE | ✓ | ✓ | $31.7 M | | |
| Energy Advancement and Innovation Center | 10/23 | ✓ | ✓ | $49.3 M | | |
| Interdisciplinary Health Sciences Center | 1/24 | ✓ | ✓ | $157.3 M | | |
| Combined Heat & Power Plant/District Heating & Cooling Loop | 3/24 | ✓ | ✓ | $289.9 M | | |
| Newark – Founders Hall Enhancements | 4/24 | ✓ | ✓ | $26.4 M | | |
| Martha Morehouse Facility Improvements | 7/24 | ✓ | ✓ | $42.2 M | | |
| Celeste Lab Renovation | 8/24 | ✓ | ✓ | $49.7 M | | |
| Cannon Drive Relocation - Phase 2 | 12/24 | ✓ | ✓ | $68.1 M | | |
| Campbell Hall Renovation | 3/25 | ✓ | ✓ | $61.2 M | | |
| Biomedical and Materials Engineering Complex Phase 2 | 8/25 | ✓ | ✓ | $90.0 M | | |
| Wexner Medical Center Inpatient Hospital | 10/25 | ✓ | ✓ | $1,904.2 M | | |
| **TOTAL – PROJECTS** | | | | **$3,291.80 M** | | |

**On Track** **Watching Closely** **Not on Track**

# The James Outpatient Care

**THE JAMES OUTPATIENT CARE**

Construct an approximately 385,000 square foot outpatient facility including a surgical center, proton therapy, and medical office space. The proton therapy facility will focus on leading-edge cancer treatments and research. The facility will also include a 640-space parking garage.

**PROJECT FUNDING:** Auxiliary funds; fundraising; partner funds
**PROJECT UPDATE**: The James Outpatient Care facility opened for first patients on July 17th. Commissioning is ongoing for the proton therapy facility to prepare for opening in October.

| CURRENT BUDGET | |
|---|---|
| Construction w/ Cont | $229.6 M |
| Total Project | $356.5 M |

| CONSULTANTS | |
|---|---|
| Architect of Record | Perkins & Will |
| CM at Risk | BoldtLinbeck |

| PROJECT SCHEDULE | |
|---|---|
| BoT Approval | 11/18 |
| Construction | 7/20-4/23 |
| Facility Opening – Outpatient | COMPLETE |
| Facility Opening – Proton | 10/23 |

**On Budget**

**On Time**

# Arts District

**ARTS DISTRICT**

Renovate and expand the School of Music (SoM) building (Timashev Family Music Building) and construct a new Department of Theatre, Film, and Media Arts (DTFMA) building. The project will also extend Annie and John Glenn Avenue from College Road to High Street and make modifications to College Road and adjacent pedestrian spaces.

**PROJECT FUNDING:** University funds; university debt; fundraising; partner funds
**PROJECT UPDATE:** DTFMA move in is complete. Teaching and performances will commence fall semester.

| CURRENT BUDGET | |
|---|---|
| Construction w/ Cont | $146.6 M |
| Total Project | $165.3 M |

| CONSULTANTS | |
|---|---|
| Architect of Record | DLR |
| CM at Risk | Holder Construction |

| PROJECT SCHEDULE | |
|---|---|
| BoT Approval | 8/15 |
| Construction – SoM | COMPLETE |
| Construction – DoTFMA | COMPLETE |
| Facility Opening – SoM | COMPLETE |
| Facility Opening – DoTFMA | COMPLETE |

**On Budget - DoTFMA**

**On Time - DoTFMA**

# Jane E. Heminger Hall and Newton Renovation

**JANE E. HEMINGER HALL AND NEWTON RENOVATION**

Construct an additional 35,000 square foot addition to the south of Newton Hall and renovate 12,300 square feet on the first floor that will include flexible classrooms, informal learning spaces and offices.

**PROJECT FUNDING:** University funds; fundraising; state funds
**PROJECT UPDATE:** The renovation in Newton Hall is complete.

| CURRENT BUDGET | |
|---|---|
| Construction w/ Cont | $28.4 M |
| Total Project | $31.7 M |

| CONSULTANTS | |
|---|---|
| Architect of Record | Meacham & Apel |
| CM at Risk | Ruscilli |

| PROJECT SCHEDULE | |
|---|---|
| BoT Approval | 2/18 |
| Construction – Heminger | COMPLETE |
| Construction – Newton | COMPLETE |
| Fac Opening - Heminger | COMPLETE |
| Fac Opening – Newton | COMPLETE |

**On Budget**

**On Time**

# Energy Advancement and Innovation Center

**ENERGY ADVANCEMENT AND INNOVATION CENTER**

Construct an approximately 66,000 square foot facility centered around diverse collaborations to propel the next generation of convergent energy research and technology incubation. The facility will prioritize passive and active strategies to reduce energy usage and will include the installation of a direct current (DC) microgrid with photovoltaics/solar panels on the roof.

**PROJECT FUNDING:** Partner funds; university funds
**PROJECT UPDATE:** The solar panels have been installed. The site work is ongoing. Interior finishes are being completed throughout.

| CURRENT BUDGET | |
|---|---|
| Construction w/ Cont | $39.0 M |
| Total Project | $49.3M |

| CONSULTANTS | |
|---|---|
| Architect of Record | Moody Nolan |
| CM at Risk | Whiting Turner/CK |

| PROJECT SCHEDULE | |
|---|---|
| BoT Approval | 2/19 |
| Construction | 10/21-10/23 |
| Facility Opening | 11/23 |

**On Budget**

**On Time**

# Interdisciplinary Health Sciences Center

**INTERDISCIPLINARY HEALTH SCIENCES CENTER**

Multiphase renovation of 120,000 square feet and addition of 100,000 square feet to create a collaborative campus for inter-professional education throughout the health sciences, including the College of Medicine, Optometry, Nursing, and the School of Health and Rehabilitation Sciences. Program spaces include classrooms, anatomy labs, research labs, administrative and building support.

**PROJECT FUNDING:** Auxiliary funds; university funds; state funds; fundraising
**PROJECT UPDATE:** Classroom Wing - Furniture installation is complete and AV installation is nearing completion. This phase of the project will be complete for use fall semester. Hamilton Hall - Forum curtainwall is nearly complete. Drywall, interior framing and painting is ongoing throughout. South half of the quad is at finish grades with paving in progress.

| CURRENT BUDGET | |
|---|---|
| Construction w/ Cont | $139.2 M |
| Total Project | $157.3 M |

| CONSULTANTS | |
|---|---|
| Architect of Record | Acock Assoc |
| CM at Risk | Gilbane |

| PROJECT SCHEDULE | |
|---|---|
| BoT Approval | 11/17 |
| Construction | 11/19-1/24 |
| Facility Opening | 2/24 |

**On Budget**

**On Time**

# CHP/DHC

**COMBINED HEAT AND POWER PLANT/ DISTRICT HEATING AND COOLING LOOP – CHP/ DHC**

105 MW combined heat and power (CHP) plant, with a heating capacity of 285 klb/hr of superheated steam. The CHP plant will also contain an 8,000-ton cooling facility with future build-out potential to 13,000-ton. Installation of heating hot water (HHW) and chilled water (CW) on the midwest and west campuses to support existing and new campus buildings. Rehabilitation of John Herrick Drive bridge to support new utilities which connect the CHP to main campus.

**PROJECT FUNDING:** Utility fee
**PROJECT UPDATE:** CHP plant mechanical and electrical work schedule continues to slip. Sub-contracts, engineering contract and project schedule development is ongoing. Distribution system installation at midwest campus in process and on target for completion. CHP bypass plant in operation and providing chilled water and heating hot water to the Pelotonia Research Center and James Outpatient Care facilities.

| CURRENT BUDGET | |
|---|---|
| Total Project | $289.9 M |

| PROJECT SCHEDULE | |
|---|---|
| BoT Approval | 8/19 |
| Construction | 11/20-TBD |
| Facility Opening | TBD |

| CONSULTANTS | |
|---|---|
| Operator's Engineer | HDR |
| Design-Builder (CHP) | MasTec |
| CMR (DHC/Bridge) | Whiting Turner/CK |
| A/E (DHC) | RMF Engineering |
| A/E (Bridge) | EMH&T |

**On Budget** **On Time**

# Newark Founders Hall Enhancements

**NEWARK FOUNDERS HALL ENHANCEMENTS**

The project will renovate approximately 90,000 square feet for Ohio State and Central Ohio Technical College. This project will address building mechanical systems, electrical, building envelope, exterior façade and improve energy savings. The renovation will include updated faculty offices, classrooms and student collaboration areas.

**PROJECT FUNDING:** University funds; state funds; fundraising, partner funds – COTC
**PROJECT UPDATE:** Demolition inside the building is complete. Framing, mechanical, electrical and plumbing work is ongoing as well as exterior façade and site work.

| CURRENT BUDGET | |
|---|---|
| Construction w/ Cont | $23.1 M |
| Total Project | $26.4 M |

| CONSULTANTS | |
|---|---|
| Architect of Record | TCI |
| CM at Risk | ROBERTSON |

| PROJECT SCHEDULE | |
|---|---|
| BoT Approval | 11/22 |
| Construction | 1/23-4/24 |
| Facility Opening | 7/24 |

**On Budget**

**On Time**

# Martha Morehouse Facility Improvements

## MARTHA MOREHOUSE FACILITY IMPROVEMENTS

Renovate 14 department areas in 5 phases. Phase 1 will renovate the auditorium, update the existing elevators and one additional elevator. Phases 2-5 will construct an 8,500 square foot addition to the north and west, expanding registration, laboratory spaces, and waiting area; renovate 105,000 square feet of existing space including pulmonary rehabilitation, urgent care, OSUWMC perioperative assessment center; comprehensive weight management, food service, and patient drop-off/pick-up canopy.

**PROJECT FUNDING:** Auxiliary funds
**PROJECT UPDATE:** Final inspections for phase 4 are complete. West registration, lab, Advanced Urgent Care, and BistrOH! opened on August 7 and OSU Preoperative Assessment Clinic and Comprehensive Weight Management opened on August 14. The final phase, phase 5, includes the renovation of the Pulmonary Function space, Lung Center and Rehab Clinic.

| CURRENT BUDGET | |
|---|---|
| Construction w/ Cont | $38.7 M |
| Total Project | $42.2 M |

| CONSULTANTS | |
|---|---|
| Architect of Record | BDTAID |
| CM at Risk | Elford |

| PROJECT SCHEDULE | |
|---|---|
| BoT Approval | 8/19 |
| Construction | 9/20-7/24 |
| Facility Opening - Phased | 8/24 |

**On Budget**

**On Time**

# Celeste Lab Renovation

**CELESTE LAB RENOVATION**

Upgrade the building mechanical, electrical and plumbing systems; renovate approximately 18,500 square feet of chemistry labs and support spaces; improve the exterior envelope.

**PROJECT FUNDING:** University funds; state funds; fundraising
**PROJECT UPDATE:** Phased construction of the laboratories continues. The phasing allows classes to continue while construction is ongoing. South labs on the 2nd and 3rd floors will be ready for fall semester. Fourth floor restroom renovations are complete, and the 3rd floor restrooms will be complete in September.

| CURRENT BUDGET | |
|---|---|
| Construction w/ Cont | $41.2 M |
| Total Project | $49.7 M |

| CONSULTANTS | |
|---|---|
| Architect of Record | BHDP |
| CM at Risk | Elford |

| PROJECT SCHEDULE | |
|---|---|
| BoT Approval | 8/18 |
| Construction | 7/20-8/24 |
| Facility Opening | 8/24 |

**On Budget**

**On Time**

# Cannon Drive Relocation – Phase 2

**CANNON DRIVE RELOCATION – PHASE 2**

Rebuild Cannon Drive between John Herrick Drive and Woody Hayes Drive at its current elevation and construct a certified ODNR flood protection levee.

Work also includes a new signalized intersection at Woody Hayes Drive and the continued expansion of the river park.

**PROJECT FUNDING:** University debt; auxiliary funds; partner funds
**PROJECT UPDATE:** Siphon construction is nearing completion. Roadway construction began April 2023. Drake Union abatement began in June with demolition to occur in the fall.

| CURRENT BUDGET | |
|---|---|
| Construction w/ Cont | $55.5 M |
| Total Project | $68.1 M |

| CONSULTANTS | |
|---|---|
| Architect/Engineer | EMH&T |
| CM at Risk | Igel/Ruhlin (JV) |

| PROJECT SCHEDULE | |
|---|---|
| BoT Approval | 8/17 |
| Construction | 8/22 – 12/24 |
| Facility Opening | 1/25 |

**On Budget**

**On Time**

# Campbell Hall Renovation

### Campbell Hall Renovation

This project will renovate 115,000 SF in Campbell Hall. The interior renovation will enable the College of Education and Human Ecology's longtime goal of centralizing teaching, research, and administrative functions along Neil Avenue. The project will address all deferred maintenance including new MEP systems, roofing, building envelope, and windows.

**PROJECT FUNDING:** State funds, fundraising & local funds
**PROJECT UPDATE:** Enabling project in Evans Lab to create swing space for building occupants to move out of Campbell is complete. Construction in Campbell Hall began in July with demolition and abatement activities.

| CURRENT BUDGET | |
|---|---|
| Construction w/ Cont | $48M |
| Total Project | $61.2M |

| CONSULTANTS | |
|---|---|
| Architect of Record | Schooley Caldwell |
| CM at Risk | Holder Construction |

| PROJECT SCHEDULE | |
|---|---|
| BoT Approval | 5/23 |
| Construction | 07/23-01/25 |
| Facility Opening | 02/25 |

**On Budget**

**On Time**

# Biomedical and Materials Engineering Complex Phase 2



**Biomedical and Materials Engineering Complex Phase 2**

This project will demolish Watts Hall (35,504 square feet) and renovate MacQuigg Laboratory (76,345 square feet) and include an addition to MacQuigg. It will provide improved building services and create a dynamic and energy efficient facility. The project will provide facilities for first year engineering, biomedical engineering and materials engineering.

**PROJECT FUNDING:** State funds, Fundraising, University funds
**PROJECT UPDATE:** Watts Hall demolition is complete. GMP1 contract has been executed. MacQuigg abatement and demolition began August 2023.

| CURRENT BUDGET | |
|---|---|
| Construction w/ Cont | $70.2 M |
| Total Project | $90.0 M |

| CONSULTANTS | |
|---|---|
| Architect/Engineer | DLR Group |
| CM at Risk | Walsh Construction |

| PROJECT SCHEDULE | |
|---|---|
| BoT Approval | 05/23 |
| Construction | 08/23 – 08/25 |
| Facility Opening | 10/25 |

**On Budget**

**On Time**

# Wexner Medical Center Inpatient Hospital

**WEXNER MEDICAL CENTER INPATIENT HOSPITAL**

New 1.9M square foot inpatient hospital tower with up to 820 beds in private room settings replacing and expanding on the 440 beds in Rhodes Hall and Doan Hall including an additional 84 James beds. Facilities include state-of-the-art diagnostic, treatment and inpatient service areas including emergency department, imaging, operating rooms, 60 neonatal intensive care unit bassinets, critical care and medical/surgical beds, and leading-edge digital technologies to advance patient care, teaching and research.

**PROJECT FUNDING:** University debt; fundraising; auxiliary funds
**PROJECT UPDATE:** Curtainwall is nearly complete. Activation of the first sets of air handlers and chilled water system for temporary conditioning has occurred. Two cranes will be removed by the end of August.

| CURRENT BUDGET | |
|---|---|
| Construction w/ Cont | $1,711.1 M |
| Total Project | $1,904.2 M |

| CONSULTANTS | |
|---|---|
| Architect of Record | HDR |
| CM at Risk | Walsh-Turner (JV) |

| PROJECT SCHEDULE | |
|---|---|
| BoT Approval | 2/18 |
| Construction | 9/20-10/25 |
| Facility Opening | Q1/Q2 2026 |

**On Budget**

**On Time**

# Resource Stewardship Update

August 2023

# Achieve Carbon Neutrality by 2050

## Accomplishments:

- **Energy efficiency programs**
  (~60,000 MTCO2e reduction)
- **Renewable Energy Credits**
  (~60,000 MTCO2e reduction)
- **Solid waste emissions**
  (~2,500 MTCO2e reduction)

## Other Impacts:

- **Air travel and commuting**
  (~45,000 MTCO2e reduction)

## Achieve Carbon Neutrality by 2050

## Opportunities:

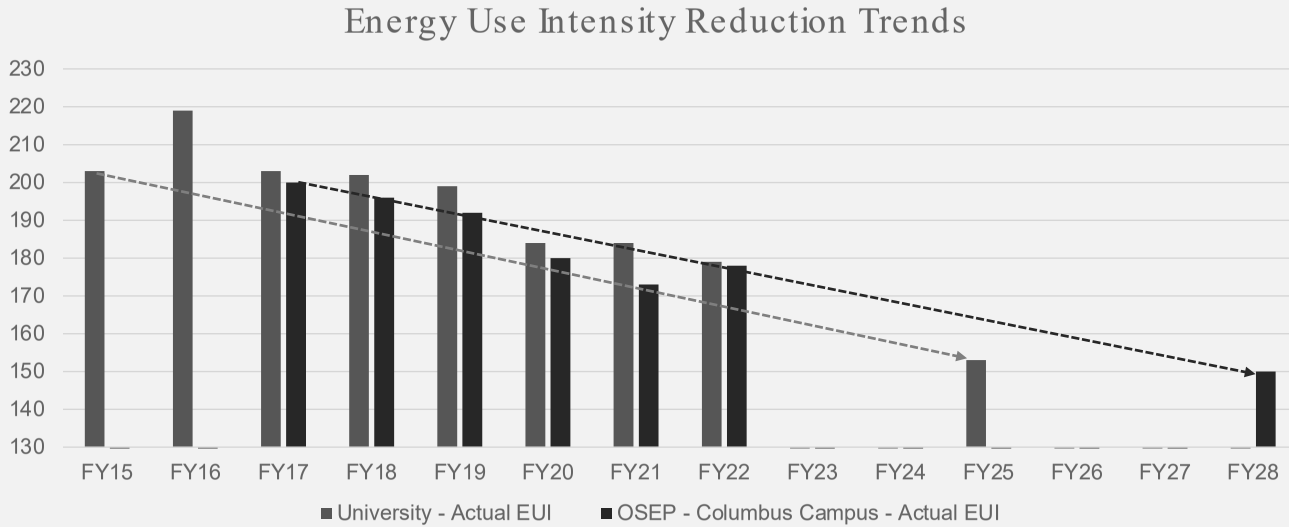
- Strategic Infrastructure Optimization Plan (SIOP)
- Energy Advancement & Innovation Center (EAIC)

*Rendering of Energy Advancement & Innovation Center*

# Increase the Energy Efficiency of the University per Building Square Foot by 25% by 2025

## Accomplishments:

- 46 Energy Conservation Projects (300,000 MMBTU in energy savings)
  - LED conversion
  - Heat recovery chillers
- Division 18 Building Design Standards




Increase the Energy Efficiency of the University per Building Sqr Ft by 25% by 2025

Opportunities:

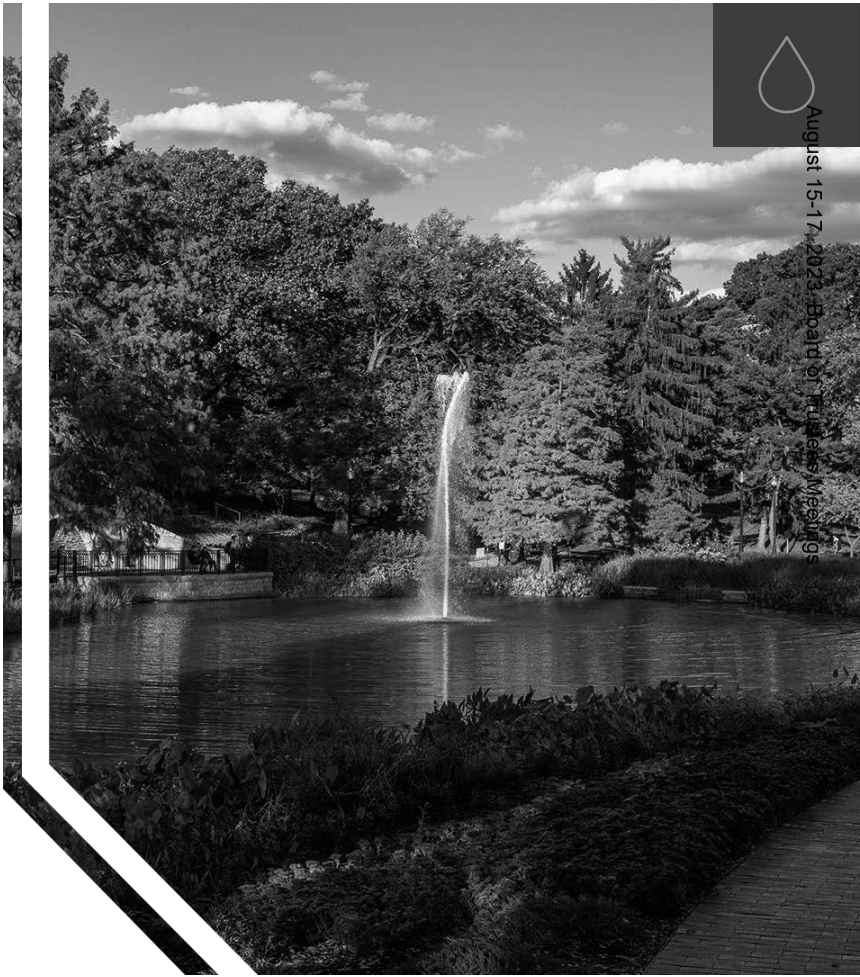
- ECM program continuation with Ohio State Energy Partners
- Regional campus energy efficiency
- Building energy setback program
- Explore feasibility of solar energy

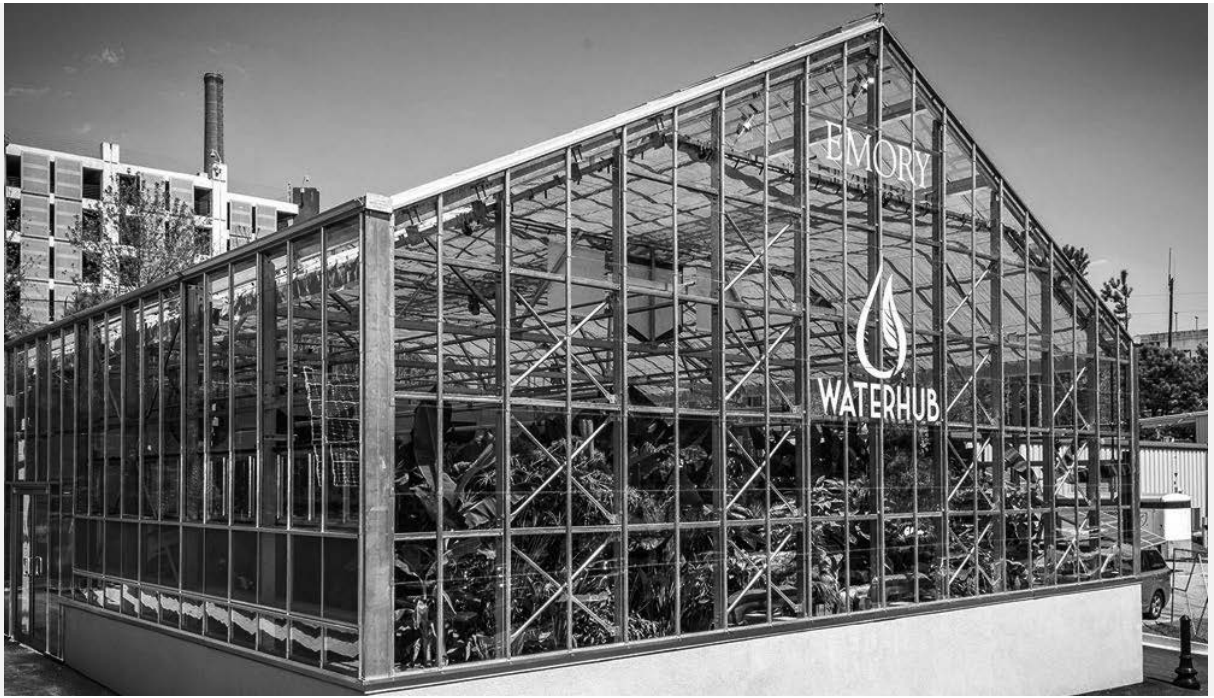
# Reduce Potable Water Consumption by 10% Per Capita Every 5 Years

- FY22 usage - 1.1 billion gallons
- FY22 water and sewage cost ~$10 million

## Accomplishments:

- Annual reduction since 2015 - 390 million gallons (savings of $1.2 million/year)






Reduce Potable Water Consumption by 10% Per Capita Every 5 Years

Opportunities:
- Wastewater Reuse and Reclamation Facility RFP Issuance

https://news.emory.edu/features/2020/04/waterhub/

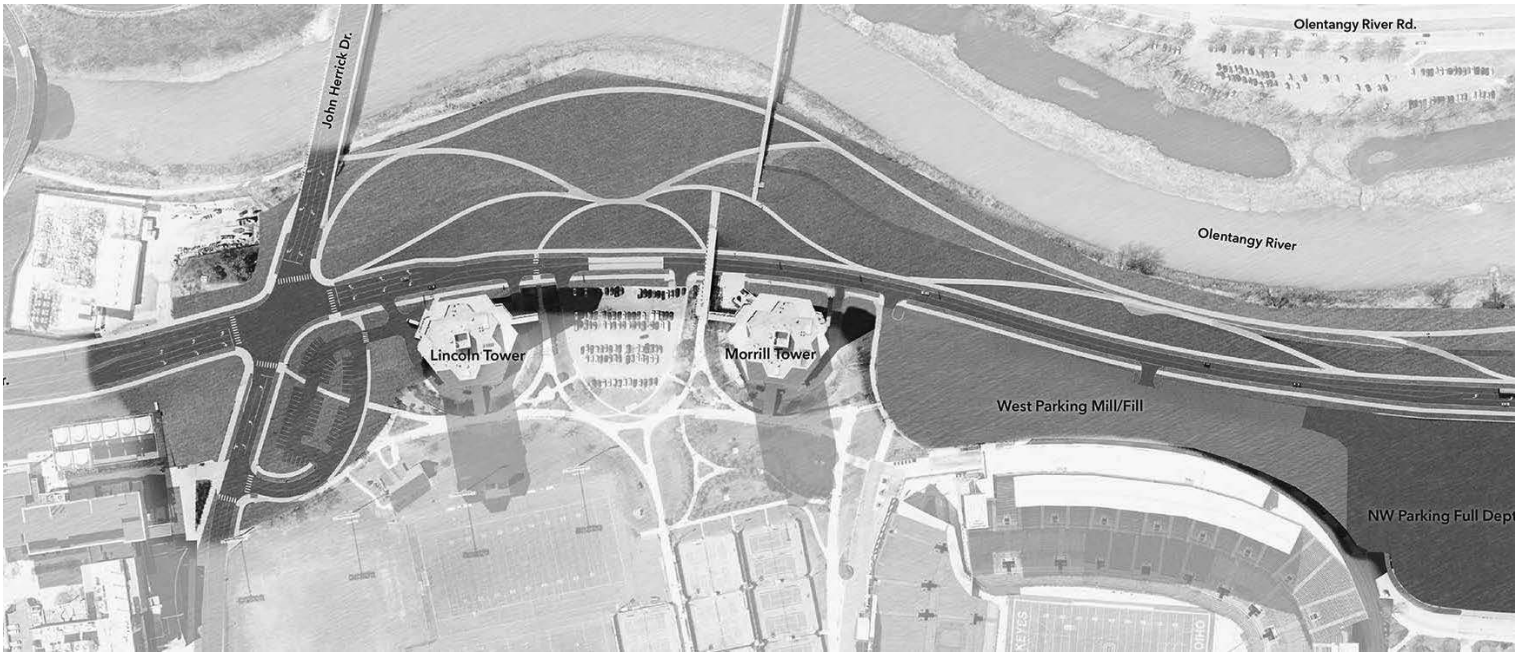
# Increase Ecosystem Services Index Score

Criteria:

- Maintain historic natural landscapes
- Preserve tree canopy
- Manage stormwater system
- Provide for physical activity and social connectivity

Accomplishments:

- Mirror Lake restoration
- Cannon Drive Phase 1 construction
- FY22 tree planting – 1,000 trees




## Increase Ecosystem Services Index Score

## Opportunities:

- Framework 3.0
- Cannon Drive Phase 2
- Tree inventory

*Rendering of Cannon Drive Phase 2 greenspace*

# Reduce Carbon Footprint of University Fleet Per Thousand Miles Traveled

## Accomplishments:

- Alternative fuel vehicles - 17.6% (164 out of 930)
- Public electric vehicle charging infrastructure: 12 locations, including 3 regional campuses
- CNG conversion - $1.72 million fuel cost savings to date


Reduce Carbon Footprint of University Fleet Per Thousand Miles Traveled by 25% by 2025

Opportunities:

- Alternative fuel/electric vehicle adoption
- Fuel efficiency standards
- Electric charging infrastructure

*Ohio State University CNG Refueling Station*

# Achieve Zero Waste by 2025 by Diverting 90% of Waste Away from Landfills

## Accomplishments:

- 40.0% diversion rate
- Ohio Stadium - largest US sports venue to achieve Zero Waste
- Compost program expansion


Achieve Zero Waste by 2025 by Diverting 90% of Waste Away from Landfills

Opportunities:

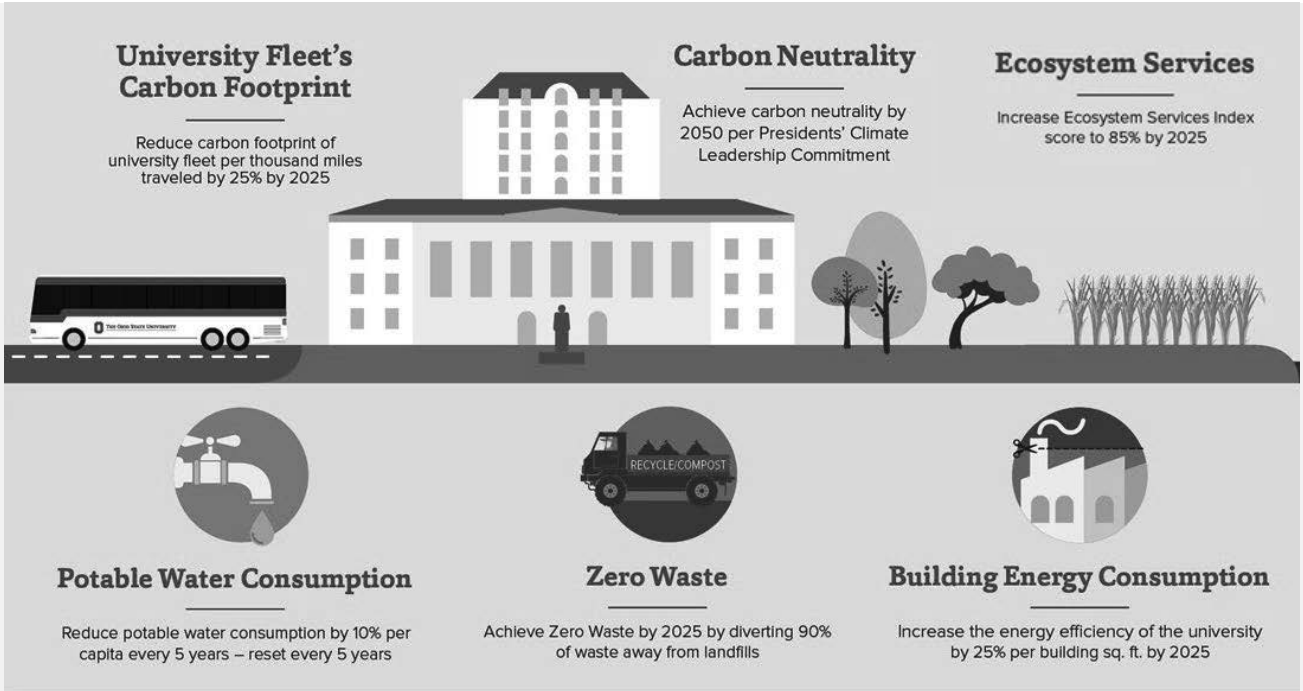
- Waste infrastructure standardization and expansion
- Waste prevention and purchasing practices

*Ohio Stadium Zero Waste | Residence hall composting program information.*

# The Ohio State Campus: A Living Laboratory

## Opportunities:

- Research and experiential learning collaboration with Sustainability Institute
- Incorporate research advances into campus operations
- Test bed for innovation, partner with Ohio State Energy Partners and leverage Energy Advancement and Innovation Center to research new clean energy technologies
- Align activities across campuses




## Several Resource Stewardship Goals End in 2025

## Next Steps:

- Annual update in November
- New goals to be shared in November 2024

**AUGUST 1, 2023**

**TO: The Ohio State Board of Trustees, Master Planning and Facilities Committee**
**FROM: Amanda Hoffsis, Vice President for Planning, Architecture and Real Estate**

# Re: Framework 3.0 Final Plan

**Dear Trustees,**

I am pleased to share Framework 3.0, the university's updated campus master plan, that was developed over the past 15 months with key input from all levels of the university community.

Since June 2022, our planning team has engaged with more than 250 faculty and staff through 30 listening sessions and a series of open houses. We met close to 400 students during poster sessions, open houses and listening sessions. Engagement is key when planning a campus of the future and our team reached more than 4,300 individuals through two separate online surveys. We believe this is a representative and diverse sample of the total Ohio State community and I am pleased with the breadth of voices that informed our planning.

Those voices led to the creation of four main planning principles that have guided Framework 3.0 through scenario development, plan refinement and recommendations with a focus on academic and research excellence:

- Stewardship
- Connectivity
- Experience
- Community

We often refer to these four principles as our compass because they have guided us through numerous planning decisions during Framework 3.0.

Framework 3.0 provides a roadmap for the university, evolving and refining concepts put forward in the two prior Framework plans. Framework 3.0 reflects strategic priorities and tests development capacity over several decades. It also includes near- to mid-term projects that may be realized in the next five to 15 years. We have taken special care to develop recommendations in terms of projects, practice and implementation principles that build on the strength of our planning principles to identify areas where the university can focus next.

Please find attached the Framework 3.0 compass of planning principles, campus planning priorities and our overall recommendations.

It has been a pleasure working on this plan to help shape the future of our campus and I hope that you are as excited as I am about the direction outlined in Framework 3.0.

Best,

Amanda Hoffsis

Amanda

# Framework 3.0

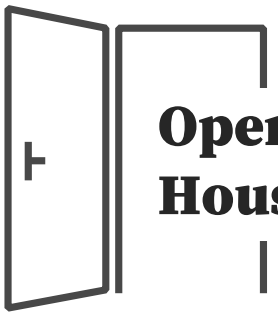
August 2023

Since June 2022, the planning team has engaged with more than

**250**
Faculty & Staff through

**30** Listening Sessions

And a series of

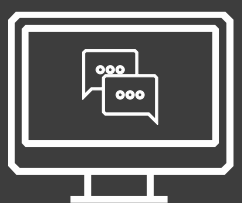


**Open Houses**

We met close to **400 students** during all poster sessions, open houses, and listening sessions.

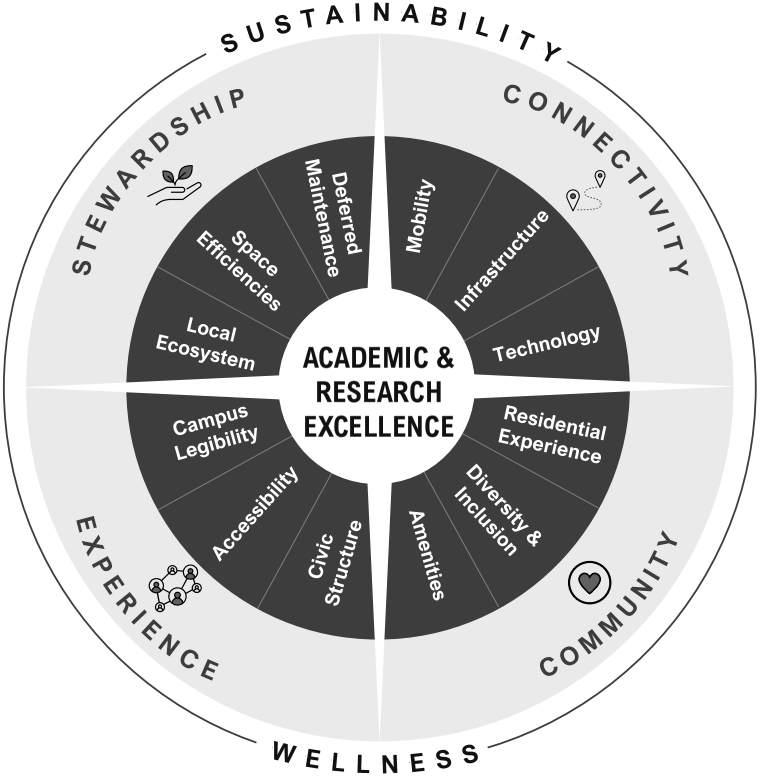
We've engaged more than

**4,300** Individuals through two separate online surveys



# Framework 3.0 Principles

The physical campus will enhance Ohio State's position as a leading public university.



# Framework 3.0 Implementation Principles

## Community

- Increase **equity of student experience** through modernization of instructional space and on-campus housing.
- Provide updated, flexible spaces that support **teaching and research excellence**.
- Reflect the **diversity** of the university's people, places and programs on campus.

## Experience

- Implement/enhance **wayfinding** from highway to hallway.
- **Enhance arrivals** by leveraging campus branding opportunities at edges and gateways.
- Explore partnerships to supplement campus **amenities** for faculty, staff, and the campus community.

## Stewardship

- **Increase** net assignable research space. **Decrease** net assignable office space.
- Address **deferred maintenance** and **renewal** with each project.
- Achieve **alignment** between physical and strategic plans.

## Connectivity

- Develop activated public spaces that are **functional**, **cohesive** and **beautiful**.
- Adopt **Complete Street** concepts in roadway design.
- **Engage the river** to enhance connectivity and user experience.

## Practice

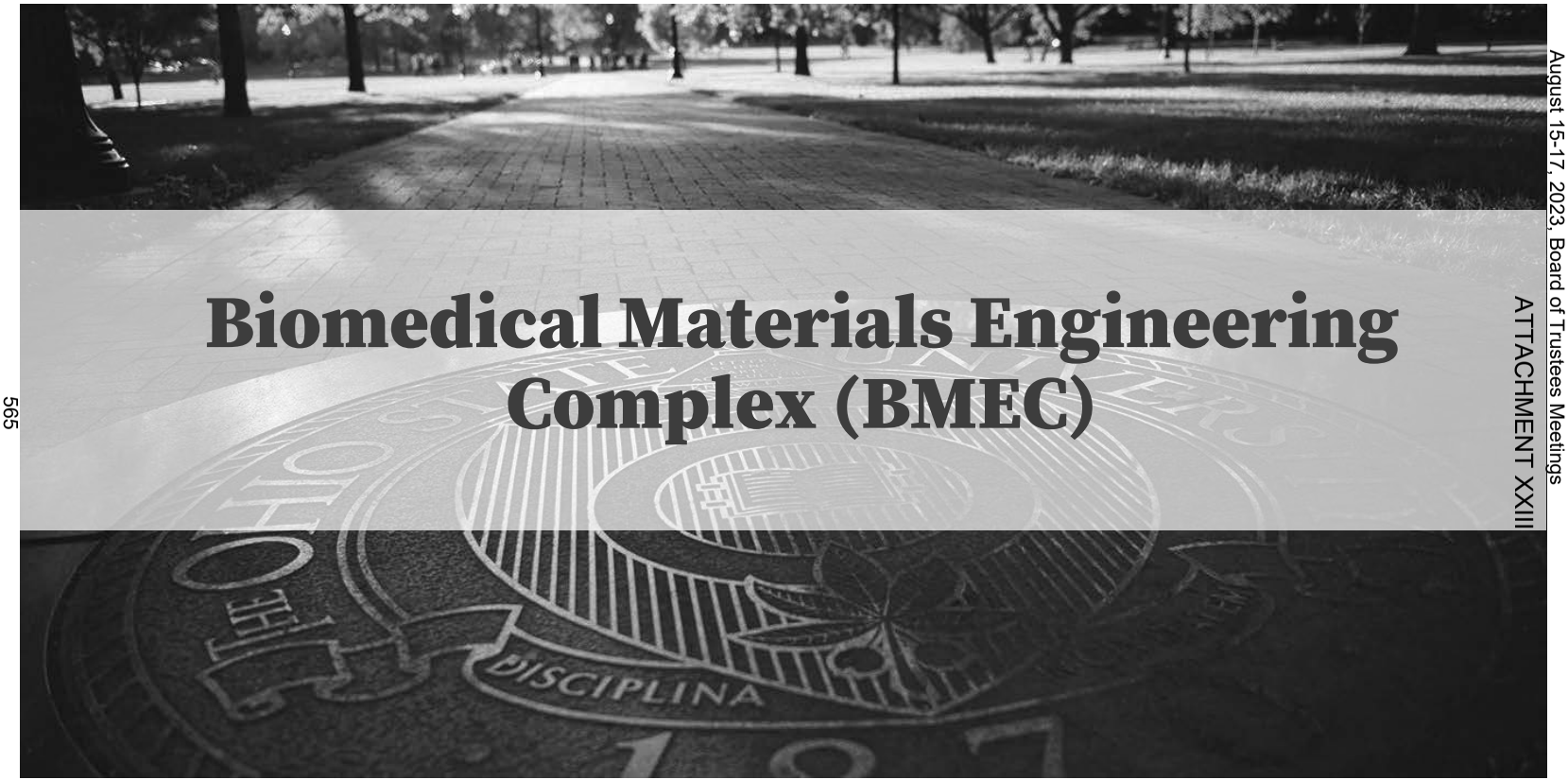
- Adopt **uniform scheduling** software to maximize utilization of classrooms and workspace.
- Implement a **space governance structure** for the university.
- Track **research metrics** to improve laboratory space allocation.
- Establish and maintain **Facility Master Plans** for all colleges and units.
- **Formalize funding model** for projects that enhance shared university spaces.

# Framework 3.0

## Near- to mid-term (5 to 15 years) campus planning priorities

- New facility for active learning classrooms and teaching labs.
- A phased replacement of Evans Lab with research labs, teaching labs and faculty offices.
- Hughes Hall renovation would modernize the building to serve future academic programs.
- Ramseyer renovation would support a STEM tutoring center and other future needs.
- South Residence Halls renovation would address condition inequities in campus housing.
- New North Residential District Resident Halls would replace current low-density buildings to create more beds.
- Neil Avenue, north of Annie and John Glenn Avenue, would close to vehicular traffic creating a pedestrian mall with dedicated bike lanes.
- New Ice Arena would be home to women's ice hockey practices and competition and men's ice hockey practices.
- Woody Hayes Complex addition would expand the facility for student athletes.
- New facility in the innovation district to house interdisciplinary research labs and research teams.
- James Outpatient Care Expansion to support patient care.
- Harding Hospital replacement would allow for a new hospital services and loading building.
- Ross Heart Hospital expansion would add patient beds and a medical hotel aimed at providing patients and families lodging before, during and after treatment.
- Two new Health Sciences academic buildings would allow for the relocation of the College of Pharmacy and School of Health and Rehabilitation Sciences.
- Complete and enhance the pedestrian path around the Oval.
- Improvements to the Woody Hayes streetscape would include dedicated bicycle, bus and pedestrian amenities.
- Railroad and SR-315 overpass improvements on Woody Hayes, Lane Avenue and Ackerman Road would include Ohio State branded murals, improved lighting and landscaping.
- Converse Hall replacement will address the deficiencies of the current facility serving the ROTC program.

# Biomedical Materials Engineering Complex (BMEC)




THE OHIO STATE UNIVERSITY

Overall Site Plan

THE OHIO STATE UNIVERSITY

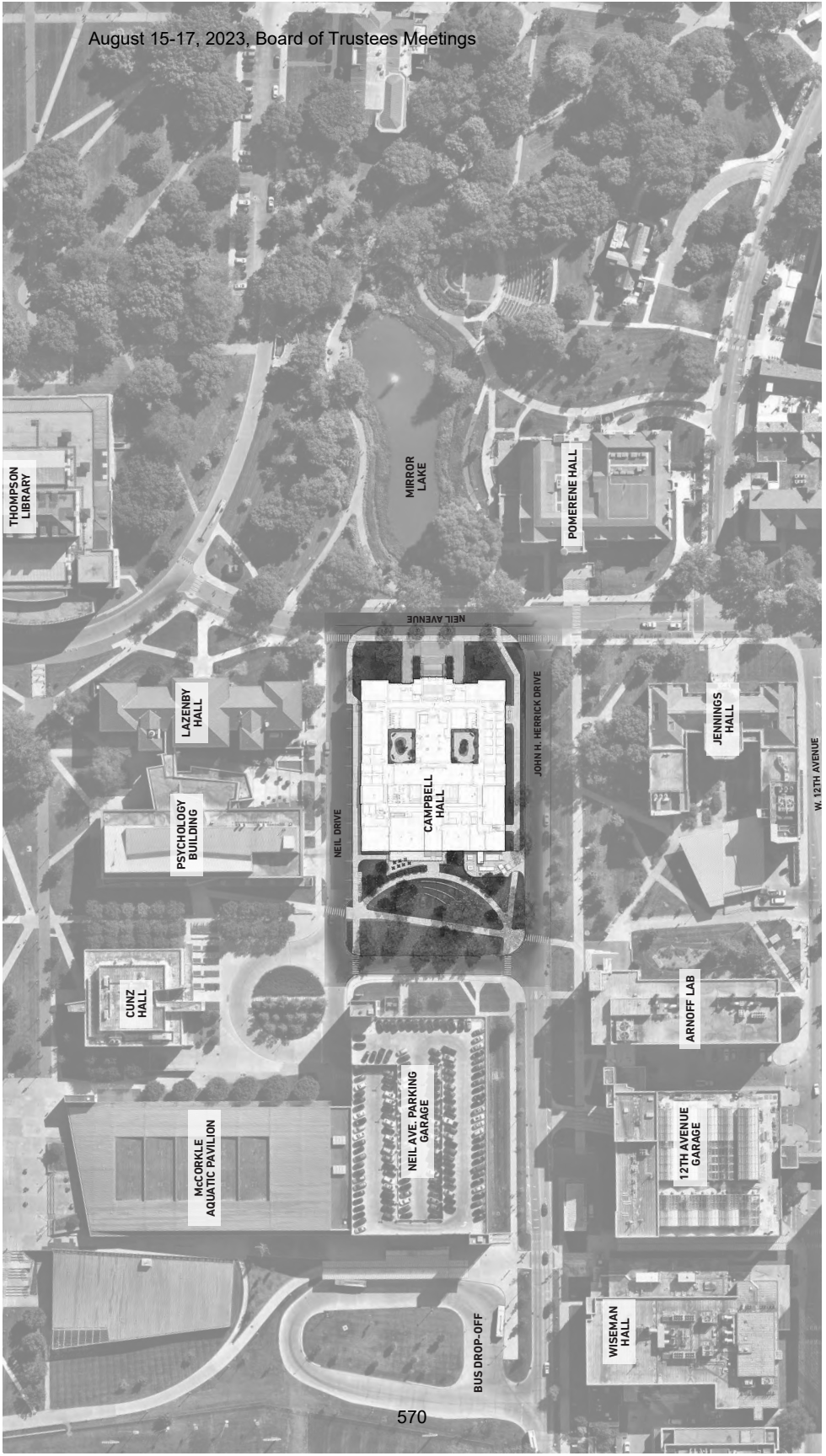
First Floor

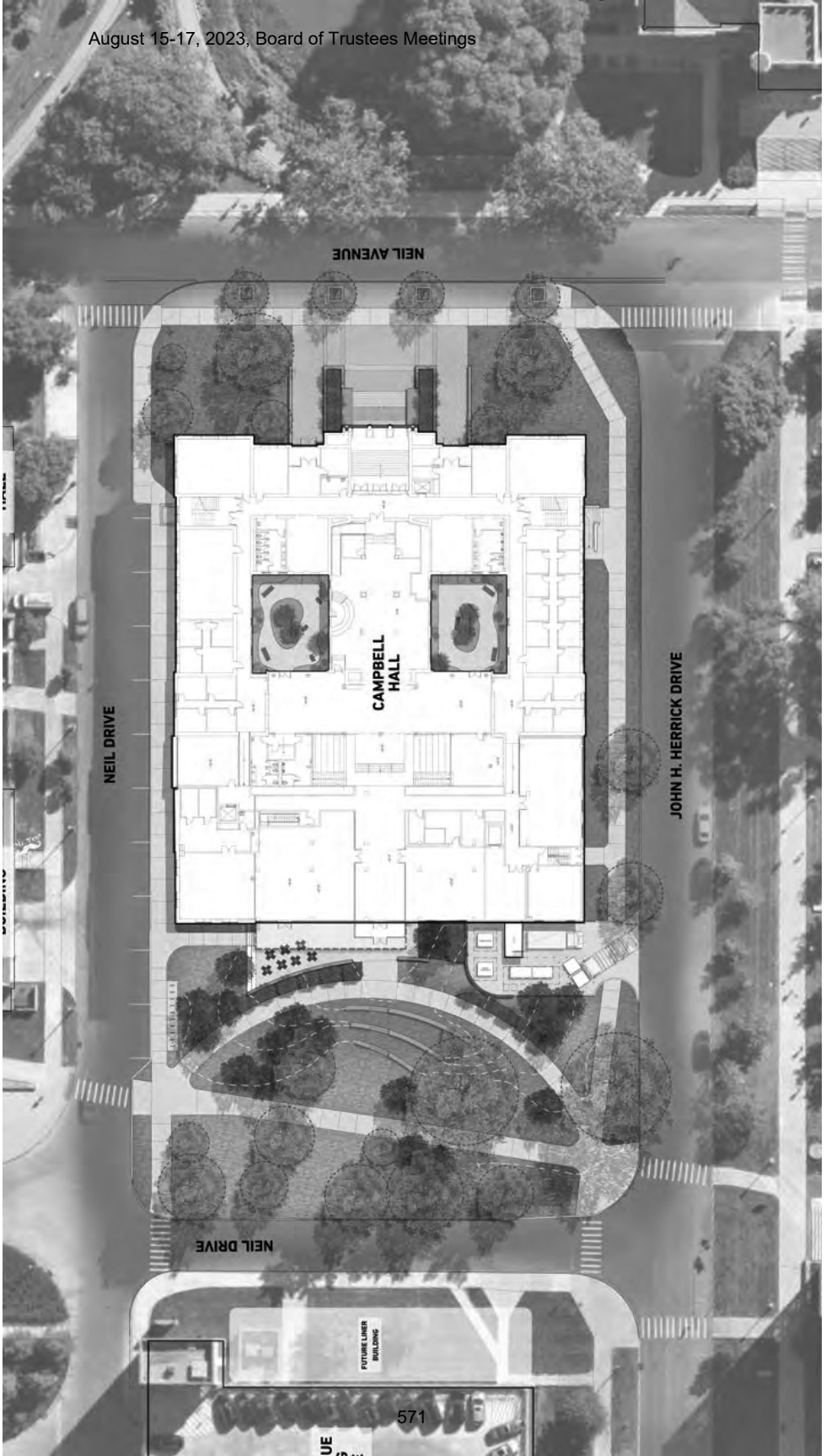
THE OHIO STATE UNIVERSITY

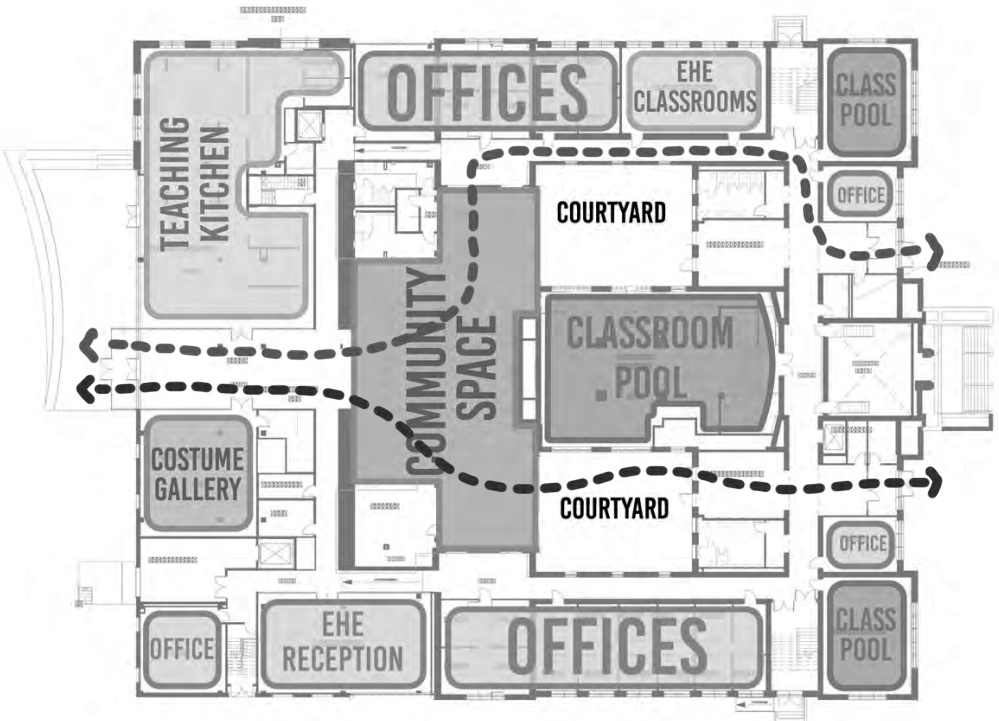
Southeast View

THE OHIO STATE UNIVERSITY

# Campbell Hall Renovation


THOMPSON LIBRARY
MIRROR LAKE
POMERENE HALL
NEIL AVENUE
LAZENBY HALL
PSYCHOLOGY BUILDING
NEIL DRIVE
CAMPBELL HALL
JOHN H. HERRICK DRIVE
JENNINGS HALL
W. 12TH AVENUE
CUNZ HALL
McCORKLE AQUATIC PAVILION
NEIL AVE. PARKING GARAGE
ARNOFF LAB
12TH AVENUE GARAGE
BUS DROP-OFF
WISEMAN HALL


NEIL AVENUE
NEIL DRIVE
CAMPBELL HALL
JOHN H. HERRICK DRIVE
NEIL DRIVE
FUTURE LINER BUILDING




CLASSROOM POOL
OFFICES
COSTUME GALLERY
EHE CLASSROOM & TEST KITCHEN

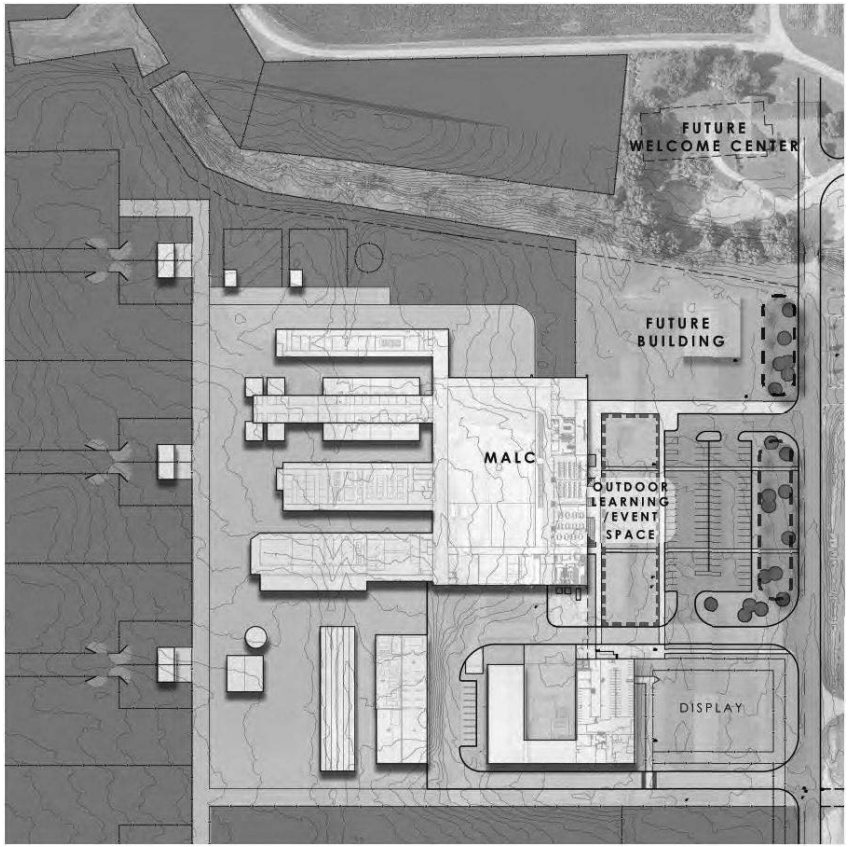
# 1ST FLOOR

# COMMUNITY SPACE

SCHOOLEY CALDWELL + EVOKE STUDIO ARCHITECTURE | THE OHIO STATE UNIVERSITY | CAMPBELL HALL RENOVATIONS

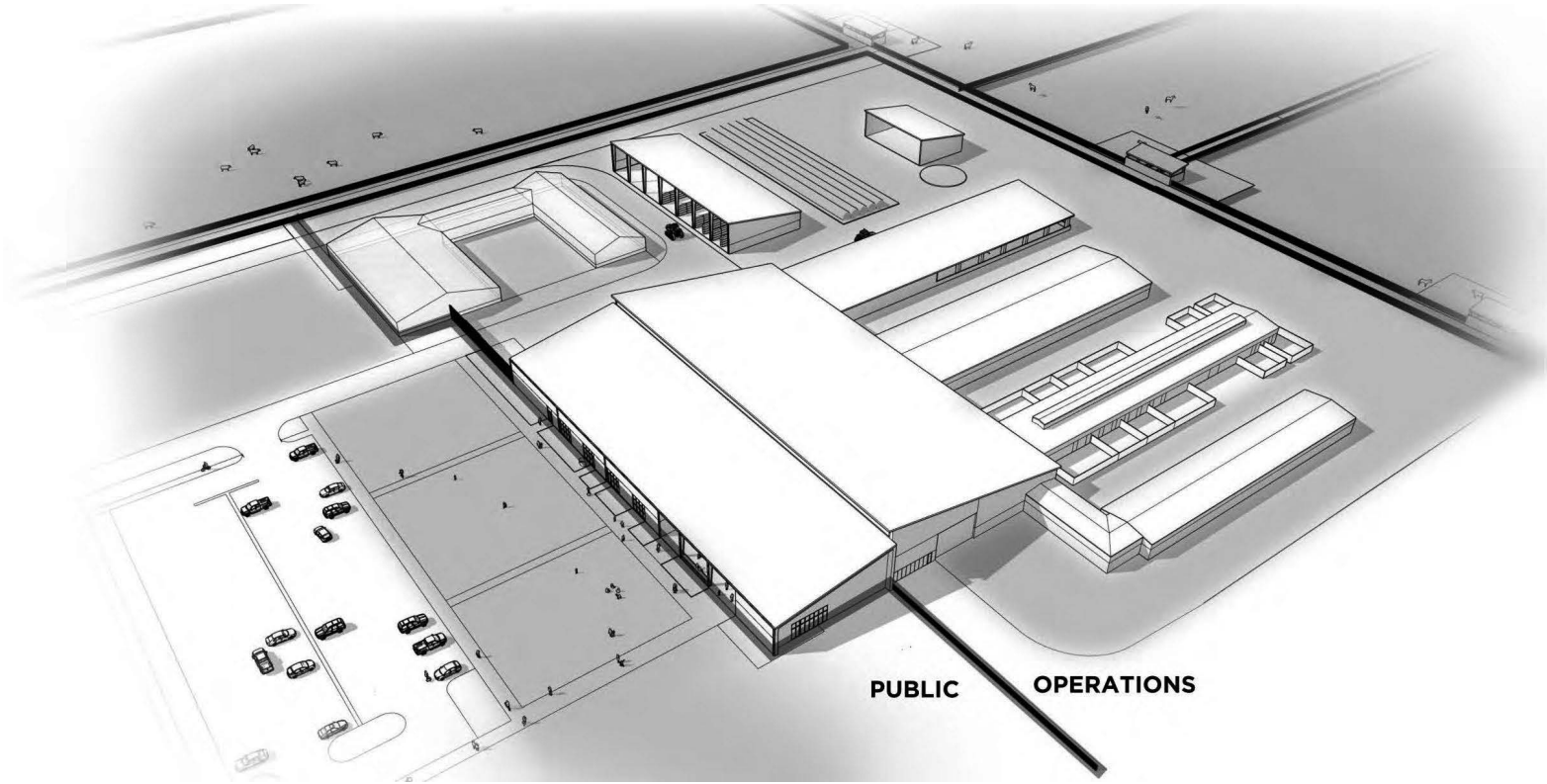
# Waterman Multi-Species Animal Learning Center (MALC)


# Conceptual Site Plan: Overall Vision

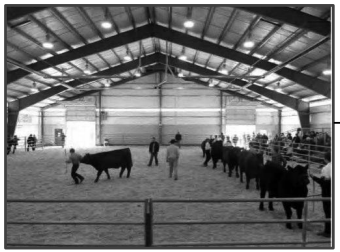


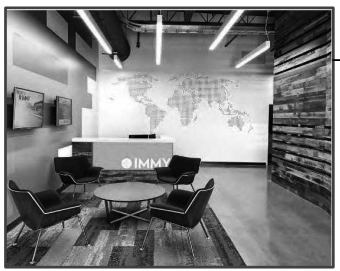


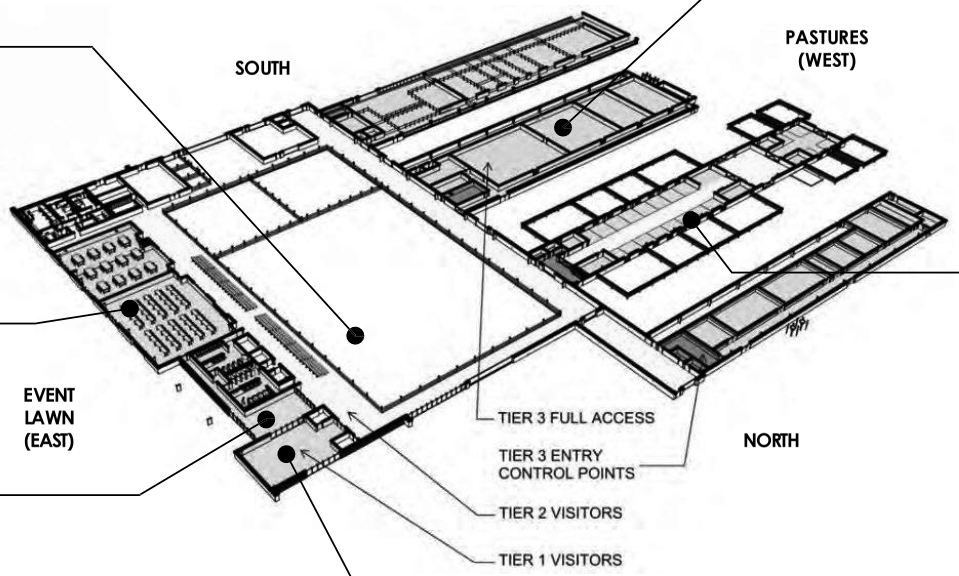
# Outdoor Teaching & Event Space




# Site Diagram








TIER 1 – VISITORS

TIER 2 – GUIDED VISITORS / STAFFED EVENTS

TIER 3 – BIOSECURE ZONES





# Program Diagram


# Rendering

THE OHIO STATE UNIVERSITY

Board of Trustees

University Square South
15 East 15th Avenue, 5th Floor
Columbus, OH 43201

Phone (614) 292-6359
Fax (614) 292-5903
trustees.osu.edu

**SUMMARY OF ACTIONS TAKEN**

*August 17, 2023 – Finance & Investment Committee Meeting*

**Voting Members Present:**

| | | |
|---|---|---|
| Tomislav B. Mitevski | Lewis Von Thaer | Hiroyuki Fujita (ex officio) |
| John W. Zeiger | Pierre Bigby | |
| Gary R. Heminger | Taylor A. Schwein | |

**Member Present via Zoom:**

| | | |
|---|---|---|
| James D. Klingbeil | Amy Chronis | Kent M. Stahl |

**Members Absent:**

Michael Kiggin

The Finance & Investment Committee of The Ohio State University Board of Trustees convened on Thursday, August 17, 2023, in person at Vitria on the Square, 14 E. 15th Avenue, Columbus, OH, 43201, and virtually over Zoom. Committee Chair Tomislav Mitevski called the meeting to order at 10:01 a.m.

**PUBLIC SESSION**

***Items for Discussion***

Chairman Mitevski welcomed Taylor Schwein to the Finance and Investment Committee.

1. Annual University Financial Overview: Michael Papadakis, chief financial officer, shared highlights from the university's FY2023 preliminary unaudited year-end financial results, including a detailed look at the institution's financial statements, cash and investments, and efficiencies. Mr. Papadakis reminded the committee of the environment of last year: 8% inflation was the norm at the time. We were probably a bit conservative given some of the headwinds at that time.

   The fiscal results for the year show strength across the board. Operating revenues increased $808 million in FY23 compared to FY22. The university's total net position is $10.2 billion in 2023. Cash and investments four-year summary starting the year before COVID, FY19 through FY23, shows a beginning cash and investment starting at $9.5 billion and ending with cash and investments at $10.8 billion. Additionally, since FY–2000, annual distributions from the Long-Term Investment Pool (LTIP) to support university priorities have grown more than six-fold from $46 million to $289 million. Based on FY23 LTIP performance, FY24 distribution is estimated to be $305 million.

   (See Attachment XXIV for background information, page 587)

2. FY24 Operating Budget Overview: Mr. Papadakis, Ms. Devine and Mr. Tammaro discussed the university budget process and the operating budget for Fiscal Year 2024. Mr. Papadakis explained the three types of funds that drive how the college/unit budgets are determined – General Funds, Earning Funds and Restricted Funds – and then shared an overview of the budgeting process for both the university and the medical center. Strategic benchmarking, revenue optimization and expense efficiency activities

occur continuously throughout the year, and efficiencies have been a focus of the institution since 2012. Mr. Papadakis shared a snapshot of the proposed FY24 operating budget on a consolidated basis with $9.6 billion in revenue sources and $9.0 billion in revenue uses. The largest categories of expenditures are personnel expenses (56%) and supplies/services (35%).

(See Attachment XXV for background information, page 608)

3. FY24 Capital investment Plan: Mr. Papadakis and Mr. Jay Kasey, senior vice president for administration & planning, discussed the FY24 Capital Investment Plan and new projects worth $34 million that had been added since approval of the Interim FY24 Capital Investment Plan during the May 2023 Board meeting.

   (See Attachment XXVI for background information, page 623)

4. Advancement Update: Michael Eicher, senior vice president for advancement provided updates on the *Time and Change* campaign, fiscal year, and *Scarlet & Gray Advantage* fundraising progress. Of note, the *Time and Change* campaign surpassed $4 billion in fundraising and recently exceeded the endowment fundraising goal of $875 million. The Foundation Report includes the establishment of endowments totaling $6.3 million.

   Three naming resolutions will be presented on the consent agenda.

   (See Attachment XXVII for background information, page 625)

***Items for Action***

5. Approval of Minutes: No changes were requested to the May 18, 2023, meeting minutes; therefore, a formal vote was not required, and the minutes were considered approved.

6. Resolution No. 2023-28: Approval of Operating Budget for Fiscal Year 2024:

   **APPROVAL OF FISCAL YEAR 2024 OPERATING BUDGET**

   Synopsis: Approval of the Operating Budget for the Fiscal Year ending June 30, 2024, is proposed.

   WHEREAS The State of Ohio Biennial Budget for State Fiscal Years 2024 and 2025, including funding levels for State institutions of higher education, has been signed into law; and

   WHEREAS Tuition and mandatory fee levels for the Columbus and Regional Campuses for the Academic Year 2023-2024, were approved at the July 14, 2023, Board of Trustees meeting; and

   WHEREAS The Administration now recommends approval of the Fiscal Year 2024 Operating Budget for the University for the Fiscal Year ending June 30, 2024.

   NOW THEREFORE

   BE IT RESOLVED, That the University's Operating Budget for the Fiscal Year ending June 30, 2024, as described in the accompanying Fiscal Year 2024 Operating Budget Book for the Fiscal Year ending June 30, 2024, be approved, with authorization for the President, or Board appointed designee, to make expenditures within the projected income.

   (See Appendix XXII for background information, page 744)

THE OHIO STATE UNIVERSITY

7. Resolution No. 2023-23: Approval of Capital Investment Plan for Fiscal Year 2024:

**APPROVAL OF FISCAL YEAR 2024 CAPITAL INVESTMENT PLAN**

Synopsis: Authorization and acceptance of the Capital Investment Plan for the fiscal year ending June 30, 2024, as proposed.

WHEREAS the university has presented the recommended capital expenditures for the fiscal year ending June 30, 2024; and

WHEREAS the recommended capital expenditures are the result of the university's comprehensive annual capital planning process; and

WHEREAS only those projects outlined in these recommendations will be approved for funding;

NOW THEREFORE

BE IT RESOLVED, That the Board of Trustees hereby approves the Capital Investment Plan for the fiscal year ending June 30, 2024, as described in the accompanying documents; and

BE IT FURTHER RESOLVED, That any request for authorization to proceed with any project contained in these recommendations must be submitted individually by the university for approval by the Board of Trustees, as provided for by Board policy.

(See Appendix XVII for background information, page 730)

8. Resolution No. 2023-29: Appointment to the Self-Insurance Board

**APPOINTMENT TO THE SELF-INSURANCE BOARD**

Synopsis: Appointment of a member to the Self-Insurance Board is proposed.

WHEREAS the Board of Trustees directed that a Self-Insurance Board be established to oversee the University Self-Insurance Program; and

WHEREAS all members of the Self-Insurance Board are appointed by The Ohio State University Board of Trustees upon recommendation of the President;

WHEREAS in the absence of a president, the recommendation is from the senior vice president and general counsel; and

WHEREAS the term of member James Gilmour expired on June 30, 2023:

NOW THEREFORE

BE IT RESOLVED, That the Board of Trustees hereby approve that the following individual be appointed as a member of the Self-Insurance Board effective September 1, 2023 for the term specified below:

D. Brent Mulgrew, term ending June 30, 2025

BE IT FURTHER RESOLVED, That this appointment entitles each member to any immunity, insurance or indemnity protection to which officers and employees of the University are, or hereafter may become, entitled.

THE OHIO STATE UNIVERSITY

9. Resolution No. 2023-30: Approval of the University Foundation Report:

**UNIVERSITY FOUNDATION REPORT**

Synopsis: Approval of the University Foundation Report as of June 30, 2023, is proposed.

WHEREAS monies are solicited and received on behalf of the university from alumni, industry, and various individuals in support of research, instructional activities, and service; and

WHEREAS such gifts are received through The Ohio State University Foundation; and

WHEREAS this report includes: (i) the establishment of two (2) endowed professorships: the John & Christine Olsen Professorship in Head and Neck Radiation Oncology, the John & Christine Olsen Professorship in Head and Neck Surgical Oncology; one (1) designated chair, the Edgar C. Hendrickson Designated Chair Fund; two (2) scholarships as part of the Scarlet and Gray Advantage Endowed Matching Gift Program; and twenty-two (22) additional named endowed funds; (ii) the revision of three (3) named endowed funds:

NOW THEREFORE

BE IT RESOLVED, that the Board of Trustees hereby approves The Ohio State University Foundation Report as of June 30, 2023.

(See Appendix XXIII for background information, page 797)

10. Resolution No. 2023-31 Naming of the Dr. Ira S. Niedweske Organic Chemistry Lab:

**NAMING OF THE DR. IRA S. NIEDWESKE (DVM, MS '77) ORGANIC CHEMISTRY LAB**
IN CELESTE LABORATORY

Synopsis: Approval for the naming of the organic chemistry lab (Room 410) in Celeste Laboratory, located at 120 West 18th Avenue, is proposed.

WHEREAS The renovation of Celeste Laboratory, a facility that provides instructional and research space for approximately 10,000 students per semester—more than 15 percent of the Columbus campus population—will have a significant impact on all students in STEM fields; and

WHEREAS updated spaces in Celeste Laboratory will empower undergraduates to collaborate with faculty and graduate students on innovative research and provide hands-on experience to complement classroom instructions, creating more well-rounded students who will go on to be leaders in science, health and medicine and engineering; and

WHEREAS Dr. Ira S. Niedweske and Jill Crawford Niedweske have provided significant contributions to Celeste Laboratory and the Department of Chemistry and Biochemistry; and

WHEREAS the naming has been reviewed according to the approval process outlined in the Naming of University Spaces and Entities policy:

NOW THEREFORE

BE IT RESOLVED, That in acknowledgement of Dr. Ira S. Niedweske and Jill Crawford Niedweske's philanthropic support, the Board of Trustees hereby approves, in accordance with paragraph (D) of rule 3335-1-08 of the Ohio Administrative Code, that for the life of the physical facility the aforementioned space be named the Dr. Ira S. Niedweske (DVM, MS '77) Organic Chemistry Lab.

THE OHIO STATE UNIVERSITY

11. Resolution No. 2023-32: Naming of Internal Space – Conard Hall at The Ohio State University at Mansfield:

**NAMING OF INTERNAL SPACES**

IN CONARD HALL AT THE OHIO STATE UNIVERSITY AT MANSFIELD

Synopsis: Approval for the naming of internal spaces in Conard Hall, located at 1760 University Drive in Mansfield, is proposed.

WHEREAS Ohio State Mansfield helps to serve the university's land grant mission by providing access to affordable education in all areas of Ohio; and

WHEREAS the recent renovations to Conard Hall have served to meet the needs of BSET students, increasing learning opportunities and providing adaptive and multi-functional spaces to benefit BSET students; and

WHEREAS the donors listed below have provided significant contributions toward the BSET program; and

- Richland County Foundation
- Charter Next Generation Films

WHEREAS the naming has been reviewed according to the approval process outlined in the Naming of University Spaces and Entities policy:

NOW THEREFORE

BE IT RESOLVED, That in acknowledgement of the aforementioned donors' philanthropic support, the Board of Trustees hereby approves, in accordance with paragraph (D) of rule 3335-1-08 of the Ohio Administrative Code, that for the life of the physical facility the aforementioned spaces be named the following:

- The Richland County Foundation Smart Manufacturing Lab (room 232)
- The Charter Next Generation Films PLC Lab (room 233)

12. Resolution No. 2023-33: Naming of the Boyce Family Lacrosse Shooting Room

**NAMING OF THE BOYCE FAMILY LACROSSE SHOOTING ROOM**
AT THE LACROSSE STADIUM

Synopsis: Approval for the naming of the shooting room at the Lacrosse Stadium, located at 630 Irving Schottenstein Drive, Columbus, OH 43210, is proposed.

WHEREAS The new state-of-the-art, 2,500-seat lacrosse stadium will be the new practice and competition space for the men's and women's varsity lacrosse teams; and

WHEREAS the lacrosse stadium will serve the community and grow the sport of lacrosse through camps and clinics hosted within the space; and

WHEREAS the shooting room will serve as an athletic classroom for lacrosse student-athletes to hone their skills; and

WHEREAS Melissa and Collis Boyce as well as Natalie and Sandford Boyce have provided significant contributions to the men's lacrosse program and the construction of the new lacrosse stadium; and

THE OHIO STATE UNIVERSITY

WHEREAS the naming has been reviewed according to the approval process outlined in the Naming of University Spaces and Entities policy:

NOW THEREFORE

BE IT RESOLVED, That in acknowledgement of Melissa and Collis Boyce's, and Natalie and Sandford Boyce's philanthropic support, the Board of Trustees hereby approves, in accordance with paragraph (D) of rule 3335-1-08 of the Ohio Administrative Code, that for the life of the physical facility the aforementioned space be named the Boyce Family Lacrosse Shooting Room.

13. Resolution No. 2023-24: Approval to Enter Into/Increase Professional Services and Enter Into Construction Contracts:

**APPROVAL TO ENTER INTO PROFESSIONAL SERVICES CONTRACTS**
BATTERY CELL RESEARCH & DEMONSTRATION CENTER

**APPROVAL TO ENTER INTO/INCREASE PROFESSIONAL SERVICES AND CONSTRUCTION CONTRACTS**
AIRPORT - TAXIWAY A REHABILITATION
DEPARTMENT OF ECONOMICS RELOCATION
WATERMAN - MULTI-SPECIES ANIMAL LEARNING CENTER (MALC)

Synopsis: Authorization to enter into/increase 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 contracts for the following project; and

| | Prof. Serv. Approval Requested | Total Req. | |
|---|---|---|---|
| Battery Cell Research & Demonstration Center | $2.3M | $2.3M | Grant funds (NIST)<br>Partner funds |

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

| | Prof. Serv. Approval Requested | Construction Approval Requested | Total Req. | |
|---|---|---|---|---|
| Airport - Taxiway A Rehabilitation | $1.0M | $3.5M | $4.5M | University funds<br>Grant funds (ODOT & FAA) |
| Department of Economics Relocation | $1.1M | $0.7M | $1.8M | University Funds |
| Waterman - Multi-Species Animal Learning Center (MALC) | $1.9M | $47.0M | $48.9M | University debt<br>University funds<br>Fundraising<br>State funds |

WHEREAS the Master Planning and Facilities Committee has reviewed the projects listed above for alignment with all applicable campus plans and guidelines; and

WHEREAS the Finance Committee has reviewed the projects listed above for alignment with the Capital Investment Plan and other applicable financial plans.

THE OHIO STATE UNIVERSITY

NOW THEREFORE

BE IT RESOLVED, that the Board of Trustees hereby approves that the President and/or Senior Vice President for Business and Finance be authorized to enter into/increase 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.

(See Appendix XVIII for background information, page 732)

**Action:** Upon the motion of Mr. Mitevski, seconded by Mr. Bigby, the committee adopted the foregoing motions by voice vote with the following members present and voting: Mr. Mitevski, Mr. Klingbeil, Mr. Zeiger, Mr. Heminger, Mr. Von Thaer, Mr. Bigby, Ms. Schwein, Ms. Chronis, Mr. Stahl, and Dr. Fujita.

**Written Reports**
In the public session materials, there were six written reports shared for the committee to review:

a. University Financial Scorecards (See Attachment XXVIII for background information, page 630)
b. Preliminary Consolidated Financial Statement for the Year Ending June 30, 2023 (See Attachment XXIX for background information, page 633)
c. Detailed Foundation Report (See Attachment XXX for background information, page 639)
d. Major Project Updates (See Attachment XXXI for background information, page 669)
e. FY23 Annual Waiver of Competitive Bidding Report (See Attachment XXXII for background information, page 673)
f. Internal Bank Update (See Attachment XXXIII for background information, page 679)

**EXECUTIVE SESSION**

It was moved by Mr. Mitevski, and seconded by Mr. Heminger, that the committee recess into executive session to discuss to consider business-sensitive trade secrets required to be kept confidential by federal and state statutes, and to consult with legal counsel regarding pending or imminent litigation.

A roll call vote was taken, and the committee voted to go into executive session with the following members present and voting: Mr. Mitevski, Mr. Klingbeil, Mr. Zeiger, Mr. Heminger, Mr. Von Thaer, Mr. Bigby, Ms. Schwein, Ms. Chronis, Mr. Stahl and Dr. Fujita.

The committee entered executive session at 11:06 a.m. and adjourned at 12:03 p.m.

# Annual Financial Overview

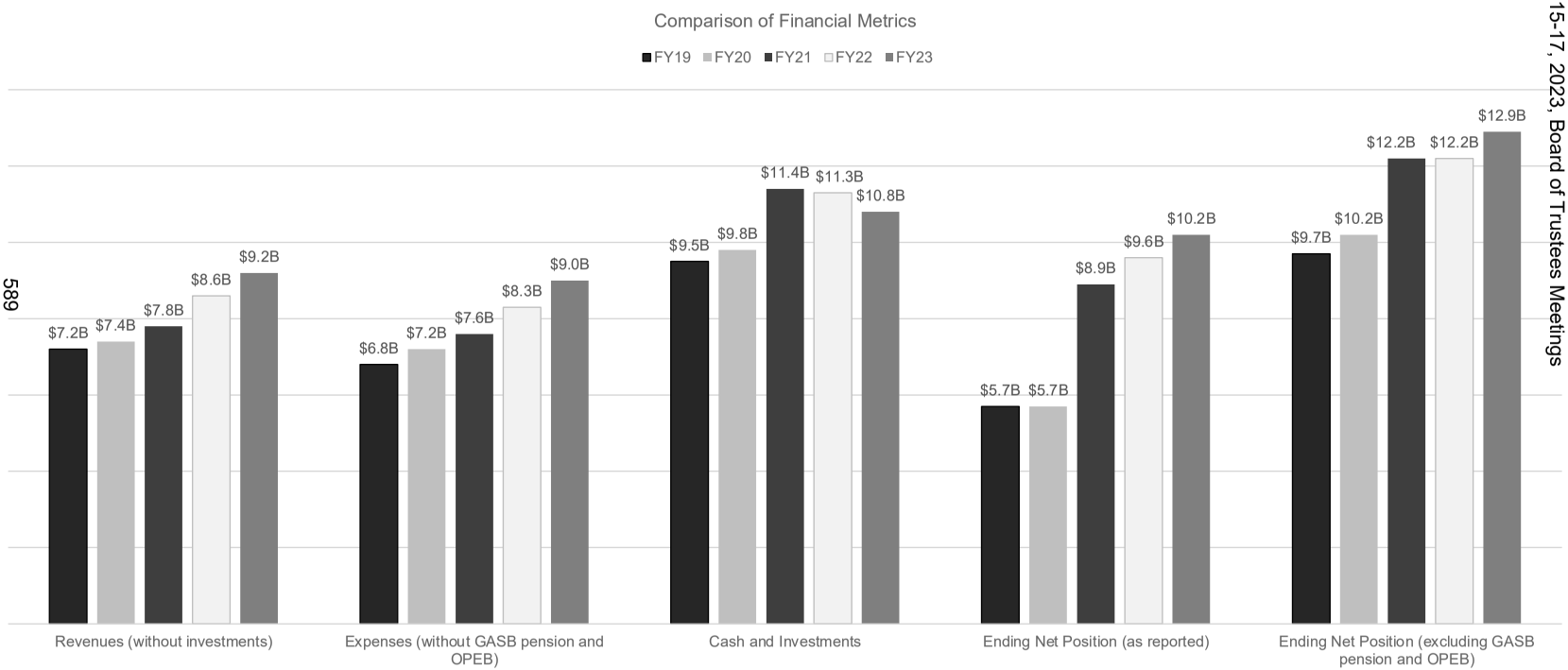
Michael Papadakis, Senior Vice President and CFO

Finance & Investment Committee | August 17, 2023

# Financial Performance Highlights

- The university's overall financial position remains strong, driven by the post-pandemic rebound. The FY23 financial results reflect a return to normal university operations and a full college experience for students.
- Operating revenues increased $808M in FY23 compared to FY22, driven primarily by strong growth in healthcare revenues, higher grant and contract revenues, increased tuition and fees, and increases in all major auxiliary enterprises. Specific impacts include:
  - A $533M increase in healthcare revenues, reflecting strong outpatient surgical activity, service mix, and practice expansion.
  - A $93M increase in grants and contracts, primarily due to increases in private grants of $52M, federal grants of $32M, and state grants of $12M, offset by decreases in local grants of $3M.
  - A $57M increase in student tuition & fees, due primarily to resident and non-resident rate increases and a rate increase for those undergraduate students not in the Ohio State Tuition Guarantee.
  - A $48M increase in auxiliary revenues, primarily due to an additional home football game and one additional premium game, housing and dining rate increases for new first-year students, the return to normal operations for Business Advancement, and increased revenues from on-campus events.
- Net investment income also came back strong in FY23 with a $520M income level based on a very strong final six months of the fiscal year for the LTIP and a rebound of solid returns for our short- and intermediate-term portfolios.
- The FY23 increase in net position was $589M bringing the total to $10.2B.
- In April 2023, the university completed a $328M refunding of its Series 2013A bonds using variable rate refunding bonds (Series 2023A) that were swapped to a fixed rate of 1.23% through two interest rate swap agreements. By replacing the coupon of the Series 2013A bonds (~4.5%) with the swap's low fixed rate (1.23%), the university will save an estimated $119M in debt service.
- The university's annual rating agency updates had positive results in FY23. Moody's and S&P affirmed both the university's credit rating and 'Stable' outlook. Fitch upgraded the university's credit rating to 'AA+/Stable Outlook' from 'AA/Positive Outlook'. This is the first rating upgrade of the university since Moody's upgrade to 'Aa1' in 2010 and the first by Fitch since it began rating the university in 2003.

# Financial Metrics Demonstrate Positive Momentum



# Consolidated Balance Sheet (as of June 30, 2023)

| Assets and Liabilities ($ in millions) | 2023 | 2022 | 2021 |
|---|---|---|---|
| Cash and cash equivalents | $ 1,246 | $ 480 | $ 1,214 |
| Total investments | $ 9,552 | $ 10,775 | $ 10,204 |
| Capital assets, net | $ 8,203 | $ 7,583 | $ 6,753 |
| Pension and OPEB assets and deferred outflows | $ 1,838 | $ 1,060 | $ 743 |
| Other assets | $ 1,550 | $ 1,524 | $ 1,457 |
| **Total Assets** | $ 22,389 | $ 21,422 | $ 20,371 |
| Accounts payable and other current liabilities | $ 1,187 | $ 1,654 | $ 1,687 |
| Debt | $ 3,701 | $ 3,777 | $ 3,128 |
| Pension and OPEB liabilities and deferred inflows | $ 4,886 | $ 3,958 | $ 4,313 |
| Concessionaire and other liabilities | $ 2,428 | $ 2,435 | $ 2,344 |
| **Total Liabilities** | $ 12,202 | $ 11,824 | $ 11,472 |

| Net Position ($ in millions) | 2023 | 2022 | 2021 |
|---|---|---|---|
| Ending net position (eliminate pension and OPEB) | $ 12,919 | $ 12,212 | $ 12,240 |
| Ending net position - pension and OPEB | $ (2,732) | $ (2,614) | $ (3,341) |
| **Total Net Position** | $ 10,187 | $ 9,598 | $ 8,899 |

# Consolidated Income Statement (for the fiscal year ended June 30, 2023)

| Total Revenue ($ in millions) | 2023 | 2022 | 2021 |
|---|---|---|---|
| Tuition and Fees | $ 1,060 | $ 1,003 | $ 870 |
| Grants and Contracts | $ 1,148 | $ 1,168 | $ 1,070 |
| Sales and Services | $ 611 | $ 523 | $ 355 |
| Health System & OSUP Sales and Services | $ 5,413 | $ 4,881 | $ 4,600 |
| State Subsidies and Capital Appropriations | $ 556 | $ 546 | $ 550 |
| Gifts and Additions to Permanent Endowments | $ 293 | $ 355 | $ 272 |
| Other Revenues | $ 127 | $ 78 | $ 76 |
| Total Revenues (w/o investments) | $ 9,208 | $ 8,554 | $ 7,793 |
| Investment income | $ 520 | $ (301) | $ 1,861 |
| **Total Revenues (w/ investments)** | **$ 9,728** | **$ 8,253** | **$ 9,654** |

| Total Expenses ($ in millions) | 2023 | 2022 | 2021 |
|---|---|---|---|
| University Education and General Expenses | $ 3,029 | $ 2,939 | $ 2,722 |
| Auxiliary Sales and Services | $ 415 | $ 364 | $ 263 |
| Health System & OSUP | $ 4,897 | $ 4,290 | $ 4,009 |
| Depreciation | $ 531 | $ 518 | $ 479 |
| Interest Expense on Plant Debt | $ 157 | $ 164 | $ 133 |
| **Total Expenses (w/o pension and OPEB)** | **$ 9,029** | **$ 8,275** | **$ 7,606** |
| Net Margin | $ 699 | $ (22) | $ 2,048 |
| Pension and OPEB Expense | $ 110 | $ (720) | $ (1,166) |
| **Total Expenses (w/o pension and OPEB)** | **$ 9,139** | **$ 7,555** | **$ 6,440** |
| **Change in Net Position** | **$ 589** | **$ 698** | **$ 3,214** |

# Consolidated Cash Flow Statement (for the fiscal year ended June 30, 2023)

| Cash Flow From: ($ in millions) | 2023 | 2022 | 2021 |
|---|---|---|---|
| Receipts from Tuition and Grants | $ 1,889 | $ 1,752 | $ 1,583 |
| Receipts from Sales and Services | $ 5,872 | $ 5,264 | $ 4,827 |
| Payments to or on Behalf of Employees, including benefits | $ (5,091) | $ (4,544) | $ (4,089) |
| Payments to Suppliers | $ (3,075) | $ (2,894) | $ (2,423) |
| Other receipts/(payments) | $ 39 | $ (115) | $ (160) |
| **Total Operating Activities** | **$ (366)** | **$ (537)** | **$ (262)** |
| State Share of Instruction and appropriations | $ 509 | $ 493 | $ 486 |
| CARES Assistance and other non-exchange grants | $ 136 | $ 302 | $ 223 |
| Gift receipts and additions to permanent endowments | $ 236 | $ 284 | $ 157 |
| Payments for purchase or construction of capital assets | $ (1,109) | $ (1,093) | $ (958) |
| Proceeds from capital debt and leases | $ 0 | $ 769 | $ 2 |
| Principal and interest payments on capital debt and leases | $ (252) | $ (242) | $ (220) |
| Other receipts | $ 70 | $ 80 | $ 188 |
| **Total Financing Activities** | **$ (410)** | **$ 593** | **$ (122)** |
| Net purchases, proceeds, and maturities from investments | $ 1,391 | $ (928) | $ (1,205) |
| Investment income | $ 151 | $ 138 | $ 371 |
| Total Investing Activities | $ 1,542 | $ (790) | $ (834) |
| **Net change in cash** | $ 766 | $ (734) | $ (1,218) |
| Beginning Cash and Cash Equivalent Balance | $ 480 | $ 1,214 | $ 2,432 |
| **Ending Cash Balance** | **$ 1,246** | **$ 480** | **$ 1,214** |

# OSU Health System and OSUP Activity Summary (for the twelve months ended June 30, 2023)

| OSUWMC Consolidated Activity Summary | Actual | Budget | Actual-Budget Variance | Budget % Variance | Prior Year | Prior Year % Variance |
|---|---|---|---|---|---|---|
| Admissions | 60,713 | 62,512 | (1,799) | -2.9% | 58,320 | 4.1% |
| Patient Days | 433,885 | 452,087 | (18,202) | -4.0% | 434,956 | -0.2% |
| Surgeries | 56,040 | 52,175 | 3,865 | 7.4% | 51,388 | 9.1% |
| Outpatient Visits | 1,773,306 | 1,939,989 | (166,683) | -8.6% | 1,786,053 | -0.7% |
| Average Length of Stay | 7.09 | 7.22 | 0.13 | 1.8% | 7.42 | 4.5% |
| Case Mix Index (CMI) | 2.06 | 2.07 | (0.01) | -0.5% | 2.07 | -0.6% |

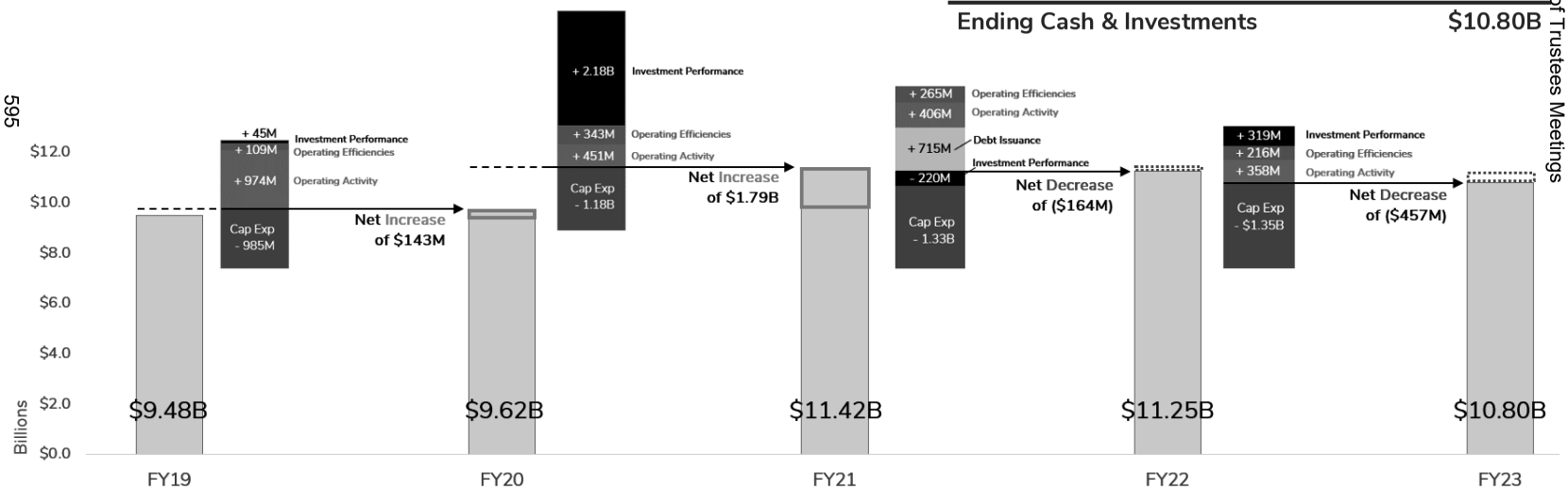
| Operations - Health System ($ in millions) | Actual | Budget | Actual-Budget Variance | Budget % Variance | Prior Year | Prior Year % Variance |
|---|---|---|---|---|---|---|
| Total Operating Revenue | $ 4,006 | $ 3,942 | $ 64 | 1.6% | $ 3,656 | 9.6% |
| Total Operating Expense | 3,704 | 3,735 | 31 | 0.8% | 3,329 | -11.3% |
| **Excess of Revenue over Expense** | **$ 302** | **$ 207** | **$ 95** | **45.5%** | **$ 327** | **-7.8%** |
| **Adjusted Admissions** | **137,055** | **129,248** | **7,807** | **6.0%** | **122,924** | **11.5%** |
| Operating Revenue per AA | $ 29,228 | $ 30,497 | (1,269) | -4.2% | $ 29,739 | -1.7% |
| Operating Expense per AA | $ 26,886 | $ 27,555 | 669 | 2.4% | $ 26,056 | -3.2% |

# Investments

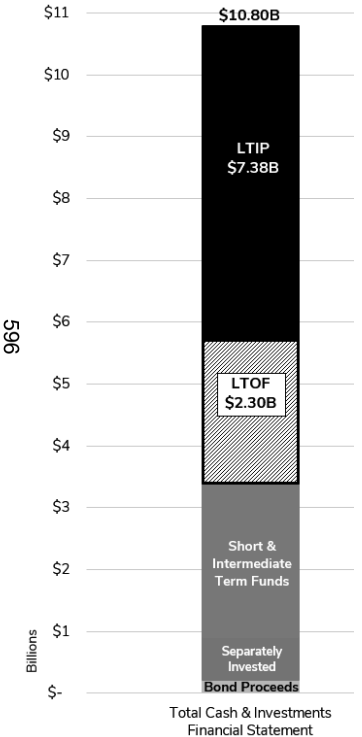
# Cash & Investments

Significant impacts to cash and investments

| 4-YEAR SUMMARY | |
|---|---|
| **Beginning Cash & Investments** | **$9.48B** |
| Investment Performance | **+ $2.32B** |
| Operating Efficiencies | **+ $933M** |
| Operating Activities | **+ $2.19B** |
| Debt Issuance | **+ $715M** |
| Capital Expenditures & Debt Service | **- $4.85B** |
| **Ending Cash & Investments** | **$10.80B** |



# University Total Cash and Investments (as of 6/30/23)




| Long Term Investment Pool | | $7.38B |
|---|---|---|
| Gifted Endowments | University | $1.30B |
| | Foundation | $1.44B |
| Quasi Endowments | Designated | $2.34B |
| Tier 3 - Long Term Operating Funds | University | $1.74B |
| | Health System | $560M |

| Short and & Intermediate Term Funds | | $2.51B |
|---|---|---|
| Tier 2 | Fixed Income Investments | $1.21B |
| Tier 1 | Bank Accounts | $283M |
| | Money Market Funds | $791M |
| | Ultra-Short Investments | $230M |

| Other Separately Invested Funds | $705M |
|---|---|

| Bond Proceeds & Project Funds | $220M |
|---|---|

- As of the of the 4th quarter, the university had $10.80B in cash and investments. Its primary components include:

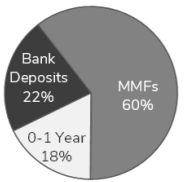
| | | |
|---|---|---|
| Gifted Endowments | $2.74B | 25% |
| Quasi Endowments (excluding LTOF) | $2.34B | 22% |
| Long Term Operating Funds | $2.30B | 21% |
| Short Term Operating Funds | $2.51B | 23% |
| Other Separately Invested Funds | $705M | 7% |
| Bond Proceeds and Project Funds | $220M | 2% |
| | **$10.80B** | |

- The University has $5.00B in total operating funds. This represents the following in days liquidity:
  - 63 Days liquidity in Tier 1 (includes OSUP)
  - 51 days liquidity in Tier 2
  - = **114 days of Operating Liquidity**
  - 97 days liquidity in Tier 3 – Long Term Operating Funds
  - = **211 days of Total Liquidity**

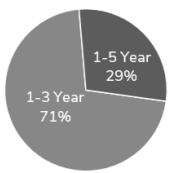
# Operating Fund Portfolio Performance Summary (as of 6/30/2023)

- In FY23, Operating Fund investments outperformed the benchmark by 103bps in Tiers 1 & 2 and 159bps including the LTOF.
- The $4.82B Operating Fund Portfolio has outperformed its composite benchmark over 1, 3 and 5-year time horizons.

| | | | MV | Duration | FY23 YTD | FY22 | 1 yr | 3 yr | 5 yr |
|---|---|---|---|---|---|---|---|---|---|
| **Tier 1 Short Term Working Capital Pool 27%** | **Investment Objective:** Liquidity and principal preservation. **Composition:** Collateralized bank deposits, AAA rated MMFs, State of Ohio local gov't investment pool, ultra-short separately managed fixed income securities. | Cash & Cash Equivalents | $1.07B | | 3.81% | 0.17% | 3.81% | 1.36% | 1.55% |
| | | 0-1 Year Mandate | $230M | 0.04 | 4.43% | -1.35% | 4.43% | 1.47% | 1.92% |
| | | **Consolidated** | **$1.31B** | **0.14** | **3.98%** | **-0.56%** | **3.98%** | **1.39%** | **1.62%** |
| | | *Composite Benchmark* | | *0.48* | *3.60%* | *0.10%* | *3.60%* | *1.27%* | *1.58%* |
| | | Excess Return | | | 0.38% | -0.66% | 0.38% | 0.13% | 0.04% |

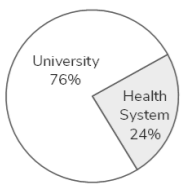



| | | | MV | Duration | FY23 YTD | FY22 | 1 yr | 3 yr | 5 yr |
|---|---|---|---|---|---|---|---|---|---|
| **Tier 2 Intermediate Term Investment Pool 25%** | **Investment Objective:** Return and principal preservation. **Composition:** A+/A1 portfolio of fixed income securities, separately custodied, and externally managed - treasuries, agencies, asset backed securities and high-grade corporate credits. | 1-3 Year Mandate | $864M | 1.71 | 2.30% | -3.76% | 2.30% | 0.23% | 1.91% |
| | | 1-5 Year Mandate | $346M | 2.64 | 1.38% | -6.22% | 1.38% | -1.34% | n/a |
| | | **Consolidated** | **$1.21B** | **1.98** | **2.05%** | **-3.73%** | **2.05%** | **0.10%** | **1.88%** |
| | | *Composite Benchmark* | | *2.06* | *0.54%* | *-3.31%* | *0.54%* | *-0.77%* | *1.25%* |
| | | Excess Return | | | 1.51% | -0.42% | 1.51% | 0.87% | 0.63% |




| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Operating Funds (Tier 1+2) Return** | | | **$2.52B** | **1.68** | **2.86%** | **-2.49%** | **2.86%** | **0.73%** | **1.73%** |
| | | *Composite Benchmark* | | *1.81* | *1.83%* | *-1.98%* | *1.83%* | *0.23%* | *1.44%* |
| | | Excess Return | | | 1.03% | -0.51% | 1.03% | 0.50% | 0.29% |

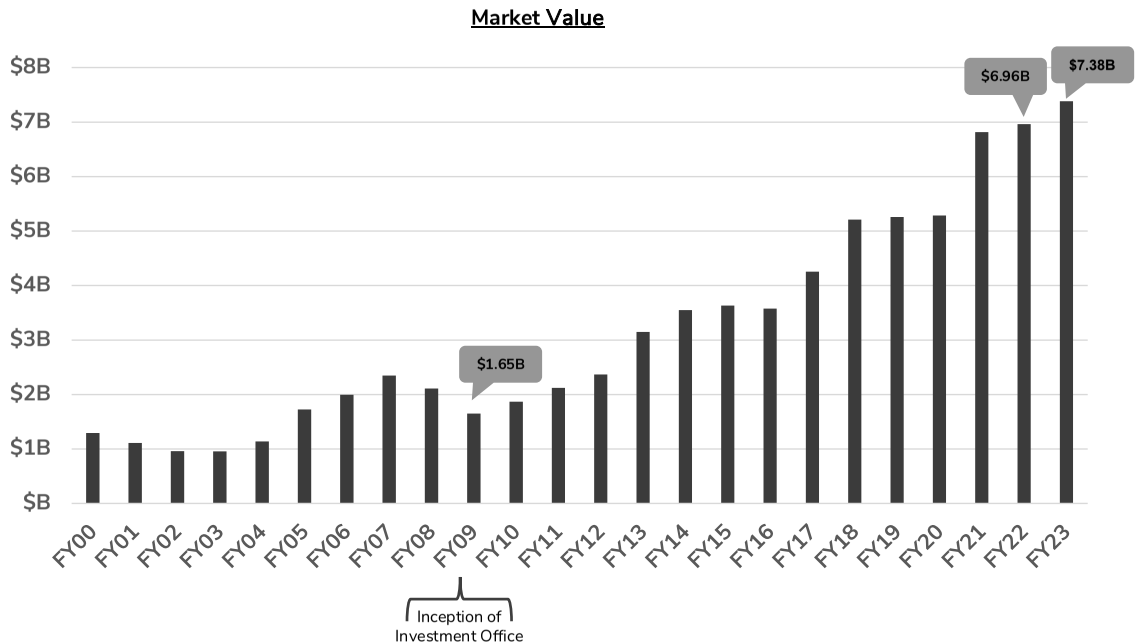
| | | | MV | FY23 YTD | FY22 | 1 yr | 3 yr | 5 yr |
|---|---|---|---|---|---|---|---|---|
| **Tier 3 Long Term Operating Funds (LTOF) In LTIP 48%** | Equity investments managed as a part of the endowment strategy. **Tier 3 composite benchmark returns are preliminary* | University | $1.74B | **Performance calculated on a consolidated basis.** | | | | |
| | | OSUWMC | $560M | | | | | |
| | | **Consolidated** | **$2.30B** | **6.86%** | **0.98%** | **6.86%** | **11.72%** | **7.36%** |
| | | *Composite Benchmark** | | *4.64%* | *-5.54%* | *4.64%* | *7.41%* | *6.76%* |
| | | Excess Return | | 2.22% | 6.52% | 2.22% | 4.31% | 0.60% |




| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Operating Fund Portfolio (Tier 1+2+3) Return** | **$4.82B** | **4.73%** | **-1.02%** | **4.73%** | **5.33%** | **3.97%** |
| *Composite Benchmark* | | *3.14%* | *-3.49%* | *3.14%* | *3.23%* | *3.56%* |
| Excess Return | | 1.59% | 2.47% | 1.59% | 2.10% | 0.41% |

# LTIP Market Value

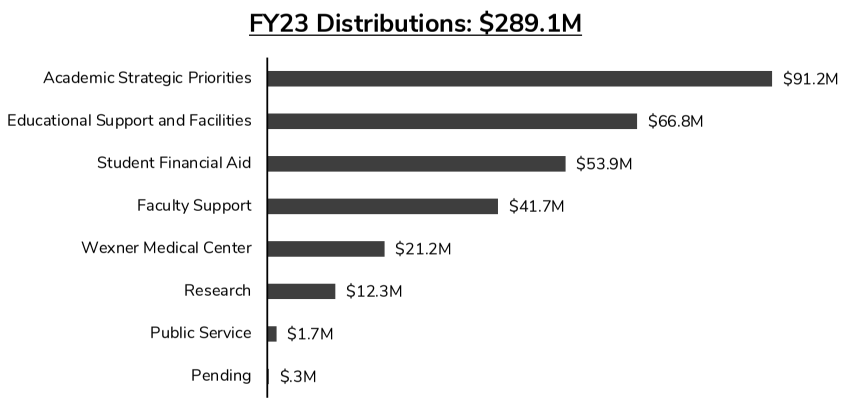
FY 2023 the LTIP has increased in value from $6.96B to $7.38B and generated $472M in investment income.



# Distributions from the LTIP

Annual payments based on a five-year average.

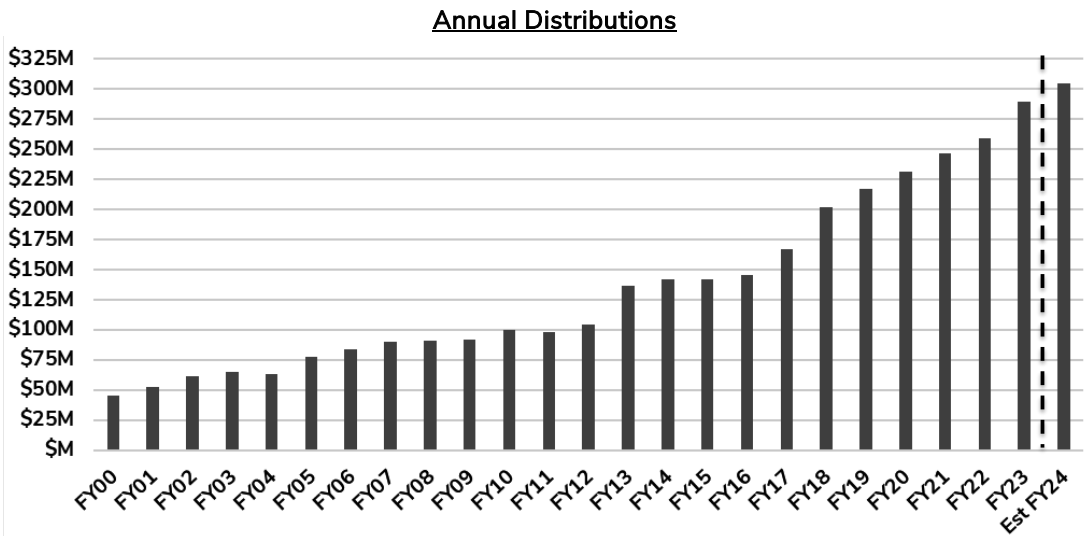
- 4.5% distributed on an annual basis.
- Policy provides steady, reliable funding for campus priorities.



# LTIP Historical and Projected Distributions

Since FY2000, annual distributions from the LTIP to support university priorities have grown more than six-fold from $46M to $289M.

- Based on 2023 LTIP performance, FY2024 distribution is estimated to be $305M.



# LTIP Summary as of June 30, 2023

## Performance

| | Performance | | | | | |
|---|---|---|---|---|---|---|
| | Qtr | 1 Year | 3 Year | 5 Year | 10 Year | 7/09-6/23 |
| Public Equity | 6.07% | 15.51% | 10.35% | | | |
| *MSCI ACWI - ND* | *6.18%* | *16.53%* | *10.99%* | | | |
| Private Equity (Including Buyouts, Growth & Venture Capital) | -0.71% | -0.91% | 23.54% | | | |
| *MSCI ACWI - ND w/one quarter lag* | *7.31%* | *-7.44%* | *15.36%* | | | |
| Real Estate & Infrastructure | 2.85% | 8.07% | 14.56% | | | |
| *Cambridge Associates Real Estate (50%) & Infrastructure (50%)* | *0.91%* | *2.00%* | *13.90%* | | | |
| Legacy Investments | -3.61% | -0.75% | 6.31% | | | |
| *Return of Actual Underlying Funds* | *-3.61%* | *-0.75%* | *6.31%* | | | |
| Hedge Funds (Including Liquid Credit & Illiquid Credit) | 2.47% | 6.60% | 8.64% | | | |
| *HFRI FOF Composite* | *1.43%* | *3.58%* | *5.01%* | | | |
| Cash & High-Grade Bonds | -0.55% | 0.06% | -1.34% | | | |
| *Bloomberg Barclays US Aggregate Bond Index* | *-0.84%* | *-0.94%* | *-3.96%* | | | |
| **LTIP Return** | **2.45%** | **6.86%** | **11.72%** | **7.36%** | **7.27%** | **8.25%** |
| ***Total Consolidated Benchmark*** | ***4.21%*** | ***4.64%*** | ***7.41%*** | ***6.76%*** | ***6.72%*** | ***7.36%*** |

## Market Value Rollforward

| | 7/22-6/23 | 7/09-6/23 |
|---|---|---|
| Beginning Market Value | $6,960,782,423 | $1,651,561,030 |
| Gifts | 62,016,183 | 774,034,005 |
| Other additions, net | 175,027,677 | 3,214,354,095 |
| Distribution | (264,875,000) | (2,455,417,618) |
| Development & Accounting | (21,389,000) | (242,267,130) |
| Investment income, net | 472,113,699 | 4,441,411,600 |
| Ending Market Value | $7,383,675,982 | $7,383,675,982 |

## Asset Allocation

| | |
|---|---|
| **Total Equity (Public & Private)** | **65.7%** |
| Public Equity | 38.2% |
| Private Equity | 27.6% |
| Buyouts | 16.2% |
| Growth Equity | 2.4% |
| Venture Capital | 9.0% |
| **Real Assets** | **12.6%** |
| Infrastructure | 4.8% |
| Real Estate | 3.2% |
| Legacy Investments | 4.6% |
| **Diversifying Assets** | **21.6%** |
| Hedge Funds | 10.5% |
| Credit | 5.8% |
| Cash & High-Grade Bonds | 5.3% |

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Note: Total Consolidated Benchmark based on preliminary data for HFRI and Cambridge Associates Indices. Finalized numbers published approximately four months after quarter end. Results and benchmarks for illiquid categories both reflect a lag of one quarter.

# Efficiency

# 3-Year Efficiency Targets

| Efficiency Targets | FY23 | FY24 | FY25 | Total |
|---|---|---|---|---|
| University | $25M | $60M | $100M | $185M |
| OSUWMC | $30M | $60M | $90M | $180M |
| Capital | $30M | $15M | $15M | $60M |
| **Total** | **$85M** | **$135M** | **$205M** | **$425M** |

# Operational Efficiency Progress Report

### FY23 Q4 Operational Efficiency Progress Report

| Efficiency Savings | FY23 Target | FY23 Actual | Progress to Goal | Status |
|---|---|---|---|---|
| University | $25M | $31.46M | 125.8% | |
| OSUWMC | $30M | $58.31M | 194.4% | |
| Capital Efficiencies | $30M | $62.08M | 207% | |

### Annual Impact – Operational Efficiency

| | FY15 | FY16 | FY17 | FY18 | FY19 | FY20 | FY21 | FY22 |
|---|---|---|---|---|---|---|---|---|
| University Efficiencies | $5.2M | $20.2M | $33.4M | $55.3M | $53.0M | $52.7M | $194.8M | $88.3M |
| OSUWMC | | $18.1M | $40.2M | $23.1M | $23.7M | $45.3M | $103.7M | $115.0M |
| Capital Efficiencies | NA | NA | NA | $33.8M | $54.1M | $11.1M | $44.7M | $61.6M |

### FY12-FY23 Total Efficiency Savings

| | Target | Actual |
|---|---|---|
| University Operational Efficiencies | $400M | $535.1M |
| OSUWMC Operational Efficiencies | $261.6M | $471.9M |
| Capital Efficiencies | $188M | $267.4M |
| Enterprise Procurement Savings | $623M | $782.1M |
| Operational Excellence@OSU (Lean Six Sigma) | $90M | $96.5M |
| OSUWMC Pharmacy, Revenue Cycle & Other | $255M | $355.9M |

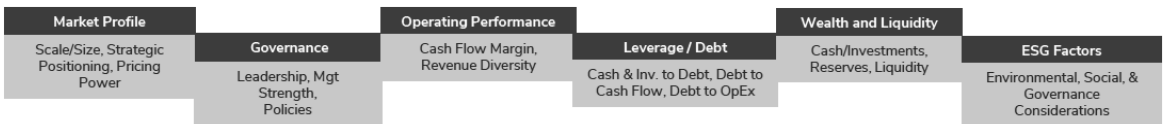
**FY12 – FY23 Enterprise Efficiencies: $2.5B**

# Credit Ratings Update

- Having completed their annual reviews in January 2023, Moody's and S&P affirmed both the university's credit rating and 'Stable' outlook.
- Fitch **upgraded** the university's credit rating to **'AA+/Stable Outlook'** from 'AA/Positive Outlook'. This is the first rating upgrade of the university since the Moody's upgrade to 'Aa1' in 2010 and the first by Fitch since it began rating the university in 2003.

| | Moody's | S&P | Fitch | Notes |
|---|---|---|---|---|
| Credit Rating | Aa1 | AA | AA+ | Moody's and Fitch 2nd highest rating; S&P 3rd highest rating |
| Rating Outlook | Stable | Stable | Stable | Outlook conveys possible direction of rating |

- Credit rating drivers for the university, as with the broader higher education sector, include the following. The rating agencies apply their own detailed methodologies, metrics, and weighting system for these factors.




## Higher Education Sector Outlook 2023

- Moody's/Fitch have 'Negative' and 'Deteriorating' outlooks while S&P is 'mixed', expecting less selective regional campuses to be more challenged than larger, more comprehensive peers.
  - Macro headwinds continue from inflation and labor and wage costs and there is pressure to restore spending cuts.
    - Compounded for AMC's due to healthcare operating pressures.
  - Increased enrollment competition, growing tuition discounts, and limits on pricing power bring muted revenue growth.
  - Higher borrowing costs plus higher constructions costs bring strain for capital projects and is felt particularly within the student housing sector.
- Outlooks could change to 'Stable' if revenues match inflation, macro conditions improve, and steady student demand prevails.

# Conclusion

# Financial State of the University

- The university's overall financial position is strong driven by a variety of factors, including our diversity of operations and our continued focus on operating and capital efficiencies.
- Operating revenues increased $808M in FY23 compared to FY22, driven primarily by strong growth in healthcare revenues, increases in all major auxiliary enterprises, and tuition and fee increases.
- Administrative efficiencies enabled us to re-direct funds to our core mission of access, affordability, academic excellence and patient care during the pandemic.
- University annual rating agency updates had positive results in FY23, receiving our first rating upgrade of the university since the Moody's upgrade to 'Aa1' in 2010 and the first by Fitch since it began rating the university in 2003.

# University Budget Process & FY 2024 Operating Budget

Michael Papadakis, Senior Vice President and CFO
Vincent Tammaro, Vice President and CFO OSUWMC
Kris Devine, Deputy CFO & Vice President of Operations

Finance & Investment Committee | August 17, 2023

# University Financial Model - Overview

The type of Fund drives how the College and Support Unit budgets are determined:

- **GENERAL FUNDS** (Instructional Fees, State Subsidy, Non-Resident Surcharge, Program, Tech, and Course Fees, Indirect Cost Recoveries) fund teaching faculty, support staff and space. Revenues generated from these sources are allocated to the Colleges (after a charge for central administration's strategic funds and administrative overhead) based on average credit hours delivered by the College.
- **EARNING FUNDS** (Medical Center, Athletics, Student Life, Conferences, Core Labs, Teaching Clinics) fund the operations of those units and are budgeted on a stand-alone business intended to earn a profit or break even, depending on the function after an overhead charge.
- **RESTRICTED FUNDS** Endowment (Investment Earnings & Principal); Current Use Gifts (one-time cash); Research Grants and Contracts; revenue from these funds are budgeted to be spent in compliance with the underlying restriction of the donor/grantor.

# University Budget - Process Overview

- The budget planning process starts with the establishment of key drivers at both the University and Health System. The drivers are utilized to calculate budget allocations and common expenses to Colleges and Support Units and to create budgets by College/Unit. These "bottom-up" budgets are reviewed and assessed for alignment with strategic initiatives and are then consolidated. Investments in strategic initiatives are made at both the College and Unit level, and at the Central Administration level to incentivize strategic activities.
- Key Assumptions are determined for revenue and expense lines that are distributed to the Colleges, Support Units and the Health System.
- Some key drivers are reviewed and established centrally, and other drivers are processed through a rigorous shared governance process with Senate Fiscal for review and recommendations, which are forwarded to the Provost & CFO for a final decision.

| CENTRAL KEY DRIVERS | SHARED GOVERNANCE |
|---|---|
| • Enrollment Plans inform Tuition/Fee Rates, which drive College-level budgets based on credit hours delivered<br>• Tuition & Fee Rates:<br>- Undergraduate & Graduate Tuition<br>- Non-Resident & International Surcharges<br>- Housing, Dining & Recreational Sports<br>- Student Health Insurance<br>• Investment Rate of Return and Endowment Distribution Formulas<br>• AMCP (Annual Merit Compensation Process) | • Master's & Professional Programs Differential Fees Request<br>• Overhead Rates<br>• Regional Campus Service Charge<br>• Plant, Operations & Maintenance (POM) Rates<br>• Support Office Budget Requests<br>• Strategic Investments<br>• Composite Benefit Rates |

- Financial, Planning & Analysis (FP&A) consolidates all College and Support Unit plans, and incorporates Central revenue and expenses to create an overall University operating budget.
- A position control process exists to validate that the position is necessary and within budget. The rigor around the process varies depending on the financial status of the College/Support Unit.
- In FY 2022, the University implemented Adaptive Insights, a new financial planning tool to collect Unit/College plans, which integrates data from Workday Finance and HR systems. As part of the annual budget planning process, FP&A implements Adaptive enhancements to support university initiatives. In FY 2024, Adaptive improvements will support position control in Workday.

# OSUWMC Budget - Process Overview

- Like the University, the Health System and OSU Physicians budget planning process starts with a bottom-up review and the establishment of key drivers.
- Cost centers and lines of business benchmark their respective key drivers to determine assumptions and set prices, which are consolidated into the budget.

| Medical Center Key Drivers |
| --- |
| ▪ Payor Mix and price implications<br>▪ Admissions/outpatient visits<br>▪ Worked Hours/Adjusted Admissions<br>▪ Surgeries<br>▪ Case mix index<br>▪ Total Beds<br>▪ Length of Stay<br>▪ Pharmaceuticals/Drugs<br>▪ Salaries/Wages/Benefits<br>▪ Interest<br>▪ Depreciation<br>▪ Annual Capital Expenditures<br>▪ Medical Center Investments (MCI) |

- Requests to hire an employee position not included in the current budget must be approved through an established budget committee prior to posting the position.

# Benchmarking, Efficiencies & Optimizing Spend

**Strategic benchmarking, revenue optimization and expense efficiency activities occur continuously throughout the year.**

- The university is a member of a higher education benchmarking consortium with 80+ member institutions. Our membership provides benchmarks for administrative FTE and employee direct costs compared to academic peers.
  - This national benchmarking of peer institutions is completed to ensure that data-informed decisions across the Colleges/Units are established in creating a Standard Activity Model (SAM) that consistently measures FTEs, expenditures and other drivers.

- General Funds Revenue (Tuition and State Subsidy) is allocated to Colleges based on average credit hours delivered aligning academic and administrative cost delivery with the revenue-generating college.

- An Efficiency Committee comprised of Executive Leadership focuses on savings opportunities and execution. Efficiencies have been a focus of the institution since FY12 and projects in FY24 include:

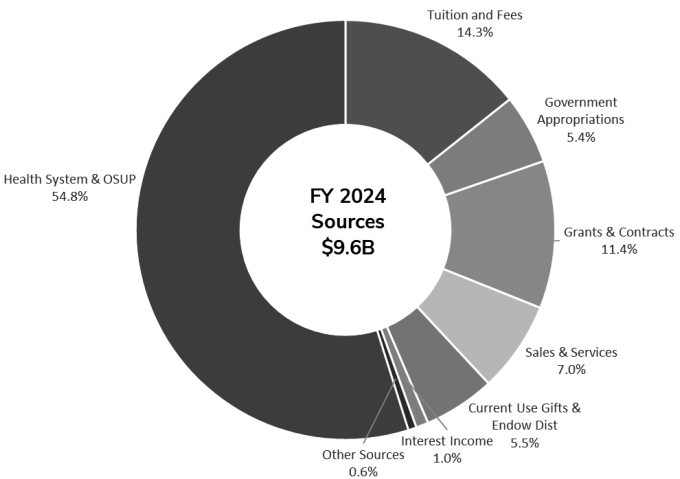
**Efficiency Projects**
- Position Control Enhancement
- Spans & Layers of Control
- Earnings Unit Assessment
- External University Benchmarking
- Annual Capital Project Targets
- Grant Submission Process
- Grant billing and closeout process
- Student Processes improvement prioritization

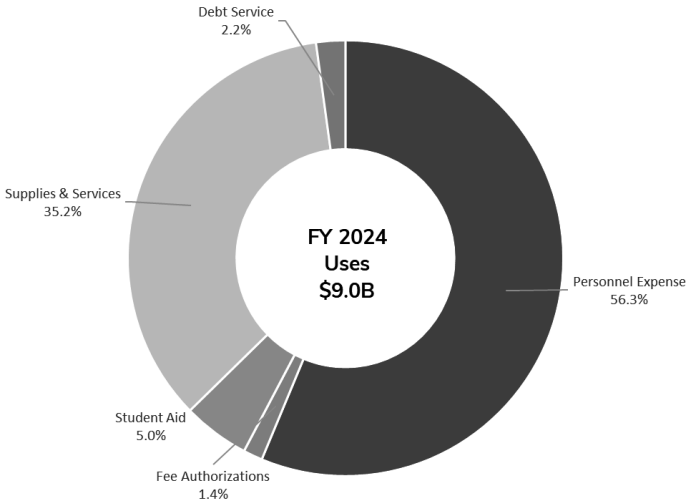
**OE@OSU Projects**
- HR Audit and Compliance
- Workday Security Segregation of Duties
- OPERS Student Exemptions
- Clinical Skills Scheduling Process
- Transportation Headway Variance Reduction
- Construction Inventory
- Billing Reconciliation
- Weekend Staffing Optimization

**Quick Improvements**
- STEP Reconciliation Process Improvement
- Standardized OAA Hiring & Recruitment Process
- Strategic Faculty Hiring Process
- Stellic Degree Audit System Implementation
- Workday Requisition Mapping
- 1099-MISC, 1099-NEC, 1042-S Mapping
- Misc. Payments Mapping
- New Supplier Setup Mapping
- Contract Terms & Conditions Process

- Administrative units have undergone repeated budget reductions and any new University Administrative budget requests follow a rigorous process including a Senate Fiscal review, which is a subcommittee of the University Senate.

# FY 2024 Financial Plan: Consolidated Sources & Uses



# FY 2024 Strategic Investments Highlights

- **Academic Excellence**
  - With the goal to support academic excellence through faculty investments supporting teaching and research, the FY24 Plan includes incremental investments of $18.9M for faculty salary and benefits, and $18.3M for start-up packages across numerous colleges.
  - The FY 2024 Plan includes funding to support market-based equity adjustments for faculty within each college.
- **Research Excellence**
  - With a goal to achieve top ten status for national university research expenditures by growing funded research and strengthening research impact, the FY24 budget includes investments totaling $37.2M, including $24.9M in research growth initiatives in Medicine, Engineering, and Arts and Sciences, and $12.3M in other investments.
- **Service and Clinical Excellence**
  - Ohio State has always been inspired by our land-grant mission of enabling all people to achieve the extraordinary. The Scarlet & Gray Advantage program offers pathways for our undergraduate students to earn their degrees debt-free through a mix of paid internships, on-campus work experiences, financial aid and philanthropy. We are excited to welcome the second cohort of students to the program this fall and to incorporate what we learned during FY23, Scarlet & Gray Advantage's inaugural year.
  - The Ohio State University Wexner Medical Center (OSUWMC) continues to reinvest projected margin in patient care and capital planning to support growing demand, including several strategic initiatives currently under construction and the development of new partnerships to continue accelerating the pace of innovation in research, education, and patient care. Our strategic growth into the surrounding communities will continue with outpatient growth being driven by the continued ramp-up of the Outpatient Care New Albany and Dublin facilities and opening of the James Outpatient Care facility.

# FY 2024 Consolidated Sources & Uses

| Total Sources ($ thousands) | FY20 Actuals | FY21 Actuals | FY22 Actuals | FY23 Unaudited Actuals | FY24 Plan | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|---|
| Tuition & Fees (gross) | $1,192,489 | $1,104,466 | $1,271,606 | $1,310,009 | $1,376,956 | $66,947 | 5.1% |
| State Share of Instruction | $377,449 | $401,420 | $403,564 | $417,224 | $421,387 | $4,163 | 1.0% |
| Other Operating Appropriations | $84,389 | $84,696 | $89,685 | $91,480 | $94,756 | $3,276 | 3.6% |
| Exchange Grants & Contracts | $796,229 | $840,451 | $888,530 | $981,778 | $985,975 | $4,197 | 0.4% |
| Non-Exchange Grants & Contracts | $257,083 | $240,197 | $290,625 | $177,450 | $107,380 | ($70,070) | -39.5% |
| Sales & Services - Auxiliaries | $338,047 | $202,336 | $407,181 | $436,181 | $440,279 | $4,098 | 0.9% |
| Sales & Services - Departmental | $151,743 | $178,760 | $176,149 | $216,471 | $216,517 | $46 | 0.0% |
| Sales & Services - Health System | $3,449,681 | $3,726,605 | $4,178,956 | $4,175,011 | $4,331,152 | $156,141 | 3.7% |
| Sales & Services - OSU Physicians | $584,222 | $647,601 | $701,680 | $842,035 | $943,215 | $101,180 | 12.0% |
| Current Use Gifts | $157,589 | $129,723 | $233,381 | $165,356 | $166,000 | $644 | 0.4% |
| Endowment Distributions | $250,140 | $290,330 | $323,532 | $348,466 | $363,182 | $14,716 | 4.2% |
| Interest Income | $88,984 | $37,230 | $43,111 | $54,492 | $91,843 | $37,351 | 68.5% |
| Other Revenues | $44,700 | $37,198 | $72,089 | $171,032 | $61,100 | ($109,933) | -64.3% |
| **Total Sources** | **$7,772,743** | **$7,921,014** | **$9,080,089** | **$9,386,985** | **$9,599,743** | **$212,757** | **2.3%** |

| Total Uses ($ thousands) | FY20 Actuals | FY21 Actuals | FY22 Actuals | FY23 Unaudited Actuals | FY24 Plan | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|---|
| **Total Personnel Expense** | **$3,992,897** | **$4,115,321** | **$4,435,562** | **$4,751,408** | **$5,086,856** | **$335,448** | **7.1%** |
| Fee Authorizations | $113,097 | $110,545 | $130,040 | $124,752 | $129,350 | $4,598 | 3.7% |
| Student Aid | $435,160 | $420,303 | $489,745 | $428,787 | $448,185 | $19,398 | 4.5% |
| Supplies, Services & Other | $2,463,844 | $2,481,648 | $2,873,276 | $3,116,492 | $3,162,442 | $45,951 | 1.5% |
| Debt Service | $192,141 | $171,718 | $229,076 | $223,611 | $196,330 | ($27,281) | -12.2% |
| **Total Non-Personnel Expense** | **$3,204,242** | **$3,184,214** | **$3,722,137** | **$3,893,641** | **$3,936,307** | **$42,666** | **1.1%** |
| **Total Uses** | **$7,197,139** | **$7,299,535** | **$8,157,699** | **$8,645,048** | **$9,023,163** | **$378,115** | **4.4%** |
| Sources Less Uses, Operating | $575,604 | $621,479 | $922,390 | $741,937 | $576,581 | | |

| Capital Sources and Uses ($ thousands) | FY20 Actuals | FY21 Actuals | FY22 Actuals | FY23 Unaudited Actuals | FY24 Plan | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|---|
| **Total Capital-Related Sources** | **$292,018** | **$398,200** | **$678,496** | **$978,571** | **$675,885** | | |
| **Total Capital-Related Uses** | **$849,813** | **$1,048,239** | **$1,286,985** | **$1,572,328** | **$1,247,943** | | |
| Sources Less Uses, Capital | ($557,795) | ($650,039) | ($608,488) | ($593,757) | ($572,057) | | |
| Sources Less Uses, Capital and Operating | $17,809 | ($28,560) | $313,901 | $148,180 | $4,522 | | |

# FY 2024 University Sources & Uses

| Total Sources ($ thousands) | FY20 Actuals | FY21 Actuals | FY22 Actuals | FY23 Unaudited Actuals | FY24 Plan | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|---|
| **External Sources** | | | | | | | |
| Tuition & Fees (gross) | $1,192,489 | $1,104,466 | $1,271,606 | $1,310,009 | $1,376,956 | $66,947 | 5.1% |
| State Share of Instruction | $377,449 | $401,420 | $403,957 | $417,224 | $421,387 | $4,163 | 1.0% |
| Other Operating Appropriations | $84,389 | $84,696 | $89,685 | $91,480 | $94,756 | $3,277 | 3.6% |
| Exchange Grants & Contracts | $743,431 | $784,021 | $814,074 | $904,886 | $892,820 | ($12,066) | -1.3% |
| Non-Exchange Grants & Contracts | $101,977 | $218,838 | $253,603 | $132,304 | $107,380 | ($24,924) | -18.8% |
| Sales & Services - Auxiliaries | $338,047 | $202,336 | $407,181 | $436,181 | $440,279 | $4,098 | 0.9% |
| Sales & Services - Departmental | $142,389 | $168,707 | $197,121 | $213,163 | $216,517 | $3,355 | 1.6% |
| Current Use Gifts | $157,589 | $129,603 | $174,362 | $129,761 | $166,000 | $36,239 | 27.9% |
| Endowment Distributions | $250,218 | $290,330 | $323,532 | $348,466 | $363,182 | $14,716 | 4.2% |
| Interest Income | $88,984 | $37,230 | $43,111 | $39,467 | $59,075 | $19,609 | 49.7% |
| Other Revenues | $42,467 | $49,693 | $53,829 | $103,899 | $58,800 | ($45,100) | -43.4% |
| **Total External Sources** | **$3,519,428** | **$3,471,341** | **$4,032,060** | **$4,126,839** | **$4,197,153** | **$70,314** | **1.7%** |
| **Internal Sources** | | | | | | | |
| Net Transfers from OSU Health System | $173,749 | $183,960 | $195,432 | $183,046 | $208,908 | $25,862 | 14.1% |
| **Total Internal Sources** | **$173,749** | **$183,960** | **$195,432** | **$183,046** | **$208,908** | **$25,862** | **14.1%** |
| **Total Sources** | **$3,693,177** | **$3,655,301** | **$4,227,492** | **$4,309,886** | **$4,406,061** | **$96,176** | **2.2%** |

| Total Uses ($ thousands) | FY20 Actuals | FY21 Actuals | FY22 Actuals | FY23 Unaudited Actuals | FY24 Plan | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|---|
| Salaries | $1,554,028 | $1,555,797 | $1,638,825 | $1,744,999 | $1,843,250 | $98,251 | 5.6% |
| Benefits | $424,143 | $455,054 | $471,656 | $479,354 | $548,920 | $69,566 | 14.5% |
| **Total Personnel Expense** | **$1,978,171** | **$2,010,851** | **$2,110,481** | **$2,224,353** | **$2,392,170** | **$167,817** | **7.5%** |
| Fee Authorizations | $113,097 | $110,545 | $130,040 | $124,327 | $129,350 | $5,023 | 4.0% |
| Student Aid | $435,160 | $420,303 | $489,745 | $428,664 | $448,185 | $19,521 | 4.6% |
| Supplies, Services & Other | $930,459 | $960,210 | $1,039,801 | $1,082,966 | $1,207,412 | $124,446 | 11.5% |
| Debt Service | $108,017 | $88,802 | $103,772 | $112,707 | $83,205 | ($29,502) | -26.2% |
| **Total Non-Personnel Expense** | **$1,586,734** | **$1,579,860** | **$1,763,358** | **$1,748,665** | **$1,868,151** | **$119,488** | **6.8%** |
| **Total Uses** | **$3,564,905** | **$3,590,711** | **$3,873,838** | **$3,973,017** | **$4,260,322** | **$287,305** | **7.2%** |
| Sources Less Uses, Operating | $128,271 | $64,590 | $353,654 | $336,868 | $145,740 | | |

| Capital Sources and Uses ($ thousands) | FY20 Actuals | FY21 Actuals | FY22 Actuals | FY23 Unaudited Actuals | FY24 Plan | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|---|
| **Total Capital-Related Sources** | **$172,716** | **$168,112** | **$418,522** | **$567,631** | **$345,397** | **($222,234)** | **-39.2%** |
| **Total Capital-Related Uses** | **$479,900** | **$482,237** | **$576,265** | **$788,663** | **$595,114** | **($193,549)** | **-24.5%** |
| Sources Less Uses, Capital | ($307,184) | ($314,126) | ($157,743) | ($221,031) | ($249,716) | | |
| Sources Less Uses, Capital and Operating | ($178,913) | ($249,536) | $195,911 | $115,837 | ($103,977) | | |

# FY 2024 Health System Operating Statement

| Health System ($ thousands) | FY20 Actuals | FY21 Actuals | FY22 Actuals | FY23 Unaudited Actuals | FY24 Plan | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|---|
| **Total Operating Revenue** | **$3,221,114** | **$3,616,126** | **$3,816,536** | **$4,005,847** | **$4,331,152** | **$325,305** | **8.1%** |
| **Operating Expenses** | | | | | | | |
| Salaries & Benefits | $1,525,951 | $1,574,237 | $1,721,204 | $1,849,425 | $1,989,846 | $140,421 | 7.6% |
| Supplies | $363,617 | $425,877 | $423,060 | $475,597 | $498,820 | $23,223 | 4.9% |
| Drugs & Pharmaceuticals | $420,152 | $464,833 | $510,658 | $548,422 | $618,888 | $70,466 | 12.8% |
| Services | $322,480 | $348,471 | $399,278 | $411,914 | $454,807 | $42,893 | 10.4% |
| Depreciation | $170,511 | $175,930 | $187,800 | $211,560 | $242,307 | $30,747 | 14.5% |
| Interest | $31,941 | $29,508 | $42,275 | $44,443 | $41,879 | ($2,564) | -5.8% |
| University Overhead | $65,825 | $73,371 | $74,793 | $75,603 | $78,581 | $2,978 | 3.9% |
| Other Expenses | $51,313 | $55,295 | $59,387 | $67,904 | $71,337 | $3,433 | 5.1% |
| **Total Expenses** | **$2,951,790** | **$3,147,522** | **$3,418,455** | **$3,684,868** | **$3,996,465** | **$311,597** | **8.5%** |
| **Gain/Loss from Operations** | **$269,324** | **$468,604** | **$398,081** | **$320,979** | **$334,687** | | |
| **Medical Center Investments** | **($173,749)** | **($183,960)** | **($190,419)** | **($230,816)** | **($240,361)** | **($9,545)** | **4.1%** |
| **Investment Income** | **$22,272** | **$90,266** | **($726)** | **$42,241** | **$26,943** | **($15,298)** | **-36.2%** |
| **Other Gains (Losses)** | **$196,218** | **$113,547** | **$119,974** | **$169,164** | **$30,223** | **($138,941)** | **-82.1%** |
| Excess of Revenue over Expenses | $314,065 | $488,457 | $326,910 | $301,569 | $151,492 | | |

# FY 2024 OSU Physicians Operating Statement

| OSU Physicians ($ thousands) | FY20 Actuals | FY21 Actuals | FY22 Actuals | FY23 Unaudited Actuals | FY24 Plan | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|---|
| **Revenue** | | | | | | | |
| Net Patient Revenue | $366,290 | $426,218 | $614,375 | $628,810 | $693,167 | $64,357 | 10.2% |
| Other Revenue | $116,889 | $121,913 | $143,826 | $213,226 | $246,448 | $33,222 | 15.6% |
| Medical Center Investments | $101,042 | $101,374 | $118,155 | $163,602 | $153,934 | ($9,668) | -5.9% |
| Interest Income | $1,668 | - | $673 | $4,050 | $3,600 | ($450) | -11.1% |
| **Total Revenue** | **$585,889** | **$649,505** | **$877,029** | **$1,005,637** | **$1,097,149** | **$91,512** | **9.1%** |
| **Expenses** | | | | | | | |
| Provider Salaries & Benefits | $375,765 | $409,616 | $627,794 | $653,270 | $692,079 | $38,809 | 5.9% |
| Non-Provider Salaries & Benefits | $113,010 | $113,992 | $136,829 | $188,693 | $209,951 | $21,258 | 11.3% |
| Other Expenses | $85,145 | $113,111 | $93,171 | $171,922 | $189,089 | $17,167 | 10.0% |
| Depreciation | $3,393 | $3,122 | $9,935 | $4,363 | $5,013 | $650 | 14.9% |
| Interest | $279 | - | $3,339 | $206 | $243 | $37 | 18.0% |
| **Total Expenses** | **$577,592** | **$639,841** | **$871,068** | **$1,018,454** | **$1,096,375** | **$77,921** | **7.7%** |
| Change in Net Assets | $8,297 | $9,664 | $5,961 | ($12,817) | $774 | | |

# Appendix

# FY24 Budget Assumptions: University Sources

| REVENUE DRIVER | DETAIL | FY24 BUDGET PLAN |
|---|---|---|
| **KEY REVENUE DRIVERS** (University Only) | | |
| **TUITION & FEES** (Including Housing, Dining) | ▪ Undergraduate Tuition (Non-Guarantee/ TG 2023 Guarantee)<br>▪ Undergraduate Non-Resident Surcharge | ▪ Cap 0.0% / Cap + CPI 3.0% tuition<br>▪ 5.2% Non-resident surcharge |
| | ▪ Graduate Base Fees<br>▪ Graduate Non-Resident Surcharge | ▪ 3.8% base fees<br>▪ 4.2% non-resident surcharge |
| | ▪ Increase in Housing and Dining for new Tuition Guarantee cohort | ▪ 3.0% housing/dining increase |
| **STATE SHARE OF INSTRUCTION** (SSI) | ▪ State of Ohio Subsidy | ▪ 1.0% Increase |
| **RESEARCH & GRANTS** | ▪ Continued increases in federal and private grants and contacts<br>▪ State and local grants and contracts<br>▪ Non-Exchange Federal Grants - Decrease CARES | ▪ 5.4% Federal; (0.4%); Private grants<br>▪ (2.8%)State; (0.2%) Local grants<br>▪ CARES decrease ($24.8M) |
| **FUNDRAISING** | ▪ Current Use Gifts – the Change from $129.8M Base in FY23<br>▪ New Fundraising Activity (NFA) measurement basis (FY23 =$647M) | ▪ +$36.2M current use gifts ($166.0M)<br>▪ $0M NFA activity |
| **ENDOWMENT DISTRIBUTION** | ▪ LTIP return and endowment distributions based on a 5-year average | ▪ 8% LTIP; 4.5% distribution |
| **ATHLETICS & BUSINESS ADVANCEMENT** | ▪ Athletics: 8 home football games FY23; 6 in FY24<br>▪ Business Advancement return to normal activity in FY23<br>▪ Student Life | ▪ ($14.8M)<br>▪ +$10.0M<br>▪ +$6.0M |

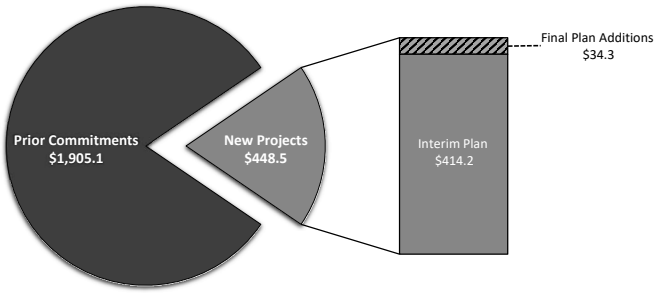
# FY24 Budget Assumptions: University Uses

| EXPENSE DRIVER | DETAIL | FY24 BUDGET PLAN |
|---|---|---|
| **KEY EXPENSE DRIVERS** (University Only) | | |
| **PERSONNEL** | ▪ Salaries – Annual Merit Compensation Pool (AMCP)<br>▪ Composite Benefit Rate Change (%) | ▪ +3% AMCP + Faculty Equity Adjustment<br>▪ +8% Medical component |
| **NUMBER OF OPEN FTEs IN FY24 Budget** | ▪ Including Faculty & Staff in Colleges & Support Units | ▪ 147 Vacant FTEs, after accounting for vacancy credits |
| **TENURE TRACK FTES** | ▪ Tenure Track Faculty Hiring Trends | ▪ +140 Tenure Track |
| **STUDENT AID** | ▪ Increase in aid for Scarlet and Grey Advantage Pilot<br>▪ Increase in Athletic Aid | ▪ +$2.0M SGA<br>▪ +$1.4M athletic student aid |
| **SUPPLIES & SERVICES** | ▪ Travel "Return to Normal"<br>▪ Increase in Non-Capital Equipment: Research<br>▪ Cost of Sales: Auxiliary Operations<br>▪ Utilities<br>▪ Other Supplies & Services: Inflation | ▪ +0.9%<br>▪ +14.6%<br>▪ +3.5%<br>▪ +4.5%<br>▪ +3.0% |
| **DEBT SERVICE** | ▪ Variable Rate Bond Refunding - Savings | ▪ ($29M) |

# Assumptions: Health System

| FACTOR | ASSUMPTIONS & EXPLANATION |
|---|---|
| PAYOR MIX AND PRICE IMPLICATIONS | MANAGED CARE 5% AVERAGE RATE INCREASE<br>GOVERNMENTAL RATES INCREASE 1-2%<br>2% PAYOR SHIFT TO MEDICARE - AGING POPULATION |
| DISCHARGES/OUTPATIENT ACTIVITY | DISCHARGES – 5.5% INCREASE<br>OUTPATIENT ACTIVITY – 4.2% INCREASE |
| SURGERIES | INPATIENT – 4.2% INCREASE<br>OUTPATIENT – 7.0% INCREASE<br>TOTAL – 5.7% INCREASE |
| CASE MIX INDEX | CMI CONTINUES AT FY23 LEVELS |
| LENGTH OF STAY | DECREASE OF 0.3% |
| TOTAL BEDS | TOTAL BEDS AVAILABLE OF 1,465 WITH AVERAGE OF 85 CLOSED BEDS |
| SALARY/WAGES | 3% MERIT INCREASE & 2% MARKET ADJUSTMENTS |
| BENEFITS | 35.7% OF SALARIES |
| PHARMA/DRUGS | DRUG COST INFLATION OF 5.0% |
| INTEREST | 5.8% DECREASE (Incremental debt planned to be issued at end of FY24) |
| DEPRECIATION | INCREASE 14.5% FROM FY23<br>NEW ADDS: JAMES OUTPATIENT CARE & FULL YEAR OF OP CARE DUBLIN |
| ANNUAL CAPITAL EXPENDITURES | ROUTINE - $195M STRATEGIC - $439M TOTAL - $634M |
| MEDICAL CENTER INVESTMENTS | $240.4M |

FY2024-2028 Final Capital Investment Plan
08/17/2023




**Total FY24 CIP: $2,353.6**

**Table 1 - Prior Commitments - Remaining Spend** **$ in Millions**

| Line | Capital Priority | Projected Capital Expenditures FY2024 | FY2025 | FY2026 | FY2027 | FY2028 | Total |
|---|---|---|---|---|---|---|---|
| 1 | A&S - Arts District | $ 9.9 | $ 2.1 | $ - | $ - | $ - | $ 11.9 |
| 2 | A&S - Celeste Lab Renovation | $ 8.4 | $ 7.0 | $ 1.4 | $ - | $ - | $ 16.8 |
| 4 | COE - BMEC Phase 2 | $ 11.6 | $ 50.6 | $ 19.6 | $ 1.1 | $ - | $ 82.9 |
| 5 | COE - CAR Bus Testing Facility | $ 3.3 | $ 9.2 | $ 5.3 | $ 5.3 | $ 2.9 | $ 25.9 |
| 6 | COM - Interdisciplinary Health Sciences Center | $ 32.5 | $ 12.1 | $ 0.7 | $ - | $ - | $ 45.2 |
| 7 | EHE - Campbell Hall Renovation | $ 4.1 | $ 22.5 | $ 32.0 | $ 0.3 | $ - | $ 58.8 |
| 8 | ERIK - Energy Advancement and Innovation Center | $ 11.6 | $ 2.7 | $ - | $ - | $ - | $ 14.3 |
| 9 | ERIK - Pelotonia Research Center | $ 19.6 | $ 13.9 | $ - | $ - | $ - | $ 33.4 |
| 10 | FOD - Cannon Drive Relocation - Phase 2 | $ 15.5 | $ 27.5 | $ 10.9 | $ - | $ - | $ 54.0 |
| 11 | FOD - Elevator Safety Repairs and Replacements | $ 3.1 | $ 1.6 | $ - | $ - | $ - | $ 4.7 |
| 12 | FOD - Roof Repairs and Replacements | $ 1.3 | $ 3.3 | $ - | $ - | $ - | $ 4.6 |
| 13 | LIB - Library Book Depository Phase 3 | $ 3.5 | $ 0.7 | $ - | $ - | $ - | $ 4.2 |
| 14 | Newark - Founders Hall Enhancements | $ 3.0 | $ 19.4 | $ 1.1 | $ - | $ - | $ 23.4 |
| 15 | Nursing - Jane E Heminger Hall and Newton Renovation | $ 5.3 | $ 0.3 | $ - | $ - | $ - | $ 5.6 |
| 16 | Vet Med - Equine Arena | $ 3.2 | $ 6.1 | $ - | $ - | $ - | $ 9.2 |
| 18 | WMC - Inpatient Hospital | $ 402.0 | $ 299.7 | $ 141.5 | $ 68.5 | $ - | $ 911.7 |
| 19 | WMC - James Outpatient Care | $ 41.7 | $ 32.4 | $ 2.6 | $ - | $ - | $ 76.7 |
| 20 | WMC - Loading Dock Expansion and Renovation | $ 8.2 | $ 6.1 | $ 0.4 | $ - | $ - | $ 14.6 |
| 22 | WMC - Martha Morehouse Facility Improvements | $ 10.4 | $ 8.4 | $ - | $ - | $ - | $ 18.7 |
| 23 | WMC - Outpatient Care New Albany | $ 3.3 | $ - | $ 1.9 | $ - | $ - | $ 5.2 |
| 24 | WMC - Outpatient Care Powell | $ 2.8 | $ 1.3 | $ 7.6 | $ 7.2 | $ 1.0 | $ 19.9 |
| 25 | Wooster - Fisher Auditorium Renovation | $ 0.4 | $ 4.1 | $ 3.5 | $ - | $ - | $ 8.0 |
| 26 | Roll Up Other Projects | $ 227.9 | $ 155.3 | $ 65.8 | $ 5.7 | $ 0.4 | $ 455.2 |
| 27 | Subtotal | **$ 832.5** | **$ 685.9** | **$ 294.3** | **$ 88.1** | **$ 4.3** | **$ 1,905.1** |

FY2024-2028 Final Capital Investment Plan
08/17/2023

**Table 2 - New Projects Beginning in FY2024** **$ in Millions**

| Line | Capital Priority | Projected Capital Expenditures FY2024 | FY2025 | FY2026 | FY2027 | FY2028 | Total |
|---|---|---|---|---|---|---|---|
| 1 | **Anticipated Spend for CIP Changes** | **$ 10.0** | **$ 0.0** | **$ 0.0** | **$ 0.0** | **$ 0.0** | **$ 10.0** |
| 2 | **Roll up of Small Infrastructure RDM Projects** | **$ 15.3** | **$ 14.4** | **$ 8.5** | **$ 2.5** | **$ 4.8** | **$ 45.6** |
| 3 | **Small Programmatic Cash Ready** | **$ 12.2** | **$ 20.1** | **$ 10.0** | **$ 0.7** | **$ 0.0** | **$ 43.1** |
| 4 | **WMC - Roll up of Multiple Cash Ready** | **$ 197.7** | **$ 0.0** | **$ 0.0** | **$ 0.0** | **$ 0.0** | **$ 197.7** |
| 5 | **New Major Projects** | | | | | | |
| 6 | A&S - Biological Sciences Building Upgrades | $ 0.4 | $ 2.4 | $ 5.3 | $ 4.7 | $ 2.3 | **$ 15.0** |
| 7 | A&S - Department of Economics Relocation | $ 0.8 | $ 3.1 | $ 3.5 | $ 2.3 | $ 0.3 | **$ 10.0** |
| 8 | CFAES - Multispecies Animal Learning Center - Waterman | $ 4.2 | $ 15.3 | $ 17.4 | $ 11.2 | $ 1.7 | **$ 49.8** |
| 9 | ERIK - Battery Cell Research and Demonstration Center | $ 1.2 | $ 4.9 | $ 7.0 | $ 5.3 | $ 1.7 | **$ 20.0** |
| 10 | VET - VMC PET/CT Space Renovation | $ 1.3 | $ 3.6 | $ 1.6 | $ 0.0 | $ 0.0 | **$ 6.5** |
| 11 | WMC - Inpatient Hospital Endo/Bronch/Admin Suite Unshelling | $ 8.0 | $ 18.0 | $ 1.0 | $ 0.0 | $ 0.0 | **$ 27.0** |
| 12 | WMC - James Cellular Therapy Lab | $ 1.3 | $ 3.8 | $ 1.7 | $ 0.0 | $ 0.0 | **$ 6.8** |
| 13 | WMC - James Outpatient Care Buildout | $ 1.3 | $ 3.8 | $ 1.7 | $ 0.0 | $ 0.0 | **$ 6.8** |
| 14 | WMC - Magnetic Resonance Linear Accelerator & Housing | $ 0.9 | $ 3.2 | $ 3.6 | $ 2.3 | $ 0.3 | **$ 10.3** |
| 15 | **Grand Total** | **$ 254.6** | **$ 92.6** | **$ 61.3** | **$ 28.9** | **$ 11.1** | **$ 448.5** |

**Table 3 - New Projects by Funding Source and Deferred Maintenance**

| Line | Unit | Local | State | Fundraising | Grant | Partnership & Other | University Debt | Grand Total | % By Unit | Def. Maint. Addressed | Def Maint. % |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Academic Support | $ 71.4 | $ 10.0 | $ 19.0 | $ 4.8 | $ 16.0 | $ 15.2 | $ 136.4 | 30% | $ 24.7 | 18% |
| 2 | Athletics | $ 14.3 | $ 0.0 | $ 2.7 | $ 0.0 | $ 0.0 | $ 0.0 | $ 17.0 | 4% | $ 4.7 | 28% |
| 3 | Infrastructure | $ 13.4 | $ 0.0 | $ 0.0 | $ 8.1 | $ 0.5 | $ 7.5 | $ 29.4 | 7% | $ 25.0 | 85% |
| 4 | Regional Campuses | $ 0.2 | $ 0.0 | $ 0.0 | $ 0.0 | $ 2.5 | $ 0.0 | $ 2.6 | 0.6% | $ 1.4 | 54% |
| 5 | Student Life | $ 14.5 | $ 0.0 | $ 0.0 | $ 0.0 | $ 0.0 | $ 0.0 | $ 14.5 | 3% | $ 12.0 | 83% |
| 6 | Wexner Medical Center | $ 248.6 | $ 0.0 | $ 0.0 | $ 0.0 | $ 0.0 | $ 0.0 | $ 248.6 | 55% | $ 35.0 | 14% |
| 7 | **Grand Total** | **$ 362.3** | **$ 10.0** | **$ 21.7** | **$ 12.9** | **$ 18.9** | **$ 22.7** | **$ 448.5** | **100%** | **$ 102.8** | **23%** |

## ADVANCEMENT SCORECARD

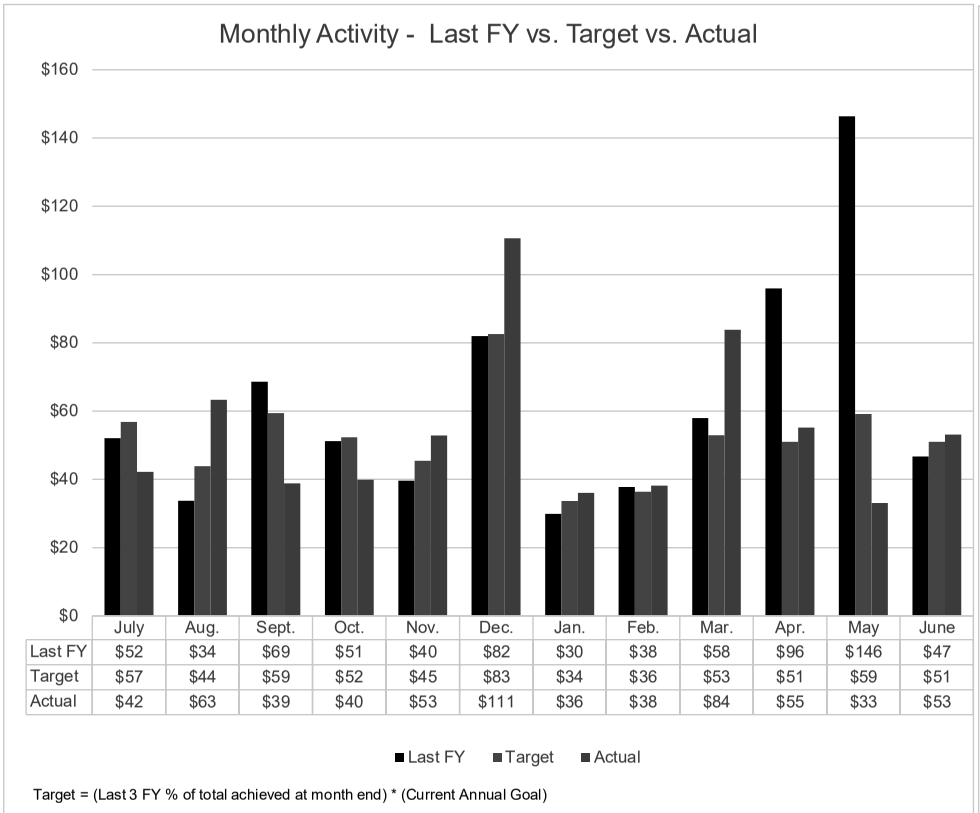
| DATA THROUGH June 30, 2023 | FY23 GOAL | FY23 TO 6/30 | FY22 TO 6/30 | 3 FY AVERAGE TO 6/30 | YTD TARGET |
|---|---|---|---|---|---|
| **A FISCAL YEAR MEASURES** | | | | | |
| 1. GIFTS AND PLEDGES | $625M | $647.2M | $743.2M | $607.0M | 103.6% |
| 2. CASH | $475M | $532.4M | $510.6M | $477.1M | 112.1% |
| 3. TOTAL DONORS | 245,000 | 225,982 | 236,174 | 222,636 | 92.2% |
| A. RENEWED DONORS | 141,000 | 132,083 | 116,462 | 121,489 | 93.7% |
| B. ACQUIRED AND REACQUIRED DONORS | 104,000 | 93,899 | 119,712 | 101,147 | 90.3% |
| **B EVENTS** | | | | | |
| 1. CONSTITUENT ATTENDANCE ACROSS EVENTS | 40,000 | 39,163 | 25,444 | 35,519 | 97.9% |
| 2. AVERAGE NET PROMOTER SCORE | 72.0 | 73.6 | 75.31 | 72.62 | 102.2% |

THE OHIO STATE UNIVERSITY

FY2023 New Fundraising Activity Report

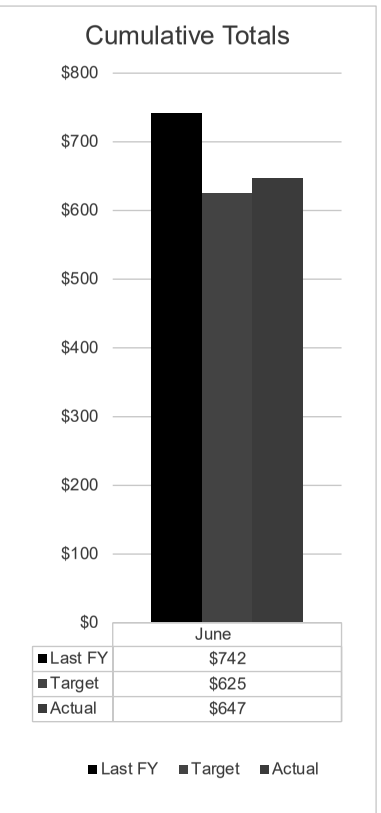
# Monthly Activity

7/1/2022 through 6/30/2023




| | July | Aug. | Sept. | Oct. | Nov. | Dec. | Jan. | Feb. | Mar. | Apr. | May | June |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Last FY | $52 | $34 | $69 | $51 | $40 | $82 | $30 | $38 | $58 | $96 | $146 | $47 |
| Target | $57 | $44 | $59 | $52 | $45 | $83 | $34 | $36 | $53 | $51 | $59 | $51 |
| Actual | $42 | $63 | $39 | $40 | $53 | $111 | $36 | $38 | $84 | $55 | $33 | $53 |

Target = (Last 3 FY % of total achieved at month end) * (Current Annual Goal)




| | June |
|---|---|
| Last FY | $742 |
| Target | $625 |
| Actual | $647 |

# Time & Change + Scarlet & Gray Advantage

| | Activity | |
|---|---|---|
| **Time & Change: Student Success** | **$1,291** | Oct. 1, 2016 to present |
| »All Scholarships | $627 | |
| »Undergrad-available Scholarships | $450 | |
| »Scarlet & Gray Advantage | $178 | Jul 1, 2021 to present |
| »Endowment | $107 | |
| »Current Use | $71 | |

All activity listed in millions.
Fundraising for Scarlet & Gray Advantage began on 7/1/2021.
As of 6/30/2023

TIME AND CHANGE
THE OHIO STATE CAMPAIGN

THE OHIO STATE UNIVERSITY

# Overall Progress

from 10/1/2016 to 6/30/2023

Time Elapsed: 84%

TIME AND CHANGE
THE OHIO STATE CAMPAIGN

## The Ohio State University

| Inspiring 1,000,000 Donors | Raising $4,500,000,000 |
|---|---|
| 717,581 | $4,026,815,441 |

### Fundraising Progress

| Metric | Received to Date | Goal | % of Goal | $ from Goal | Target | % of Target | $ from Target | |
|---|---|---|---|---|---|---|---|---|
| New Fundraising Activity | $4,026.82M | $4,500.00M | 89% | ($473.18M) | $3,686.45M | 109% | $340.36M | ● |
| Endowment | $866.86M | $875.00M | 99% | ($8.14M) | $716.81M | 121% | $150.05M | ● |
| Capital | $478.28M | $718.50M | 67% | ($240.22M) | $559.36M | 86% | ($81.08M) | ● |

New Fundraising Activity current target of 82% of goal based on required compound annual growth from FY2017 through FY2024

Endowment current target of 82% of goal based on required compound annual growth from FY2017 through FY2024

Capital current target of 78% of goal based on scheduled approval of capital projects

● % of Target > = 100%

● % of Target between 95% and 100%

● % of Target < 95%

THE OHIO STATE UNIVERSITY

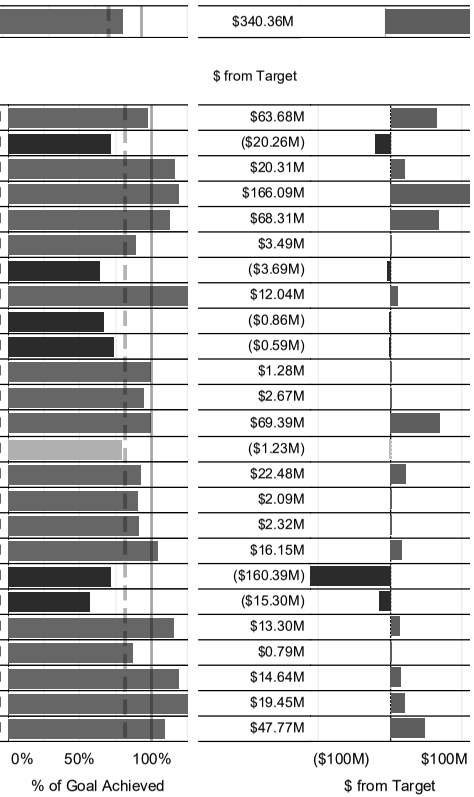
# New Fundraising Activity

from 10/1/2016 to 6/30/2023

TIME AND CHANGE
THE OHIO STATE CAMPAIGN

## The Ohio State University

| Group | Unit Modified | Goal | Received to Date | Target | $ from Target |
|---|---|---|---|---|---|
| Overall | | $4,500.00M | $4,026.82M | $3,686.45M | $340.36M |
| Colleges | Arts and Sciences (College of) | $400.00M | $391.37M | $327.68M | $63.68M |
| | Business (Fisher College of) | $200.00M | $143.58M | $163.84M | ($20.26M) |
| | Education and Human Ecology (College of) | $60.00M | $69.46M | $49.15M | $20.31M |
| | Engineering (College of) | $450.00M | $534.74M | $368.65M | $166.09M |
| | Food, Agricultural and Enviro Sciences (C.. | $225.00M | $252.63M | $184.32M | $68.31M |
| | Law (Michael E. Moritz College of) | $50.00M | $44.45M | $40.96M | $3.49M |
| | Public Affairs (John Glenn College of) | $20.00M | $12.69M | $16.38M | ($3.69M) |
| | Social Work (College of) | $15.00M | $24.33M | $12.29M | $12.04M |
| Regional Campuses | OSU Lima | $5.50M | $3.65M | $4.51M | ($0.86M) |
| | OSU Mansfield | $6.90M | $5.06M | $5.65M | ($0.59M) |
| | OSU Marion | $7.40M | $7.34M | $6.06M | $1.28M |
| | OSU Newark | $20.20M | $19.22M | $16.55M | $2.67M |
| Academic Support Units | Athletics | $400.00M | $397.07M | $327.68M | $69.39M |
| | Libraries | $45.00M | $35.64M | $36.86M | ($1.23M) |
| | Scholarship and Student Support | $225.00M | $206.80M | $184.32M | $22.48M |
| | Student Life | $25.00M | $22.57M | $20.48M | $2.09M |
| | Wexner Center for the Arts | $25.00M | $22.80M | $20.48M | $2.32M |
| | WOSU Public Media | $70.00M | $73.49M | $57.34M | $16.15M |
| Wexner Medical Center | Medical Center (Wexner) | $1,600.00M | $1,150.35M | $1,310.74M | ($160.39M) |
| Health Sciences Colleges | Dentistry (College of) | $60.00M | $33.85M | $49.15M | ($15.30M) |
| | Nursing (College of) | $40.00M | $46.07M | $32.77M | $13.30M |
| | Optometry (College of) | $15.00M | $13.08M | $12.29M | $0.79M |
| | Pharmacy (College of) | $40.00M | $47.40M | $32.77M | $14.64M |
| | Public Health (College of) | $20.00M | $35.83M | $16.38M | $19.45M |
| | Veterinary Medicine (College of) | $175.00M | $191.13M | $143.36M | $47.77M |




Target Percentage to Date: 82%

## CONSOLIDATED FINANCIAL SCORECARD

| Enterprise Operating Activity | FY23 Actual | FY23 Plan | Status |
|---|---|---|---|
| 1. Sources | $9.4B | $8.8B | 107% |
| 2. Uses | $8.6B | $8.2B | 105% |
| 3. Sources less Uses | $741.9M | $572.1M | 130% |

| Capital Projects / Financing | FY23 Actual | FY23 Plan | Status |
|---|---|---|---|
| 1. Capital Spend Activity - All sources | $1,048M | $1,170M | 90% |
| 2. Net Capital Spend Activity - Cash | $520M | $640M | 81% |
| 3. Debt Service & Financing Activity | $277M | $270M | 102% |

*(Includes principal repayment and affiliate loan activity)*

| Liquidity | FY23 Actual | Target | Status |
|---|---|---|---|
| 1. Operating Liquidity - Days Cash on Hand | 114 | Policy > 90 Days | Stable |
| 2. Total Enterprise Liquidity - Days Cash on Hand | 211 | > 180 Days | Stable |

**Investment Performance**

| Operating Funds | FY23 Actual | Benchmark | Status |
|---|---|---|---|
| FYTD Performance | 2.86% | 1.83% | +1.03% |
| 3-Year Performance | 0.73% | 0.23% | +0.50% |

| Long Term Investment Pool | FY23 Actual | Benchmark | Status |
|---|---|---|---|
| FYTD Performance | 6.86% | 4.64% | +2.22% |
| 3-Year Performance | 11.72% | 7.41% | +4.31% |

| Institutional Financial Metrics | FY23 Actual | Target | Status |
|---|---|---|---|
| 1. Credit Rating | Aa1 / AA / AA+ | Aa1 / AA / AA+ | Stable |
| 2. Debt Service to Operating Expenses (OpEx) | 2.6% | < 4.0% | Stable |
| | **FY 23 Actual** | **Target** | **Status** |
| 3. Debt Service Coverage (EBIDA/DS) *(FY23 -Estimate)* | 4.7x | ≥ 3.0x | Stable |
| | **FY23 Actual** | **FYE 22** | **Status** |
| 4. Cash & Investments to OpEx | 1.22x | 1.27x | Stable |

## UNIVERSITY FINANCIAL SCORECARD

| University Operating Activity | FY23 Actual | FY23 Plan | Status |
|---|---|---|---|
| 1. Sources | $4.3B | $4.1B | 104% |
| 2. Uses | $4.0B | $4.0B | 99% |
| 3. Sources less Uses | $336.9M | $112.6M | 299% |

| Revenue Drivers | FY23 Actual | FY23 Plan | Status |
|---|---|---|---|
| 1. Enrollment - summer, autumn, spring | 149,187 | 152,292 | 98% |
| 2. Credit Hours - summer, autumn, spring | 1,860,346 | 1,899,659 | 98% |
| 3. Tuition and Fees, gross | $1,310.0M | $1,318.8M | 99% |
| 4. Total Grants and Contracts (Exchange & Non-Exchange) | $1,037.2M | $915.3M | 113% |
| 5. State Operating Support | $508.7M | $494.5M | 103% |
| 6. LTIP Distributions | $348.5M | $352.8M | 99% |
| 7. Advancement Cash Receipts | $129.8M | $166.0M | 78% |
| 8. Net Contribution from Auxiliary Enterprises (Operating) | $15.1M | $19.7M | 76% |

| Performance Metrics | Current Year | Prior Year | Status |
|---|---|---|---|
| 1. New first year student retention | 93.4% | 94.0% | 99% |
| 2. Four year graduation rate | 72.3% | 70.8% | 102% |
| 3. Six year graduation rate | 88.1% | 88.0% | 100% |

## MEDICAL CENTER FINANCIAL SCORECARD

| Medical Center Operating Activity | FY23 Actual | FY23 Plan | Status |
|---|---|---|---|
| 1. Sources | $4.0B | $3.9B | 102% |
| 2. Uses | $3.6B | $3.5B | 103% |
| 3. Sources less Uses, Operating | $411.6M | $446.1M | 92% |
| 4. Sources less Uses, *Including Non-Operating* | $301.6M | $207.3M | 145% |
| 5. OSUP Sources less Uses | $26.1M | $41.5M | 63% |

| Revenue Drivers | FY23 Actual | FY23 Plan | Status |
|---|---|---|---|
| 1. Patient Admissions | 60,713 | 62,512 | 97% |
| 2. Patients in Inpatient Beds | 77,438 | 77,675 | 100% |
| 3. Patient Discharges | 61,228 | 62,647 | 98% |
| 4. Total Surgeries | 56,040 | 52,175 | 107% |
| 5. Outpatient Visits | 1,773,306 | 1,939,989 | 91% |
| 6. ED Visits | 120,486 | 116,458 | 103% |

| Performance / Activity Metrics | FY23 Actual | FY23 Plan | Status |
|---|---|---|---|
| 1. Adjusted Admissions | 137,055 | 129,248 | 106% |
| 2. Operating Revenue / Adjusted Admit | $29,228 | $30,497 | 96% |
| 3. Expense / Adjusted Admit | $26,886 | $27,555 | 98% |
| 4. Operating EBIDA Margin | 14.0% | 12.1% | 116% |
| 5. Liquidity Days Cash on Hand | 157.3 Days | 130.0 Days | Stable |
| 6. Debt Service Coverage | 6.8x | 6.1x | Stable |

**THE OHIO STATE UNIVERSITY**

**TOPIC**: Preliminary consolidated financial statements for the year ending June 30, 2023

**CONTEXT**: The purpose of this report is to provide an update of financial results for the year ending June 30, 2023.

**FINANCIAL SUMMARY**

The university's overall financial position remains strong, driven by the post-pandemic rebound. The year-to-date financial results reflect a return to normal university operations and a full college experience for our students. Operating revenues increased $808 million in fiscal year 2023 compared to fiscal year 2022, driven primarily by strong growth in healthcare revenues, higher grant and contract revenues, increased tuition and fees, and increases in all major auxiliary enterprises. Specific impacts include:

- A $533 million increase in healthcare revenues, reflecting strong outpatient surgical activity, service mix and practice expansion.
- A $93 million increase in grants and contracts, primarily due to increases in private grants of $52 million, federal grants of $32 million, and state grants of $12 million, offset by decreases in local grants of $3 million.
- A $57 million increase in student tuition, due primarily to resident and non-resident rate increases and a rate increase to those undergraduate students not in the Ohio State Tuition Guarantee.
- A $48 million increase in auxiliary revenues, primarily due to an additional home football game and one additional premium game, housing and dining rate increases for new first-year students, the return to normal operations for Business Advancement, and increased revenues from on-campus events.

The year-to-date increase in net position was $589 million, down $109 million compared to the prior year. The change is primarily due to a $784 million increase in operating loss, a $111 million decrease in federal COVID-19 assistance programs, and a $62 million decrease in gift revenues, offset by an $821 million increase in net investment income and a $10 million increase in state share of instruction and appropriations. Operating loss increased $784 million primarily due to $829 million increases in pension and OPEB expenses. Additional details on university revenues, expenses, cash and investments and cash flows are provided below.

**Revenues**
*Student tuition and fees, net* - increased $57 million or 5.7%, to $1,060 million in fiscal year 2023 compared to fiscal year 2022, due primarily to an increase in gross tuition and other student fees of $38 million and a decrease in scholarship allowances of $19 million. While overall university enrollments declined by 1%, between fiscal year 2022 and fiscal year 2023, rate increases effective Autumn 2022, for the incoming (undergraduate) tuition guarantee cohort and graduate students, combined with an increasing share of non-resident students increased tuition $34.5 million. Summer academic year 2023 tuition decreased $2 million primarily due to a two-day shift in academic calendars. An incremental $5 million in revenue is attributable to the new engineering program fee, assessed to the new first year student cohort of undergraduate students. Scholarship allowances decreased $19 million due to decreases in HEERF financial aid to students and a decrease in undergraduate institutional aid based on the declining enrollments.

*Grants and contracts* – increased $93 million in fiscal year 2023 compared to fiscal year 2022 due primarily to increases in private grants and contracts of $52 million, federal grants and contracts of $32 million, and state grants and contracts of $12 million, offset by decreases in local grants and contracts of $3 million.

*Gifts* – decreased $62 million over the prior year due primarily to decreases in current use gifts of $68 million and decreases in additions to permanent endowments of $7 million, offset by increases in private capital gifts of $13 million.

*Sales and services of auxiliary enterprises* - increased $48 million over the prior year due primarily to a $19 million increase in Athletics revenues due to an additional home football game and one additional premium game, a $17 million increase in Student Life housing and dining revenues, and a $11 million increase in Business Advancement revenues (Schottenstein Center, Blackwell, and Fawcett Center).

*Federal COVID-19 assistance programs* – decreased $111 million from the prior year primarily due to decreases in HEERF institutional grants of $64 million; HEERF grants to students of $60 million; Ohio Department of Health COVID-19 reimbursement of $13 million; Shuttered Venue Operators Grant for the Schottenstein Center of $10 million; and Payroll Protection Program grants of $1 million; offset by increases in Provider Relief Funds of $25 million, Ohio Governor's Emergency Education Relief of $8 million; and FEMA funding of $4 million. This trend will continue as we return to normal business operations post-pandemic as COVID financial assistance programs dissipate.

*Sales and services of the OSU Health System and OSU Physicians, Inc* - increased $533 million to $5,413 million. The Health System has had strong outpatient surgical activity and service mix. The Health System also experienced growth in oncology and non-oncology infusion volume and increased nuclear medicine treatments. OSU Physicians revenues increased $305 million due primarily to practice expansion and integration of the departments from the Health System to OSU Physicians.

*Sales and services of educational departments* – increased $40 million to $216 million primarily reflecting the return to normal operations.

*Other operating revenues* – increased $36 million primarily due to increases in royalties and licensing revenues.

**Expenses**
*University* – expenses increased $502 million to $3,640 million in fiscal year 2023, partially due to a $364 million increase in allocated pension and OPEB expenses. Additional information about pension and OPEB is provided in a separate section below. Excluding pension and OPEB, total university expenses increased $138 million. Salaries increased $98 million, or 7%, primarily due to a 3% increase in faculty and staff salary guidelines and additional investments in human capital related to research growth, faculty investment, staffing support returning to normal operations, and equity adjustments due to the current competitive workforce marketplace. Benefits (excluding pension and OPEB) increased $31 million, primarily due to increases in salary guidelines and composite benefit rates as well as strategic hiring. Graduate fee authorizations decreased $5 million, or 4%. Supplies and services increased $46 million, primarily due to increased travel activity and related expenses of $27 million, research growth of $20 million, and increases due to inflation and the resumption of normal operations, offset by a reduction in COVID-19-related expenses of $11 million. Student aid decreased $45 million primarily due to decreases in Federal assistance from HEERF III funding. Depreciation increased $13 million compared to prior year primarily due to new assets being placed in service.

*OSU Health System and OSU Physicians* - expenses increased $1,006 million to $4,925 million in fiscal year 2023, partially due to a $430 million increase in allocated pension and OPEB expenses. Excluding pension and OPEB, expenses increased $576 million, to $4,867 million. The Health System experienced increased expenses due to growth in outpatient surgery and pharmaceutical volumes. The Health System continues to experience high agency spend due to the hiring and staffing challenges that continue to impact the healthcare industry.

*Auxiliary* – expenses increased $84 million to $418 million in fiscal year 2023. Excluding pension and OPEB, expenses increased $48 million, primarily due to increases in Athletics of $22 million, Student Life housing and dining of $19 million, and Business Advancement (Schottenstein Center, Blackwell, and Fawcett Center) of $8 million due primarily to increased number of events and labor and supply costs.

**Cash and Investments**
For the twelve months ending June 30, 2023, total university cash and investments decreased $456 million to $10,798 million compared to June 30, 2022, primarily due to decreases in temporary investments (including unexpended bond proceeds) of $1,374 million, investments held under securities lending program of $202 million, and other long-term investments of $69 million, offset by increases in cash and cash equivalents of $766 million and Long-Term Investment Pool of $423 million. Additional details are provided below.

**Long-Term Investment Pool and Temporary Investments**
For the year ending June 30, 2023, the fair value of the university's Long-Term Investment Pool increased by $423 million to $7,384 million. Changes in total valuation compared to the prior year are summarized below:

| | 2023 | 2022 |
|---|---|---|
| Market Value at July 1 | $ 6,960,782 | $ 7,041,973 |
| Net Principal Additions | 260,228 | 367,319 |
| Change in Market Value | 369,561 | (253,784) |
| Income Earned | 182,933 | 160,638 |
| Distributions | (289,137) | (259,211) |
| Expenses | (100,691) | (96,153) |
| Market Value at June 30 | $ 7,383,676 | $ 6,960,782 |

Net principal additions include new endowment gifts ($65.6 million), reinvestment of unused endowment distributions ($25.4 million), and other net transfers of university monies ($166.2 million, with approximately 60% directed to the Med Center Long-Term Operating Fund). Change in fair value includes realized gains (losses) on the sale of investment assets and unrealized gains (losses) associated with assets held in the pool on June 30, 2023. Income earned includes interest and dividends and is used primarily to help fund distributions. Expenses include investment management expenses ($74.3 million), University Development related expenses ($22.7 million), and other administrative-related expenses ($0.6 million).

LTIP Investment Returns
For the year ending June 30, 2023, the LTIP earned a return, net of investment fees, of 6.86%, compared to the preliminary policy benchmark return of 4.64%. The comparable year ending June 30, 2022, saw a net investment return of 0.98%.

Temporary Investments
For the year ending June 30,2023, the Tier 1 Investments (0-1 Year maturity) earned a return of 3.98%, outperforming the blended benchmark of ICE Bofa 6m US Treasury Bill benchmark and Bank of America ML 91-day T-Bill (3.60%) by 0.38%. Tier 2 Investments (1-5 Year maturity) earned 2.05%, outperforming the blended benchmark of ICE Bofa US Corp & Govt 1-3 Years, BBG US Govt/Credit 1-5 Years, and ICE Bofa 6m US Treasury Bill (0.54%) by 1.51%.

For the comparable year ending June 30, 2022, Tier 1 Investments earned a return of -0.56%. Tier 2 Investments returned -3.73% for the same time period.

**Pension and Other post-employment benefit (OPEB) plans**
The university participates in two multi-employer cost-sharing retirement systems, OPERS and STRS-Ohio, and is required to record its proportionate share of the net liabilities or net assets in these retirement systems, along with related deferrals. In 2023, the university's share of OPERS and STRS-Ohio net pension liabilities increased $2.72 billion, to $4.22 billion at June 30, 2023. OPERS and STRS-Ohio net pension liabilities increased $2.25 billion and $468 million, respectively, reflecting negative investment returns for both retirement systems. OPERS realized a -12.03% return on defined benefit plan investments for calendar year 2022, compared to a projected return of 6.9%. STRS-Ohio realized a -3.73% return for the fiscal year ended June 30, 2022, compared to a projected return of 7.0%. Pension deferred outflows increased $890 million and pension deferred inflows decreased $1.57 billion. The changes in pension deferrals relate primarily to OPERS and STRS-Ohio projected vs actual investment returns. Deferred outflows and deferred inflows related to pensions will be amortized to expense in future periods.

In 2023, the university's proportionate share of OPEB liabilities for OPERS swung from a net OPEB asset of $336 million to a net OPEB liability of $68 million at June 30, 2023, reflecting a combination of negative investment returns and a reduction in the discount rate used to calculate the total OPEB liability from 6% to 5.22%. OPERS realized a -15.51% return on its health care investments for calendar year 2022, compared to a projected return of 6.0%. The university's proportionate share of STRS-Ohio net OPEB assets increased $24 million to $129 million at June 30, 2023, primarily reflecting changes in actuarial assumptions from the most recent 2016-2021 experience study and negative investment returns (-3.73% for the fiscal year ended June 30, 2022). Deferred outflows related to OPEB increased $202 million, to $214 million at June 30, 2023, and deferred inflows related to OPEB decreased $324 million, to $133 million at June 30, 2023. The changes in OPEB deferrals relate primarily to OPERS projected vs actual investment returns Deferred outflows and deferred inflows related to OPEB will be amortized to expense in future periods.

**Other Noncurrent Assets and Other Noncurrent Liabilities**
The university maintains two supplemental 415(m) retirement plans. The university sets aside assets for the plans, which are invested primarily in mutual funds. These assets total $210 million and are included in Other noncurrent assets and Other noncurrent liabilities.

**Cash Flows**
University cash and cash equivalents increased $766 million in fiscal year 2023 compared to June 30, 2022. Net cash used in operating activities was $366 million, compared to net cash used by operating activities of $537 million in the prior fiscal year. The decrease in cash usage relates primarily to increases in receipts from sales and services, grants and contracts, and tuition and fees, partially offset by payments made to employees and vendors. Net cash provided by noncapital financing activities was $884 million in fiscal year 2023, compared to $1,087 million for the prior year. The decrease is due primarily to decreases in Federal COVID-19 assistance. Net cash used by capital financing activities was $1,293 million in fiscal year 2023 due primarily to the payments for capital assets of $1,109 million. Net cash provided by investing activities was $1,542 million, primarily due to sales of investments.

**THE OHIO STATE UNIVERSITY**
**CONSOLIDATED STATEMENTS OF NET POSITION - UNAUDITED**
**June 30, 2023 and June 30, 2022**
**(in thousands)**

| | As of June 2023 | As of June 2022 | Increase/(Decrease) Dollars | Increase/(Decrease) % |
|---|---|---|---|---|
| **ASSETS:** | | | | |
| Current Assets: | | | | |
| Cash and cash equivalents | $ 1,245,655 | $ 479,601 | $ 766,054 | 159.7% |
| Temporary investments | 1,725,129 | 2,631,011 | (905,882) | -34.4% |
| Accounts receivable, net | 796,936 | 848,760 | (51,824) | -6.1% |
| Notes receivable - current portion, net | 12,263 | 25,231 | (12,968) | -51.4% |
| Pledges receivable - current portion, net | 61,445 | 61,395 | 50 | 0.1% |
| Accrued interest receivable | 22,065 | 23,109 | (1,044) | -4.5% |
| Inventories, prepaid expenses, and other assets | 190,026 | 146,401 | 43,625 | 29.8% |
| Investments held under securities lending program | - | 201,994 | (201,994) | -100.0% |
| Total Current Assets | 4,053,519 | 4,417,502 | (363,983) | -8.2% |
| Noncurrent Assets: | | | | |
| Unexpended bond proceeds | 210,358 | 679,040 | (468,682) | -69.0% |
| Notes receivable, net | 23,635 | 19,213 | 4,422 | 23.0% |
| Pledges receivable, net | 116,230 | 116,230 | - | 0.0% |
| Net other post-employment benefit asset | 128,942 | 441,127 | (312,185) | -70.8% |
| Long-term investment pool | 7,383,676 | 6,960,782 | 422,894 | 6.1% |
| Other long-term investments | 232,968 | 301,855 | (68,887) | -22.8% |
| Leases receivable, net | 64,906 | 55,272 | 9,634 | 17.4% |
| Other noncurrent assets | 263,168 | 228,907 | 34,261 | 15.0% |
| Capital assets, net | 8,202,842 | 7,583,147 | 619,695 | 8.2% |
| Total Noncurrent Assets | 16,626,725 | 16,385,573 | 241,152 | 1.5% |
| **Total Assets** | 20,680,244 | 20,803,075 | (122,831) | -0.6% |
| Deferred Outflows: | | | | |
| Pension | 1,474,386 | 584,364 | 890,022 | 152.3% |
| Other post-employment benefits | 213,518 | 11,545 | 201,973 | 1749.4% |
| Other deferred outflows | 21,271 | 22,505 | (1,234) | -5.5% |
| **Total Assets and Deferred Outflows** | $ 22,389,419 | $ 21,421,489 | $ 967,930 | 4.5% |
| **LIABILITIES AND NET POSITION:** | | | | |
| Current Liabilities: | | | | |
| Accounts payable and accrued expenses | $ 730,506 | $ 783,201 | $ (52,695) | -6.7% |
| Medicare advance payment program | - | 79,601 | (79,601) | -100.0% |
| Deposits and advance payments for goods and services | 333,094 | 450,115 | (117,021) | -26.0% |
| Current portion of bonds, notes and leases payable | 113,038 | 112,937 | 101 | 0.1% |
| Long-term bonds payable, subject to remarketing | 275,000 | 275,000 | - | 0.0% |
| Liability under securities lending program | - | 201,994 | (201,994) | -100.0% |
| Other current liabilities | 123,035 | 139,325 | (16,290) | -11.7% |
| Total Current Liabilities | 1,574,673 | 2,042,173 | (467,500) | -22.9% |
| Noncurrent Liabilities: | | | | |
| Bonds, notes and leases payable | 3,313,267 | 3,388,885 | (75,618) | -2.2% |
| Concessionaire payable | 337,032 | 355,786 | (18,754) | -5.3% |
| Net pension liability | 4,214,821 | 1,497,793 | 2,717,028 | 181.4% |
| Net other post-employment benefit liability | 92,020 | 15,661 | 76,359 | 487.6% |
| Compensated absences | 239,881 | 203,505 | 36,376 | 17.9% |
| Self-insurance accruals | 83,725 | 100,497 | (16,772) | -16.7% |
| Amounts due to third-party payors - Health System | 72,897 | 87,306 | (14,409) | -16.5% |
| Irrevocable split-interest agreements | 32,764 | 32,324 | 440 | 1.4% |
| Refundable advances for Federal Perkins loans | 20,821 | 23,238 | (2,417) | -10.4% |
| Advance from concessionaire | 958,816 | 963,663 | (4,847) | -0.5% |
| Other noncurrent liabilities | 304,256 | 281,045 | 23,211 | 8.3% |
| Total Noncurrent Liabilities | 9,670,300 | 6,949,703 | 2,720,597 | 39.1% |
| **Total Liabilities** | 11,244,973 | 8,991,876 | 2,253,097 | 25.1% |
| Deferred Inflows: | | | | |
| Parking service concession arrangement | 378,021 | 387,652 | (9,631) | -2.5% |
| Pension | 109,418 | 1,681,316 | (1,571,898) | -93.5% |
| Other post-employment benefits | 133,209 | 456,823 | (323,614) | -70.8% |
| Other deferred inflows | 337,000 | 306,166 | 30,834 | 10.1% |
| **Total Deferred Inflows** | 957,648 | 2,831,957 | (1,874,309) | -66.2% |
| **Total Net Position** | 10,186,798 | 9,597,656 | 589,142 | 6.1% |
| **Total Liabilities, Deferred Inflows, and Net Position** | $ 22,389,419 | $ 21,421,489 | $ 967,930 | 4.5% |

**THE OHIO STATE UNIVERSITY**
**CONSOLIDATED STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION - UNAUDITED**
**For the Twelve Months Ended June 30, 2023 and June 30, 2022**
**(in thousands)**

| | June 2023 | June 2022 | Increase/(Decrease) Dollars | Increase/(Decrease) % |
|---|---|---|---|---|
| Operating Revenues: | | | | |
| Student tuition and fees, net | $ 1,060,454 | $ 1,003,060 | $ 57,394 | 5.7% |
| Federal grants and contracts | 476,659 | 444,951 | 31,708 | 7.1% |
| State grants and contracts | 97,970 | 85,976 | 11,994 | 14.0% |
| Local grants and contracts | 29,904 | 32,538 | (2,634) | -8.1% |
| Private grants and contracts | 377,245 | 325,065 | 52,180 | 16.1% |
| Sales and services of educational departments | 216,471 | 176,149 | 40,322 | 22.9% |
| Sales and services of auxiliary enterprises | 394,832 | 346,411 | 48,421 | 14.0% |
| Sales and services of the OSU Health System, net | 4,407,062 | 4,178,956 | 228,106 | 5.5% |
| Sales and services of OSU Physicians, Inc., net | 1,006,203 | 701,680 | 304,523 | 43.4% |
| Other operating revenues | 108,422 | 72,089 | 36,333 | 50.4% |
| Total Operating Revenues | 8,175,222 | 7,366,875 | 808,347 | 11.0% |
| Operating Expenses: | | | | |
| Educational and General: | | | | |
| Instruction and departmental research | 1,273,747 | 1,035,793 | 237,954 | 23.0% |
| Separately budgeted research | 618,743 | 525,244 | 93,499 | 17.8% |
| Public service | 182,711 | 157,850 | 24,861 | 15.7% |
| Academic support | 311,441 | 235,370 | 76,071 | 32.3% |
| Student services | 119,471 | 86,345 | 33,126 | 38.4% |
| Institutional support | 300,080 | 287,501 | 12,579 | 4.4% |
| Operation and maintenance of plant | 179,119 | 128,325 | 50,794 | 39.6% |
| Scholarships and fellowships | 123,508 | 164,093 | (40,585) | -24.7% |
| Auxiliary enterprises | 417,517 | 333,657 | 83,860 | 25.1% |
| OSU Health System | 3,941,119 | 3,236,935 | 704,184 | 21.8% |
| OSU Physicians, Inc. | 983,993 | 681,610 | 302,383 | 44.4% |
| Depreciation | 531,299 | 517,945 | 13,354 | 2.6% |
| Total Operating Expenses | 8,982,748 | 7,390,668 | 1,592,080 | 21.5% |
| Operating Loss | (807,526) | (23,793) | (783,733) | -3294.0% |
| Non-operating Revenues (Expenses): | | | | |
| State share of instruction and line-item appropriations | 508,704 | 493,248 | 15,456 | 3.1% |
| Federal subsidies for Build America Bonds interest | 11,321 | 11,304 | 17 | 0.2% |
| Federal non-exchange grants | 63,433 | 64,077 | (644) | -1.0% |
| Federal COVID-19 assistance programs | 69,939 | 180,653 | (110,714) | -61.3% |
| State non-exchange grants | 32,757 | 34,591 | (1,834) | -5.3% |
| Gifts | 165,356 | 233,381 | (68,025) | -29.1% |
| Net investment income (loss) | 519,936 | (300,714) | 820,650 | 272.9% |
| Interest expense | (156,660) | (163,957) | 7,297 | 4.5% |
| Other non-operating revenues (expenses) | 7,307 | (5,759) | 13,066 | 226.9% |
| Net Non-operating Revenues | 1,222,093 | 546,824 | 675,269 | 123.5% |
| Income (loss) before changes in net position | 414,567 | 523,031 | (108,464) | -20.7% |
| Changes in Net Position | | | | |
| State capital appropriations | 47,023 | 52,886 | (5,863) | -11.1% |
| Private capital gifts | 56,963 | 44,112 | 12,851 | 29.1% |
| Additions to permanent endowments | 70,589 | 77,206 | (6,617) | -8.6% |
| Capital contributions and other changes in net position | - | 1,182 | (1,182) | 0.0% |
| Total Changes in Net Position | 174,575 | 175,386 | (811) | -0.5% |
| Increase (decrease) in Net Position | 589,142 | 698,417 | $ (109,275) | -15.6% |
| Net Position - Beginning of Year | 9,597,656 | 8,899,239 | | |
| Net Position - End of Period | $ 10,186,798 | $ 9,597,656 | | |

**THE OHIO STATE UNIVERSITY**
**STATEMENTS OF CASH FLOWS - UNAUDITED**
**For the Twelve Months Ended June 30, 2023 and June 30, 2022**
(in thousands)

| | June 2023 | June 2022 | Increase/(Decrease) Dollars | % |
|---|---|---|---|---|
| **Cash Flows from Operating Activities:** | | | | |
| Tuition and fee receipts | $ 912,661 | $ 868,342 | $ 44,319 | 5.1% |
| Grant and contract receipts | 976,136 | 883,570 | 92,566 | 10.5% |
| Receipts for sales and services | 5,872,151 | 5,264,046 | 608,105 | 11.6% |
| Receipt from energy concessionaire | 16,783 | 16,408 | 375 | 2.3% |
| Payments to or on behalf of employees | (4,113,239) | (3,640,289) | (472,950) | -13.0% |
| University employee benefit payments | (978,409) | (904,405) | (74,004) | -8.2% |
| Payments to vendors for supplies and services | (3,074,706) | (2,894,021) | (180,685) | -6.2% |
| Payments to students and fellows | (106,985) | (151,727) | 44,742 | 29.5% |
| Student loans issued | (2,984) | (4,092) | 1,108 | 27.1% |
| Student loans collected | 12,761 | 12,263 | 498 | 4.1% |
| Student loan interest and fees collected | 1,416 | 1,437 | (21) | -1.5% |
| Other receipts (payments) | 118,174 | 11,238 | 106,936 | 951.6% |
| Net cash provided (used) by operating activities | (366,241) | (537,230) | 170,989 | 31.8% |
| **Cash Flows from Noncapital Financing Activities:** | | | | |
| State share of instruction and line-item appropriations | 508,704 | 493,248 | 15,456 | 3.1% |
| Non-exchange grant receipts | 103,190 | 100,766 | 2,424 | 2.4% |
| Federal COVID-19 assistance programs | 33,217 | 200,532 | (167,315) | -83.4% |
| Gift receipts for current use | 165,306 | 206,882 | (41,576) | -20.1% |
| Additions to permanent endowments | 70,589 | 77,206 | (6,617) | -8.6% |
| Drawdowns of federal direct loan proceeds | 319,127 | 320,043 | (916) | -0.3% |
| Disbursements of federal direct loans to students | (315,674) | (317,934) | 2,260 | 0.7% |
| Amounts received for annuity and life income funds | 1,086 | 750 | 336 | 44.8% |
| Amounts paid to annuitants and life beneficiaries | (1,644) | (2,191) | 547 | 25.0% |
| Agency funds receipts | 5,284 | 5,588 | (304) | -5.4% |
| Agency funds disbursements | (5,588) | (5,051) | (537) | -10.6% |
| Other receipts | 85 | 6,721 | (6,636) | -98.7% |
| Net cash provided by noncapital financing activities | 883,682 | 1,086,560 | (202,878) | -18.7% |
| **Cash Flows from Capital Financing Activities:** | | | | |
| Proceeds from capital debt and leases | - | 769,253 | (769,253) | -100.0% |
| Gift receipts for capital projects | 56,963 | 56,061 | 902 | 1.6% |
| Payments for purchase or construction of capital assets | (1,109,240) | (1,092,643) | (16,597) | -1.5% |
| Principal payments on capital debt and leases | (93,876) | (81,080) | (12,796) | -15.8% |
| Interest payments on capital debt and leases | (158,333) | (161,060) | 2,727 | 1.7% |
| Federal subsidies for Build America Bonds interest | 11,321 | 15,921 | (4,600) | -28.9% |
| Net cash provided (used) by capital financing activities | (1,293,165) | (493,548) | (799,617) | -162.0% |
| **Cash Flows from Investing Activities:** | | | | |
| Purchases of investments | (8,492,476) | (8,116,175) | (376,301) | -4.6% |
| Proceeds from sales and maturities of investments | 9,882,594 | 7,187,502 | 2,695,092 | 37.5% |
| Investment income | 151,660 | 138,105 | 13,555 | 9.8% |
| Net cash provided (used) by investing activities | 1,541,778 | (790,568) | 2,332,346 | 295.0% |
| **Net Increase (Decrease) in Cash** | 766,054 | (734,786) | $ 1,500,840 | 204.3% |
| Cash and Cash Equivalents - Beginning of Year | 479,601 | 1,214,387 | | |
| Cash and Cash Equivalents - End of Period | $ 1,245,655 | $ 479,601 | | |

**Edgar C. Hendrickson Designated Chair Fund**

The Board of Trustees of The Ohio State University shall establish the Edgar C. Hendrickson Designated Chair Fund effective August 17, 2023, with a fund transfer by the College of Engineering of college funds and distribution from The Edgar C. Hendrickson Fund.

This fund supports a chair in the College of Engineering, Department of Biomedical Engineering. The position holder shall be appointed for a term of five years and reviewed in accordance with the current guidelines and procedures for faculty appointment. Should the position be vacated before the five-year term is completed, a new position holder may be appointed to complete the five-year term.

This designated chair position shall cease to exist when annual funding ends.

**John G. and Patricia N. Kramer Fund for Academic Excellence**

The Board of Trustees of The Ohio State University shall establish the John G. and Patricia N. Kramer Fund for Academic Excellence effective August 17, 2023, with gifts from Dr. John G. (DDS 1957), Mrs. Patricia N. Kramer, their family, and their estate.

Ten percent (10%) of the annual distribution shall be reinvested in the endowment principal. The remaining ninety percent (90%) shall be divided as follows: fifty percent (50%) to the College of Dentistry, twenty-five percent (25%) to the Max M. Fisher College of Business, and twenty-five percent (25%) to the Michael E. Moritz College of Law to be used for academic excellence as determined by the dean of the respective college.

In any given year that the endowment distribution is not fully used for its intended purpose, the unused distribution from this endowed fund shall be reinvested in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donors that the endowment established herein should benefit the University in perpetuity. The University reserves the right to modify the purposes of this fund, if such purposes become unlawful, impracticable, impossible to achieve, or wasteful, provided that such fund shall only be used for the University's charitable purposes. In seeking such modification, the University shall consult the deans of the College of Dentistry, the Max M. Fisher College of Business, the Michael E. Moritz College of Law. Modifications to endowed funds shall be approved by the University's Board of Trustees, in accordance with the policies of the University.

**Glenn College Alumni Society Student Scholarship Fund**

The Board of Trustees of The Ohio State University, shall establish the Glenn College Alumni Society Student Scholarship Fund effective August 17, 2023, with alumni and friends of the John Glenn College of Public Affairs.

The annual distribution from this fund provides support to undergraduate and graduate students at the John Glenn College of Public Affairs. Scholarship recipients, the number of recipients, and amount of each scholarship shall be determined in accordance with the then current guidelines and procedures for scholarship administration established by the college, in consultation with Student Financial Aid.

The University may modify any criteria used to select scholarship recipients should the criteria be found, in whole or in part, to be contrary to federal or state law or University policy.

The highest ranking official in the John Glenn College of Public Affairs or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donors that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University may modify the purpose of this fund, in consultation with the donors named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University may modify the purpose of this fund. The University shall consult the highest ranking official in the John Glenn College of Public Affairs or his/her designee to identify a similar purpose consistent with the original intent of the donors. Modifications to endowed funds shall be approved by the University's Board of Trustees, in accordance with the policies of the University.

**Integrated Systems Engineering Department Fund**

The Board of Trustees of The Ohio State University shall establish the Integrated Systems Engineering Department Fund effective August 17, 2023, with gifts from members of the Department of Integrated Systems Engineering Advisory Board.

The annual distribution from this fund supports the key priorities and strategic initiatives of the Department of Integrated Systems Engineering as recommended by the highest ranking official of the department, in consultation with department leadership. Expenditures shall be approved in accordance with the then current guidelines and procedures established by the College of Engineering.

The highest ranking official in the College of Engineering or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donors that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University may modify the purpose of this fund, in consultation with the donors named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University may modify the purpose of this fund. The University shall consult the highest ranking official in the College of Engineering or his/her designee to identify a similar purpose consistent with the original intent of the donors. Modifications to endowed funds shall be approved by the University's Board of Trustees, in accordance with the policies of the University.

**John & Christine Olsen Professorship in Head and Neck Radiation Oncology**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, established the John & Christine Olsen Professorship Fund in Head and Neck Radiation Oncology effective May 20, 2021, with gifts from Dr. John O. Olsen and Christine E. Olsen. The required funding level for a professorship has been reached. Effective August 17, 2023, the fund name and description shall be revised and the position shall be established.

The annual distribution from this fund shall support a professorship position in OSUCCC – James supporting a faculty physician specializing in head and neck radiation oncology. It is the donors' preference that consideration be given to a faculty physician specializing in head, neck, and brain cancers. If the position is vacant, the annual distribution may be used to support OSUCCC – James as recommended by the highest ranking official(s) in OSUCCC - James or his/her/their designee(s). The position holder shall be appointed and reviewed in accordance with the then current guidelines and procedures for faculty appointment.

If at any time the gifted principal balance of the fund reaches the then current minimum required for an endowed chair position, the fund name and purpose shall be revised to support a chair position in OSUCCC – James supporting a faculty physician specializing in head and neck radiation oncology. It is the donors' preference that consideration be given to a faculty physician specializing in head, neck, and brain cancers. If the position is vacant, the annual distribution may be used to support OSUCCC – James as recommended by the highest ranking official(s) in OSUCCC - James or his/her/their designee(s). The position holder shall be appointed and reviewed in accordance with the then current guidelines and procedures for faculty appointment.

The highest ranking official(s) in OSUCCC – James or his/her/their designee(s) has(have) the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donors that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University and the Foundation may modify the purpose of this fund, in consultation with the donors named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official(s) in OSUCCC – James or his/her/their designee(s) to identify a similar purpose consistent with the original intent of the donors. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**John & Christine Olsen Professorship in Head and Neck Surgical Oncology**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, established the John & Christine Olsen Professorship Fund in Head and Neck Surgical Oncology effective May 20, 2021, with gifts from Dr. John O. Olsen and Christine E. Olsen. The required funding level for a professorship has been reached. Effective August 17, 2023, the fund name and description shall be revised and the position shall be established.

The annual distribution from this fund shall support a professorship position in OSUCCC – James supporting a faculty physician specializing in head and neck surgical oncology. It is the donors' preference that consideration be given to a faculty physician specializing in head and neck cancers. If the position is vacant, the annual distribution may be used to support OSUCCC – James as recommended by the highest ranking official(s) in OSUCCC - James or his/her/their designee(s). The position holder shall be appointed and reviewed in accordance with the then current guidelines and procedures for faculty appointment.

If at any time the gifted principal balance of the fund reaches the then current minimum required for an endowed chair position, the fund name and purpose shall be revised to support a chair position in OSUCCC – James supporting a faculty physician specializing in head and neck surgical oncology. It is the donors' preference that consideration be given to a faculty physician specializing in head and neck cancers. If the position is vacant, the annual distribution may be used to support OSUCCC – James as recommended by the highest ranking official(s) in OSUCCC - James or his/her/their designee(s). The position holder shall be appointed and reviewed in accordance with the then current guidelines and procedures for faculty appointment.

The highest ranking official(s) in OSUCCC – James or his/her/their designee(s) has(have) the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donors that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University and the Foundation may modify the purpose of this fund, in consultation with the donors named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official(s) in OSUCCC – James or his/her/their designee(s) to identify a similar purpose consistent with the original intent of the donors. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**Elizabeth and William Ralston Engineering Scholarship Fund**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, shall establish the Elizabeth and William Ralston Engineering Scholarship Fund effective August 17, 2023, with gifts from Douglas E. Ralston.

Douglas E. Ralston established this fund to honor the legacies of his grandfather and great-aunt, William and Elizabeth Ralston. Elizabeth, a school teacher, was determined for her two brothers and father to escape work in coal mines near their hometown of Massillon, Ohio. Elizabeth volunteered to pay for her brother William's college education, if he promised in turn to do the same for their younger brothers. William graduated with a degree in Mining Engineering from The Ohio State University and went on to a successful career with The American Steel Wiring Company. In the spirit of Elizabeth and William's hard work and determination, the donor hopes that recipients will be similarly inspired to pay it forward to future generations.

The annual distribution from this fund provides one or more scholarships to students who are enrolled in the College of Engineering and are studying a major in one of the following departments:

- Civil, Environmental and Geodetic Engineering
- Mechanical and Aerospace Engineering
- William G. Lowrie Department of Chemical and Biomolecular Engineering
- Electrical and Computer Engineering

Preference shall be given to candidates who are involved in extracurricular activities outside of the classroom such as organized sports teams. The donor desires that when awarding this scholarship special consideration be given to students who are United States citizens or permanent residents. Scholarship recipients, the number of recipients, and amount of each scholarship shall be determined in accordance with the then current guidelines and procedures for scholarship administration established by the college, in consultation with Student Financial Aid.

The University may modify any criteria used to select scholarship recipients should the criteria be found, in whole or in part, to be contrary to federal or state law or University policy.

The highest ranking official in the College of Engineering or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donor that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University and the Foundation may modify the purpose of this fund, in consultation with the donor named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official in the College of Engineering or his/her designee to identify a similar purpose consistent with the original intent of the donor. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**Earl D. Shurtz Endowed Fund**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, shall establish the Earl D. Shurtz Endowed Fund effective August 17, 2023, with gifts from the estate of Earl Shurtz (BS 1956).

One half of the annual distribution from this fund shall be reinvested in the endowment principal. The remaining half of the annual distribution shall be used in a business curriculum for real estate teaching and research at The Ohio State University at Newark. Should there be no real estate teaching and research at Ohio State Newark, the fund may be used in a general business curriculum at Ohio State Newark. Expenditures shall be approved in accordance with the then current guidelines and procedures established by Ohio State Newark. If used for scholarships, recipients, the number of recipients, and amount of each scholarship shall be determined in accordance with the then current guidelines and procedures for scholarship administration established by Ohio State Newark, in consultation with Student Financial Aid.

The University may modify any criteria used to select scholarship recipients should the criteria be found, in whole or in part, to be contrary to federal or state law or University policy.

The highest ranking official in The Ohio State University at Newark or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donor that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official in The Ohio State University at Newark or his/her designee to identify a similar purpose consistent with the original intent of the donor. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**The Molly Caren Agriculture Vice Presidents Excellence Fund**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, shall establish The Molly Caren Agriculture Vice Presidents Excellence Fund effective August 17, 2023, with a gift from Molly Caren (1935 BA) of Columbus, Ohio.

The annual distribution from this fund shall be used as follows:

25% of annual distribution shall support the Study Abroad Programs within the College of Food, Agricultural, and Environmental Sciences. The distribution shall be used to assist students from all economic backgrounds with travel expenses. Expenditures shall be approved in accordance with the then current guidelines and procedures established by the college. ·

50% of annual distribution shall be used to support programs identified by the highest ranking official in the College of Food, Agricultural, and Environmental Sciences, or his/her designee, at his/her discretion. Expenditures shall be approved in accordance with the then current guidelines and procedures established by the college.

25% of annual distribution shall be used to support the Gwynne Conservation area at the Molly Caren Agriculture Center. The distribution shall be used to support all areas of farm conservation. Expenditures may be recommended by the highest ranking official of the Molly Caren Agricultural Center, or his/her designee, and shall be approved in accordance with the then current guidelines and procedures established by the college.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donor that this fund should benefit the University in perpetuity. If, in the future, the need for this fund should cease to exist or so diminish as to provide unused distributions, then another use shall be designated by the Board of Trustees and Foundation Board as recommended by the highest ranking official in College of Food, Agricultural, and Environmental Sciences or his/her designee. Any such alternate distributions shall be made in a manner as nearly aligned with the original intent of the donor as good conscience and need dictate.

**Lean Into Leadership Health Care Scholarship Fund**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, shall establish the Lean Into Leadership Health Care Scholarship Fund effective August 17, 2023, with gifts from the estate of Kathleen L. Sharp.

Kathleen L. Sharp, MBOE 2015, was a passionate advocate for improving healthcare for over 30 years. Her work received national acclaim for quality and innovation. She credits the Max M. Fisher MBOE program with enhancing her career and expanding her ability to make a positive impact in healthcare. Kathleen realized the connection and benefit of the MBOE coursework, specifically the Lean Six Sigma curriculum, to improving quality and simplifying processes throughout healthcare.

Building on the experience of her lifelong career in healthcare, Kathleen adopted the Lean Six Sigma approach from the MBOE to address the unique industry of patient care. This approach drives improvement in work and outcomes through direct engagement of care teams and patients. With healthcare ever evolving, it is essential to put people at the center – people first.

Kathleen encourages students to maintain their curiosity and continually learn to develop expertise. Speak the language of the people – don't get caught up in the terminology and most importantly, approach the work, not as the expert, but as a partner.

The annual distribution from this fund provides one or more scholarships to students who are enrolled in the Max M. Fisher College of Business, are participating in the Master of Business Operational Excellence (MBOE) program, are interested in the healthcare profession, and demonstrate financial need. If no students meet the selection criteria, the scholarship(s) will be open to all students enrolled in the College and participating in the MBOE program. If no students meet the selection criteria, scholarships may be awarded to students who are enrolled in the College and demonstrate financial need with preference given to students who are interested in the healthcare profession. Recipients shall be selected in accordance with the then current guidelines and procedures for scholarship administration established by the College, in consultation with Student Financial Aid.

The University may modify any criteria used to select scholarship recipients should the criteria be found, in whole or in part, to be contrary to federal or state law or University policy.

The highest ranking official in the Max M. Fisher College of Business or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donor that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official in the Max M. Fisher College of Business or his/her designee to identify a similar purpose consistent with the original intent of the donor. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**The Dr. Ronald E. Myers & Kathleen A. Kiefer Endowed Dental Scholarship Fund**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, shall establish The Dr. Ronald E. Myers & Kathleen A. Kiefer Endowed Dental Scholarship Fund effective August 17, 2023, with a gift from Dr. Ronald Eugene Myers (BA 1973, DDS 1979) and Kathleen Ann Kiefer (BS 1974, MS 1979) and matching funds from the College of Dentistry.

The annual distribution from this fund provides one or more scholarships to students enrolled in the DDS program. Scholarship recipients, the number of recipients, and amount of each scholarship shall be determined in accordance with the then current guidelines and procedures for scholarship administration established by the College of Dentistry, in consultation with Student Financial Aid.

The University may modify any criteria used to select scholarship recipients should the criteria be found, in whole or in part, to be contrary to federal or state law or University policy.

The highest ranking official in the College of Dentistry or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donors that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University and the Foundation may modify the purpose of this fund, in consultation with the donors named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official in the College of Dentistry or his/her designee to identify a similar purpose consistent with the original intent of the donors. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**Georganne M. Shockey Undergraduate Scholarship Fund**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, shall establish the Georganne M. Shockey Undergraduate Scholarship Fund effective August 17, 2023, with gifts from Georganne M. Shockey (BS 1980) and matching funds as part of the Scarlet and Gray Advantage Endowed Matching Gift Program.

The annual distribution from this fund provides one or more scholarships to undergraduate students who are enrolled in the College of Public Health with preference given to students participating in faculty-led and/or interdisciplinary research. Additional preference shall be given for students participating in research engaging with the Byrd Polar and Climate Research Center. If no students meet the selection criteria, the scholarship(s) will be open to all undergraduate students who are enrolled in the college. Scholarship recipients, the number of recipients, and amount of each scholarship shall be determined in accordance with the then current guidelines and procedures for scholarship administration established by the college, in consultation with Student Financial Aid.

The University may modify any criteria used to select scholarship recipients should the criteria be found, in whole or in part, to be contrary to federal or state law or University policy.

The highest ranking official in the College of Public Health or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donor that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University and the Foundation may modify the purpose of this fund, in consultation with the donor named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official in the College of Public Health or his/her designee to identify a similar purpose consistent with the original intent of the donor. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**Davison, Bauer and Stanley Families Women's Athletics Scholarship Fund**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, shall establish the Davison, Bauer and Stanley Families Women's Athletics Scholarship Fund effective August 17, 2023, with gifts from Marilyn Bauer Davison (MS 1975) and Dr. Thomas C. B. Davison (PhD 1977) and matching funds as part of the Scarlet and Gray Advantage Endowed Matching Gift Program.

The annual distribution from this fund supplements the grant-in-aid costs of an undergraduate student-athlete participating on a women's varsity team with a preference for those participating on the women's basketball team, women's tennis team, women's golf team or the women's rowing team. Scholarship recipients, the number of recipients, and amount of each scholarship shall be determined in accordance with the then current guidelines and procedures for scholarship administration established by the Department of Athletics, in consultation with Student Financial Aid.

The University may modify any criteria used to select scholarship recipients should the criteria be found, in whole or in part, to be contrary to federal or state law or University policy.

The highest ranking official in the Department of Athletics or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donors that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University and the Foundation may modify the purpose of this fund, in consultation with the donors named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official in the Department of Athletics or his/her designee to identify a similar purpose consistent with the original intent of the donors. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**The Jean Kauffman Yost Scholars Program Fund**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, shall establish The Jean Kauffman Yost Scholars Program Fund effective August 17, 2023, with gifts from Jean Kauffman Yost (MSW 1989) and Robert D. Yost.

The annual distribution from this fund provides supplemental opportunities to recipients of The Jean Kauffman Yost Pharmacy Scholarship Fund for specialized training and support beyond the classroom to ensure their ability to make the most of their educational experience. Annual distribution may be used for program support and/or provide financial support to students to assist with extracurricular and/or professional development opportunities or to help remove barriers to their ability to access educational experiences. Expenditures shall be approved in accordance with the then current guidelines and procedures established by the College of Pharmacy.

The highest ranking official in the College of Pharmacy or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donors that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University and the Foundation may modify the purpose of this fund, in consultation with the donors named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official in the College of Pharmacy or his/her designee to identify a similar purpose consistent with the original intent of the donors. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**The Ramaswamy Family Endowed Fund for Breast Cancer Translational Research**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, shall establish The Ramaswamy Family Endowed Fund for Breast Cancer Translational Research effective August 17, 2023, with gifts from Dr. Bhuvaneswari Ramaswamy and Dr. Chakravarthi R. Ramaswamy.

The annual distribution from this fund supports breast cancer translational research. Expenditures shall be recommended by director of Translational Research within the breast cancer program or his/her designee and approved in accordance with the then current guidelines and procedures established by The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute.

If at any time the gifted principal balance reaches the then current minimum required to establish a professorship, the fund name and purpose shall be revised to support a professorship position in the Division of Medical Oncology. If the position is vacant, the annual distribution may be used to support the faculty in the division. The position holder shall be appointed and reviewed in accordance with the then current guidelines and procedures for faculty appointment.

The highest ranking official in The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donors that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University and the Foundation may modify the purpose of this fund, in consultation with the donors named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official in The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute or his/her designee to identify a similar purpose consistent with the original intent of the donors. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**Robert and Janet Lee Family Fund**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, shall establish the Robert and Janet Lee Family Fund effective August 17, 2023, with gifts from Robert Eugene Lee (BS 1978) and Janet Matson Lee.

The annual distribution from this fund provides one or more scholarship(s) to students who are enrolled in the College of Engineering and are majoring in mechanical, electrical and/or computer science engineering. Candidates must demonstrate financial need. The donors desire that when awarding this scholarship special consideration be given to candidates that are members of organizations recognized by the University that are open to all but whose missions seek to advance the need of women in engineering. The donors desire to provide as significant financial support as possible to one eligible recipient annually. Any remaining distribution shall be used to provide as significant financial support as possible to additional eligible recipients. Scholarship(s) are renewable as long as recipient(s) remain in good academic standing. Scholarship recipients, the number of recipients, and amount of each scholarship shall be determined in accordance with the then current guidelines and procedures for scholarship administration established by the college, in consultation with Student Financial Aid.

The University may modify any criteria used to select scholarship recipients should the criteria be found, in whole or in part, to be contrary to federal or state law or University policy.

The highest ranking official in the College of Engineering or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donors that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University and the Foundation may modify the purpose of this fund, in consultation with the donors named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official in the College of Engineering or his/her designee to identify a similar purpose consistent with the original intent of the donors. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**Bost Family Fellowship Support Fund**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, shall establish the Bost Family Fellowship Support Fund effective August 17, 2023, with a gift from Glenn Eugene Bost II (JD 1978).

The annual distribution from this fund supports first or second-year fellows who are enrolled in the Michael E. Moritz College of Law and pursuing work opportunities in the area of entrepreneurial business law for a nonprofit, academic institution other than the college, or similar organizations that advance opportunities in entrepreneurship, business, technology, industry, and/or economic development. If no students meet the selection criteria, support will be open to all fellows in the college. Recipients, the number of recipients, and amount of support shall be determined in accordance with the then current guidelines and procedures for scholarship administration established by the college, in consultation with Student Financial Aid. Expenditures shall be approved in accordance with the then current guidelines and procedures established by the college.

The University may modify any criteria used to select scholarship recipients should the criteria be found, in whole or in part, to be contrary to federal or state law or University policy.

The highest ranking official in the Michael E. Moritz College of Law or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donor that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University and the Foundation may modify the purpose of this fund, in consultation with the donor named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official in the Michael E. Moritz College of Law or his/her designee to identify a similar purpose consistent with the original intent of the donor. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**Bost Family Scholarship Fund**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, shall establish the Bost Family Scholarship Fund effective August 17, 2023, with a gift from Glenn Eugene Bost II (JD 1978).

The annual distribution from this fund provides one or more scholarships to first-year students who are enrolled in the Michael E. Moritz College of Law and demonstrate financial need. The donor desires that when awarding this scholarship special consideration be given to candidates who have taken at least one year off from school between earning their undergraduate degree and enrolling in the college. If no students meet the selection criteria, the scholarship(s) will be open to all students who are enrolled in the college and demonstrate financial need. Scholarships are renewable as long as recipients remain in good academic standing. Scholarship recipients, the number of recipients, and amount of each scholarship shall be determined in accordance with the then current guidelines and procedures for scholarship administration established by the college, in consultation with Student Financial Aid.

The University may modify any criteria used to select scholarship recipients should the criteria be found, in whole or in part, to be contrary to federal or state law or University policy.

The highest ranking official in the Michael E. Moritz College of Law or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donor that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University and the Foundation may modify the purpose of this fund, in consultation with the donor named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official in the Michael E. Moritz College of Law or his/her designee to identify a similar purpose consistent with the original intent of the donor. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**Rick Freuler and John Demel FEH Design Project Support Fund**

The Board of Trustees of The Ohio State University shall establish the Rick Freuler and John Demel FEH Design Project Support Fund effective August 17, 2023, with gifts from family, friends and colleagues.

The annual distribution from this fund. supports Fundamentals of Engineering - Honors (FEH) design-based projects in the Department of Engineering Education. Expenditures shall be approved in accordance with the then current guidelines and procedures established by the College of Engineering.

The highest ranking official in the College of Engineering or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donors that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University may modify the purpose of this fund, in consultation with the donors named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University may modify the purpose of this fund. The University shall consult the highest ranking official in the College of Engineering or his/her designee to identify a similar purpose consistent with the original intent of the donors. Modifications to endowed funds shall be approved by the University's Board of Trustees, in accordance with the policies of the University.

**John N. King Fund for the Center for Medieval and Renaissance Studies**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, shall establish the John N. King Fund for the Center for Medieval and Renaissance Studies effective August 17, 2023, with gifts from Pauline G. King.

The annual distribution from this fund supports initiatives and priorities of the Center for Medieval and Renaissance Studies at the discretion of the highest ranking official in the center or his/her designee. Expenditures may include, but are not limited to, student education, the University's membership with The Folger Shakespeare Library, and future programming. Expenditures shall be approved in accordance with the then current guidelines and procedures established by the College of Arts and Sciences.

The highest ranking official in the College of Arts and Sciences or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donor that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University and the Foundation may modify the purpose of this fund, in consultation with the donor named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official in the College of Arts and Sciences or his/her designee to identify a similar purpose consistent with the original intent of the donor. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**Kocan Family Fund**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, shall establish the Kocan Family Fund effective August 17, 2023, with gifts from Jerome Anthony Kocan and Nancy Kocan.

The annual distribution from this fund supports undergraduate students who are enrolled in the College of Arts and Sciences. Preference shall be given to candidates who demonstrate financial need and are from Trumbull or Mahoning County, Ohio, Mercer County, Pennsylvania, or the state of Alabama. Recipients, the number of recipients, and amount of support shall be determined in accordance with the then current guidelines and procedures for scholarship administration established by the college, in consultation with Student Financial Aid.

The University may modify any criteria used to select scholarship recipients should the criteria be found, in whole or in part, to be contrary to federal or state law or University policy.

The highest ranking official in the College of Arts and Sciences or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donors that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University and the Foundation may modify the purpose of this fund, in consultation with the donors named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official in the College of Arts and Sciences or his/her designee to identify a similar purpose consistent with the original intent of the donors. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**John and Barbara Morrison Veterinary Medicine Endowed Scholarship Fund**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, shall establish the John and Barbara Morrison Veterinary Medicine Endowed Scholarship Fund effective August 17, 2023, with gifts from John Thomas Morrison (BA 1969) and Barbara Durphy Morrison.

The annual distribution from this fund provides one or more scholarships to third or fourth-year DVM students who graduated from an Ohio high school and demonstrate financial need. First preference shall be given to candidates who are interested in equine medicine. Second preference shall be given to candidates who are interested in farm animal medicine. If no students meet the selection criteria, scholarship(s) will be open to all third or fourth-year DVM students who graduated from an Ohio high school. Scholarship recipients, the number of recipients, and amount of each scholarship shall be determined in accordance with the then current guidelines and procedures for scholarship administration established by the College of Veterinary Medicine, in consultation with Student Financial Aid.

The University may modify any criteria used to select scholarship recipients should the criteria be found, in whole or in part, to be contrary to federal or state law or University policy.

The highest ranking official in the College of Veterinary Medicine or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donors that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University and the Foundation may modify the purpose of this fund, in consultation with the donors named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official in the College of Veterinary Medicine or his/her designee to identify a similar purpose consistent with the original intent of the donors. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**The Newmark Family Endowed Scholarship Fund**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, shall establish The Newmark Family Endowed Scholarship Fund effective August 17, 2023, with gifts from Dr. Arnold P. Good and Lisa M. Newmark.

The annual distribution from this fund provides one or more scholarships to MD students who are enrolled in the College of Medicine, demonstrate financial need, and graduated from high school in the state of Ohio with preference given to candidates who graduated from high school in Youngstown. If no students meet the selection criteria, the scholarship(s) will be open to all MD students enrolled in the college. Scholarship recipients, the number of recipients, and amount of each scholarship shall be determined in accordance with the then current guidelines and procedures for scholarship administration established by the college, in consultation with Student Financial Aid.

The University may modify any criteria used to select scholarship recipients should the criteria be found, in whole or in part, to be contrary to federal or state law or University policy.

The highest ranking official in the College of Medicine or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donors that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University and the Foundation may modify the purpose of this fund, in consultation with the donors named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official in the College of Medicine or his/her designee to identify a similar purpose consistent with the original intent of the donors. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**Ohio Expositions Commission I – Youth Reserve Program Scholarship Fund**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, shall establish the Ohio Expositions Commission I – Youth Reserve Program Scholarship Fund effective August 17, 2023, with gifts from the Ohio Expositions Commission.

The annual distribution from this fund provides one or more scholarships to incoming first-year students who are enrolled in the College of Food, Agricultural, and Environmental Sciences, are attending any campus, including The Ohio State University Agricultural Technical Institute, and are current junior exhibitors at the Ohio State Fair. If there are no candidates enrolled in the college, scholarship(s) will be open to students enrolled in any college in the University that otherwise meet the selection criteria above. If no students meet the selection criteria above, the scholarship(s) will be open to all students who are enrolled in the college and are attending any campus, including ATI. Scholarship recipients, the number of recipients, and amount of each scholarship shall be determined in accordance with the then current guidelines and procedures for scholarship administration established by the college, in consultation with Student Financial Aid.

The University may modify any criteria used to select scholarship recipients should the criteria be found, in whole or in part, to be contrary to federal or state law or University policy.

Unused annual distribution shall be reinvested in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donor that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University and the Foundation may modify the purpose of this fund, in consultation with the donor named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official in the College of Food, Agricultural, and Environmental Sciences or his/her designee to identify a similar purpose consistent with the original intent of the donor. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**Carol Zelizer Stoff Endowed Memorial Scholarship Fund**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, shall establish the Carol Zelizer Stoff (BS 1972, MA 1975, JD 1977) Endowed Memorial Scholarship Fund effective August 17, 2023, with gifts from Richard A. Stoff.

The annual distribution from this fund provides one or more scholarships to students who are enrolled in the Michael E. Moritz College of Law, demonstrate financial need, and possess an undergraduate degree from the College of Social Work at The Ohio State University with a minimum 3.0 grade point average on a 4.0 scale upon graduation. Candidates must demonstrate leadership qualities, a commitment to social and economic justice, and aspire for a career in public service. If no students meet the selection criteria, the scholarship(s) will be open to all students who are enrolled in the Michael E. Moritz College of Law, demonstrate financial need, and possess an undergraduate degree from The Ohio State University.

The donor desires that when awarding this scholarship special consideration be given for students who have experience living or working in diverse environments. The donor also desires to provide as significant financial support as possible to one eligible recipient. Any remaining distribution shall be used to provide as significant financial support as possible to additional eligible recipients.

Scholarship recipients, the number of recipients, and amount of each scholarship shall be determined in accordance with the then current guidelines and procedures for scholarship administration established by the Michael E. Moritz College of Law, in consultation with Student Financial Aid.

The University may modify any criteria used to select scholarship recipients should the criteria be found, in whole or in part, to be contrary to federal or state law or University policy.

The highest ranking official in the Michael E. Moritz College of Law or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donor that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University and the Foundation may modify the purpose of this fund, in consultation with the donor named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official in the Michael E. Moritz College of Law or his/her designee to identify a similar purpose consistent with the original intent of the donor. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**The Law Class of 1982 Scholarship Fund**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, shall establish The Law Class of 1982 Scholarship Fund effective August 17, 2023, with gifts from members and friends of the College of Law Class of 1982.

The annual distribution from this fund provides renewable, tuition-only scholarship support to students enrolled in the Michael E. Moritz College of Law who demonstrate financial need and an interest in public service law. Scholarship recipients, the number of recipients, and amount of each scholarship shall be determined in accordance with the then current guidelines and procedures for scholarship administration established by the college, in consultation with Student Financial Aid.

The University may modify any criteria used to select scholarship recipients should the criteria be found, in whole or in part, to be contrary to federal or state law or University policy.

The highest ranking official in the Michael E. Moritz College of Law or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donors that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University and the Foundation may modify the purpose of this fund, in consultation with the donors named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official in the Michael E. Moritz College of Law or his/her designee to identify a similar purpose consistent with the original intent of the donors. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**The Adrienne M. Gavula Memorial Scholarship Fund**
**at The Ohio State University College of Social Work**

The Board of Trustees of The Ohio State University, in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, shall establish The Adrienne M. Gavula Memorial Scholarship Fund at The Ohio State University College of Social Work effective August 17, 2023, with gifts from family, friends, and colleagues of Adrienne Gavula (MSW 2009).

The annual distribution from this fund shall be used at the discretion of the highest ranking official in the College of Social Work or his/her designee. Expenditures shall be approved in accordance with the then current guidelines and procedures established by the college.

The endowment may be revised when the gifted endowment principal reaches the minimum funding level required at that date for a restricted endowment. Thereafter, the annual distribution from this fund shall provide one or more scholarships to MSW1 or MSW2 ranked graduate students who are enrolled in the College of Social Work and demonstrate financial need. Preference shall be given to students who are interested in but not limited to advocacy/social justice, women's rights, and/or domestic violence. It is the group's preference to award to one student. It is the group's intent to provide significant financial support to the scholarship recipients, rather than provide smaller scholarships to several recipients. If no students meet the selection criteria, the scholarship(s) will be open to all students who are enrolled in the college. Scholarship recipients, the number of recipients, and amount of each scholarship shall be determined in accordance with the then current guidelines and procedures for scholarship administration established by the college, in consultation with Student Financial Aid.

The University may modify any criteria used to select scholarship recipients should the criteria be found, in whole or in part, to be contrary to federal or state law or University policy.

The highest ranking official in the College of Social Work or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donors that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University and the Foundation may modify the purpose of this fund, in consultation with the donors named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official in the College of Social Work or his/her designee to identify a similar purpose consistent with the original intent of donors. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**The Sarah Ross Soter Endowed Chair**
**for Women’s Cardiovascular Health Research**

The Sarah Ross Soter Endowed Chair Fund in Women’s Cardiovascular Health at OSU Heart Center was established February 4, 2005, by the Board of Trustees of The Ohio State University in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, with a gift from Sarah Ross Soter. The description was revised July 8, 2005. The funding level was reached and the chair was established December 8, 2006. Effective August 17, 2023, the fund name shall be revised.

The annual distribution shall provide a chair position in the Division of Cardiovascular Medicine in the College of Medicine in order to advance the medical science related to women's cardiovascular health. The position shall be held by a nationally eminent physician/researcher specializing in women's cardiovascular health as recommended by the senior vice president for Health Sciences and the dean of the College of Medicine in consultation with the director of the Division of Cardiovascular Medicine and the donor. The activities of the endowed chair holder shall be reviewed no less than every five years by the senior vice president for Health Sciences and the dean of the College of Medicine to determine compliance with the intent of the donor as well as the academic and research standards of the University.

In any given year that the endowment distribution is not fully expended, the unused portion should be reinvested in the endowment principal.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

It is the desire of the donor that this fund should benefit the University in perpetuity. If, in the future, the need for this fund should cease to exist or so diminish as to provide unused distributions, then another use shall be designated by the Board of Trustees and Foundation Board as recommended by senior vice president for Health Sciences, the dean of the College of Medicine, and the director of the Division of Cardiovascular Medicine. Any such alternate distributions shall be made in a manner as nearly aligned with the original intent of the donor as good conscience and need dictate.

**The Steven Heath and Sarah Shireen Eddleblute Endowed Scholarship Fund**

The Steven Heath and Sarah Shireen Eddleblute Endowed Scholarship Fund was established June 22, 2012, by the Board of Trustees of The Ohio State University in accordance with the guidelines approved by the Board of Directors of The Ohio State University Foundation, with gifts from Steven Heath Eddleblute (BA 1994) and Sarah Shireen Eddleblute (BSBA 1993), of Scottsdale, Arizona, in memory of Major Ray Mendoza (BA 1995), a Buckeye and member of the U.S. Marine Corps, who was killed in the line of duty while serving in Iraq. Effective August 17, 2023, the fund description shall be revised.

The annual distribution from this fund provides scholarship support to students enrolled in one of the degree-seeking programs at the John Glenn College of Public Affairs. To qualify, candidates must demonstrate financial need and outstanding leadership skills both inside and outside the classroom. Preference shall be given to military-connected students. If no students meet the selection criteria, the scholarship(s) will be open to all students enrolled in the college. It is the donors' desire to provide as significant financial support as possible to one eligible recipient. Any remaining distribution shall be used to provide as significant financial support as possible to additional eligible recipients. Scholarship recipients, the number of recipients, and amount of each scholarship shall be determined in accordance with the then current guidelines and procedures for scholarship administration established by the college, in consultation with Student Financial Aid.

The University may modify any criteria used to select scholarship recipients should the criteria be found, in whole or in part, to be contrary to federal or state law or University policy.

The investment and management of and expenditures from all endowment funds shall be in accordance with University policies and procedures, as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's costs of development and fund management.

The highest ranking official in the John Glenn College of Public Affairs or his/her designee has the discretion to hold all or a portion of the unused distribution in the distribution fund to be used in subsequent years, and/or reinvest all or a portion of the unused distribution in the endowment principal.

It is the desire of the donors that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University and the Foundation may modify the purpose of this fund, in consultation with the donors named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official in the John Glenn College of Public Affairs or his/her designee to identify a similar purpose consistent with the original intent of the donors. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

**The Walt M. Rudin Football Manager's Scholarship Fund**

The Walt Rudin Sr. Football Manager Scholarship Fund was established May 4, 2007, by the Board of Trustees of The Ohio State University in accordance with guidelines approved by the Board of Directors of The Ohio State University Foundation, with a gift from Walt M. Rudin Jr. (B.S. 1977), of Columbus, Ohio. The name was revised July 11, 2008. Effective August 17, 2023, the fund description shall be revised.

The annual distribution from this fund shall be used to supplement the grant-in-aid scholarship costs of the head senior football manager who is pursuing an undergraduate degree at The Ohio State University. Any remaining distribution shall be used to supplement the grant-in-aid scholarship costs of football managers who are pursuing undergraduate degrees. Scholarship recipients, the number of recipients, and amount of each scholarship shall be determined in accordance with the then current guidelines and procedures for scholarship administration established by the Department of Athletics, in consultation with Student Financial Aid.

Unused annual distribution shall be reinvested in the endowment principal.

The investment and management of and expenditures from all endowed funds shall be in accordance with University policies and procedures as approved by the Board of Trustees. As authorized by the Board of Trustees, a fee may be assessed against the endowment portfolio for the University's cost of development and fund management.

It is the desire of the donor that the endowment established herein should benefit the University in perpetuity. Should the University units referenced in this endowment restructure in the future, the terms of the endowment shall apply to their successors in interest. The University and the Foundation may modify the purpose of this fund, in consultation with the donor named above. In accordance with Ohio Revised Code, if the purpose of the fund becomes unlawful, impracticable, impossible to achieve, or wasteful, the University and Foundation may modify the purpose of this fund. The University and the Foundation shall consult the highest ranking official in the Department of Athletics or his/her designee to identify a similar purpose consistent with the original intent of the donor. Modifications to endowed funds shall be approved by the University's Board of Trustees and the Foundation's Board of Directors, in accordance with the policies of the University and Foundation.

ATTACHMENT XXXI



# Major Project Updates

## Projects Over $20M

AUGUST 2023




THE OHIO STATE UNIVERSITY

# **Project Status Report** - Current Projects Over $20M

| PROJECT NAME | CONSTRUCTION COMPLETION DATE | APPROVALS | | BUDGET | ON TIME | ON BUDGET |
|---|---|---|---|---|---|---|
| | | DES | CON | | | |
| The James Outpatient Care | COMPLETE | ✓ | ✓ | $356.5 M | | |
| Arts District | COMPLETE | ✓ | ✓ | $165.3 M | | |
| Jane E. Heminger Hall and Newton Renovation | COMPLETE | ✓ | ✓ | $31.7 M | | |
| Energy Advancement and Innovation Center | 10/23 | ✓ | ✓ | $49.3 M | | |
| Interdisciplinary Health Sciences Center | 1/24 | ✓ | ✓ | $157.3 M | | |
| Combined Heat & Power Plant/District Heating & Cooling Loop | 3/24 | ✓ | ✓ | $289.9 M | | |
| Newark – Founders Hall Enhancements | 4/24 | ✓ | ✓ | $26.4 M | | |
| Martha Morehouse Facility Improvements | 7/24 | ✓ | ✓ | $42.2 M | | |
| Celeste Lab Renovation | 8/24 | ✓ | ✓ | $49.7 M | | |
| Cannon Drive Relocation - Phase 2 | 12/24 | ✓ | ✓ | $68.1 M | | |
| Campbell Hall Renovation | 3/25 | ✓ | ✓ | $61.2 M | | |
| Biomedical and Materials Engineering Complex Phase 2 | 8/25 | ✓ | ✓ | $90.0 M | | |
| Wexner Medical Center Inpatient Hospital | 10/25 | ✓ | ✓ | $1,904.2 M | | |
| **TOTAL – PROJECTS** | | | | **$3,291.80 M** | | |

On Track  Watching Closely  Not on Track

# The James Outpatient Care

**THE JAMES OUTPATIENT CARE**

Construct an approximately 385,000 square foot outpatient facility including a surgical center, proton therapy, and medical office space. The proton therapy facility will focus on leading-edge cancer treatments and research. The facility will also include a 640-space parking garage.

**PROJECT FUNDING:** Auxiliary funds; fundraising; partner funds
**PROJECT UPDATE**: The James Outpatient Care facility opened for first patients on July 17th. Commissioning is ongoing for the proton therapy facility to prepare for opening in October.

| CURRENT BUDGET | |
|---|---|
| Construction w/ Cont | $229.6 M |
| Total Project | $356.5 M |

| CONSULTANTS | |
|---|---|
| Architect of Record | Perkins & Will |
| CM at Risk | BoldtLinbeck |

| PROJECT SCHEDULE | |
|---|---|
| BoT Approval | 11/18 |
| Construction | 7/20-4/23 |
| Facility Opening – Outpatient | COMPLETE |
| Facility Opening – Proton | 10/23 |

**On Budget**

**On Time**

# CHP/DHC

**COMBINED HEAT AND POWER PLANT/ DISTRICT HEATING AND COOLING LOOP – CHP/ DHC**

105 MW combined heat and power (CHP) plant, with a heating capacity of 285 klb/hr of superheated steam. The CHP plant will also contain an 8,000-ton cooling facility with future build-out potential to 13,000-ton. Installation of heating hot water (HHW) and chilled water (CW) on the midwest and west campuses to support existing and new campus buildings. Rehabilitation of John Herrick Drive bridge to support new utilities which connect the CHP to main campus.

**PROJECT FUNDING:** Utility fee
**PROJECT UPDATE:** CHP plant mechanical and electrical work schedule continues to slip. Sub-contracts, engineering contract and project schedule development is ongoing. Distribution system installation at midwest campus in process and on target for completion. CHP bypass plant in operation and providing chilled water and heating hot water to the Pelotonia Research Center and James Outpatient Care facilities.

| CURRENT BUDGET | |
|---|---|
| Total Project | $289.9 M |

| PROJECT SCHEDULE | |
|---|---|
| BoT Approval | 8/19 |
| Construction | 11/20-TBD |
| Facility Opening | TBD |

| CONSULTANTS | |
|---|---|
| Operator's Engineer | HDR |
| Design-Builder (CHP) | MasTec |
| CMR (DHC/Bridge) | Whiting Turner/CK |
| A/E (DHC) | RMF Engineering |
| A/E (Bridge) | EMH&T |

**On Budget** **On Time**

THE OHIO STATE UNIVERSITY BOARD OF TRUSTEES
FINANCE COMMITTEE

**TOPIC**: Annual Waiver Report for the 2023 Fiscal Year

Note: Pursuant to the purchasing policy adopted by the Board of Trustees (BOT) on November 17, 2022, Bid Waiver/BoT Resolutions reporting has changed from Calendar Year to Fiscal Year, beginning with the August 17, 2023, BOT Meeting.

**SUMMARY**:

2023 Fiscal Year (7/1/2022 - 6/30/2023)

A total of 2,048 waivers of competitive bidding were approved as sole source, emergency or for economic reasons, and by Board of Trustees resolution totaling approximately $764.0 million.

- Twenty percent (20%) or $149.4 million of spend was sole source waivers
- One percent (1%) or $4.9 million of spend was emergency purchase waivers
- Twenty-one percent (21%) or $160.6 million of spend was for sufficient economic reason
- Fifty-seven (57%) or $449.1 million of spend was Board of Trustees resolution waivers

2021 Calendar Year (1/1/2021 - 12/31/2021)

A total of 1,008 waivers of competitive bidding were approved as sole source, emergency or for economic reasons, and by Board of Trustees resolution totaling approximately $471.7 million.

- Thirty-nine percent (39%) or $180.8 million of spend was sole source waivers
- Three percent (3%) or $13.7 million of spend was emergency purchase waivers
- Thirty-eight percent (38%) or $180.1 million of spend was for sufficient economic reason
- Twenty percent (20%) or $97.1 million of spend was Board of Trustees resolution waivers

Period-Over-Period Comparison

Period-over-period increase in number of waivers was 1,040 and the waiver spend increased by $292.3 million. This increase was primarily attributed to Health Systems Waivers Authorized by BoT Resolutions of $354.1 million for Pharmaceuticals and Surgical Products/Implants.

Board of Trustees resolution waivers consist of items such as software license renewals, term orders for utilities, talent fees for performers, renovations and repairs, pharmaceuticals, surgical products, and consulting and physician services.

Note: Pursuant to the purchasing policy adopted by the Board of Trustees (BoT) on November 17, 2022, Bid Waiver/BOT Resolutions reporting has changed from Calendar Year to Fiscal Year, beginning with the August 17, 2023 BOT Meeting.

**The Ohio State University**
**Competitive Bid Waiver Report for Fiscal Year 2023**

| Category | Sufficient Economic Reason | Count | Emergency | Count | Sole Source | Count | Total | Count |
|---|---|---|---|---|---|---|---|---|
| Academic Support | $ 15,631,427 | 35 | $ 293,832 | 4 | $ 9,226,095 | 51 | $ 25,151,354 | 90 |
| Administrative Support Equipment and Services | $ 31,851,342 | 91 | $ 3,085,374 | 15 | $ 32,357,099 | 128 | $ 67,293,815 | 234 |
| Instructional and Academic Research Equipment and Services | $ 16,367,374 | 98 | $ 153,391 | 4 | $ 68,431,747 | 280 | $ 84,952,512 | 382 |
| Health Systems - Professional Health Care Services | $ 23,041,810 | 24 | $ 1,403,180 | 4 | $ 35,240,842 | 41 | $ 59,685,832 | 69 |
| Health Systems - Administrative Equipment and Services | $ 73,673,000 | 18 | | | $ 4,123,269 | 13 | $ 77,796,269 | 31 |
| **TOTAL WAIVERS** | **$ 160,564,953** | **266** | **$ 4,935,777** | **27** | **$ 149,379,052** | **513** | **$ 314,879,782** | **806** |
| Waivers Authorized by BOT Resolutions | | | | | | | $ 15,506,256 | 44 |
| Health Systems - Waivers Authorized by BOT Resolutions | | | | | | | $ 433,589,649 | 1,198 |
| **TOTAL BOT Resolutions** | | | | | | | **$ 449,095,905** | **1,242** |
| **GRAND TOTAL** | | | | | | | **$ 763,975,687** | **2,048** |

**The Ohio State University**
**Competitive Bid Waiver Report for Calendar Year 2021**

| Category | Sufficient Economic Reason | Count | Emergency | Count | Sole Source | Count | Total | Count |
|---|---|---|---|---|---|---|---|---|
| Academic Support | $ 16,312,449 | 36 | $ 4,812,535 | 6 | $ 4,043,603 | 28 | $ 25,168,587 | 70 |
| Administrative Support Equipment and Services | $ 124,235,746 | 89 | $ 1,247,810 | 10 | $ 18,868,847 | 89 | $ 144,352,403 | 188 |
| Instructional and Academic Research Equipment and Services | $ 8,221,554 | 67 | $ 64,200 | 2 | $ 82,337,600 | 233 | $ 90,623,354 | 302 |
| Health Systems - Professional Health Care Services | $ 29,116,073 | 17 | $ 6,950,000 | 5 | $ 11,537,034 | 13 | $ 47,603,107 | 35 |
| Health Systems - Administrative Equipment and Services | $ 2,194,519 | 15 | $ 671,134 | 5 | $ 64,027,571 | 76 | $ 66,893,223 | 96 |
| **TOTAL WAIVERS** | **$ 180,080,341** | **224** | **$ 13,745,679** | **28** | **$ 180,814,655** | **439** | **$ 374,640,674** | **691** |
| Waivers Authorized by BOT Resolutions | | | | | | | $ 17,587,876 | 59 |
| Health Systems - Waivers Authorized by BOT Resolutions | | | | | | | $ 79,460,084 | 258 |
| **TOTAL BOT Resolutions** | | | | | | | **$ 97,047,960** | **317** |
| **GRAND TOTAL** | | | | | | | **$ 471,688,634** | **1,008** |

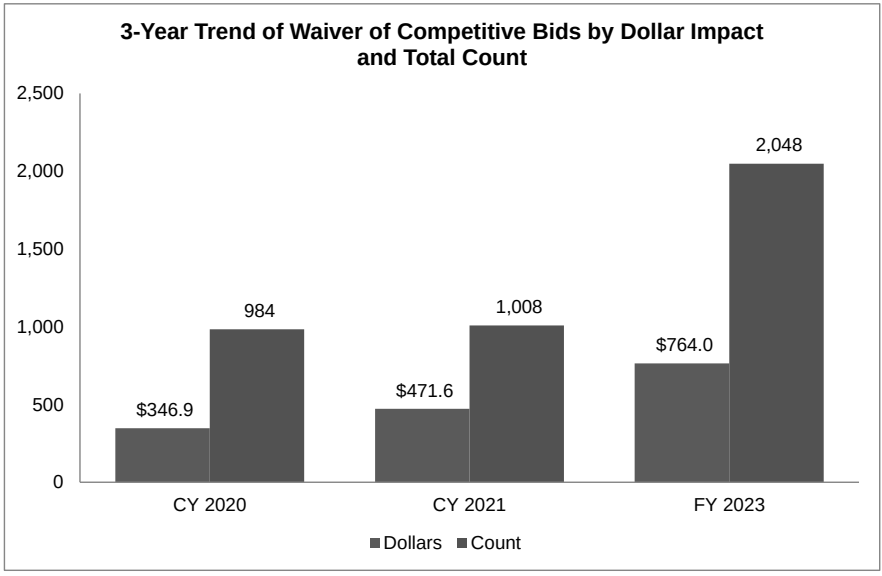
**The Ohio State University**
**Competitive Bid Waiver Report Comparison for Fiscal Year 2023 and Calendar Year 2021**

| Category | Sufficient Economic Reason | Count | Emergency | Count | Sole Source | Count | Total | Count |
|---|---|---|---|---|---|---|---|---|
| Academic Support | $ (681,022) | (1) | $ (4,518,703) | (2) | $ 5,182,492 | 23 | $ (17,233) | 20 |
| Administrative Support Equipment and Services | $ (92,384,404) | 2 | $ 1,837,564 | 5 | $ 13,488,252 | 39 | $ (77,058,588) | 46 |
| Instructional and Academic Research Equipment and Services | $ 8,145,820 | 31 | $ 89,191 | 2 | $ (13,905,853) | 47 | $ (5,670,842) | 80 |
| Health Systems - Professional Health Care Services | $ (6,074,263) | 7 | $ (5,546,820) | (1) | $ 23,703,808 | 28 | $ 12,082,725 | 34 |
| Health Systems - Administrative Equipment and Services | $ 71,478,481 | 3 | $ (671,134) | (5) | $ (59,904,302) | (63) | $ 10,903,046 | (65) |
| **TOTAL WAIVERS** | **$ (19,515,388)** | **42** | **$ (8,809,902)** | **(1)** | **$ (31,435,602)** | **74** | **$ (59,760,892)** | **115** |
| Waivers Authorized by BOT Resolutions | | | | | | | $ (2,081,620) | (15) |
| Health Systems - Waivers Authorized by BOT Resolutions | | | | | | | $ 354,129,565 | 940 |
| **TOTAL BOT Resolutions** | | | | | | | **$ 352,047,945** | **925** |
| **GRAND TOTAL** | | | | | | | **$ 292,287,053** | **1,040** |

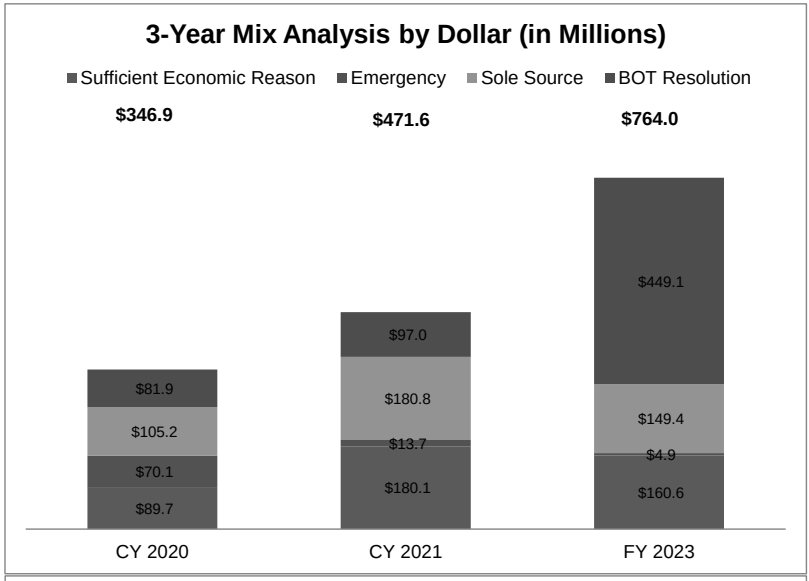
# Annual Waiver Report for Fiscal Year 2023

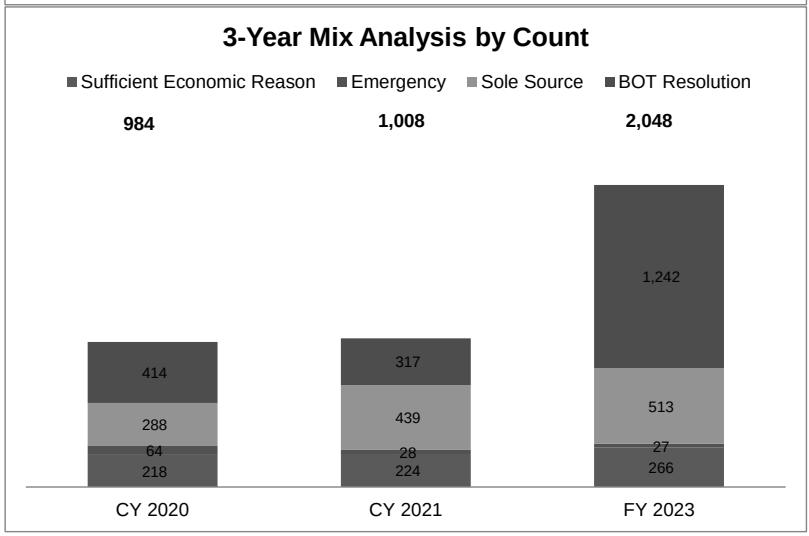
## Waiver of Competitive Bids Summary 2020 - 2021CY; 2023FY

| Waiver Type | CY 2020 | | CY 2021 | | FY 2023 | |
|---|---|---|---|---|---|---|
| *($ in Millions)* | Dollars | Count | Dollars | Count | Dollars | Count |
| **Sufficient Economic Reason** | $ 89.7 | 218 | $ 180.1 | 224 | $ 160.6 | 266 |
| **Emergency** | $ 70.1 | 64 | $ 13.7 | 28 | $ 4.9 | 27 |
| **Sole Source** | $ 105.2 | 288 | $ 180.8 | 439 | $ 149.4 | 513 |
| **BOT Resolution** | $ 81.9 | 414 | $ 97.0 | 317 | $ 449.1 | 1,242 |
| **TOTAL** | **$ 346.9** | **984** | **$ 471.6** | **1,008** | **$ 764.0** | **2,048** |



**Waiver of Competitive Bids Summary**
**Calendar Years 2020 - 2021 and FY23**



# FY 2023 Internal Bank Update

Office of Financial Services

Jake Wozniak, University Treasurer

Finance & Investment Committee | August 17, 2023

Jake Wozniak, Treasurer and Vice President Financial Services & Innovation, Deputy CFO

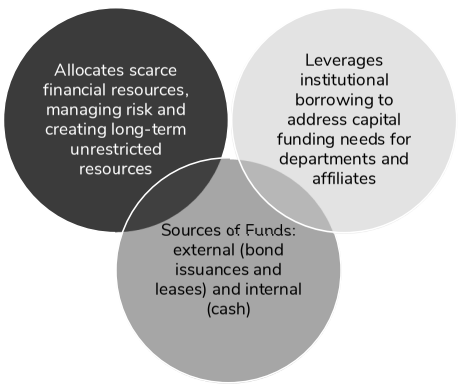
Finance & Investment Committee | August 17, 2023

THE OHIO STATE UNIVERSITY

# Internal Bank Overview

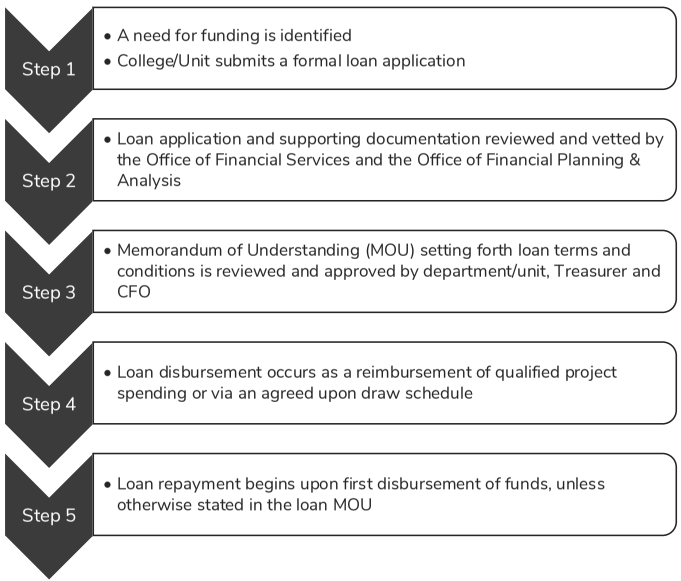
The Office of Financial Services (OFS) manages cash, investments, and debt for the university and serves as a "bank" to university departments by issuing debt, approving loans, and administering debt and loan disbursements and repayments. The internal bank coordinates these activities and provides a consolidated view of the associated assets, liabilities, revenues and expenses.

- **Policy:** Internal bank loans and capital equipment leases must adhere to the principles set forth in sections three and five of the University's Debt Policy.
- **Governance:** Oversight is provided by the Office of Financial Services and Financial Planning & Analysis.
- **Scope:** Internal Bank loans address three purposes:
  - Capital project financing (1-30 years).
  - Equipment leases (1-10 years).
  - Capital project cash flow 'gap' loans (1-5 years).
- **Capital Planning Process:** Internal Bank loans are analyzed as a potential funding source for projects during the university's capital planning process.
- **Rates:** Updated quarterly, each loan/lease rate is based on the term, asset life, and prevailing market conditions. Current loan/lease rates range from 3.25% to 4.75%.



# Internal Bank Process and Loan Portfolio

## Loan Process



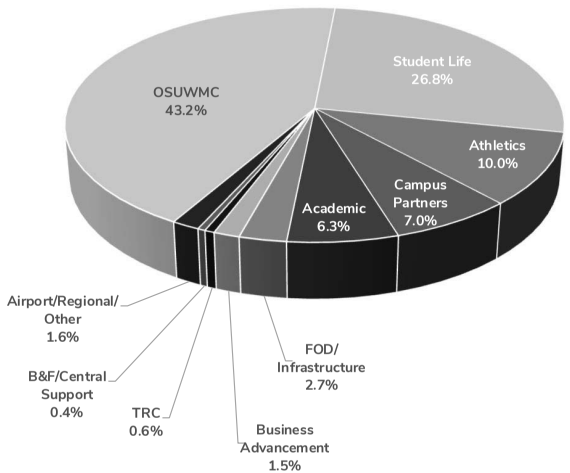

## Loan Statistics (as of 6.30.2023)

| Loan Summary | Number | Amount |
|---|---|---|
| Active Loans | 155 | $2.77B |
| Loans in Repayment | 149 | $2.73B |
| Weighted Avg Loan Rate | 4.00% | |
| Average Remaining Life | 19.1 Years | |

More information about the Internal Bank loan application process can be found here: https://busfin.osu.edu/university-business/debt-management/internal-bank

THE OHIO STATE UNIVERSITY

# Internal Bank Active Loans (as of 6.30.2023)




| Internal Bank Funding | Outstanding Balance ($M) |
|---|---|
| Loans | $2,723.3 |
| Equipment Leases | $2.2 |
| **Total** | **$2,725.5** |

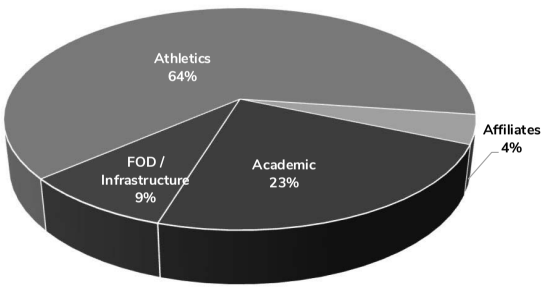
| Borrowing Unit/Obligor | Outstanding Balance ($M) |
|---|---|
| OSUWMC | $1,176.5 |
| Student Life | $729.1 |
| Athletics | $272.7 |
| Campus Partners | $191.0 |
| Academic | $171.5 |
| FOD / Infrastructure | $73.4 |
| Business Advancement | $40.6 |
| TRC | $15.2 |
| B&F / Central Support | $12.1 |
| Airport/Regional/Other | $43.4 |
| **Total** | **$2,725.5** |

# Internal Bank FY 2023 Activity

- In FY22, the Internal Bank executed 8 new loans totaling $768M (including $715M for the Inpatient Hospital) and disbursed $321M of funds.
- In FY23, the Internal Bank executed 7 new loans totaling $78.6M and disbursed $546M of funds across 21 projects.
- Internal Bank loan rates were raised by 25-50 basis points in FY23 to reflect rising prevailing market interest rates (see Appendix).
- Annual rating agency updates in November presented the University's FY22 financial results and strategic position.
  - Fitch raised the University's credit rating to AA+
  - Moody's and S&P affirmed the University's Aa1/AA ratings, respectively.

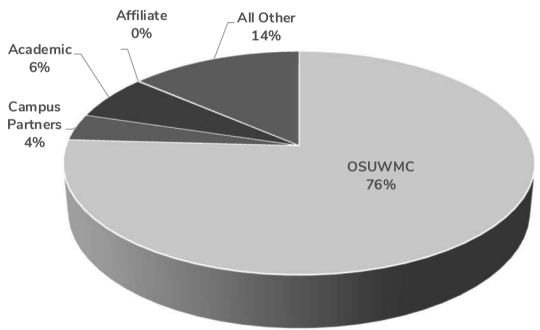
| FY 2023 Loan Activity | Number | Amount |
|---|---|---|
| New Loans | 7 | $78.6M |
| Disbursements | 21 | $546M |

# FY 2023 New Loan Commitments




| Borrowing Unit/Obligor | Amount ($M) |
|---|---|
| **Academic** | |
| Multi-Species Animal Learning Center | $15.2 |
| Newton Hall Renovation | $3.1 |
| | $18.3 |
| **FOD / Infrastructure** | |
| Tunnel Top Roof Replacement | $1.7 |
| Tunnel Rehabilitation | $1.3 |
| Herrick Drive Rebuild | $4.0 |
| | $7.0 |
| **Athletics** | |
| Pandemic Relief | $48.0 |
| Buckeye Village Demolition | $2.0 |
| | $50.0 |
| **Affiliates** | |
| TRC Vehicle Research Transportation Ctr. LOC | $3.3 |
| **Total** | **$78.6** |

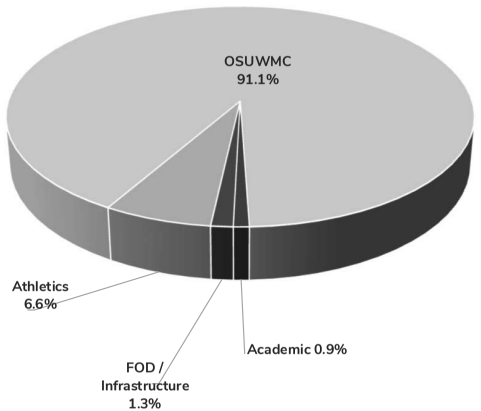
# FY 2023 Loan Disbursements




| Borrowing Unit/Obligor | Amount ($M) |
|---|---|
| **OSUWMC** | |
| Inpatient Hospital Tower | $416.3 |
| **Campus Partners** | |
| University Square Building B-1 | $13.2 |
| University Square Event Center Fit-Out | $7.2 |
| University Square Building A | $0.5 |
| | $20.9 |
| **Academic** | |
| Arts District | $20.8 |
| Interdisciplinary Research Center | $7.3 |
| Controlled Environment Agricultural Research Com | $6.7 |
| Instructional Science Bldgs Deferred Maintenance | $0.7 |
| Postle Partial Replacement | -$2.7 |
| | $32.9 |
| **Affiliate** | |
| TRC SMART Center Expansion Project LOC | $0.4 |
| TRC SMART Center Phase 1 | $0.1 |
| | $0.5 |
| **All Other** | |
| Athletics | $61.1 |
| FOD / Infrastructure | $5.2 |
| Student Life | $7.0 |
| Regional Campuses | $1.7 |
| | $75.1 |
| **Total** | **$545.7** |

THE OHIO STATE UNIVERSITY

# Anticipated Loan Requests




| Borrowing Unit/Obligor | Amount ($M) |
|---|---|
| **OSUWMC** | |
| Inpatient Hospital Tower (~$270M/TBD) | $270.0 |
| **Academic** | |
| Dentistry Simulation Lab Modernization | $2.8 |
| **FOD / Infrastructure** | |
| Tunnel System Rehabilitation (increase) | $4.0 |
| **Athletics** | |
| Fawcett Center Renovation | $12.5 |
| East Side Stadium Club | $7.0 |
| **Total** | **$296.3** |

# Appendix

THE OHIO STATE UNIVERSITY

# Appendix: IB Loan Rates

**Internal Bank**

**Term Sheet**

**Effective July 1 to September 30, 2023**

| Capital Project Internal Bank Loan/Lease Rates | Rate |
|---|---|
| 1 to 3 years | 3.25% |
| More than 3 years up to 5 years | 3.50% |
| More than 5 years up to 7 years | 3.75% |
| More than 7 years up to 10 years | 4.00% |
| More than 10 years up to 20 years | 4.50% |
| More than 20 years up to 30 years | 4.75% |

Draws on internal bank loans will be set forth in a Memorandum of Understanding (MOU). Interest and principal will be repaid based on a schedule set forth in the IB Loan MOU. Typically, loan repayments are made on a monthly basis while lease repayments are made on a quarterly basis.

Lease rates may be adjusted to reflect the specific terms and conditions of each requested lease on a case-by-case basis.

THE OHIO STATE UNIVERSITY

Board of Trustees

University Square South
15 East 15th Avenue, 5th Floor
Columbus, OH 43201

Phone (614) 292-6359
Fax (614) 292-5903
trustees.osu.edu

**SUMMARY OF ACTIONS TAKEN**

*August 17, 2023 – Research, Innovation & Strategic Partnerships Committee*

**Members Present:**

| | | |
|---|---|---|
| Lewis Von Thaer | Juan Jose Perez | Phillip Popovich |
| Reginald A. Wilkinson | Taylor A. Schwein | Hiroyuki Fujita (ex officio) |

**Members Present via Zoom:** N/A

**Members Absent:** N/A

The Research, Innovation & Strategic Partnerships Committee of The Ohio State University Board of Trustees convened on Thursday, August 17, 2023, in person at Vitria on the Square, 14 E. 15th Avenue, Columbus, OH, 43201. Committee Chair Lewis Von Thaer called the meeting to order at 12:59 p.m.

**PUBLIC SESSION**

***Items for Discussion***

1. Committee Chair's Remarks: Mr. Von Thaer kicked off the meeting by welcoming trustee, Taylor Schwein, to the committee. He also took a moment to acknowledge Peter Mohler as the executive vice president for the Enterprise for Research, Innovation and Knowledge.

2. Quarterly Highlights for Research, Innovation and Knowledge: Dr. Peter Mohler highlighted a couple of big research awards specifically $12M to a team in the Department of Obstetrics and Gynecology to study treatment option when medication becomes necessary in patients with gestational diabetes and $22M to allow Ohio State researchers to develop new approaches to treat multiple neurodegenerative diseases. In addition he highlighted a few recent innovation successes including Tom Darrah, Ohio State's 2023 Innovator of the Year, whose startup recently exited stealth mode and raised $91M.

   (See Attachment XXXIV for background information, page number 691)

3. Ohio State Strategic Focus Areas – Smart Mobility: Ohio State's Role in the Future of Transportation: Mr. Brett Roubinek, president and CEO for Transportation Research Center, Inc. was joined by Larry Geise, executive vice president, Honda Development & Manufacturing of America, LLC, and Trey Brown, aerospace engineering PhD student, to give an overview of Transportation Research Center's physical space, partnership development, research expenditure growth and employment numbers. Mr. Geise was able to provide an overview of Honda's ongoing partnership with TRC while Mr. Brown provided his experiences with TRC as a recruitment tool for him joining Ohio State and how it is accelerated his learning.

   (See Attachment XXXV for background information, page number 699)

THE OHIO STATE UNIVERSITY

***Item for Action***

4. Approval of Minutes: No changes were requested to the May 18, 2023, meeting minutes; therefore, a formal vote was not required, and the minutes were considered approved.

**EXECUTIVE SESSION**

It was moved by Mr. Von Thaer, and seconded by Dr. Wilkinson, that the committee recess into executive session to consider business-sensitive trade secrets required to be kept confidential by federal and state statutes, and to consult with legal counsel regarding pending or imminent litigation.

A roll call vote was taken, and the committee voted to go into executive session with the following members present and voting: Mr. Von Thaer, Dr. Wilkinson, Mr. Perez. Ms. Schwein, Dr. Popovich, and Dr. Fujita.

The committee entered executive session at 1:28 p.m. and the meeting adjourned at 2:27 p.m.

# Research, Innovation and Knowledge – Quarterly Highlights

August 2023

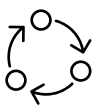
# Research, Innovation and Knowledge Strategy

**Inspire a culture of research, innovation and knowledge excellence**

**Be renowned for discoveries, knowledge generation and creative expression**

**Develop partnerships, innovation and entrepreneurship to drive impact**

**Create and sustain dynamic infrastructure that drive discoveries**



**Increase operational excellence to enable success**

# $12 million awarded to study therapies for gestational diabetes

Maternal Fetal Medicine team in Department of Obstetrics and Gynecology awarded funding to study the best treatment options when medication becomes necessary in patients with gestational diabetes.

Funding from Patient-Centered Outcomes Research Institute (PCORI)

https://wexnermedical.osu.edu/mediaroom/pressreleaselisting/12-million-award-to-study-gestational-diabetes

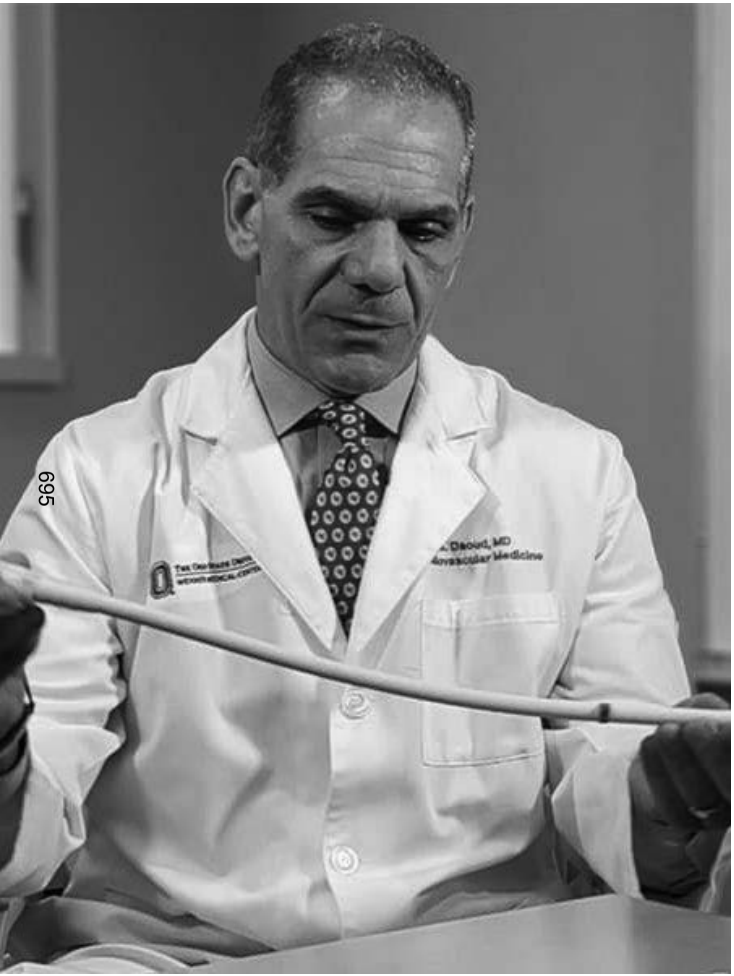
# $22 million NIH award will accelerate gene editing research at Ohio State, UC Berkeley

This funding will allow Ohio State researchers to develop new approaches to treat multiple neurodegenerative diseases, including Huntington's Disease and ALS, with new gene editing therapies.

The research team is working towards an approved Investigational New Drug application within five years.

Collaboration between Department of Neurosurgery in College of Medicine and Dr. Doudna at UC Berkeley.

https://wexnermedical.osu.edu/mediaroom/pressreleaselisting/nih-crispr-award




# Ohio State spinoff raises $5 million to take device to market

Emile Daoud, clinical cardiac electrophysiologist, is co-inventor of a medical device that protects the esophagus during treatment for atrial fibrillation.

The device is licensed to Ohio State startup S4 Medical.

These funds are expected to take the medical device through regulatory approvals and into use by mid-2024.

https://wexnermedical.osu.edu/mediaroom/pressreleaselisting/afib-mmr

# Ohio State startup exits stealth mode, raises significant funds

Ohio State's 2023 Innovator of the Year, Tom Darrah, co-founded Koloma, a geologic hydrogen company, which recently announced it had raised $91 million.

Initial funding comes from several venture firms including Breakthrough Energy Ventures, Energy Impact Partners, Evök Innovations, Prelude Ventures and Piva Capital.


https://www.forbes.com/sites/alanohnsman/2023/07/19/bill-gates-koloma-geologic-hydrogen/?sh=4bc3350698f7

https://www.bizjournals.com/columbus/inno/stories/news/2023/07/20/koloma-clean-hydrogen-startup.html




# Ohio State spinoff gets FDA approval for heart surgery simulation software

Dasi Simulations received FDA medical device approval for its AI-guided 3D modeling software that is used in heart valve replacement surgery.

Currently, heart surgeons at more than 50 heart centers nationwide are using the software. Approval will allow for additional marketing, increased use in procedures and eligibility for insurance reimbursement.

https://www.bizjournals.com/columbus/inno/stories/news/2023/06/06/dasi-simulations-fda-clearance.html

The Columbus Dispatch

FRIDAY, AUGUST 4, 2023 | DISPATCH.COM 152 YEARS | SINCE 1871 PART OF THE USA TODAY NETWORK

# Labs provide a way to see 'science on display'

People work at labs in Ohio State's new Pelotonia Research Center, which officially opened in May at Carmenton. This 305,000-square-foot laboratory building is equipped with new spaces, technologies and resources needed for researchers to work across disciplines to accelerate new discoveries. COURTNEY HERGESHEIMER/COLUMBUS DISPATCH

## Ohio State recently opened its $227M Pelotonia Research Center in Carmenton

**Sheridan Hendrix**
Columbus Dispatch
USA TODAY NETWORK

Ohio State University students aren't the only ones moving in this month.

Researchers have started setting up shop in the Pelotonia Research Center, a $227.8 million, 305-square-foot interdisciplinary laboratory building that officially opened in May in Carmenton, Ohio State's burgeoning West Campus research district.

At full occupancy, the building, located at 2255 Kenny Road, will be home to 150 principal researchers and more than 1,000 scientists, faculty members, students and other research staff.

The space is named in recognition of Pelotonia's collaboration with Ohio State. About 6,500 cyclists will cruise into downtown Columbus this weekend for Pelotonia Ride Weekend, all with the goal of raising money for cancer research at Ohio State. Since 2008,

See LABS, Page 13A

https://www.dispatch.com/story/news/education/2023/08/04/inside-ohio-state-university-new-pelotonia-research-center-in-carmenton/70408323007/

# Smart Mobility: Ohio State's Role in the Future of Transportation

August 2023

# Featured Strategic Area: Mobility & Transportation

Foundational R&D ● Innovation & Commercialization ● Economic Development & Impact to State of Ohio


**Center for Automotive Research**

**CARMEN+ University Transportation Center**


**Transportation Research Center (TRC)**

**Brett Roubinek**
President and CEO
Transportation Research Center, Inc.

# Celebrating 50 Years of Shaping the Future of Transportation

*TRC is the leading engineering services firm featuring two locations.*

## East Liberty, Ohio

- 4,500 acres
- 540 acre autonomous and connected testing facility
- 7.5 mile high speed test track
- Over 70 acres of vehicle dynamic areas
- 4 labs


## Research & Testing Areas

- ADS Development test planning
- Connectivity application assessment
- FMVSS, CMVSS, ECE, Lane change, Fishhook, SAE J1321 & J2263
- Advanced driver assist technologies
- Automated driving systems
- NCAP, EuroNCAP, IIHS, RCAR
- ADAS development test planning

TRC next

# TRC SMARTCenter

- 540 acres
- Dedicated AV/CV test facility
- 6 lane high speed intersection
- Configurable traffic signals
- Urban network
- 10,200 sq. ft. Control building
- Fiber network
- Facility monitoring cameras
- V2X communications with DSRC
- High-speed wireless communications



TRC next

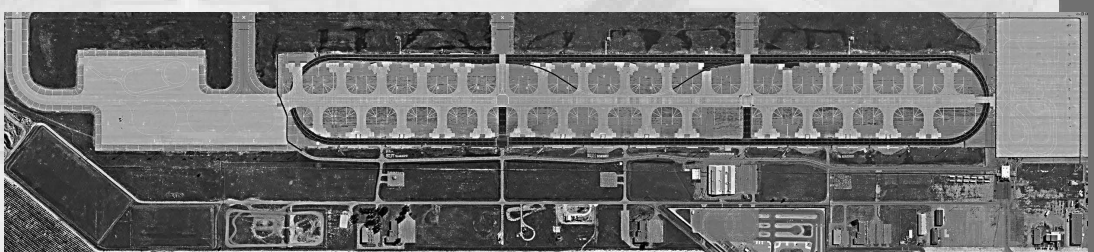
# TRC California: Providing a Pipeline for West Coast Innovators to Ohio

**Atwater, California**

- **225 acres**
- **39+ acres of vehicle dynamic areas**
- **2.2 mile Oval and 1 mile of intersections**
- **Multi-lane roadways and intersections, highway on and off ramps**
- **Traffic signals, road signs, barriers and other roadside furniture**
- **Low mu pad**
- **Planned durability course**
- **Off road area**

**Research & Testing Areas:**

- **NHTSA, IIHS, RCAR & EuroNCAP**
- **ADS Development Test Planning**
- **Connectivity Assessment**
- **Dynamics, durability, performance, compliance & more**



TRC next

# TRC History


**1974**

State of Ohio opens TRC as a state entity to drive economic development

**1976**

NHTSA establishes onsite presence with the only Vehicle Research Test Center in the Country

**1988**

Honda purchases the property. TRC Inc. nonprofit created as affiliated entity to The Ohio State University. Annually, OSU recognizes TRC revenue as Research Expenditures

**2018**

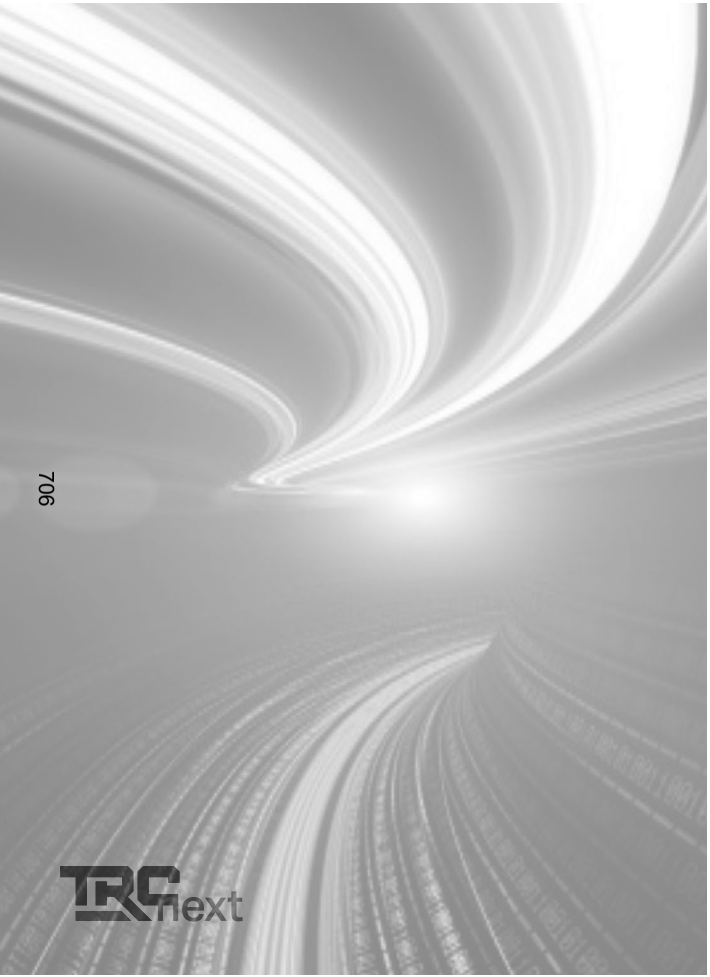
TRC & Honda leadership reimagine relationship to fuel TRC growth. SMARTCenter AV/CV campus opens

**2021**

TRC establishes presence in California providing a pipeline for West Coast innovators to Ohio

**2023**

TOP WORK PLACES 2023





# Vision

To help our clients solve problems and address critical challenges to **safely, effectively, and efficiently move goods and people** throughout the world by applying the most advanced, **leading-edge expertise, by a team of passionate and dedicated professionals** not found anywhere else.

# Mission

To be an indispensable partner and **the most trusted leader** enabling solutions that **shape our transportation future and make the world a safer place.**

# BOARD OF DIRECTORS

## Ex-Offcio Directors

**Dr. Ayanna Howard**

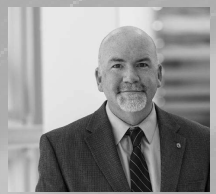
Dean, College of Engineering
*The Ohio State University*

**Brett Roubinek**

President & CEO
*TRC Inc.*

**Michael Papadakis**

Sr. VP Business & Finance
*The Ohio State University*



**Dr. Peter Mohler**

VP Research
*The Ohio State University*

## Public Directors

**Joanna Pinkerton**

President & CEO
*Central Ohio Transit Authority*

**Kenny McDonald**

President & CEO
*Columbus Partnership*
Chief Economic Officer
*One Columbus*

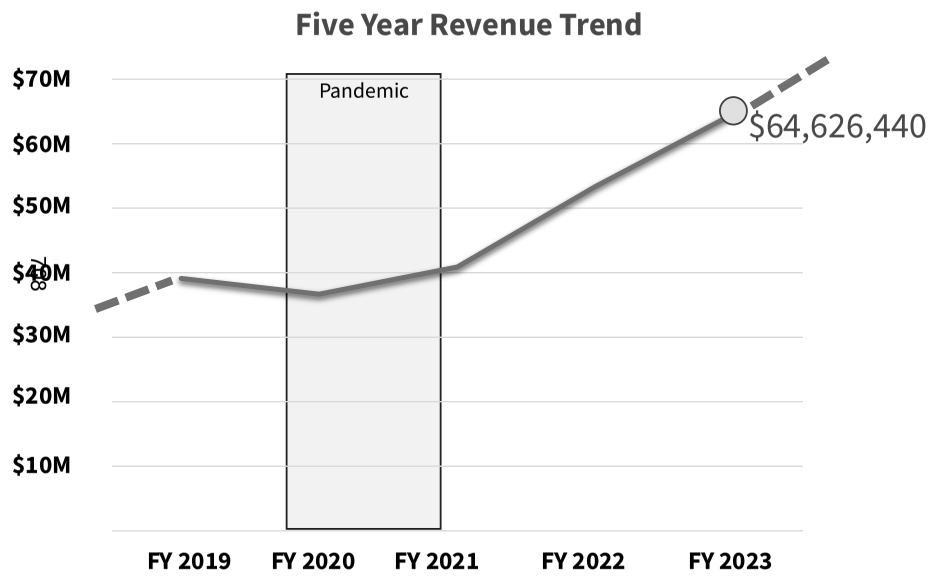
**Stephanie Villegas**

Founder, Chef
*Laurel*
Retired Autonomous Specialist

**Mark Kvamme**

Co-Founder & Partner Emeritus
*Drive Capital*

# Key Financial Metrics





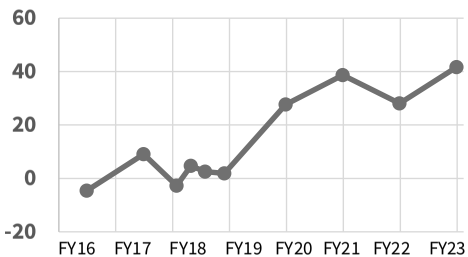
*Annually since 1988, TRC Revenue is recognized and reported in OSU Research Expenditures*

# Our Expert Team Gives Us a Competitive Advantage

*"One of my favorite parts of working here is that TRC is continually looking for new ways to improve things for their employees."*

709

**Employee Engagement Survey**




**504 employees**

**169 employees embedded in client operations**

**Employees reside in 23 different Counties**

**Test drivers, technicians, research scientists, engineers**

**Serving more than 370 clients annually**

**Supporting 25 Resident clients**



TRSnext

# Michelle Murach

***Manager, Crash Safety, Vehicle Research & Test Center***

Master's Degree
Science in Biomedical Engineering
The Ohio State University

Bachelor's Degree
Biomedical Engineering
The Ohio State University

711

- Provide data analysis & technical reports summarizing experimental results
- Facilitate experimental testing specific to the development of anthropomorphic test devices
- Communication across business units within TRC to develop, improve, and enforce business and operational processes to ensure compliance
- Member, TRC WOMEN ( Women Offering Mentorship, Education & Networking)

TRC next

# Mohit Mandikot

***Manager, Engineering, Advanced Mobility***

Master's Degree
Mechanical Engineering
The Ohio State University

Bachelor's Degree
Mechanical Engineering
BITS Pilani Goa Campus

- Develop test plans for performance & safety evaluation of autonomous vehicles in on-track scenarios
- Develop test proposals for validation of L1 & L2 ADAS systems per NHTSA & Euro NCAP Standards.
  - CIB-DBS, Automated Emergency Braking
  - Park Assist, Traffic Jam Assist Systems
- Member, TRC Employee Recognition Team


**Larry Geise**
Executive Vice President, Honda Development & Manufacturing of America, LLC

**Trey Brown**
Aerospace Engineering
PhD Student

# Stuart L. Cooper

Distinguished Professor of Engineering
William G. Lowrie Department of Chemical
and Biomolecular Engineering
College of Engineering

Stuart Cooper is a formidable scientist, leader, teacher and mentor of world acclaim who has, in many ways, served as an inspiration to the fields of biomedical and biological engineering, noted a nominator. Known for his immense contributions to fundamental understanding and technological application, Cooper is a true pioneer in the biomaterials field, having broken vital new ground in understanding interactions of polymeric materials with physiological fluids and tissues.

In addition, Cooper is a consummate scientific mentor who is welcoming and supportive of all ideas and able to stimulate individuals to think creatively. His reputation as a teacher and mentor extends to his outstanding graduate students, for whom he has always been readily available, as well as to younger faculty and colleagues in the field. He mentored 62 PhD students, many of whom have succeeded at high levels. In 2018, he won the College of Engineering Faculty Mentoring Award celebrating these efforts. He served as chair of the William G. Lowrie Department of Chemical and Biomolecular Engineering from 2004 to 2014.

Cooper has won major national and international awards that derive not only from his brilliant work but his incredible service across a broad domain. His contributions were recognized at the highest level within the engineering profession when he was elected to the National Academy of Engineering. Other awards include Founders Award, American Institute of Chemical Engineers; Founders Award, Society for Biomaterials; Founding Fellow, American Institute of Medical and Biological Engineering; International Award for Achievement in Biomaterials, Japanese Society for Biomaterials; Chemistry of Thermoplastic Elastomers Award, American Chemical Society; Fellow, American Chemical Society, Polymer Division.

# Elena G. Irwin

Distinguished Professor of Food, Agricultural, and Environmental Sciences, Economics and Sustainability
Department of Agricultural, Environmental, and Development Economics College of Food, Agricultural, and Environmental Sciences
Faculty Director, Sustainability Institute

Elena Irwin's research addresses the sustainability of human-natural systems at local and regional scales, focusing on land use and ecosystem services across urban and rural areas. She has been principal investigator or co-principal investigator on multiple research projects totaling over $19 million in funding, including funding from the National Science Foundation (NSF), the U.S. Department of Agriculture, the James S. McDonnell Foundation and other private and public sources.

In August 2021, she was appointed by the U.S. Environmental Protection Agency administrator as an advisory member of the chartered Science Advisory Board as well as the Agricultural Science Committee. She is also an elected member of the Agriculture and Applied Economics Association executive board, and in 2022 was selected as a Fellow of the Association of Environmental and Resource Economists, the association's highest honor. She has served on multiple national research committees with the National Research Council and NSF, including as a member of NSF's Advisory Committee for Environmental Research and Education Subcommittee on Sustainable Urban Systems. As faculty director and co-founder of Ohio State's Sustainability Institute, she provides leadership to interdisciplinary sustainability research and teaching across the university, including cultivating campus-wide collaborative research and curriculum development efforts.

Irwin's mentorship of students includes an emphasis on interdisciplinary research for which she is well-known, along with a focus on inclusion in all aspects of the grant writing and publication process and an overall dedication to their success, noted a nominator. In 2015, she was honored with the North American Colleges and Teachers of Agriculture Educator Award.

## OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER BOARD BYLAWS

**3335-97-03 Quality and professional affairs committee.**

(B) Composition. The committee shall consist of: no fewer than four voting members of the university Wexner medical center board, appointed annually by the chair of the university Wexner medical center board, one of whom shall be appointed as chair of the committee. The executive vice president and chief executive officer; the chief executive officer of the Ohio state university health system; the chief clinical officer of the medical center; the chief administrative officer of the Ohio state university health system; the director of medical affairs of the James; the medical director of credentialing for the James; the chief of the medical staff of the university hospitals; the chief of the medical staff of the James; the associate dean of graduate medical education; the chief quality and patient safety officer; the chief nursing ~~executive~~ officer for ~~the Ohio state health system~~ University Hospital; and the chief nursing officer for the James shall serve as ex-officio, voting members. Such other members as appointed by the chair of the university Wexner medical center board, in consultation with the chair of the quality and professional affairs committee.

**3335-101-05 Appointment to the medical staff and assignment of clinical privileges.**

Upon recommendation of the medical staff of university hospitals or the James cancer hospital and in accordance with the medical staff bylaws, the university Wexner medical center board may appoint and reappoint physicians, dentists, psychologists, and podiatrists meeting the qualifications prescribed in the medical staff bylaws, to membership on the medical staff of the university hospitals and the James cancer hospital and shall grant clinical privileges to such practitioners. Appointment to the medical staff carries with it full responsibility for the treatment of patients of the university Wexner medical center subject to such limitations as may be imposed by the university Wexner medical center board or the medical staff bylaws, rules, and regulations of the medical staff. ~~Appointment and reappointment to the medical staff shall be for a period not to exceed two years and shall be renewable in accordance with the reappointment procedure set forth in the medical staff bylaws.~~ The chief medical officer of the medical center and the director of medical affairs for the James cancer hospital are delegated the responsibility by the university Wexner medical center board to grant temporary clinical privileges. The granting of temporary privileges shall be limited to situations which fulfill an important patient care need, and shall not be granted for a period of more than one hundred twenty days.

**PROGRAM DEVELOPMENT PLAN**

**1. Designation of the new degree program, rationale for that designation, definition of the focus of the program and a brief description of its disciplinary purpose and significance.**

The new Doctorate of Education (Ed.D.) degree program is initiated through the Department of Teaching and Learning at The Ohio State University. The proposed program will uniquely focus on *Practitioner Inquiry for Equity-based Advocacy*. Housed in the Department of Teaching and Learning, the proposed Ed.D. program will draw on the expertise of the faculty to prepare educational professionals to develop knowledge, skills, and dispositions for transforming their communities towards equity-based advocacy. The Department of Teaching and Learning has long established national and international reputations in teacher education, boasting highly-ranked teacher education programs. According to the recent U.S. News and World Report's Best Graduate Schools, the department's Secondary Education and Elementary Education programs are both ranked No. 9 in the nation, and the Curriculum and Instruction ranks No. 8. In addition, the Department is working at the frontier of international collaborations to create global opportunities and experience for students across all programs. Since the proposed EdD is at the department level, it is anticipated that there will be no other EdD specializations in the future.

The proposed Ed.D. program in Teaching and Learning will uniquely focus on *Practitioner Inquiry for Equity-based Advocacy.* It will be a professional degree with a focus on practice-oriented inquiries located within practitioners' professional settings. It has become increasingly clear that the current educational environment requires practitioners who can advocate for equity having conducted inquiries within their own contexts to understand and communicate more effectively about pressing issues in education. Practitioners can meet this need by engaging in systemic inquiry and strategic advocacy to address and seek to resolve problems that they identify in their professional contexts. The Ed.D. in Teaching and Learning – *Practitioner Inquiry for Equity-based Advocacy* is designed to support working professionals in honing and developing their knowledge, skills and dispositions needed for leading in their respective educational communities, both in and out of school settings. Ed.D. participants will leave the program as highly-equipped professionals ready to implement theory-guided practices and take on challenges as classroom teachers, curriculum specialists, policy designers, related service personnel (e.g. speech therapist, school psychologist, school counselor), higher education instructors and/or in other pertinent roles.

The need for an Ed.D. program is further highlighted in a recent survey of the faculty in the Department of Teaching and Learning. Thirty-five tenure-track and clinical faculty members participated in the survey. On a 5-point Likert scale with 1 being strongly disagree and 5 being strongly agree, the average ratings were 4.06 and 4.12 respectively for the following two statements: "*I believe an EdD is a valuable graduate program option*" and "*An EdD program could help support our department's mission and vision*". Nearly all the respondents stated that they could "*see a distinction in the goals and content between an EdD and PhD program*".

In a separate exploration of creating a critical practitioner inquiry doctoral strand in the Department, a group of faculty members organized 2 focus-group discussions with 13 local educators. Themes that emerged from the discussions included integrating educational theories

into practice, making what is learned applicable to educators' classroom instruction, and preparing doctoral candidates with advocacy power to impact the educational system. These findings all point to an urgent need for an EdD program that focuses on practice-driven inquiry, advocacy, and equity in teaching and learning.

The proposed EdD program also creates new and sustainable possibilities for the Department. Specifically, the program will (a) enable the Department of Teaching and Learning to develop richer and more productive relationships with local and regional school districts; (b) increase opportunities for scholarly inquiries in districts that need support; (c) provide authentic opportunities to develop outreach across the state of Ohio in ways that explicitly use our research to support teaching and learning in classrooms, schools, and communities; (d) raise the department profile locally, nationally, and globally.

## II. DESCRIPTION OF THE PROPOSED CURRICULUM

The EdD proposal is consistent with provisions of the Graduate School and respective program handbooks. The number of credit hours required for graduation is consistent with the Graduate School policies for professional doctorates. The proposed EdD presents a broad outline of study in foundational courses, practitioner research/inquiry, practice-based inquiry, and **degree** specialization courses and electives [See the attached EdD course sequence document]. The course of study is linked to programs goals and learning outcomes [See the attached EdD curriculum map identifying how courses link to program goals and learning outcomes document]. The student-advising sheet is explicit providing advisors and students with a clear path for student course work once admitted to the EdD program [See the attached Student Advising Sheet document].

Each student's program of study will devise a course of study and a cohort–organized matriculation schedule of completion. The EdD degree in Teaching and Learning will meet all doctoral program requirements as set forth by Graduate School guidelines. The total credit hours required to complete the EdD post masters: minimum 51 hours. The program is designed as a three year program. The first two years consist of courses with the third year focused on the dissertation of practice. This program model is fairly consistent with other programs in the state of Ohio. Most programs are between 51-60 hours, use a cohort model, and can be finished in 7-8 semesters (e.g., Franklin University, Ashland University, University of Dayton)

We differentiate the EdD from the PhD through our Guiding *Principles* for EdD Practice-based Educational Research. Practiced-based educational research inquiry into local and regional school districts will be the focal point of the EdD candidate's research. Practice-based educational research explicitly recognizes the value of local knowledge within each district and operates on the premise that working with school districts as co-researchers produces research more accessible, accountable, and authentic opportunities to develop outreach across the state of Ohio.

Practice-based educational research takes place in school settings where the EdD candidate involves schools and districts in the design and implementation of the research project. The

practice-based educational research project respects the culture, strengths and assets of the school districts as well as being guided by the principle of "doing no harm." The following principles guide the development of practice-based educational EdD research projects:

**Principles**

1. EdD students with an earned master's degree and a minimum of 5 years of professional experience work with colleagues in a cohort over a 3-year period to engage in practice-driven inquiries.
2. EdD students come from, develop, and sustain collaborative relations with local and regional communities for practice-driven inquiry
3. EdD students carry out inquiries intending to address and resolve problems in practice
4. EdD students develop the knowledge, skills, and dispositions needed to take on leadership positions as they engage in equity-based advocacy through policy making and teacher leadership.

**Goals**

Graduates of the EdD program will:

1. apply educational research and theories to advocate for equity-based practices in their professional settings.
2. engage in careful, systemic inquiry to identify, analyze, grapple with, and work to resolve aspects of problems intending to bring about and advocate for more equity within their professional settings.
3. effectively communicate outcomes of their practitioner-inquiries, from within and beyond the program, to various stakeholders and constituents.
4. create inclusive practices, policies, and procedures that will ensure every individual has a chance for success.
5. lead their colleagues toward equity-based advocacy in their professional contexts and be able to influence administrative work and policies to support teachers, students, families, and communities.

**Learning Outcomes**

- Theoretical Foundations: Candidates can comprehend and apply educational theory and research that serves as a foundation for practice.
- Community Relationships: Candidates can effectively and ethically establish, nurture, and provide leadership for collaborative relationships in professional community settings
- Advocacy: Candidates can use practitioner inquiry to facilitate equity-based change in educational-related organizations.
- Research and Evaluation: Candidates can critically evaluate research and apply scientific and other methodologies to analysis of empirical data and conduct inquiry projects to resolve aspects of problems that they identify in their educational communities.
- Diversity: Candidates can comprehend and value human diversity in professional settings
- Professional Identity: Candidates can value and demonstrate attitudes essential for continual learning and scholarly inquiry

**Anticipated impact on the PhD program**

The Department thought carefully about the impact on the PhD program. As such, we do not believe it will have a significant impact. Per the T & L Graduate Student Handbook, the PhD is described as "a rigorous research-based degree designed to prepare graduates to work and succeed in research-intensive settings". Through surveys and focus groups, we know that teachers and other education personnel desire a doctoral program that allows them to work full time, provides an opportunity to expand their knowledge base, and most importantly apply what has been learned to their current job situation. Thus, we believe that people who apply to the EdD will be different in their goals and aspirations then those that apply to the PhD program. We are also cognizant that EdD students should follow a different curriculum than PhD students which the department has carefully crafted so that the majority of the courses are EdD specific.

**EdD Curriculum**

To match the above program goals and learning outcomes, the proposed curriculum is presented as a model with the following six integrated components.

1. *Doctoral Core*

   *(a) Core courses*

   | | |
   |---|---|
   | EDUTL8003 | Theorizing and Researching Teaching and Learning (3 cr. hrs.) |
   | EDUTL8015 | Diversity and Equity in Education (3 cr. hrs.) |
   | EDUTLXXXX | A course on equity-based advocacy and community relationship will be developed. (3 cr. hrs) |

   *(b) Professional Seminars*

   | | |
   |---|---|
   | **Prosem 1** | Introduction to EdD program, addresses questions that include what is a dissertation in practice, how to work in a cohort, and how to draw on professional resources (3 cr. hrs.) |
   | **Prosem 2** | EdD candidacy assessment and preparation for dissertation in practice (3 cr. hrs.) |

2. *Practitioner Research/Inquiry*

   *(a) Survey of research methodologies*

   A course on qualitative and quantitative methodologies for practitioner inquiry will be developed. It will be equivalent to ESQREM 6625 Introduction to Educational Research that is required of PhD students in T&L (3 cr. hrs.)

   *(b) Practice-based inquiry*

   A course on practitioner inquiry will be developed. It will be a doctoral level course similar to EDUTL 6052 Classroom-based Inquiry (3 cr. hrs.)

3. *Specialization/Concentration*

   The Department of Teaching and Learning is restructured into three sections, each presenting an area of study. There is one broad specialization:

   *Practitioner Inquiry for Equity Based Advocacy,* students take five courses from three sections within T & L for the specialization.

4. *Electives*

   Each section in the department will identify courses that will be listed as electives. 2 courses/6 credit hours**)** for Electives.

5. *Research Composition and Dissemination*

A course will be created to support EdD students in generating, presenting and disseminating various inquiry products including written documents, digital/visual outputs and creative/artistic work. (3 cr. hrs.)

6. *Dissertation*

A total of 6 credit hours is required of EdD students to engage in inquiries and complete dissertation in practice

**Ed.D. Assessment of student performance**

Student performance in the Teaching and Learning Ed.D. program will occur in the following ways:

1. Student mastery of coursework at a 3.5 GPA or higher.
2. Faculty advisor and committee members will meet to review students in their final semester of coursework to determine their readiness for the candidacy examination.
3. Students must successfully pass a written candidacy examination based on the criteria established for the Ed.D. in Teaching and Learning.
4. Successfully complete the dissertation in practice.
5. Defend their dissertation of practice

**Dissertation in Practice**

**Section 7.17.8 of the Graduate School Handbook outlines that** Students in professional doctoral programs submit an original final document demonstrating original thinking and the ability to evaluate research in the field analytically. Students in professional doctoral programs are expected to follow the document formatting standards of their disciplines. Each committee member indicates approval of the student's final document by posting their decision on the Report on Final Document in GRADFORMS. The final version of the student's final document is retained permanently by the student's program. Final documents must not contain material restricted from public disclosure.

To comply with the graduate school rules, students in the EdD program are required to successfully complete a dissertation in practice before receiving the degree. By nature, EdD is a doctoral degree, and hence the EdD dissertation in practice must be of high rigor and meet the standards required of all doctoral candidates. The production of the EdD dissertation should culminate through a sequence of steps, which include:

1. By the end of Year 1, candidates develop preliminary ideas for issues/problems in their professional contexts that can potentially serve as the focus of their inquiry topics.
2. By the end of Year 2, candidates formulate questions/problems of practice as their inquiry topics. If possible, candidates also develop preliminary methodologies pertinent to their chosen inquiry topics. Candidates should successfully complete candidacy assessment by the end of Year 2.
3. By the end of Year 3, candidates complete dissertation and satisfactorily defend their work.

The format of EdD dissertation in practice should follow the general guidelines for doctoral dissertation outlined by the Graduate School Handbook Section 7.8.5 (https://gradsch.osu.edu/document-preparation). Candidates should organize their dissertations in ways that can clearly identify, investigate and resolve issues/problems in their chosen topics.

Each candidate will be advised by a dissertation committee consisting of a tenure-track faculty member and one clinical faculty member. The clinical faculty member is a designated manager of the EdD program and will serve on the dissertation committees for all EdD candidates. See Section VIII for the need of hiring a clinical faculty member to oversee the EdD program.

**III. ADMINISTRATIVE ARRANGEMENTS FOR THE PROGRAM: DEPARTMENT AND SCHOOL INVOLVED**

As a proposal for a Department of Teaching & Learning degree within the College of Education and Human Ecology, the plan that follows is consistent with provisions of the Graduate School and respective program handbooks. The final document and the final document process will follow the rules for professional doctorates in the Graduate School Handbook [Note: To remain consistent with Graduate School policy for professional doctorates, all references to the final document refer to the standards for dissertations agreed on and approved by faculty governing committees at all levels in the College of Education and Human Ecology].

The EdD within the Department of Teaching and Learning will have admission requirements that emphasize demonstrated excellence as a professional in the field and demonstrated ability for academic doctoral work. Graduate School as well as College program area guidelines for professional doctorates will be used in the determination of admissions criteria. Admission criteria will include evaluation of traditional academic measures, such as successful graduate or professional school coursework and strong recommendations from faculty and from leaders in their educational settings, as required by the faculty in each EdD program of study. Moreover, the quality of candidate admitted into this program will be consistent with the quality of candidates admitted into PhD programs in the Department of Teaching and Learning within the College of Education and Human Ecology. Additionally, EdD candidates will hold a master's degree and have a minimum of 5 years of professional experience in teaching positions or other education related fields, preferably in educational settings, both broadly construed. We expect the majority of candidates to be currently practicing teachers in Ohio public school settings. We expect these candidates will already hold some form of teaching licensure granted by the State of Ohio.

There will be an ongoing oversight process for the EdD that will review curriculum, program, and graduate student advisement. The policies for oversight will be consistent with current rules governing the Department of Teaching and Learning. The Graduate Studies Committee will provide oversight consistent with their role in all Department of Teaching and Learning graduate degrees.

EdD students will be required to submit an approved advising sheet/program of study within the first year of study. The approved advising sheet/program of study will be developed between the student and the student's advisor. It will be submitted for review to the student's committee.

**IV. EVIDENCE OF NEED FOR THE NEW DEGREE PROGRAM,** including the opportunities for employment of graduates. This section should also address other similar programs in the state addressing this need and potential duplication of programs in the state and region.

The EdD Program at The Ohio State University is proposed in alignment with the vision of Teaching and Learning (T&L) within the College of Education and Human Ecology. To stay relevant and provide graduate opportunities that reflect a commitment to teacher education, T&L proposes an EdD that serves the needs and interests of current educators, aligned with the vision of the department. Earning an Ed.S. degree is no longer a viable option for practicing professionals who already hold a master's degree and the PhD does not serve the needs and interests of this population. Through the creation and implementation of an EdD in T&L, our department will be able to develop richer and more productive relationships with local school districts, increase opportunity for research in districts that want and need support, provide authentic opportunities to develop outreach across the state of Ohio, raise the profile of T&L locally, nationally, and globally, and create opportunities that may facilitate openings for regional campuses to generate cohorts.

Beginning in 2020, in response to a motion passed by the T&L Faculty to investigate the option of creating an EdD, three separate planning committees have worked on this proposal to provide evidence of the need for a new degree program, including an investigation of similar programs and opportunities for employment of program graduates.

Within the state of Ohio, there are EdD programs offered within specific departments at eight (8) Ohio institutions, including Bowling Green, Miami, Ohio University, University of Akron, University of Cincinnati, University of Dayton, University of Toledo, Youngstown State, and Ashland. In addition, there are two (2) EdD options available within the Department of Educational Studies within the College of Education and Human Ecology at Ohio State: Higher Education and Student Affairs and Educational Administration; there is currently no EdD programming within T&L. In addition to Ohio institutions, committee research explored additional EdD offerings at Big Ten universities, including Illinois, Indiana, Maryland, Michigan – Dearborn, Michigan State, Nebraska, Penn State, and Rutgers.

In studying the structure and design of these programs, we learned that most current programs tend to focus on leadership, catering to principals and other leadership. There was an absence of programs that offer a venue for teachers or teacher leaders to study systematic methods of inquiry that improve practice. Equipping teachers and teacher leaders, and other education personnel with the knowledge and skills that will allow them to lead efforts and advocate for policies that govern equitable educational practices is central to creating and sustaining just communities. The T&L proposal of an EdD in Practitioner Inquiry, Equity-based Advocacy, and Equity is unique, filling a niche that will allow current educators to expand their knowledge to support their practitioner roles. This proposed degree will target classroom teachers and teacher leaders who wish to develop skills for transforming their communities towards advocacy, equity, and inclusion.

Franklin county alone houses 19 school districts, each employing many educators who have already secured master's Degrees and are looking for alternative options to a PhD Degree. Although the intention is to start locally, the long-term plan for the EdD Program is to branch out across the state, country, and internationally. Graduates will be well-prepared for professional career paths that focus on solutions to problems within real-world settings, continuing as educators within school settings, but prepared with the knowledge and advocacy skills needed to

step up as teacher leaders, without assuming responsibilities that come with administrative roles. Graduates will be well-equipped to apply inquiry for problem solving, generate solutions for classroom issues, practice and publish success strategies, collaborate with other professionals to determine best outcomes, and lead efforts that advocate for policies that govern equality in education.

**V. PROSPECTIVE ENROLLMENT**

The 19 school districts in Franklin County currently employ a large number of educators, many of whom have already secured a Master's Degree, and are looking for opportunities to earn a doctoral degree. The traditional PhD degree is theory-heavy and not ideal for these educators. Instead, they wish to participate in a program that allows them to engage in practitioner-driven inquiries that can lead to resolving practical issues in their own professional and educational communities. Although our intention is to start locally, we plan to eventually branch out across the state, country, and internationally. We expect to begin with a cohort of 12-15 EdD candidates in the first year and subsequently admit new cohorts every other year. Over the next three years we will have enrolled two cohorts totaling approximately 24-30 students.

**VI. SPECIAL EFFORTS TO ENROLL AND RETAIN UNDERREPRESENTED GROUPS IN THE GIVEN DISCIPLINE**

The Department of Teaching and Learning will continue to be committed to recruiting, retaining, and advancing aspiring underrepresented student groups for the EdD program while closely working with the College and the University. The Department of Teaching and Learning will collaborate with university initiatives and centers on campus. For instance, we will work with the Graduate and Professional Student Recruitment Initiative (GPS), which is the premier diversity recruitment program on campus. We also have outreach resources in local School Districts and State Agencies. In addition, the Department of Teaching and Learning has a track record of fostering strong partnerships with local school districts by offering professional development and research opportunities to local teachers and administratorsIn addition, the Department will engage in active, whole-person mentoring along with visible role models for success in the recruitment and retention of underrepresented minorities in the program.

**VII. AVAILABILITY AND ADEQUACY OF THE FACULTY AND FACILITIES AVAILABLE FOR THE PROGRAM.**

Most of the courses will be EdD specific. However, it is anticipated that 40% of courses that EdD students take will be with MA or PhD students. Faculty who have submitted a CV have agreed to have some involvement in the EdD program which consists of advising or teaching or both. We believe that we have the capacity to offer this new curriculum including courses that will be EdD only. More importantly, in addition, the department recently hired three Senior Lecturers who could contribute some of their teaching to course delivery in the program. There is faculty expertise in the department to teach the new EdD courses. No additional facilities will be needed.

**VIII. NEED FOR ADDITIONAL FACILITIES AND STAFF AND PLANS TO MEET THIS NEED.**

One additional faculty member is required. As in the Department of Educational Studies, we will require a clinical faculty member to both administer cohorts, take primary responsibility for teaching the required proseminars, act as a member of the EdD committee, and **a**dvise at least half of the cohort. advise. The clinical faculty member, in addition to their administrative tasks, will teach at least five required EdD courses, which includes several of the newly designed courses for the degree. A redesign of the Office of Student Services has allowed for the assignment of EdD support to a staff member. Thus, we believe we will have the necessary support to administer this new degree program.

**IX. PROJECTED ADDITIONAL COSTS ASSOCIATED WITH THE PROGRAM AND EVIDENCE OF INSTRUCTIONAL COMMITMENT AND CAPACITY TO MEET THESE COSTS.**

There are no projected additional costs associated with the program to initiate the EdD in Teaching and Learning and maintain a cohort of 12-15 students. We anticipate a significantly higher demand for the EdD.

# APPENDIX XVI

Appointments/Reappointments of Chairpersons

PAUL BELLAIR**, Director, Criminal Justice Research Center, July 1, 2023, through June 30, 2027

MARTHA BELURY, Chair, Department of Food Science and Technology, July 1, 2023, through June 30, 2027

ADAM CARBERRY*, Chair, Department of Engineering Education, August 1, 2023, through May 31, 2027 (change of dates)

ISABELLE DESCHENES**, Chair, Department of Physiology and Cell Biology, August 1, 2023, through June 30, 2027

HAROLD FISK (extension), Interim Director, Center for Life Sciences Education, July 1, 2023, through June 30, 2024

BRIAN FOCHT, Interim Chair, Department of Educational Studies, August 15, 2023, through August 14, 2024

WENDY FRANKEL (extension), Chair, Department of Pathology, July 1, 2023, through June 30, 2024

MARK FULLERTON, Chair, Department of Classics, July 1, 2023, through June 30, 2027

BENNET GIVENS (extension), Secretary of the University Senate, OAA, July 1, 2023, through June 30, 2024

ANDREW GLASSMAN**, Chair, Department of Orthopaedic Surgery, July 1, 2023, through June 30, 2025

TIM HAAB, Interim Director, School of Environment and Natural Resources, August 15, 2023, through June 30, 2024, or until a new Director is named.

ELLY KAIZAR, Chair, Department of Statistics, July 15, 2023, through June 30, 2027

ANDREW LEBER**, Director, Center for Cognitive and Brain Sciences, July 1, 2023, through June 30, 2027

KINH LUAN PHAN**, Chair, Department of Psychiatry and Behavioral Health, July 1, 2023, through June 30, 2027

JODI MCDANIEL, Director, Center for Healthy Aging, Self-Management, and Complex Care, July 1, 2023, through June 30, 2024

HARVEY MILLER**, Director, Center for Urban and Regional Planning (CURA), July 1, 2023, through June 30, 2027

MARK PARTHUN**, Chair, Department of Biological Chemistry and Pharmacology, July 1, 2023, through June 30, 2027

PIERCE PAUL, Chair, Department of Plant Pathology, July 1, 2023, through June 30, 2027

WILLIAM SCHULER, Interim Chair, Department of Linguistics, July 1, 2023, through June 30, 2024

STEPHANIE SCHULTE, Interim Director, Prior Health Sciences Library, July 1, 2023, through June 30, 2024

SCOTT SHEARER**, Chair, Department of Food, Agricultural, and Biological Engineering, July 1, 2023, through June 30, 2027

DONGBIN XIU, Interim Chair, Department of Mathematics, July 1, 2023, through June 30, 2024

**Reappointment
*New Hire

Faculty Professional Leaves

DONNA BOBBITT-ZEHER, Associate Professor, Department of Sociology, Marion, FPL for Spring 2024

QIAN CHEN, Professor, Department of Food, Agricultural and Biological Engineering, FPL for Fall 2023, and Spring 2024

NJERI KAGOTHO, Associate Professor, College of Social Work, FPL for Fall 2023

KENNETH MADSEN, Associate Professor, Department of Geography, Newark, FPL for Spring 2024

MARK MITTON-FRY, Associate Professor, College of Pharmacy, FPL for Spring 2024

TASLEEM PADAMSEE, Associate Professor, College of Public Health, FPL for Fall 2023, and Spring 2024

KELLEY TILMON, Professor, Department of Entomology, FPL for Spring 2024

CHRISTOPHER WOLTERS, Professor, Department of Educational Studies, FPL for Spring 2024

Faculty Professional Leave Changes/Cancellations

HANNA CHO, Associate Professor, Department of Mechanical and Aerospace Engineering, Change of FPL from Fall 2023, and Spring 2024 to Fall 2023 only.

NOAH DORMADY, Associate Professor, John Glenn College of Public Affairs, Change of FPL from Fall 2023 to Fall 2023 and Spring 2024

KATHY FAGAN-GRANDINETTI, Professor, Department of English, FPL cancellation

KATHY NORTHERN, Associate Professor, College of Law, FPL cancellation

DAVID APSLEY, Department of Extension, with the title of Associate Professor-Emeritus, effective September 1, 2023

BHAVIK BAKSHI, Department of Chemical and Biomolecular Engineering, with the title of Professor-Emeritus, effective July 1, 2023

CHUNSHENG BAN, Department of Mathematics, with the title of Professor-Emeritus, effective July 1, 2023

WILLIAM BENNETT, Department of Radiology, with the title of Associate Professor-Emeritus, effective August 1, 2023

DAVID CLAMPITT, School of Music, with the title of Professor-Emeritus, effective June 1, 2023

JAMES COE, JR., Department of Chemistry and Biochemistry, with the title of Professor-Emeritus, effective July 1, 2023

NENA COUCH, University Libraries, with the title of Professor-Emeritus, effective March 16, 2023

PAUL DE BOECK, Department of Psychology, with the title of Professor-Emeritus, effective August 15, 2023

ANNE DORRANCE, Department of Plant Pathology, with the title of Professor-Emeritus, effective September 1, 2023

MARTIN GOLUBITSKY, Department of Mathematics, with the title of Professor-Emeritus, effective July 1, 2023

DAVID GREENBERG, Department of Pediatrics, with the title of Professor-Emeritus, effective July 1, 2023

BARBARA KEYFITZ, Department of Mathematics, with the title of Professor-Emeritus, effective July 1, 2023

TERESA LANKER, Agricultural Technical Institute, with the title of Associate Professor-Emeritus, effective September 1, 2023

STEPHEN LESSNICK, Department of Pediatrics, with the title of Professor-Emeritus, effective July 1, 2023

KENNETH ALAN LOPER, Department of Mathematics, with the title of Professor-Emeritus, effective June 1, 2023

MARY ALICE MOMEYER, College of Nursing, with the title of Assistant Professor-Clinical Emeritus, effective June 1, 2023

LYNN SCHOENFIELD, Department of Pathology, with the title of Associate Professor-Clinical Emeritus, effective July 1, 2023

MICHAEL TWEEDLE, Department of Radiology, with the title of Professor-Emeritus, effective July 1, 2023

PAUL WAKELY, Department of Pathology, with the title of Professor-Emeritus, effective July 1, 2023

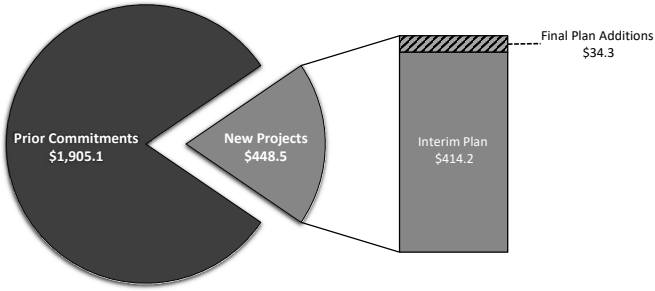
Promotion, Tenure, and Reappointments

**COLLEGE OF VETERINARY MEDICINE**
**CLINICAL**

REAPPOINTMENT
Lerche, Phillip, Veterinary Clinical Sciences, August 15, 2024

# APPENDIX XVII

FY2024-2028 Final Capital Investment Plan
08/17/2023




**Total FY24 CIP: $2,353.6**

**Table 1 - Prior Commitments - Remaining Spend**

**$ in Millions**

| Line | Capital Priority | Projected Capital Expenditures FY2024 | FY2025 | FY2026 | FY2027 | FY2028 | Total |
|---|---|---|---|---|---|---|---|
| 1 | A&S - Arts District | $ 9.9 | $ 2.1 | $ - | $ - | $ - | $ 11.9 |
| 2 | A&S - Celeste Lab Renovation | $ 8.4 | $ 7.0 | $ 1.4 | $ - | $ - | $ 16.8 |
| 4 | COE - BMEC Phase 2 | $ 11.6 | $ 50.6 | $ 19.6 | $ 1.1 | $ - | $ 82.9 |
| 5 | COE - CAR Bus Testing Facility | $ 3.3 | $ 9.2 | $ 5.3 | $ 5.3 | $ 2.9 | $ 25.9 |
| 6 | COM - Interdisciplinary Health Sciences Center | $ 32.5 | $ 12.1 | $ 0.7 | $ - | $ - | $ 45.2 |
| 7 | EHE - Campbell Hall Renovation | $ 4.1 | $ 22.5 | $ 32.0 | $ 0.3 | $ - | $ 58.8 |
| 8 | ERIK - Energy Advancement and Innovation Center | $ 11.6 | $ 2.7 | $ - | $ - | $ - | $ 14.3 |
| 9 | ERIK - Pelotonia Research Center | $ 19.6 | $ 13.9 | $ - | $ - | $ - | $ 33.4 |
| 10 | FOD - Cannon Drive Relocation - Phase 2 | $ 15.5 | $ 27.5 | $ 10.9 | $ - | $ - | $ 54.0 |
| 11 | FOD - Elevator Safety Repairs and Replacements | $ 3.1 | $ 1.6 | $ - | $ - | $ - | $ 4.7 |
| 12 | FOD - Roof Repairs and Replacements | $ 1.3 | $ 3.3 | $ - | $ - | $ - | $ 4.6 |
| 13 | LIB - Library Book Depository Phase 3 | $ 3.5 | $ 0.7 | $ - | $ - | $ - | $ 4.2 |
| 14 | Newark - Founders Hall Enhancements | $ 3.0 | $ 19.4 | $ 1.1 | $ - | $ - | $ 23.4 |
| 15 | Nursing - Jane E Heminger Hall and Newton Renovation | $ 5.3 | $ 0.3 | $ - | $ - | $ - | $ 5.6 |
| 16 | Vet Med - Equine Arena | $ 3.2 | $ 6.1 | $ - | $ - | $ - | $ 9.2 |
| 18 | WMC - Inpatient Hospital | $ 402.0 | $ 299.7 | $ 141.5 | $ 68.5 | $ - | $ 911.7 |
| 19 | WMC - James Outpatient Care | $ 41.7 | $ 32.4 | $ 2.6 | $ - | $ - | $ 76.7 |
| 20 | WMC - Loading Dock Expansion and Renovation | $ 8.2 | $ 6.1 | $ 0.4 | $ - | $ - | $ 14.6 |
| 22 | WMC - Martha Morehouse Facility Improvements | $ 10.4 | $ 8.4 | $ - | $ - | $ - | $ 18.7 |
| 23 | WMC - Outpatient Care New Albany | $ 3.3 | $ - | $ 1.9 | $ - | $ - | $ 5.2 |
| 24 | WMC - Outpatient Care Powell | $ 2.8 | $ 1.3 | $ 7.6 | $ 7.2 | $ 1.0 | $ 19.9 |
| 25 | Wooster - Fisher Auditorium Renovation | $ 0.4 | $ 4.1 | $ 3.5 | $ - | $ - | $ 8.0 |
| 26 | Roll Up Other Projects | $ 227.9 | $ 155.3 | $ 65.8 | $ 5.7 | $ 0.4 | $ 455.2 |
| 27 | Subtotal | **$ 832.5** | **$ 685.9** | **$ 294.3** | **$ 88.1** | **$ 4.3** | **$ 1,905.1** |

FY2024-2028 Final Capital Investment Plan
08/17/2023

**Table 2 - New Projects Beginning in FY2024** **$ in Millions**

| Line | Capital Priority | Projected Capital Expenditures FY2024 | FY2025 | FY2026 | FY2027 | FY2028 | Total |
|---|---|---|---|---|---|---|---|
| 1 | **Anticipated Spend for CIP Changes** | **$ 10.0** | **$ 0.0** | **$ 0.0** | **$ 0.0** | **$ 0.0** | **$ 10.0** |
| 2 | **Roll up of Small Infrastructure RDM Projects** | **$ 15.3** | **$ 14.4** | **$ 8.5** | **$ 2.5** | **$ 4.8** | **$ 45.6** |
| 3 | **Small Programmatic Cash Ready** | **$ 12.2** | **$ 20.1** | **$ 10.0** | **$ 0.7** | **$ 0.0** | **$ 43.1** |
| 4 | **WMC - Roll up of Multiple Cash Ready** | **$ 197.7** | **$ 0.0** | **$ 0.0** | **$ 0.0** | **$ 0.0** | **$ 197.7** |
| 5 | **New Major Projects** | | | | | | |
| 6 | A&S - Biological Sciences Building Upgrades | $ 0.4 | $ 2.4 | $ 5.3 | $ 4.7 | $ 2.3 | **$ 15.0** |
| 7 | A&S - Department of Economics Relocation | $ 0.8 | $ 3.1 | $ 3.5 | $ 2.3 | $ 0.3 | **$ 10.0** |
| 8 | CFAES - Multispecies Animal Learning Center - Waterman | $ 4.2 | $ 15.3 | $ 17.4 | $ 11.2 | $ 1.7 | **$ 49.8** |
| 9 | ERIK - Battery Cell Research and Demonstration Center | $ 1.2 | $ 4.9 | $ 7.0 | $ 5.3 | $ 1.7 | **$ 20.0** |
| 10 | VET - VMC PET/CT Space Renovation | $ 1.3 | $ 3.6 | $ 1.6 | $ 0.0 | $ 0.0 | **$ 6.5** |
| 11 | WMC - Inpatient Hospital Endo/Bronch/Admin Suite Unshelling | $ 8.0 | $ 18.0 | $ 1.0 | $ 0.0 | $ 0.0 | **$ 27.0** |
| 12 | WMC - James Cellular Therapy Lab | $ 1.3 | $ 3.8 | $ 1.7 | $ 0.0 | $ 0.0 | **$ 6.8** |
| 13 | WMC - James Outpatient Care Buildout | $ 1.3 | $ 3.8 | $ 1.7 | $ 0.0 | $ 0.0 | **$ 6.8** |
| 14 | WMC - Magnetic Resonance Linear Accelerator & Housing | $ 0.9 | $ 3.2 | $ 3.6 | $ 2.3 | $ 0.3 | **$ 10.3** |
| 15 | **Grand Total** | **$ 254.6** | **$ 92.6** | **$ 61.3** | **$ 28.9** | **$ 11.1** | **$ 448.5** |

**Table 3 - New Projects by Funding Source and Deferred Maintenance**

| Line | Unit | Local | State | Fundraising | Grant | Partnership & Other | University Debt | Grand Total | % By Unit | Def. Maint. Addressed | Def Maint. % |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Academic Support | $ 71.4 | $ 10.0 | $ 19.0 | $ 4.8 | $ 16.0 | $ 15.2 | $ 136.4 | 30% | $ 24.7 | 18% |
| 2 | Athletics | $ 14.3 | $ 0.0 | $ 2.7 | $ 0.0 | $ 0.0 | $ 0.0 | $ 17.0 | 4% | $ 4.7 | 28% |
| 3 | Infrastructure | $ 13.4 | $ 0.0 | $ 0.0 | $ 8.1 | $ 0.5 | $ 7.5 | $ 29.4 | 7% | $ 25.0 | 85% |
| 4 | Regional Campuses | $ 0.2 | $ 0.0 | $ 0.0 | $ 0.0 | $ 2.5 | $ 0.0 | $ 2.6 | 0.6% | $ 1.4 | 54% |
| 5 | Student Life | $ 14.5 | $ 0.0 | $ 0.0 | $ 0.0 | $ 0.0 | $ 0.0 | $ 14.5 | 3% | $ 12.0 | 83% |
| 6 | Wexner Medical Center | $ 248.6 | $ 0.0 | $ 0.0 | $ 0.0 | $ 0.0 | $ 0.0 | $ 248.6 | 55% | $ 35.0 | 14% |
| 7 | **Grand Total** | **$ 362.3** | **$ 10.0** | **$ 21.7** | **$ 12.9** | **$ 18.9** | **$ 22.7** | **$ 448.5** | **100%** | **$ 102.8** | **23%** |

Project Data Sheet for Board of Trustees Approval

## Battery Cell Research & Demonstration Center

OSU-230897 (REQ ID# RCH230011)

*Project Location: 1305 Kinnear Road*

- **Approval Requested and Amount**

| | |
|---|---|
| Professional services | $2.3M |
| Total requested | $2.3M |

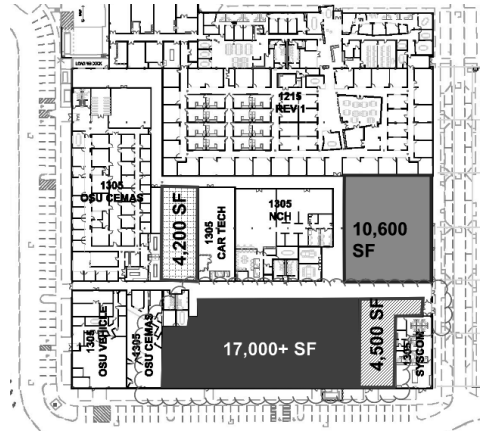
- **Project Budget**

| | |
|---|---|
| Professional services | $2.3M |
| Construction w/contingency | $17.7M |
| Total project budget | $20.0M |

- **Project Funding**
  Grant funds (NIST), partner funds

- **Project Schedule**

| | |
|---|---|
| BoT professional services approval | 08/23 |
| Design | 10/23 – 03/24 |
| BoT construction approval | 11/23 |
| Construction | 04/24 – 03/25 |
| Facility opening | 04/25 |




- **Project Delivery Method**
  Construction Manager at Risk

- **Planning Framework**
  - This project is included in the FY24 Capital Investment Plan.
  - The project scope is consistent with the vision of Kinnear Road as a materials, manufacturing and mobility corridor.

- **Project Scope**
  - The project will renovate 25,560 square foot of warehouse space at the 1305 Kinnear Road facility into a dedicated battery cell research, production, and support space for the Institute for Materials Research.
  - When complete, the lab will accelerate the domestic development of battery cell materials and manufacturing technologies while providing an experiential learning setting for advanced battery technology workforce development.
  - The completed project will also create a hub for academic and industry connections across chemical and physical sciences, engineering, business, and policy.

- **Approval Requested**
  - Approval is requested to enter into professional services contracts.

- **project team**

| | |
|---|---|
| University project manager: | Flaherty, Brendan |
| AE/design architect: | TBD |
| CM at Risk or Design Builder: | TBD |

Project Data Sheet for Board of Trustees Approval

## Airport - Taxiway A Rehabilitation

OSU-220282 (REQ ID# ENG22APT0048)

*Project Location: 2160 W. Case Road*

- **Approval Requested and Amount**

| | |
|---|---|
| Professional services | $1.0M |
| Construction w/contingency | $3.5M |
| Total requested | $4.5M |

- **Project Budget**

| | |
|---|---|
| Professional services | $1.0M |
| Construction w/contingency | $3.5M |
| Total project budget | $4.5M |

- **Project Funding**
  University funds, grant funds (ODOT & FAA)

- **Project Schedule**

| | |
|---|---|
| BoT professional services approval | 08/23 |
| Design | 05/22 – 05/23 |
| BoT construction approval | 08/23 |
| Construction | 10/23 – 09/24 |
| Facility opening | 10/24 |

- **Project Delivery Method**
  General contracting

- **Planning Framework**
  - This project is included in the FY23 and FY24 Capital Investment Plans and is consistent with the 2022 Airport Master Plan.

- **Project Scope**
  - The project will reconstruct the pavement on Taxiway A for better stability and longer life.

- **Approval Requested**
  - Approval is requested to enter into professional services and construction contracts.

- **project team**

| | |
|---|---|
| University project manager: | Hyde, Carrie |
| AE/design architect: | RDM International, Inc. |
| CM at Risk or Design Builder: | Shelly and Sands, Inc. |

Project Data Sheet for Board of Trustees Approval

## Department of Economics Relocation

OSU-230838 (REQ ID# CAS220009)

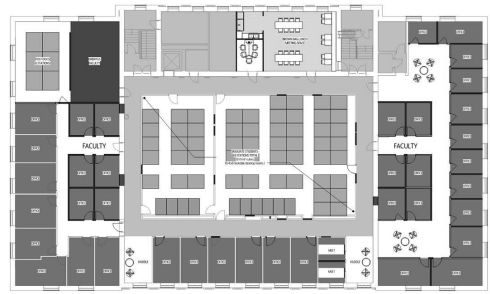
*Project Location: Bricker Hall (001)*

- **Approval Requested and Amount**

| | |
|---|---|
| Professional services | $1.1M |
| Construction w/contingency | $0.7M |
| Total requested | $1.8M |

- **Project Budget**

| | |
|---|---|
| Professional services | $1.9M |
| Construction w/contingency | $8.1M |
| Total project budget | $10.0M |




- **Project Funding**
  University funds

- **Project Schedule**

| | |
|---|---|
| BoT professional services approval | 08/23 |
| Design | 09/23 – 07/24 |
| BoT construction approval (enabling) | 08/23 |
| BoT construction approval | 05/24 |
| Construction | 01/24 – 05/25 |
| Facility opening | 06/25 |

- **Project Delivery Method**
  Construction Manager at Risk

- **Planning Framework**
  - This project is included in the FY 2024 Capital Investment Plan.
  - The project scope is based on a study completed in October 2022 for the backfill of Bricker Hall.

- **Project Scope**
  - This project will relocate the department of Economics from Arps Hall into a portion of the second floor and the entire third floor of Bricker Hall.
  - The renovation will include computational laboratory spaces, faculty offices, conference rooms, as well as upgrades to supporting and common spaces.
  - This request includes funds for enabling work in advance of full construction.

- **Approval Requested**
  - Approval is requested to enter into professional services and construction contracts.

- **project team**
  University project manager: Munger, Steve
  AE/design architect: TBD
  CM at Risk or Design Builder: TBD

Project Data Sheet for Board of Trustees Approval

## Waterman - Multi-Species Animal Learning Center (MALC)

OSU-180048 (REQ ID# FAES22CO0001 )

*Project Location: Waterman Laboratory - Multispecies Animal Learning Center (1321)*

- **Approval Requested and Amount**

| | |
|---|---|
| Professional Services | $1.9M |
| Construction w/contingency | $47.0M |
| Total requested | $48.9M |

- **Project Budget**

| | |
|---|---|
| Professional services | $5M |
| Construction w/contingency | $47M |
| Total project budget | $52M |

- **Project Funding**
  University debt, univeristy funds, fundraising, state funds

- **Project Schedule**

| | |
|---|---|
| BoT professional services approval | 08/17 |
| Design | 08/22 – 11/23 |
| BoT construction approval | 8/23 |
| Construction | 01/24 – 07/25 |
| Facility opening | 10/25 |

- **Project Delivery Method**
  Construction manager at risk

- **Planning Framework**
  - This project is included in the FY18 and FY23 Capital Investment Plans.

- **Project Scope**
  - The project will consist of an interconnected series of barns housing different species which include swine, equine, poultry and others. The facility will include an arena, wet labs, classrooms, storage areas and public viewing areas. MALC will replace aging storm and animal waste management infrastructure as well as provide new gas, electric and water utilities to the project site.
  - The MALC will allow the college to eliminate multiple logistical constraints associated with transporting undergraduate students off campus for coursework, instead allowing animals to be brought to the facility for teaching purposes.

- **Approval Requested**
  - Approval is requested to increase professional services contracts and enter into construction contracts.

- **project team**

| | |
|---|---|
| University project manager: | Munger, Steve |
| AE/design architect: | Wellogy |
| CM at Risk or Design Builder: | Corna Kokosing (CK) |

**AUGUST 1, 2023**

**TO: The Ohio State Board of Trustees, Master Planning and Facilities Committee**
**FROM: Amanda Hoffsis, Vice President for Planning, Architecture and Real Estate**

# Re: Framework 3.0 Final Plan

**Dear Trustees,**

I am pleased to share Framework 3.0, the university's updated campus master plan, that was developed over the past 15 months with key input from all levels of the university community.

Since June 2022, our planning team has engaged with more than 250 faculty and staff through 30 listening sessions and a series of open houses. We met close to 400 students during poster sessions, open houses and listening sessions. Engagement is key when planning a campus of the future and our team reached more than 4,300 individuals through two separate online surveys. We believe this is a representative and diverse sample of the total Ohio State community and I am pleased with the breadth of voices that informed our planning.

Those voices led to the creation of four main planning principles that have guided Framework 3.0 through scenario development, plan refinement and recommendations with a focus on academic and research excellence:

- Stewardship
- Connectivity
- Experience
- Community

We often refer to these four principles as our compass because they have guided us through numerous planning decisions during Framework 3.0.

Framework 3.0 provides a roadmap for the university, evolving and refining concepts put forward in the two prior Framework plans. Framework 3.0 reflects strategic priorities and tests development capacity over several decades. It also includes near- to mid-term projects that may be realized in the next five to 15 years. We have taken special care to develop recommendations in terms of projects, practice and implementation principles that build on the strength of our planning principles to identify areas where the university can focus next.

Please find attached the Framework 3.0 compass of planning principles, campus planning priorities and our overall recommendations.

It has been a pleasure working on this plan to help shape the future of our campus and I hope that you are as excited as I am about the direction outlined in Framework 3.0.

Best,

Amanda Hoffsis

Amanda

# Framework 3.0

August 2023

Since June 2022, the planning team has engaged with more than

**250** Faculty & Staff through

**30** Listening Sessions

And a series of

**Open Houses**

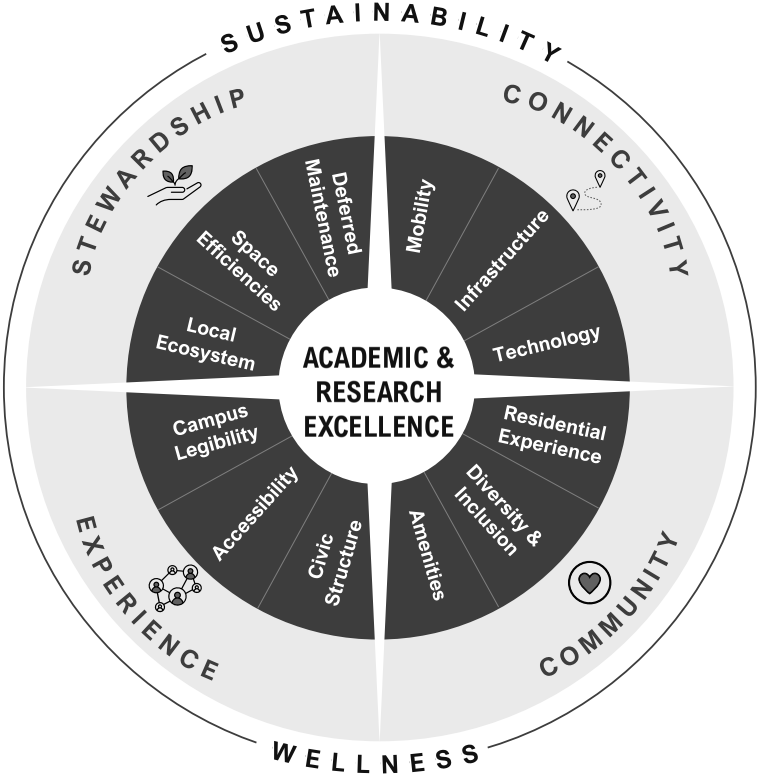
We met close to **400 students** during all poster sessions, open houses, and listening sessions.

We've engaged more than

**4,300** Individuals through two separate online surveys

# Framework 3.0 Principles

The physical campus will enhance Ohio State's position as a leading public university.



# Framework 3.0 Implementation Principles

## Community

- Increase **equity of student experience** through modernization of instructional space and on-campus housing.
- Provide updated, flexible spaces that support **teaching and research excellence**.
- Reflect the **diversity** of the university's people, places and programs on campus.

## Experience

- Implement/enhance **wayfinding** from highway to hallway.
- **Enhance arrivals** by leveraging campus branding opportunities at edges and gateways.
- Explore partnerships to supplement campus **amenities** for faculty, staff, and the campus community.

## Stewardship

- **Increase** net assignable research space. **Decrease** net assignable office space.
- Address **deferred maintenance** and **renewal** with each project.
- Achieve **alignment** between physical and strategic plans.

## Connectivity

- Develop activated public spaces that are **functional**, **cohesive** and **beautiful**.
- Adopt **Complete Street** concepts in roadway design.
- **Engage the river** to enhance connectivity and user experience.

## Practice

- Adopt **uniform scheduling** software to maximize utilization of classrooms and workspace.
- Implement a **space governance structure** for the university.
- Track **research metrics** to improve laboratory space allocation.
- Establish and maintain **Facility Master Plans** for all colleges and units.
- **Formalize funding model** for projects that enhance shared university spaces.

# Framework 3.0

## Near- to mid-term (5 to 15 years) campus planning priorities

- New facility for active learning classrooms and teaching labs.
- A phased replacement of Evans Lab with research labs, teaching labs and faculty offices.
- Hughes Hall renovation would modernize the building to serve future academic programs.
- Ramseyer renovation would support a STEM tutoring center and other future needs.
- South Residence Halls renovation would address condition inequities in campus housing.
- New North Residential District Resident Halls would replace current low-density buildings to create more beds.
- Neil Avenue, north of Annie and John Glenn Avenue, would close to vehicular traffic creating a pedestrian mall with dedicated bike lanes.
- New Ice Arena would be home to women's ice hockey practices and competition and men's ice hockey practices.
- Woody Hayes Complex addition would expand the facility for student athletes.
- New facility in the innovation district to house interdisciplinary research labs and research teams.
- James Outpatient Care Expansion to support patient care.
- Harding Hospital replacement would allow for a new hospital services and loading building.
- Ross Heart Hospital expansion would add patient beds and a medical hotel aimed at providing patients and families lodging before, during and after treatment.
- Two new Health Sciences academic buildings would allow for the relocation of the College of Pharmacy and School of Health and Rehabilitation Sciences.
- Complete and enhance the pedestrian path around the Oval.
- Improvements to the Woody Hayes streetscape would include dedicated bicycle, bus and pedestrian amenities.
- Railroad and SR-315 overpass improvements on Woody Hayes, Lane Avenue and Ackerman Road would include Ohio State branded murals, improved lighting and landscaping.
- Converse Hall replacement will address the deficiencies of the current facility serving the ROTC program.

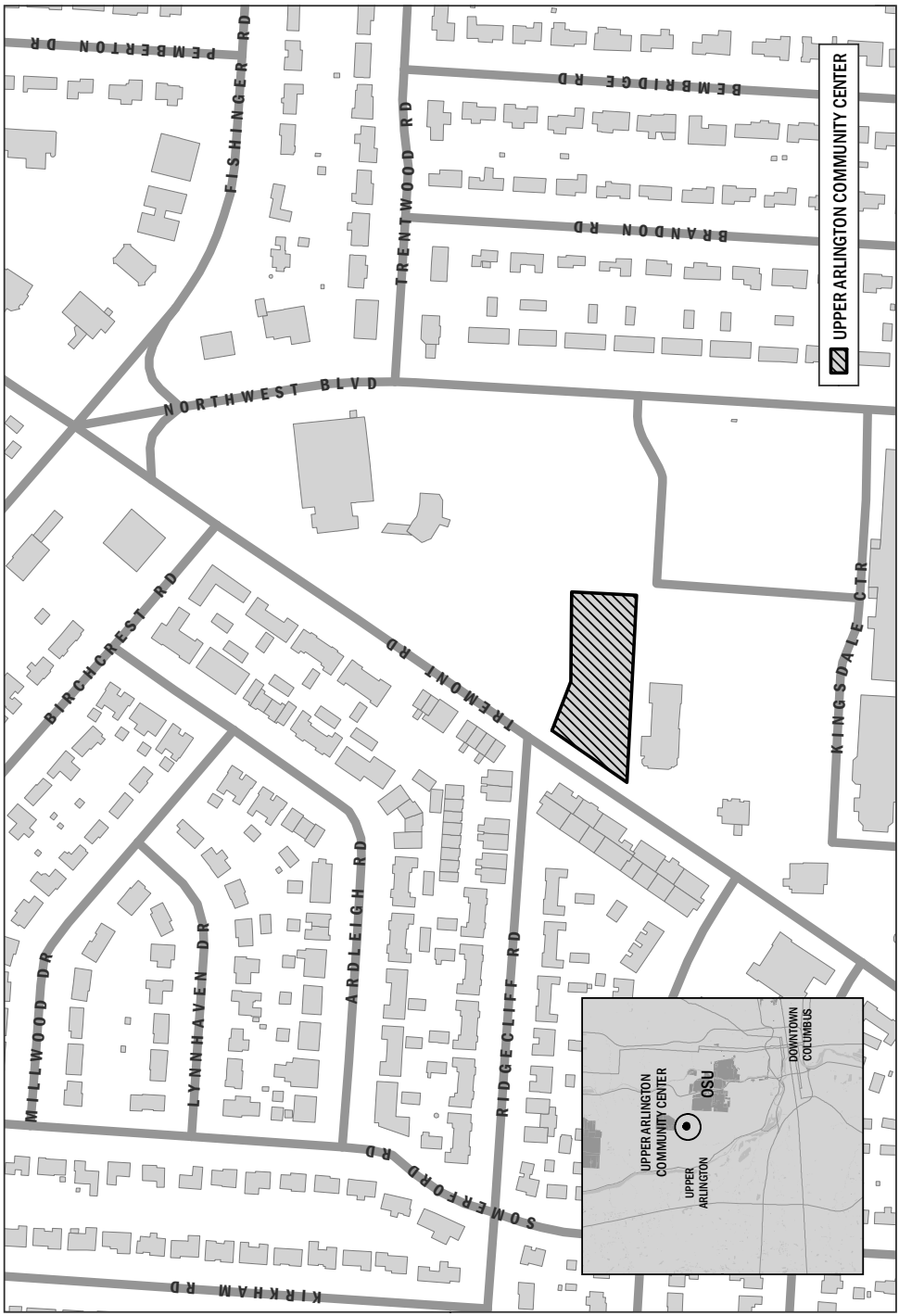
APPENDIX XX




**JOINT USE AGREEMENT BETWEEN**
**THE OHIO STATE UNIVERSITY AND OHIO MANUFACTURING AND INNOVATION CENTER**
**4261 LYMAN DRIVE**
**HILLIARD, OHIO 43026**

THE OHIO STATE UNIVERSITY

APPENDIX XXI




THE OHIO STATE UNIVERSITY

**JOINT USE AGREEMENT BETWEEN**
**THE OHIO STATE UNIVERSITY AND UPPER ARLINGTON COMMUNITY CENTER**
**3200 TREMONT ROAD**
**UPPER ARLINGTON, OHIO 43221**

Prepared By: The Ohio State University
Facilities Information and Technology Services (FITS)
Issue Date: July 21, 2023
The Ohio State University Board of Trustees


THE OHIO STATE UNIVERSITY

# FY 2024 Financial Plan

Office of Business and Finance
Financial Planning and Analysis

# FY 2024 Financial Plan

# Chapter 1 | Executive Summary

We are pleased to submit the Fiscal Year 2024 Financial Plan. This plan builds on the university's strengths and provides an operating margin to be reinvested into strategic initiatives and capital projects at the university.

We are presenting the Operating Plan alongside the Capital Investment Plan to provide more clarity about funding sources – which funding sources are fungible and can be spent for unrestricted purposes, and which funding sources must be spent on legally mandated or designated programs and projects. The narratives throughout this financial plan utilize this managerial-based presentation.

This document includes an Executive Summary, an introduction to the budget process at Ohio State, the full FY 2024 Operating Plan, FY 2024 Capital Investment Plan, and detailed material provided in the Appendix.

## Highlights of the Consolidated Financial Plan

| Total Sources ($ thousands) | FY23 Forecast | FY24 Plan | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|
| University, External Sources | $4,139,727 | $4,197,153 | $57,427 | 1.4% |
| Health System | $4,010,722 | $4,363,920 | $353,198 | 8.8% |
| OSU Physicians, Inc, External Sources | $866,101 | $943,215 | $77,114 | 8.9% |
| DPCUs | $91,974 | $95,455 | $3,481 | 3.8% |
| **Total Sources** | **$9,108,523** | **$9,599,743** | **$491,219** | **5.4%** |

| Total Uses ($ thousands) | FY23 Forecast | FY24 Plan | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|
| **Total Personnel Expense** | **$4,751,408** | **$5,086,856** | **$335,448** | **7.1%** |
| **Total Non-Personnel Expense** | **$3,716,744** | **$3,936,307** | **$219,562** | **5.9%** |
| **Total Uses** | **$8,468,153** | **$9,023,163** | **$555,010** | **6.6%** |
| Sources Less Uses, Operating | $640,371 | $576,580 | | |

| Capital Sources and Uses ($ thousands) | FY23 Forecast | FY24 Plan | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|
| **Total Capital-Related Sources** | **$978,571** | **$675,885** | | |
| **Total Capital-Related Uses** | **$1,572,328** | **$1,247,943** | | |
| Sources Less Uses, Capital | ($593,757) | ($572,057) | | |
| Sources Less Uses, Capital and Operating | $46,613 | $4,522 | | |

***Sources:*** We anticipate consolidated sources will increase $491.2 million or 5.4% to $9.6 billion in FY 2024 compared to FY 2023 forecast.

- The university is projecting $4.2 billion of total sources, excluding net transfer from the Health System, which is an increase of $57.4 million over FY 2023 Forecast. Specifically, we anticipate increases in the areas of tuition and fees (increasing $53.9 million) driven by increases in rates for the incoming tuition guarantee class and non-resident fees; exchange grants and contracts (increasing $21.1 million); current use gifts, endowment distribution, and interest income driven by fundraising and market returns that are projected to increase in FY 2024 (increasing $57.5 million). Increases in these areas are offset by decreases in non-exchange grants and contracts, which are down $23.0 million due to the ending of federal COVID-19 assistance in FY 2023; and one-time revenues associated with auxiliary activities and royalty payments as compared to the forecast, a decrease of $50.7 million.

- The Health System and OSU Physicians, Inc. (OSUP) together account for a total increase in sources of $430.3 million due to a combination of an estimated increase in adjusted admissions, outpatient growth, and some rate increases.

***Uses:*** We anticipate consolidated uses will increase $555.0 million or 6.6% to $9.0 billion.

- The university is projecting $4.3 billion of total uses, which is an increase of $174.9 million or 4.3%. The most significant driver of this increase is salaries, which are increasing $101.3 million or 5.8% over FY 2023 forecast and related benefit cost increases of $45.1 million. Increased salaries reflect a 3% merit increase pool ($44.7 million) and related benefits expense. Increases in excess of the merit pool are driven by investments in research growth, faculty hiring initiatives, and other strategic investments. The FY 2024 personnel plan includes assumed faculty hiring of $24.2 million across the College of Engineering, the College of Medicine, the College of Arts and Sciences, Fisher College of Business, College of Veterinary Medicine, and College of Food Agricultural, and Environmental Sciences. Non-personnel uses are increasing by $28.6 million, or 1.6%, driven by increases in student scholarships of $11.6 million, supplies, services, and other cost increases of $47.1 million, or 4.1%, offset by an annual reduction in debt service of $29.2 million driven by the April 2023 bond refunding.

- The Health System and OSUP's increase in uses are due to expenses to support their continued revenue growth and merit increase pool of 3% with an additional 2% planned in the budget relating to market increases for employee retention and recruitment.

***Sources Less Uses:*** We anticipate a consolidated surplus, excluding capital, of $576.6 million. After including capital sources and uses, this surplus decreases to $4.5 million. Excess operating sources less uses will be predominately invested in the university capital plan. Details of the FY 2024 capital plan are included in chapter 8 below.

- The university is projecting an operating surplus of $145.7 million, excluding capital. This surplus becomes a loss of $104.0 million after including the capital sources and uses. University surpluses are not completely fungible as some funds are for restricted purposes. The university is comprised of general funds used for teaching and other unrestricted uses, restricted funds from grants, gifts, or governmental appropriations, and earnings funds such as housing and dining and health sciences clinical operations. University funds are tracked and managed to ensure all restrictions are met. Of the $145.7 million surplus before capital, $99.8 million is from general funds, $24.0 million is from earnings funds, and the remainder is for restricted purposes.

- The Health System FY 2024 Operating Plan projects a surplus of $98.3 million, including capital, based on $4.4 billion of operating sources, $3.9 billion of operating uses, and net capital uses of $322.3 million.

- The OSU Physicians, Inc. FY 2024 Operating Plan projects a surplus of $6.0 million, based on $1.097 billion of operating sources (including $153.9M of Medical Center Investment transfers, see Chapter 7) and $1.091 billion of operating uses.

# Strategic Context

The fiscal year 2024 Financial Plan demonstrates Ohio State's firm footing. Due to strong investment performance, continued positive momentum at the Health System, a post-pandemic rebound and significant progress in achieving operational efficiencies, the university outperformed prior fiscal years in 2023. Looking ahead, the university's fiscal stability, strength and resiliency position us to further our continued commitment to enhancing academic excellence, advancing research and innovation, service to the state of Ohio, making Ohio State a workplace of choice, and financial and operational stewardship.

## Academics

The university's Academic Plan, launched in November 2022, defines six areas of focus for transforming academic life at Ohio State: faculty eminence; student academic excellence; external engagement; inclusive excellence; technology and digital innovation and online learning; and operational effectiveness. Many of the plan's objectives are being advanced through investment in such initiatives as the new Office of Faculty Affairs and the Office of Strategic Enrollment Management, as well as the Office of Institutional Research and Planning. Additional programs provide strategic investments in elevating the impact of an Ohio State education. Ohio State's Good-to-Great Grants Program, for example, provides funding to tenure-initiating departments, schools or colleges committed to collaborations across disciplines, centers, institutes and external communities that align with national or international opportunities.

## Advancing Research and Innovation

Ohio State's research and creative expression communities conduct more than $1 billion in research and development expenditures annually. This past year, the university achieved a new institutional record of approximately $1.38 billion in research expenditures. Federal expenditures totaled $636.9 million, with growth observed across the portfolio of federal agencies, including the National Science Foundation, the National Institutes of Health, the Department of Defense and the Department of Energy. Ohio State has risen significantly in the research rankings of U.S. universities, to 12th from 24th, as part of the Higher Education Research and Development survey released by the National Science Foundation.

The university has 2.5 million square feet of assigned research space, which is growing through ongoing capital improvement plans. Faculty, staff and students work and learn in state-of-the-art laboratories, classrooms and performance spaces, while industries turn to Ohio State to help investigate new frontiers and apply groundbreaking research and knowledge to their sectors. Carmenton, the university's fast-growing innovation district, is bringing together private, public and academic sectors to exchange knowledge, understand problems that seem insurmountable, develop technologies, and accelerate delivering solutions to the market and the world. Ohio State also played an integral role in helping to attract a more than $20 billion planned investment by Intel to build two new semiconductor factories in central Ohio — a partnership that involves research and education initiatives to grow and train tomorrow's workforce.

## Ohio State as a Workplace of Choice

With an emphasis on professional development, the Office of Human Resources (OHR) works collaboratively to maintain and enhance our status as an employer of choice — a destination for teachers, scholars, artists and educational support and clinical professionals that prioritizes career growth as well as a safe and healthy environment.

In the coming fiscal year, OHR is focused on improving and enhancing HR Service Delivery and addressing equity and compensation concerns in faculty, staff and student pay. For HR Service Delivery, our work should recognize needed differences across the organization, while reinforcing necessary consistency and efficiency in practices, policies and resources. HR services must be delivered in a coordinated way while ensuring logical deployment of our people via a structure that serves the university and medical center. A comprehensive review of the model, including needed funding, will occur in FY 2024 and will help us identify a more optimal approach to meeting our customers' needs.

Recent reviews of faculty, staff and student compensation show that we have fallen behind the market in some areas. If we are to remain competitive and retain and attract outstanding talent to help us achieve our aspirations, we must identify and assess gaps and develop a coordinated approach to advancing our employees within their pay ranges. Without this, much of what we have set out to accomplish could be compromised.

Finally, with the recent implementation of Workday and ongoing focus on the optimization of its use, there is an opportunity moving forward, and an expectation, that teams and technology will be better aligned to enable the achievement of the university and medical center's strategic plans.

## Service to the State of Ohio

With six campuses across the state, growing online education offerings and a presence in each of Ohio's 88 counties, Ohio State is deeply committed to engaging people whether they live in rural, urban or suburban settings. Broadly, the university contributes over $19 billion annually to Ohio's economy while supporting nearly 117,000 jobs. At the same time, Ohio State is focused on expanding statewide engagement into public health, engineering, business management, the arts and more through multiple pathways. These include regional campuses, extension offices, extensive public-private partnerships and, importantly, the Wexner Medical Center.

A workforce of approximately 25,000 provides care in seven medical center hospitals and an extensive network of ambulatory locations to nearly 60,000 adult inpatients and more than 2.2 million outpatient visits annually. It is a major tertiary and quaternary referral center for Ohio and the Midwest, offering healthcare services in virtually every adult specialty and subspecialty in medicine through a unified practice of more than 1,800 physicians. More than $3 billion has been invested in capital in support of Ohio State's health enterprise, including a new 820-bed inpatient hospital; an interdisciplinary health sciences complex; an interdisciplinary research facility; three large suburban outpatient care centers; and an outpatient cancer care center.

Finally, service to our communities is exemplified through Ohio State's affordability efforts. The university's comprehensive focus on affordability includes locking in in-state tuition for each incoming undergraduate class, expanding financial aid to meet students' needs, enhancing student success programs and addressing student debt. These efforts include the Scarlet & Gray Advantage program, which will empower eligible Ohio

State students to earn their bachelor's degree debt-free. During the coming year, the university budget will also include $2 million for the Scarlet & Gray Advantage pilot program, an additional $7 million in increased current-use gift development funding for new student scholarships, as well as an increase of $500 per student for the Ohio College Opportunity Grant program.

### Financial and Operational Stewardship

Strategic benchmarking, revenue optimization and diligent efficiency initiatives are pillars of Ohio State's efforts to be a trusted steward of our resources. Comprehensive administrative efficiencies enable us to direct funds to our core mission and support excellence in the above areas and across the university and medical center. To continue safeguarding the university's resources during the pandemic and enable crucial investments in the future, the university set three efficiency savings goals for FY 2023.

- ***University*** - $25 million of targeted savings across all colleges and support offices. $31.5 million of savings were realized through June 30, 2023.
- ***Ohio State Wexner Medical Center*** - $30 million of targeted savings. $58.3 million of savings were realized through June 30, 2023.
- ***Capital*** - $15 million of targeted savings. $62.0 million of savings were realized through June 30, 2023.

Targets for FY 2024 efficiency savings total $80 million: university, $35 million; Ohio State University Wexner Medical Center, $30 million; and capital, $15 million.

## Benchmarking

The university continues to partner with a third-party membership organization to benchmark administrative labor costs across a consortium of 80 higher education institutions. A Standard Activity Model (SAM) is applied to the data to allocate spend across nine key areas (communications, development, facilities, finance, general administration, human resources, information technology, research, and student services), and normalization factors are applied to account for differences in scale between institutions. This partnership provides access to an online platform for ad-hoc analysis with the ability to change peers and normalization factors.

The Efficiency Committee will continue to utilize benchmarking information to identify future savings opportunities.

# FY 2024 Operating Plan Summary

The following table shows consolidated sources and uses for FY 2024 and compares those numbers to the forecast for FY 2023 and actual results for FY 2022.

| Total Sources ($ thousands) | FY22 Actuals | FY23 Forecast | FY24 Plan | CAGR FY22-FY24 | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|
| Tuition & Fees (gross) | $1,271,606 | $1,323,030 | $1,376,956 | 4.1% | $53,926 | 4.1% |
| State Share of Instruction | $403,564 | $417,215 | $421,387 | 2.2% | $4,173 | 1.0% |
| Other Operating Appropriations | $89,685 | $91,441 | $94,756 | 2.8% | $3,315 | 3.6% |
| Exchange Grants & Contracts | $888,530 | $961,454 | $985,975 | 5.3% | $24,521 | 2.6% |
| Non-Exchange Grants & Contracts | $290,625 | $130,331 | $107,380 | -39.2% | ($22,951) | -17.6% |
| Sales & Services - Auxiliaries | $407,181 | $436,181 | $440,279 | 4.0% | $4,098 | 0.9% |
| Sales & Services - Departmental | $176,149 | $229,520 | $216,517 | 10.9% | ($13,003) | -5.7% |
| Sales & Services - Health System | $4,178,956 | $3,995,697 | $4,331,152 | 1.8% | $335,455 | 8.4% |
| Sales & Services - OSU Physicians | $701,680 | $866,101 | $943,215 | 15.9% | $77,114 | 8.9% |
| Current Use Gifts | $233,381 | $143,564 | $166,000 | -15.7% | $22,436 | 15.6% |
| Endowment Distributions | $323,532 | $347,727 | $363,182 | 6.0% | $15,455 | 4.4% |
| Interest Income | $43,111 | $54,491 | $91,843 | 46.0% | $37,351 | 68.5% |
| Other Revenues | $72,089 | $111,771 | $61,100 | -7.9% | ($50,671) | -45.3% |
| **Total Sources** | **$9,080,089** | **$9,108,523** | **$9,599,743** | **2.8%** | **$491,219** | **5.4%** |

| Total Uses ($ thousands) | FY22 Actuals | FY23 Forecast | FY24 Plan | CAGR FY22-FY24 | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|
| **Total Personnel Expense** | **$4,435,562** | **$4,751,408** | **$5,086,856** | **7.1%** | **$335,448** | **7.1%** |
| Fee Authorizations | $130,040 | $130,348 | $129,350 | -0.3% | ($998) | -0.8% |
| Student Aid | $489,745 | $436,537 | $448,185 | -4.3% | $11,647 | 2.7% |
| Supplies, Services & Other | $2,873,276 | $2,918,770 | $3,162,442 | 4.9% | $243,672 | 8.3% |
| Debt Service | $229,076 | $231,089 | $196,330 | -7.4% | ($34,759) | -15.0% |
| **Total Non-Personnel Expense** | **$3,722,137** | **$3,716,744** | **$3,936,307** | **2.8%** | **$219,562** | **5.9%** |
| **Total Uses** | **$8,157,699** | **$8,468,153** | **$9,023,163** | **5.2%** | **$555,010** | **6.6%** |
| **Sources Less Uses, Operating** | **$922,390** | **$640,371** | **$576,580** | | | |
| **Total Capital-Related Sources** | **$678,496** | **$978,571** | **$675,885** | | | |
| **Total Capital-Related Uses** | **$1,286,985** | **$1,572,328** | **$1,247,943** | | | |
| **Sources Less Uses, Capital** | **($608,488)** | **($593,757)** | **($572,057)** | | | |
| **Sources Less Uses, Capital and Operating** | **$313,901** | **$46,613** | **$4,522** | | | |

## Sources

***Tuition and fees*** are charged to students to cover the cost of instruction and university operations. All students are charged a base instructional fee depending on their program of study. Non-Ohio residents and international students also pay a non-resident and/or international surcharge. Select graduate and professional programs charge a market-based differential instructional fee. Certain programs also charge a program/special and/or technology fee. Tuition and fees also include Student Life fees, including the Ohio Union fee, the recreation fee, the student activities fee, and other miscellaneous fees for applications, orientation, transcripts, and the like.

***Government Appropriations*** are divided between State Share of Instruction (SSI) and State Operating Appropriations. SSI is allocated between all Ohio public colleges based on a State of Ohio performance-based formula and is used to fund instruction, operations, and strategy. State Operating Appropriations are direct line-item allocations for Ohio State University and are restricted in use.

***Grants and Contracts*** include research projects administered through the Office of Sponsored Programs (OSP), grants and contracts administered directly by colleges and support units, and funding from federal and state government financial aid programs. In prior years, grants and contracts also included federal funding received from the Higher Education Emergency Relief Fund (HEERF) and other provisions of the Coronavirus Aid, Relief, and Economic Security Act (CARES) and the American Rescue Plan Act. Grants and contract funds are highly restricted in use and are typically disbursed on a reimbursement basis.

***Sales and Services*** are goods and services sold to students or the general public. Housing, dining, athletics, and instructional clinical services make up the majority of this revenue. University sales and services operations retain their earnings and are charged an overhead rate to fund central operations and strategy.

***Health System and OSU Physicians Revenues*** are derived from patient and insurance billing. The Health System and OSU Physicians retain their earnings and are charged an overhead rate to fund central operations and strategy.

***Current Use Gifts*** are gifts that are available for immediate use based on donor restrictions. These funds are highly restricted based on donor intent and may or may not be expended in the year received.

***Endowment Distributions*** are received from endowed funds established for the purpose of generating a distribution in perpetuity for a donor-restricted purpose. For purposes of the Operating Plan, only distributions are counted as sources and are restricted to each endowment description.

***Interest Income*** is generated by the university on all cash balances. The short and intermediate-term interest revenue is unrestricted and used to fund operations and strategy.

***Other Sources*** include miscellaneous university earnings such as royalties and rental income.

Uses

***Personnel Expenses*** are salaries, wages, and bonus payments to university employees and benefits paid on their behalf. Units pay into benefits pools based on composite rates by employee type; these rates are reviewed by the University Senate Fiscal Committee and approved by the Provost and Chief Financial Officer.

***Student Aid*** includes all institutional, departmental, governmental, gifted endowment distributions, and athletic financial aid.

***Fee Authorizations*** pay for the tuition and fees for graduate teaching, research, or administrative appointments.

***Supplies & Services*** cover all other operating expenses for the university. Utilities, repairs and maintenance, consulting expenses, and research subcontract expenses are reflected in this category.

***University Debt Service*** is interest expense and principal repayment incurred on all outstanding debt.

# Chapter 2 | Operating Plan Scope

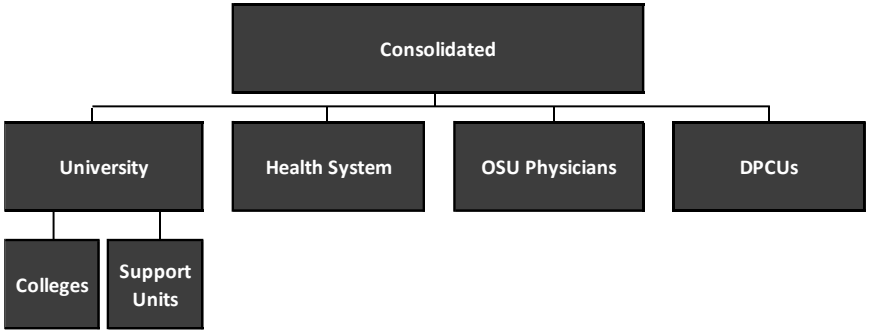
The university is a complex institution with planning units responsible for diverse missions: patient care, introductory accounting instruction, and automotive engineering research are all under the same umbrella. Diverse revenue streams fund these diverse missions, and the financial plan takes all these differences into account.

## Operating Plan Units

All funds operating plans are intended to represent planned revenue and expenses. They are collected from each unit across the university and reviewed and consolidated by the Office of Financial Planning and Analysis. This all-funds total operating plan provides the base framework for evaluating the activities of all academic and support units within the university, allowing proactive responses to changing economic issues as they arise. For the FY 2024 planning cycle, the university used Workday Adaptive Planning, a financial planning tool to collect college and unit plans and integrate data directly from Workday Finance and Human Resources. The university continues to optimize use of Adaptive to reinforce consistent planning and forecasting, commitment tracking, and efficient position control at the college and unit level.

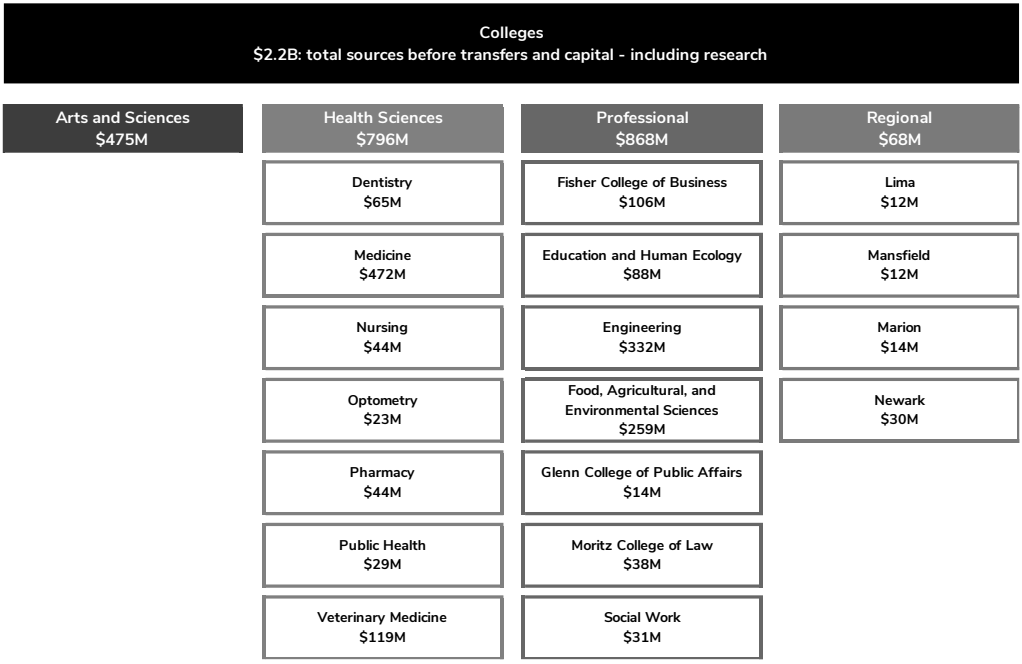
The financial structure of units throughout the organization reflects our complex mission. The financial plan is based on a hierarchical structure where individual plans are collected from colleges and support units and then consolidated. Financial Planning and Analysis performs a bottom-up review and consolidation of individual plans. It then reconciles the resulting numbers with a top-down forecasted approach to arrive at the final submitted plan. Note that this hierarchy does not necessarily imply personnel reporting lines but serves as a graphical representation of how the plan is compiled and consolidated.

The top-level of consolidation is made up of the university, Health System, OSU Physicians, and Discretely Presented Component Units (DPCUs). Numerous eliminations occur at this level that reflect the transfer of funds among these four entities. In turn, the university is split between colleges and support units; the Health System is divided among five hospitals, dozens of ambulatory care facilities, and other administrative units; and OSU Physicians is split into 19 physicians' practices. The Health System and OSU Physicians are discussed in greater detail in Chapters 6 and 7. The remainder of this chapter and Chapters 4 and 5 address the structure and details of the University portion of the consolidated budget.



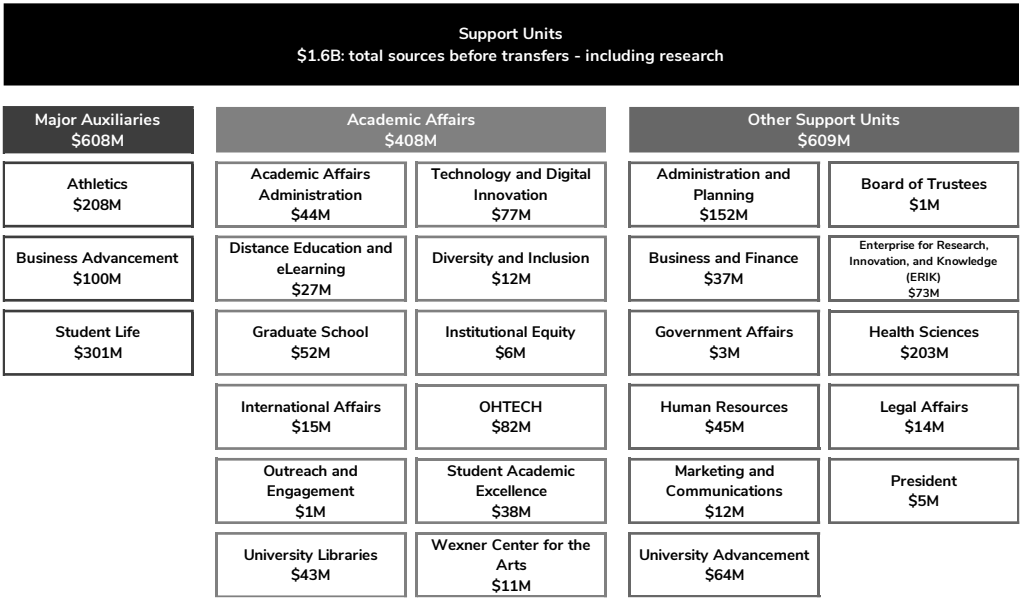
## FY 2024 FINANCIAL PLAN

Colleges are segmented into their respective Executive Dean clusters, Arts and Sciences, Health Sciences Colleges, Professional Colleges, and Regional Campuses for the university consolidation. Figures below represent sources before transfers for all funds.



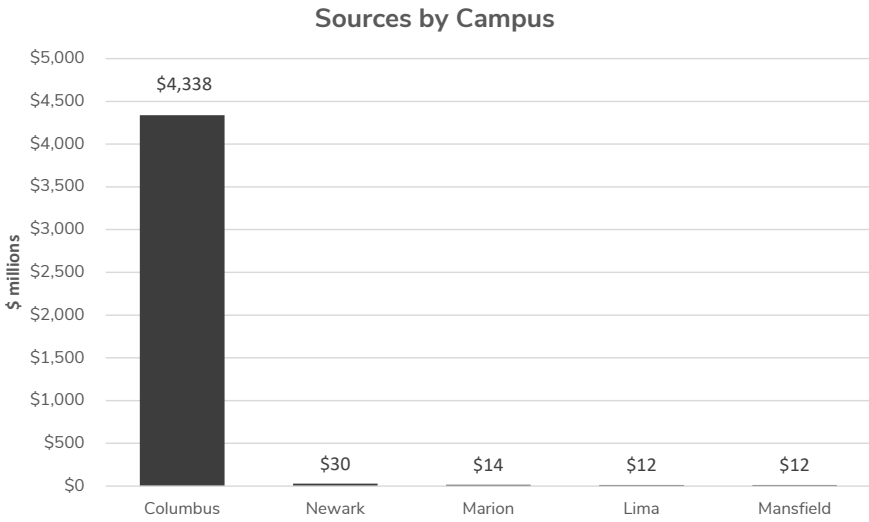
## FY 2024 FINANCIAL PLAN

Sources before transfers for all funds for support units are as follows:

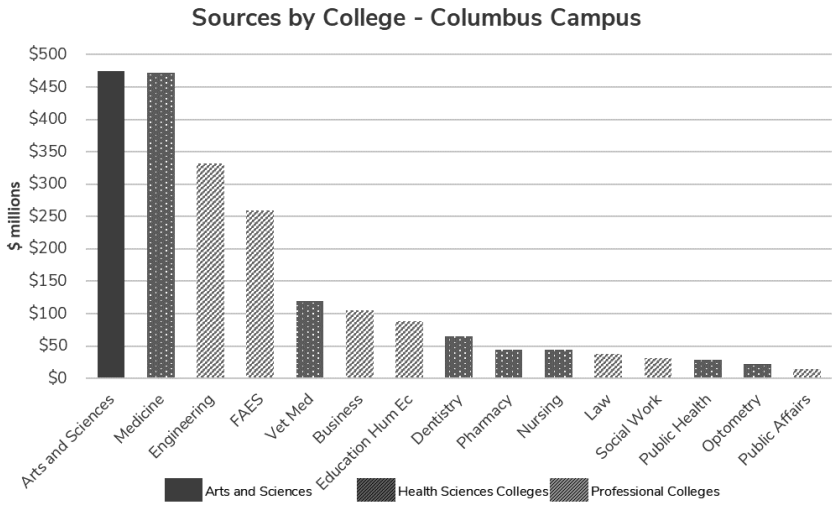



Note: Each college and support unit depicted is also divided into many additional planning sub-units, which include divisions such as academic departments, deans' offices, centers, specific earnings operations, sports teams, physicians' practices, etc. University Advancement is shown after central funding transfers that comprise a majority of their budget.

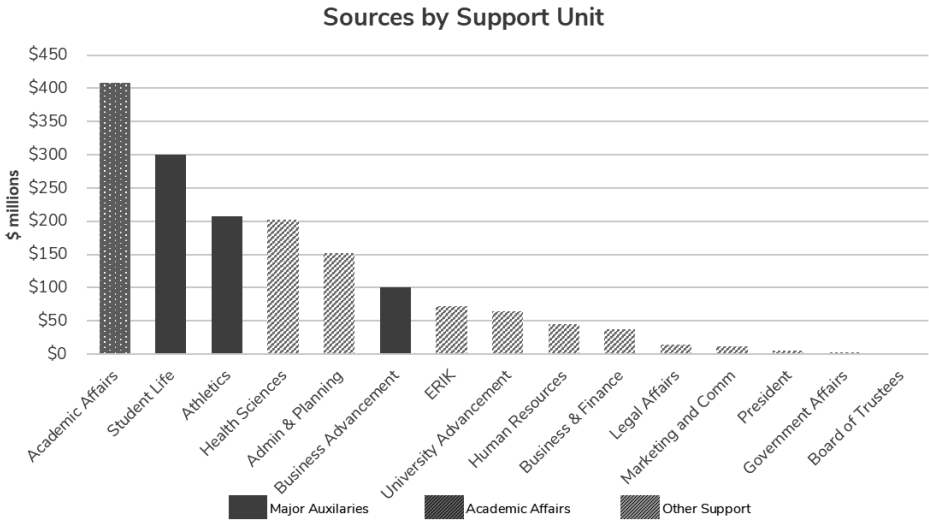
The size of campuses varies widely. The Columbus Campus is by far the largest in terms of sources:




The College of Arts and Sciences is the largest college by sources, followed by the College of Medicine, the College of Engineering, and the College of Food, Agricultural and Environmental Sciences:



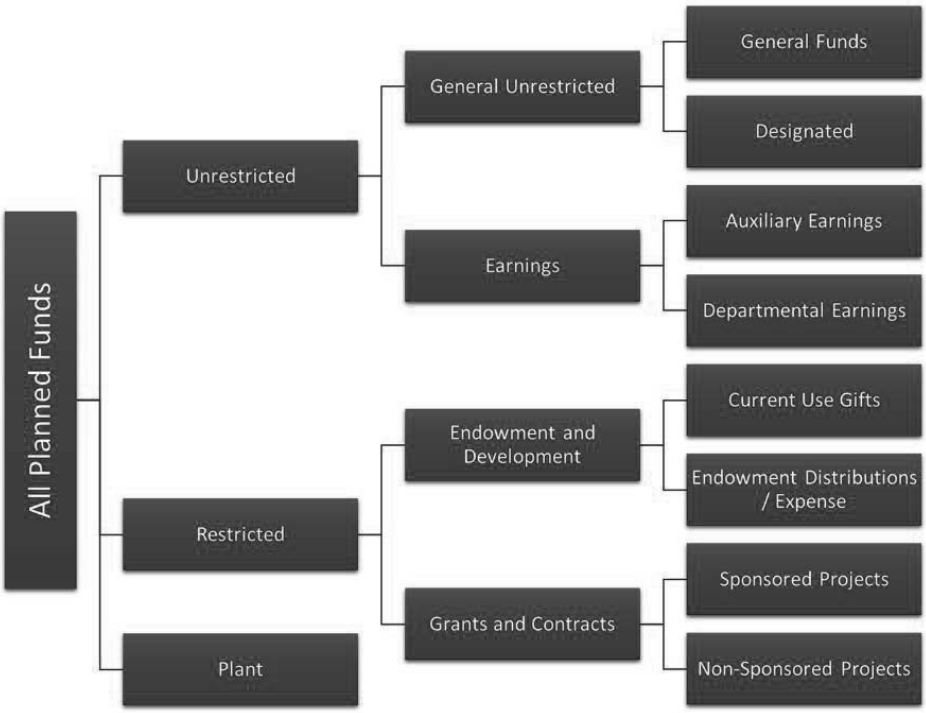
The Office of Academic Affairs and its component units is the largest support unit, followed by Student Life and Athletics:



## Operating Plan Funds

Not only is the university divided into planning units of vastly varying sizes, but each planning unit is also tracked using funds to ensure that fund restrictions are met. For the FY 2024 Financial Plan, the university continues a planning process encompassing all university operating funds. This approach affords a holistic view of all university operations in an easily understood format that will enable the university to highlight the evolution of funding sources. This will allow leadership to make informed strategic decisions in a timely manner.

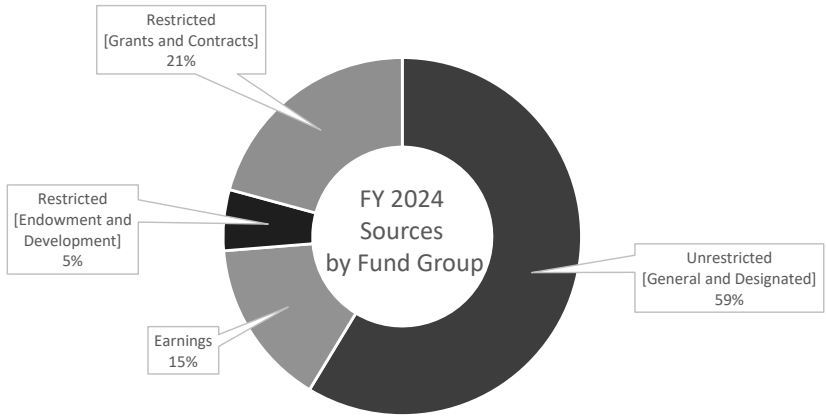
The operating plan is comprised of the following fund groups:




The university's plan is developed and managed according to the principles of fund accounting. Not all funds are created alike, and many are not fungible. Revenue is separated into a variety of fund types, the use of which is governed by the restrictions of the specific fund. Some fund types are unrestricted, including general funds and some earnings funds. Others have restrictions derived from the source of the revenue, including current use gifts, endowments, and grants and contracts received from government agencies, foundations, and other outside sponsors. For both planning and spending decision purposes, the source of funding matters: only certain fund groups can be used for all purposes at the university. Roughly 59% of total university operating

sources are completely unrestricted general funds. An additional 15% are from earnings sources, in which customers and users may expect revenue to only support specific goods or services, and the remaining 26% are restricted to the purposes set forth by the donor, contract, or granting agency.

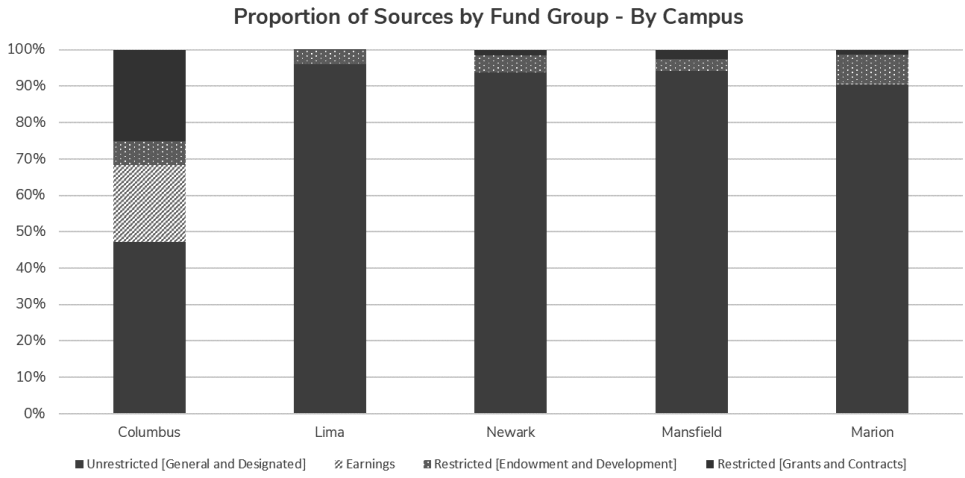
As a feature of decentralized budgeting authority, all colleges and support units carry forward their own equity balances into the following year. They hold these equity balances to apply to strategic opportunities, including hires and startup packages, strategic procurement, capital uses, etc.



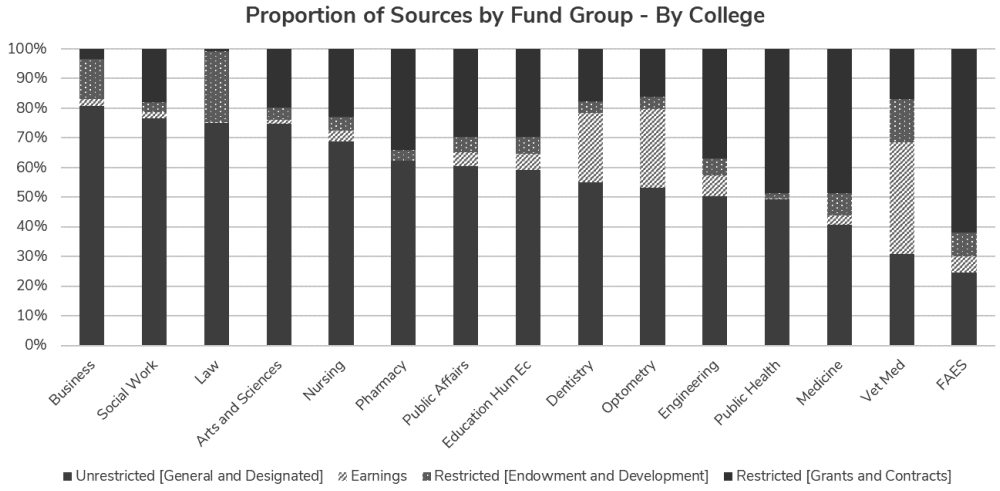

Funding sources and restrictions vary greatly by fund type:

| Fund Group | Fund Type | Typical Funding Sources | Restrictions |
|---|---|---|---|
| **Unrestricted** | General Funds | Tuition and student fees, state share of instruction, short term interest income, grant facilities and administrative cost allowances, cost allocations from earnings funds and Health System | None |
| | Designated | Originally from General Funds or unrestricted gifts, internally designated for a specific purpose | Not legally restricted but internally restricted for stated purposes |
| **Earnings** | Auxiliary Earnings | User fees, e.g., housing, dining, athletics ticket revenue | Not legally restricted, but customer/user may expect specific fees to only support specific goods or services |
| | Departmental Earnings | User fees, including internal billings, e.g., instructional clinic revenue, lab services revenue, etc. | Not legally restricted, but customer/user may expect specific fees to only support specific goods or services |
| **Restricted Endowment and Development** | Current Use Gifts | Donor gifts without either a requirement to be deposited into an endowment or used for a capital project | Restricted based on donor intent, may be governed by a gift agreement |
| | Endowment Income/Expense | Income from investment of donor gifts in the endowment | Restricted based on donor intent as memorialized in fund description |
| **Restricted Grants and Contracts** | Grants and Contracts | Grant or contract dollars received from external entities; includes specific line-item appropriations from the State of Ohio | Restricted based on grant agreement, contract, or line-item appropriation description |

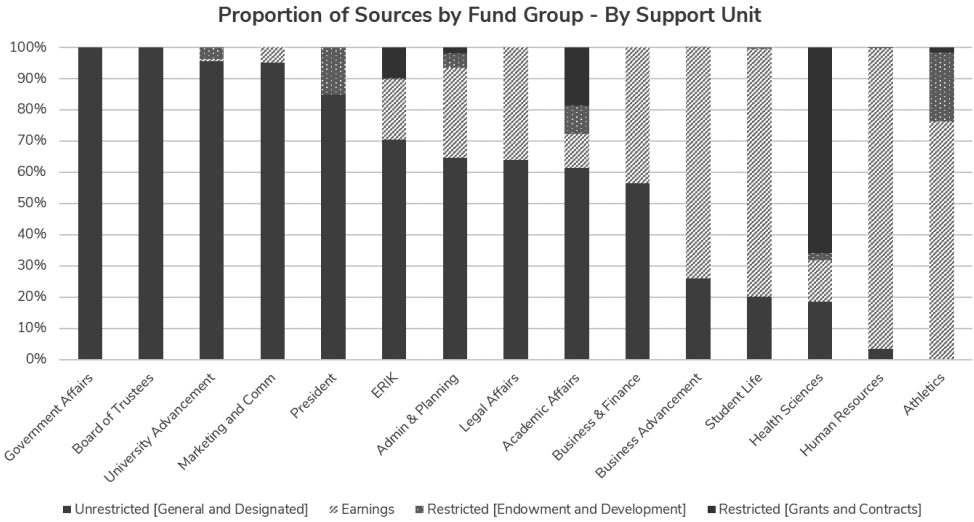
As units vary in size, units also vary by funding type. The following charts show the differences in funding proportions among general unrestricted, earnings, and restricted funds. Differences in funding sources result in different risk profiles. A unit with heavy reliance on general funds will be more sensitive to changes in enrollment, tuition and fees (including restrictions on tuition rates from the State of Ohio), the proportion of non-resident students, and changes in subsidy received from the State of Ohio than a more balanced unit. Support units with reliance on earnings are more susceptible to market-driven factors and typically must carry greater equity balances as reserves to maintain facilities and replace capital equipment. Units more reliant on restricted funding may not have the flexibility to spend all available equity balances based on the original gift or grant restrictions and are likely more susceptible to changes in the grant funding landscape or the loss of a large donor.




The Columbus Campus has more varied funding sources than the regional campuses, which rely primarily on general funds sources – tuition and subsidy.




Like the Colleges of Business, Social Work, Law, and Arts and Sciences, some colleges are highly dependent on general funds sources – tuition and subsidy. Colleges such as Dentistry, Optometry, and Veterinary Medicine earn significant earnings revenue through their instructional clinics. Colleges like Food Agricultural and Environmental Sciences (FAES), the College of Veterinary Medicine and the College of Medicine operate with significant earnings and restricted funding that supplements their general fund sources.




Support units also demonstrate a wide variety of funding dependencies, from units that are entirely reliant on general funds – Government Affairs and Board of Trustees – to units that heavily utilize earnings funds – such as Student Life and Athletics.

Units use a variety of techniques to prepare their plans. General funds plans are based on fixed uses and historical patterns coupled with preliminary estimates of tuition and subsidy allocations provided by Financial Planning and Analysis. Earnings units typically plan based on their business plans, approved fees, and projected use of their products and services. Grants and contracts revenue and current use gifts are projected based on historical patterns and anticipated gifts and grants that may be received.

The Ohio State University Health System and Ohio State University Physicians, Inc. prepare their plans based on projected activity and associated costs. External factors, such as government regulations and reimbursement rates, as well as contractual agreements with health care payers, also play an integral part in developing the Health System's plan.

# General Funds Allocations

Although emphasis was placed on including all university funds in the FY 2024 planning process, general funds continue to remain a significant component of the plan. General funds can broadly be used for any university purpose, whereas restricted funds are more specifically targeted. These funds play an essential role in both the plan and operations of the university, as they cover many expenses in the colleges and support units for which it is difficult to raise money. The primary sources of general funds are tuition and other student fees, State Share of Instruction, indirect cost recovery, and overhead charged to earnings units.

## Allocation of Funds

For general funds, the Columbus campus uses an allocation model that is comprised of two components: a modified Responsibility Center Management (RCM) model and the strategic investment of central funds. This structure allows for decentralized decision-making and control of financial resources at the colleges and support units while still retaining central funds for holistic strategic investment purposes. The modified RCM allocation model assigns substantial control over resource decisions to individual colleges and support units. The underlying premise of the university's decentralized budget model is entrusting academic and support unit leaders with significant control over financial resources, leading to more informed decision making and better outcomes for the university. Through this resource funding model, colleges are incentivized to increase resources by teaching more credit hours and growing research activity.

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

Revenue is allocated to colleges based on three primary funding formulas: pooled undergraduate, graduate tuition, and graduate state support. The pooled undergraduate formula utilizes a model to distribute undergraduate marginal tuition and state support. In prior years, sixty percent of the total marginal undergraduate revenue was allocated based on total credit hours taught, while forty percent was allocated based on the cost of instruction. In FY 2023, this funding model began a six-year phase-out to more closely align to an "as earned" allocation. The new allocation will treat tuition revenue and state support separately and allocate tuition revenue based on total credit hours taught and state support revenue based on the type of course taught/cost of instruction. This allocation method is more in line with the allocation methods for graduate tuition and state support and will be fully phased in by FY 2028.

The other two funding formulas allocate graduate tuition and state support based on a two-year average of credit hours in fee-paying categories (tuition) and the type of course taught based on the cost of instruction (state support). As a college teaches more of the share of total credit hours, it receives a proportionally larger share of the incremental funding.

Conversely, if a college's share of the hours taught declines, the college's allotted share of incremental funding will correspondingly decline proportionally. The two-year average credit hour driver acts as a smoothing mechanism in times of unforeseen volatility. Colleges will receive their share of marginal revenue on indirect

research cost recovery, based upon the college's share of research revenue. Fee revenue from differential, learning technology, course and program/special fees are provided directly to colleges.

Support units are funded through a combination of central tax, specific activity-based assessments, and an overhead rate charged to auxiliary and earnings units. The central tax, assessments and overhead charges are designed to provide the funds necessary to maintain support services such as payroll, central human resources, and academic support. Support units are generally ineligible for marginal revenue changes because the funding formulas rely on credit hours taught; instead, support units must request additional funding during the annual planning process to support new services or mandates. For FY 2024, the following requests were prioritized for central investment, assuming no local funds are available, through the shared governance support office budget request process.

| Service Excellence Investment | | FY2024 Plan |
|---|---|---|
| Public Safety | $ | 657,000 |
| Enterprise Security | $ | 1,316,450 |
| | **$** | **1,973,450** |

In addition to the requested central investments, in FY 2024 $8.9 million in unit investments have been committed for strategic initiatives including $5.4 million for the Student Information Systems Project, $2.0 million for the incoming cohort of Scarlet & Gray Advantage Pilot Program, and $1.5 million of incremental resources for mental health program support.

Allocations of expenses are also made through the general funds' allocation model. Both colleges and support units receive a net allocation that considers both marginal revenue and marginal expenses. Current expense assessments include:

| Assessment | Allocation Basis | Notes |
|---|---|---|
| **Plant Operation and Maintenance** | Assigned square footage | The square footage is multiplied by a flat rate per square foot for four types of costs: utilities, custodial service, maintenance, and deferred maintenance. |
| **Student Services** | Credit hours | • **Cost Pool 1 (Undergraduate):** 90% of this cost pool is Undergraduate Financial Aid. It also includes operating budgets for Financial Aid and First-Year Experience. Expense is allocated by average undergraduate credit hours.<br>• **Cost Pool 2 (Graduate):** 83% of this cost pool is Non-Resident Fee Authorizations and Graduate Fellowships. This is the largest student services cost pool and includes the operating budget of the Graduate School. Expense is allocated by average graduate credit hours.<br>• **Cost Pool 3 (All Students):** This is the smallest student services cost pool and includes portions of operating budgets for Student Life. Expense is allocated by an average of ALL credit hours. |
| **Research** | Modified Total Direct Costs | Research cost allocation covers the budgets of units that support sponsored research. |
| **Distance Education** | Distance Education credit hours | Funds operations of Office of Distance Education and eLearning. |
| **Central Tax** | % of marginal tuition and subsidy revenue | Funds support units such as the President's Office, OAA, Controller, Public Safety, etc. as well as promotion and tenure and strategic investments. |

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

Regional campuses develop their individual campus plans primarily based on the student tuition and fees received from the regional campus students, the state share of instruction they expect to collect, and costs directly incurred to operate those campuses.

# Chapter 3 | FY 2024 Financial Plan

The FY 2024 Financial Plan is displayed in a modified cash flow presentation that includes operating sources and uses. The purpose of this presentation is to provide a more complete understanding of the university's funding and margins generated by operations. Additional information on the Capital Plan can be found in Chapter 8.

## Consolidated

| Total Sources ($ thousands) | FY22 Actuals | FY23 Forecast | FY24 Plan | CAGR FY22-FY24 | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|
| Tuition & Fees (gross) | $1,271,606 | $1,323,030 | $1,376,956 | 4.1% | $53,926 | 4.1% |
| State Share of Instruction | $403,564 | $417,215 | $421,387 | 2.2% | $4,173 | 1.0% |
| Other Operating Appropriations | $89,685 | $91,441 | $94,756 | 2.8% | $3,315 | 3.6% |
| Exchange Grants & Contracts | $888,530 | $961,454 | $985,975 | 5.3% | $24,521 | 2.6% |
| Non-Exchange Grants & Contracts | $290,625 | $130,331 | $107,380 | -39.2% | ($22,951) | -17.6% |
| Sales & Services - Auxiliaries | $407,181 | $436,181 | $440,279 | 4.0% | $4,098 | 0.9% |
| Sales & Services - Departmental | $176,149 | $229,520 | $216,517 | 10.9% | ($13,003) | -5.7% |
| Sales & Services - Health System | $4,178,956 | $3,995,697 | $4,331,152 | 1.8% | $335,455 | 8.4% |
| Sales & Services - OSU Physicians | $701,680 | $866,101 | $943,215 | 15.9% | $77,114 | 8.9% |
| Current Use Gifts | $233,381 | $143,564 | $166,000 | -15.7% | $22,436 | 15.6% |
| Endowment Distributions | $323,532 | $347,727 | $363,182 | 6.0% | $15,455 | 4.4% |
| Interest Income | $43,111 | $54,491 | $91,843 | 46.0% | $37,351 | 68.5% |
| Other Revenues | $72,089 | $111,771 | $61,100 | -7.9% | ($50,671) | -45.3% |
| **Total Sources** | **$9,080,089** | **$9,108,523** | **$9,599,743** | **2.8%** | **$491,219** | **5.4%** |

| Total Uses ($ thousands) | FY22 Actuals | FY23 Forecast | FY24 Plan | CAGR FY22-FY24 | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|
| **Total Personnel Expense** | **$4,435,562** | **$4,751,408** | **$5,086,856** | **7.1%** | **$335,448** | **7.1%** |
| Fee Authorizations | $130,040 | $130,348 | $129,350 | -0.3% | ($998) | -0.8% |
| Student Aid | $489,745 | $436,537 | $448,185 | -4.3% | $11,647 | 2.7% |
| Supplies, Services & Other | $2,873,276 | $2,918,770 | $3,162,442 | 4.9% | $243,672 | 8.3% |
| Debt Service | $229,076 | $231,089 | $196,330 | -7.4% | ($34,759) | -15.0% |
| **Total Non-Personnel Expense** | **$3,722,137** | **$3,716,744** | **$3,936,307** | **2.8%** | **$219,562** | **5.9%** |
| **Total Uses** | **$8,157,699** | **$8,468,153** | **$9,023,163** | **5.2%** | **$555,010** | **6.6%** |
| **Sources Less Uses, Operating** | **$922,390** | **$640,371** | **$576,580** | | | |
| **Total Capital-Related Sources** | **$678,496** | **$978,571** | **$675,885** | | | |
| **Total Capital-Related Uses** | **$1,286,985** | **$1,572,328** | **$1,247,943** | | | |
| **Sources Less Uses, Capital** | **($608,488)** | **($593,757)** | **($572,057)** | | | |
| **Sources Less Uses, Capital and Operating** | **$313,901** | **$46,613** | **$4,522** | | | |

**FY 2024 FINANCIAL PLAN**

# University [excluding Health System, OSUP, DPCUs, and eliminations]

| Total Sources ($ thousands) | FY22 Actuals | FY23 Forecast | FY24 Plan | CAGR FY22-FY24 | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|
| **External Sources** | | | | | | |
| Tuition & Fees (gross) | $1,271,606 | $1,323,030 | $1,376,956 | 4.1% | $53,926 | 4.1% |
| State Share of Instruction | $403,957 | $417,215 | $421,387 | 2.1% | $4,173 | 1.0% |
| Other Operating Appropriations | $89,685 | $91,441 | $94,756 | 2.8% | $3,315 | 3.6% |
| Exchange Grants & Contracts | $814,074 | $871,751 | $892,820 | 4.7% | $21,069 | 2.4% |
| Non-Exchange Grants & Contracts | $253,603 | $130,331 | $107,380 | -34.9% | ($22,951) | -17.6% |
| Sales & Services - Auxiliaries | $407,181 | $436,181 | $440,279 | 4.0% | $4,098 | 0.9% |
| Sales & Services - Departmental | $197,121 | $229,520 | $216,517 | 4.8% | ($13,003) | -5.7% |
| Current Use Gifts | $174,362 | $143,564 | $166,000 | -2.4% | $22,436 | 15.6% |
| Endowment Distributions | $323,532 | $347,727 | $363,182 | 6.0% | $15,455 | 4.4% |
| Interest Income | $43,111 | $39,467 | $59,075 | 17.1% | $19,609 | 49.7% |
| Other Revenues | $53,829 | $109,500 | $58,800 | 4.5% | ($50,700) | -46.3% |
| **Total External Sources** | **$4,032,060** | **$4,139,727** | **$4,197,153** | **2.0%** | **$57,427** | **1.4%** |
| **Internal Sources** | | | | | | |
| Net Transfers from OSU Health System | $195,432 | $204,575 | $208,908 | 3.4% | $4,333 | 2.1% |
| **Total Internal Sources** | **$195,432** | **$204,575** | **$208,908** | **3.4%** | **$4,333** | **2.1%** |
| **Total Sources** | **$4,227,492** | **$4,344,302** | **$4,406,061** | **2.1%** | **$61,760** | **1.4%** |

| Total Uses ($ thousands) | FY22 Actuals | FY23 Forecast | FY24 Plan | CAGR FY22-FY24 | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|
| Salaries | $1,638,825 | $1,741,992 | $1,843,250 | 6.1% | $101,258 | 5.8% |
| Benefits | $471,656 | $503,840 | $548,920 | 7.9% | $45,080 | 8.9% |
| **Total Personnel Expense** | **$2,110,481** | **$2,245,832** | **$2,392,170** | **6.5%** | **$146,338** | **6.5%** |
| Fee Authorizations | $130,040 | $130,348 | $129,350 | -0.3% | ($998) | -0.8% |
| Student Aid | $489,745 | $436,537 | $448,185 | -4.3% | $11,647 | 2.7% |
| Supplies, Services & Other | $1,039,801 | $1,160,347 | $1,207,412 | 7.8% | $47,065 | 4.1% |
| Debt Service | $103,772 | $112,356 | $83,205 | -10.5% | ($29,151) | -25.9% |
| **Total Non-Personnel Expense** | **$1,763,358** | **$1,839,588** | **$1,868,151** | **2.9%** | **$28,563** | **1.6%** |
| **Total Uses** | **$3,873,838** | **$4,085,421** | **$4,260,322** | **4.9%** | **$174,901** | **4.3%** |
| **Sources Less Uses, Operating** | **$353,654** | **$258,881** | **$145,740** | | | |
| **Total Capital-Related Sources** | **$418,522** | **$567,631** | **$345,397** | | | |
| **Total Capital-Related Uses** | **$576,265** | **$788,663** | **$595,114** | | | |
| **Sources Less Uses, Capital** | **($157,743)** | **($221,031)** | **($249,716)** | | | |
| **Sources Less Uses, Capital and Operating** | **$195,911** | **$37,850** | **($103,977)** | | | |

# University by Fund Group [FY 2024 Plan]

As explained in Chapter 2, not all funding is fungible at the university. The following gives a breakout by fund group indicating the level of restriction of dollars:

| Total Sources ($ thousands) | Unrestricted [General and Designated] | Earnings | Restricted Endowment and Development | Restricted Grants and Contracts | Total University |
|---|---|---|---|---|---|
| **External Sources** | | | | | |
| Tuition & Fees (gross) | $1,374,624 | $1,731 | $53 | $548 | $1,376,956 |
| State Share of Instruction | $421,387 | - | - | - | $421,387 |
| Other Operating Appropriations | - | - | - | $94,756 | $94,756 |
| Exchange Grants & Contracts | $175,327 | $592 | $818 | $716,084 | $892,820 |
| Non-Exchange Grants & Contracts | - | $415 | - | $106,965 | $107,380 |
| Sales & Services - Auxiliaries | - | $440,279 | - | - | $440,279 |
| Sales & Services - Departmental | $113,258 | $102,256 | $1,004 | - | $216,517 |
| Current Use Gifts | $580 | - | $165,420 | - | $166,000 |
| Endowment Distributions | $248,843 | - | $114,339 | - | $363,182 |
| Interest Income | $58,456 | $604 | - | $15 | $59,075 |
| Other Revenues | $47,188 | $10,862 | $150 | $600 | $58,800 |
| **Total External Sources** | **$2,439,663** | **$556,739** | **$281,784** | **$918,968** | **$4,197,153** |
| **Internal Sources** | | | | | |
| Net Transfers In (Out) | $154,551 | $93,393 | ($38,502) | ($533) | $208,908 |
| **Total Internal Sources** | **$154,551** | **$93,393** | **($38,502)** | **($533)** | **$208,908** |
| **Total Sources** | **$2,594,214** | **$650,132** | **$243,281** | **$918,435** | **$4,406,061** |

| Total Uses ($ thousands) | Unrestricted [General and Designated] | Earnings | Restricted Endowment and Development | Restricted Grants and Contracts | Total University |
|---|---|---|---|---|---|
| Salaries | $1,130,930 | $322,158 | $45,786 | $344,377 | $1,843,250 |
| Benefits | $334,468 | $102,080 | $12,471 | $99,901 | $548,920 |
| **Total Personnel Expense** | **$1,465,398** | **$424,238** | **$58,256** | **$444,278** | **$2,392,170** |
| Fee Authorizations | $104,677 | $1,412 | $6,386 | $16,874 | $129,350 |
| Student Aid | $265,480 | $36,234 | $53,130 | $93,340 | $448,185 |
| Supplies, Services & Other | $575,657 | $164,265 | $111,431 | $356,060 | $1,207,412 |
| Debt Service | $83,205 | - | - | - | $83,205 |
| **Total Non-Personnel Expense** | **$1,029,019** | **$201,911** | **$170,947** | **$466,274** | **$1,868,151** |
| **Total Uses** | **$2,494,418** | **$626,148** | **$229,203** | **$910,552** | **$4,260,322** |
| Sources Less Uses, Operating | $99,796 | $23,984 | $14,078 | $7,882 | $145,740 |

For the FY 2024 Plan, Unrestricted General and Designated funds generate a margin of $99.8 million, which is mainly used for operating reserves and strategic investments. Earnings operations are planned to generate a positive margin of $24.0 million. Restricted Endowment and Development funds generate a margin of $14.1 million mainly due to anticipated timing differences between gift receipt and spend. Restricted grants and contracts generate a margin of $7.9 million due to the timing of reimbursements on research projects.

# Chapter 4 | University Operating Plan | Sources

## Tuition and Fees

| $ thousands | FY22 Actuals | FY23 Forecast | FY24 Plan | CAGR FY22-FY24 | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|
| Instructional Fees | $788,205 | $792,699 | $812,835 | 1.6% | $20,135 | 2.5% |
| Non-Resident Fees | $365,244 | $401,097 | $424,887 | 7.9% | $23,790 | 5.9% |
| General Fees | $25,087 | $26,025 | $27,238 | 4.2% | $1,212 | 4.7% |
| International Surcharge | $9,259 | $9,186 | $9,805 | 2.9% | $619 | 6.7% |
| Program and Tech Fees | $38,472 | $45,537 | $51,730 | 16.0% | $6,192 | 13.6% |
| Other Student Fees | $18,708 | $21,005 | $22,974 | 10.8% | $1,969 | 9.4% |
| **Total Academic Fees** | **$1,244,975** | **$1,295,550** | **$1,349,468** | **4.1%** | **$53,918** | **4.2%** |
| Student Activity Fees | $4,596 | $4,689 | $4,672 | 0.8% | ($17) | -0.4% |
| Recreational Fees | $13,888 | $14,324 | $14,379 | 1.8% | $55 | 0.4% |
| Ohio Union Fees | $8,147 | $8,468 | $8,437 | 1.8% | ($30) | -0.4% |
| **Total Student Life Fees** | **$26,631** | **$27,480** | **$27,488** | **1.6%** | **$8** | **0.0%** |
| **Total Tuition & Fees (gross)** | **$1,271,606** | **$1,323,030** | **$1,376,956** | **4.1%** | **$53,926** | **4.1%** |

Gross tuition and fees are expected to increase by $53.9 million, or 4.1%, from $1.32 billion in FY 2023 to $1.38 billion in FY 2024. The growth in gross tuition revenue is primarily driven by the increase in instructional and non-resident surcharge. Additionally, the university is expecting the non-resident mix of new first-year students (NFYS) in autumn 2023 to remain primarily unchanged from autumn 2022 at 33.5%. The FY 2024 Operating Plan assumes the summer 2023 enrollment and mix will be consistent with the summer 2022 enrollment. Furthermore, autumn 2023 and spring 2024 semesters reflect the continued trend of a reduced time to degree as students enter with more credit hours.

The FY 2024 Operating Plan reflects a 3.0% increase in resident (base) tuition and mandatory fees for undergraduate students not in the Ohio State Tuition Guarantee. Ohio resident undergraduate students in the Tuition Guarantee cohort that began in autumn of 2019 (FY 2020), will move to the Tuition Guarantee cohort rates established for FY 2021. Ohio resident undergraduate students in the Tuition Guarantee cohorts that began in fiscal years 2021, 2022 and 2023 will continue at the rates established for their cohorts and will therefore see no change (0%) in their tuition, mandatory fees, and room and board rates for academic year 2023-2024. New first-year Ohio resident undergraduate students enrolled at all campuses in 2023-24 will be part of a new Ohio State Tuition Guarantee cohort.

Based on market research, the FY 2024 Operating Plan reflects a 3.8% increase in resident (base) tuition and mandatory fees and a 4.2% increase in the non-resident surcharge for graduate students. Some tagged masters and professional programs have differential fees based on the market demands for those programs.

The university is committed to access, affordability, and excellence. In areas where tuition and fee increases are planned, the proceeds will be used to cover inflation and to invest in excellence within the core academic mission. Tuition and fees provide approximately 75% of general funds revenue available to fund the core academic mission. The remaining 25% is largely provided through the State of Ohio instructional subsidy (SSI) and indirect cost recovery from research. Ohio State remains one of the most affordable options in Ohio and among its Big Ten peers.

## FY 2024 FINANCIAL PLAN

Three distinct drivers generally impact revenue in academic fees for undergraduates at the Columbus campus: price (relating to rates charged), volume (total size of enrollments), and mix (proportion of resident/non-resident student populations) as detailed below. When comparing FY 2023 to FY 2024 plan, instructional and non-resident revenue are expected to increase by $13.1 million and $18.8 million, respectively. The revenue variances are predominately due to our normal revenue drivers of price, volume, and mix.

- ***Price (+$33.2 million):*** Students paying lower instructional fees graduate and leave the university, and the average price per student rises. The instructional average price is planned to grow by 3.3% or $172 per full-time equivalent (FTE) over FY 2023. This growth in price accounts for $17.5 million in instructional fee revenue. The non-resident fee is planned to increase 5.2% or $635 per FTE as compared to the FY 2023 rate and when charged to all non-resident students' accounts for $15.7 million increase.

- ***Volume (-$4.6 million):*** Total FTE is projected to decline 0.6% or 593 FTE due to a continuing trend of the decreased time-to-degree due to undergraduate students arriving with existing credit hours and increased sensitivity around total student debt. This decrease in volume accounts for approximately $4.6 million in instructional and non-resident surcharge revenue.

- ***Mix (+$3.3 million):*** Non-resident FTE is planned to increase 1.3% due to a larger domestic and international non-resident cohort as compared to the autumn 2022 and a continuing trend of increasing the non-resident mix specific to the autumn 2023 cohort. The increase in non-resident mix accounts for approximately $3.3 million of non-resident surcharge fees.

Volume Driver: Total Enrollment (Undergraduate, Graduate and Professional)

| Headcounts | 2020 | 2021 | 2022 | 2023 | 2024 | 1 YR Chg | 1 YR % Chg | 5 YR % Chg |
|---|---|---|---|---|---|---|---|---|
| Columbus | 61,391 | 61,369 | 61,677 | 60,540 | 60,183 | -357 | -0.6% | -2.0% |
| Lima | 982 | 998 | 874 | 818 | 826 | 8 | 1.0% | -15.9% |
| Mansfield | 1,078 | 1,012 | 954 | 828 | 828 | 0 | 0.0% | -23.2% |
| Marion | 1,274 | 1,158 | 1,047 | 900 | 834 | -66 | -7.3% | -34.5% |
| Newark | 2,943 | 2,873 | 2,730 | 2,263 | 2,288 | 25 | 1.1% | -22.3% |
| ATI | 594 | 547 | 490 | 446 | 495 | 49 | 11.0% | -16.7% |
| **Grand Total** | **68,262** | **67,957** | **67,772** | **65,795** | **65,454** | **-341** | **-0.5%** | **-4.1%** |
| **Total Regionals** | **6,871** | **6,588** | **6,095** | **5,255** | **5,271** | **16** | **0.3%** | **-23.3%** |

Autumn 2023 enrollment is expected to decline slightly compared with FY 2023 levels.

Regional campuses account for 8.1% of the university's enrollment. Autumn 2023 enrollments at all regional campuses have been declining over the past five years because of demographic changes and declining numbers of high school graduates outside of Ohio's largest cities. The most significant declines are at Mansfield, Marion, and ATI campuses. Each campus is engaged in efforts to improve student retention and success by enhancing students' academic experiences and elevating the quality of campus life. The regional campuses are working with the Office of Academic Affairs and University Marketing to incorporate regional recruitment and marketing strategies into the university's overall strategy and provide increased visibility, greater resources, an improved internet presence, and an easier application process.

## Price Driver: Fees

See Appendix for a listing of student fees.

### Instructional, General & Student Life Fees

The university continues to focus on affordability. The Ohio State Tuition Guarantee was established in FY 2018 to provide predictability and transparency for Ohio resident students and their families by locking in a set price for tuition, mandatory fees, housing, and dining for four years. Increases for entering cohorts will allow the university to continually invest in quality while addressing the inflationary cost increases that affect the rest of the economy.

Undergraduate tuition (instruction and general fees) will increase by 3.0% or $374 for new first-year students (2023-24 cohort) compared with the 2022-23 tuition guarantee cohort. Undergraduate tuition rates for students who are part of the Ohio State Tuition Guarantee (2020-21, 2021-22 and 2022-23) will not change. Students in the Tuition Guarantee cohort that began in autumn of 2019 (FY 2020), will move to the Tuition Guarantee cohort rates established for FY 2021. Ohio resident undergraduate students, not included in the Ohio State Tuition Guarantee program, resident (base) tuition and mandatory fees will remain unchanged.

Master's and Ph.D. resident (base) tuition and mandatory fees will increase by 3.8% or $500 in FY 2024. Some graduate and professional programs charge a differential instructional fee based principally on market demand and pricing. Revenue generated from these additional fees directly supports the graduate or professional program that is charging the student. Eleven programs across nine colleges are seeking changes or new differential instruction fees:

- Seven Colleges — Business, Dentistry, Law, Medicine, Optometry, Pharmacy, and Veterinary Medicine — have requested changes.
- Two Colleges — Engineering and Nursing — have requested new differentials.

### Non-Resident & International Surcharges

The non-resident surcharge will increase 5.2% or $1,269 for undergraduates and 4.2% or $1,129 for most graduate programs at each campus.

In addition, two colleges are seeking changes to the non-resident surcharge. These changes would apply instead of the standard increase (4.2%) proposed for Fiscal Year 2024:

- The College of Dentistry is requesting a 4.0% increase for all ranks.
- The College of Veterinary Medicine is requesting a 2.0% increase for Rank 1 and no change for Rank 2-4.

The undergraduate international surcharge will be held flat for FY 2024.

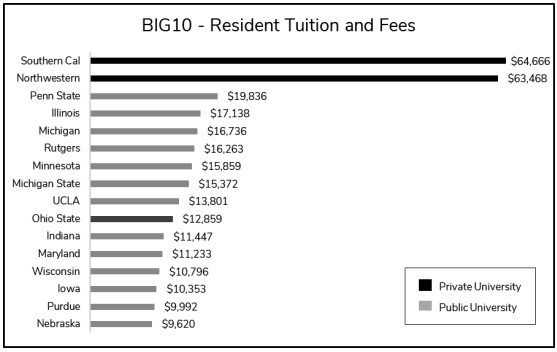
## Program / Special & Technology Fees

The College of Engineering implemented a special fee effective autumn 2022 (FY 2023) that when fully implemented will have the benefits of lower student-faculty ratio, increased program quality and rankings, more academic advisors, more internships/industry immersion, increased research activity, and alignment with future multi-disciplinary STEM degrees. This increase to the special fee applies to New First-Year Undergraduates to The Ohio State University and transfers that were New First-Year Undergraduates in autumn 2022 at another college or university. The special fee of $2,000 per semester replaced the existing program fee of $590 per semester. Students enrolled prior to autumn 2022 will continue to pay the existing program fee of $590 per semester.

Several colleges and academic programs have additional fees to support specific initiatives. In accordance with the Ohio Revised Code, these types of fees will be frozen for undergraduate students for FY 2024. Program fees are designed to provide financial support for specific academic and student programs, and technology fees support learning technology. Course fees provide classroom supplies, and distance education fees support distance education technology.

## Peer Comparison of Fees

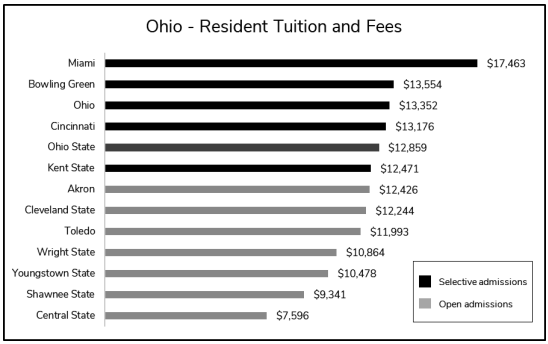
*Note: Charts below compare tuition guarantee cohort entering autumn 2023 with peers' published FY 2023 rates. Peer rates are sourced from the Association of American Universities' Data Exchange.*

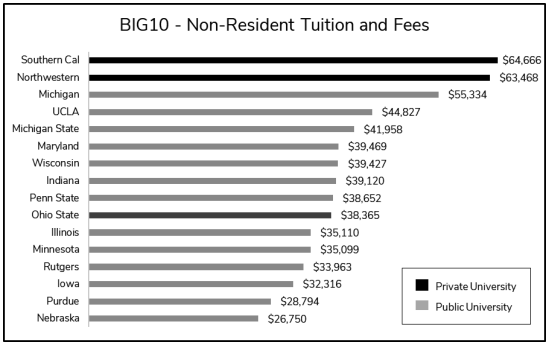



In the Big Ten, Ohio State is near the median and is more affordable than 9 of 15 Big Ten universities.

## FY 2024 FINANCIAL PLAN

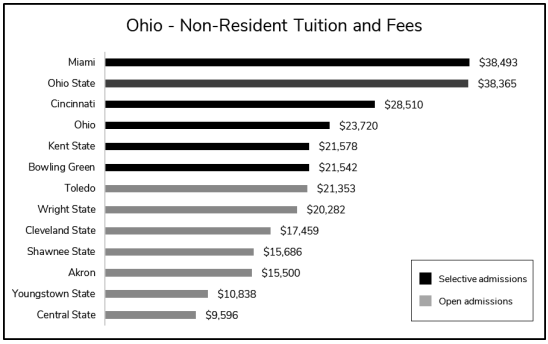
Among Ohio's six public four-year universities with selective admissions, Ohio State ranks highest in academic reputation and is the second most affordable rate for resident tuition and fees – even including the most expensive tuition guarantee cohort.

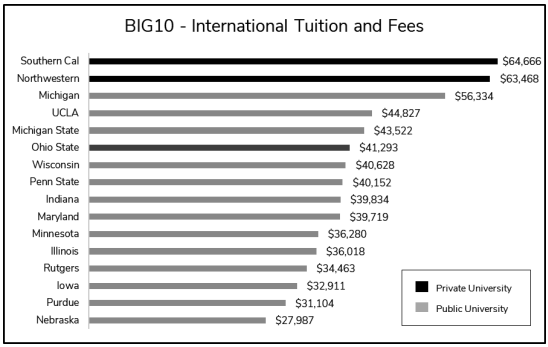



Ohio State is more affordable than 9 of 15 Big Ten schools for undergraduate non-resident tuition and fees.

Among Ohio's six public four-year universities with selective admissions, Ohio State is more affordable than one other university for non-resident tuition and fees.






Ohio State is the eleventh most affordable among the 16 Big Ten schools for undergraduate international student tuition and fees.

## Government Appropriations

The university receives funding from the State of Ohio, the federal government, and local governments to support various aspects of the university's operations. The largest category received is the State Share of Instruction (SSI), which is expected to account for approximately 82% of State funding in FY 2024.

| $ thousands | FY22 Actuals | FY23 Forecast | FY24 Plan | CAGR FY22-FY24 | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|
| State Share of Instruction | $403,957 | $417,215 | $421,387 | 2.1% | $4,173 | 1.0% |
| State Appropriations \| Operating | $89,685 | $91,441 | $94,756 | 2.8% | $3,315 | 3.6% |
| **Total Government Appropriations** | **$493,642** | **$508,656** | **$516,144** | **2.3%** | **$7,488** | **1.5%** |

### State Share of Instruction (SSI)

The SSI allocation is the State of Ohio's primary funding support for higher education. The allocation between public colleges and universities in Ohio is based on their share of enrollment and degree completions, indexed for financially and academically at-risk resident undergraduate students, medical and doctoral subsidy, and other criteria intended to advance the goals of the state. The FY 2023 forecast reflects final payout guidance from the state and is an increase over FY 2022 of 3.3%, or $13.3 million. The FY 2024 Financial Plan assumes a 1.0% state appropriation increase as part of Ohio's biennial state operating budget. The Columbus campus expects to receive approximately 95.0% of the total SSI allocation in FY 2024, or $400.5 million, with the remaining SSI earned by the regional campuses.

### State Appropriations | Operating

In addition to SSI funding, the university also receives funding directed for specific purposes through state line-item appropriations. Total appropriations for FY 2024 are projected to be $94.8 million, a $3.3 million increase over FY 2023. Major line items are anticipated to increase by 3.0% based on the biennial state operating budget, as passed by the House. Currently, the state's biennial operating budget includes a 6.7% increase for the Ohio Library and Information Network (OhioLINK/$6.1 million).

# Grants and Contracts

Grants and contracts revenue is administered in two ways: recorded by individual units in segregated grants and contracts funds or sponsored projects administered by the Office of Sponsored Programs. For FY 2024, revenue from grants and contracts (including non-exchange grants) is expected to be $1.0 billion, which is down 0.2% from FY 2023. This planned decrease is driven by Federal COVID assistance decreasing by $27.5 million to $0 in FY 2024 offset by growth in Federal grants.

| $ thousands | FY22 Actuals | FY23 Forecast | FY24 Plan | CAGR FY22-FY24 | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|
| Federal Grants and Contracts | $426,216 | $460,309 | $485,288 | 6.7% | $24,979 | 5.4% |
| Private Grants and Contracts | $269,344 | $280,023 | $279,006 | 1.8% | ($1,017) | -0.4% |
| State Grants and Contracts | $85,976 | $100,476 | $97,655 | 6.6% | ($2,821) | -2.8% |
| Local Grants and Contracts | $32,538 | $30,944 | $30,873 | -2.6% | ($71) | -0.2% |
| **Total Exchange Grants & Contracts** | **$814,074** | **$871,751** | **$892,820** | **4.7%** | **$21,069** | **2.4%** |
| Federal Grants and Contracts \| Non-Exchange | $64,077 | $64,853 | $69,558 | 4.2% | $4,705 | 7.3% |
| State Grants and Contracts \| Non-Exchange | $34,591 | $26,696 | $26,519 | -12.4% | ($177) | -0.7% |
| Federal COVID Assistance | $143,631 | $27,479 | $0 | -100.0% | ($27,479) | -100.0% |
| Federal Build America Bonds Subsidy | $11,304 | $11,304 | $11,304 | 0.0% | $0 | 0.0% |
| **Total Non-Exchange Grants & Contracts** | **$253,603** | **$130,331** | **$107,380** | **-34.9%** | **($22,951)** | **-17.6%** |
| **Total Grants & Contracts** | **$1,067,677** | **$1,002,082** | **$1,000,200** | **-3.2%** | **($1,882)** | **-0.2%** |

Of the $1.0 billion, $722.7 million is administered by the Office of Sponsored Programs, $181.9 million is administered directly by colleges and support units, $84.3 million is administered by Student Financial Aid for student aid programs, and $11.3 million is received as federal subsidy for Build America Bond interest. Projects administered by the Office of Sponsored Programs typically have a more stringent process and documentation requirements than projects that are directly administered through the Colleges and Support Units.

## Exchange Grants and Contracts

Exchange grants and contracts are administered either through the Office of Sponsored Programs or directly by colleges and support units. The university secures funding for sponsored research programs from a variety of external sources. External grants are awarded by federal, state, and local agencies along with private foundations and corporate sponsors. Total revenue for sponsored research programs administered by the Office of Sponsored Programs is expected to increase from $701.3 million in FY 2023 to approximately $722.7 million in FY 2024, an increase of 3.0%.

The sponsored research revenues include facilities and administrative (F&A) cost recoveries, which are projected to be $172.7 million, a 17.6% increase over estimated FY 2023 recovery of $146.9 million. F&A costs are recovered from most sponsored programs to offset the cost of maintaining the physical and administrative infrastructure that supports the research enterprise at the university. It is important to note that direct and indirect cost expenditures do not necessarily align when comparing expected revenue streams, which occurs for two reasons. First, certain direct cost expenditures do not recover F&A. Second, not all sponsors allow the university to recover F&A at the university's fully negotiated rate. The full negotiated F&A rate for FY 2024 will remain at 57.5%, the same rate in effect for FY 2023.

FY 2024 revenue for exchange grants and contracts administered directly by individual colleges and support units is expected to increase to $181.9 million, an increase of 4.0%.

### Non-Exchange Grants and Contracts

Some grants and contract revenues are considered non-exchange items and appear in the non-operating section of the external income statement as Non-Exchange Grants. These items include $84.3 million of grants administered by Student Financial Aid sourced from federal funding for Pell Grants and Supplemental Educational Opportunity Grants (SEOG) and state funding for Ohio College Opportunity Grants (OCOG). Final passage of the FY 2024-2025 state budget increased need-based awards for the Ohio College Opportunity Grant (OCOG) Program by $500 per student and expanded eligibility criteria that will allow more students to qualify for the grant. Student Financial Aid is currently awaiting final guidance issued by the Ohio Department of Higher Education that will provide more insight on the positive impact to need-based Ohio students enrolled in FY 2024. Any increase in OCOG revenues will have a corresponding increase in student financial aid expenses, not yet included in the FY 2024 Plan.

Two special revenue items included in non-exchange grants and contracts are federal COVID-19 assistance and funds from the JobsOhio agreement. In FY 2023, the university is forecasted to receive $27.4 million in federal COVID-19 assistance. No federal COVID-19 assistance is expected in FY 2024. The university received $7.5 million in funding from the JobsOhio agreement in FY 2023; no JobsOhio funding is planned in FY 2024.

## Sales and Services

| $ thousands | FY22 Actuals | FY23 Forecast | FY24 Plan | CAGR FY22-FY24 | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|
| Sales and Services \| Auxiliaries | $407,181 | $436,181 | $440,279 | 4.0% | $4,098 | 0.9% |
| Sales and Services \| Departmental | $197,121 | $229,520 | $216,517 | 4.8% | ($13,003) | -5.7% |
| **Total Sales and Services** | **$604,302** | **$665,701** | **$656,796** | **4.3%** | **($8,905)** | **-1.3%** |

Student Life, Athletics, and Business Advancement comprise the majority of sales and services of auxiliary enterprises. Revenue from sales and services of auxiliary enterprises before scholarship allowances is expected to increase $4.1 million or 0.9% in FY 2024 over FY 2023. There are increases in revenue in Student Life and Business Advancement with a decline in Athletics. Athletics is decreasing $14.0 million compared to FY 2023 due to 8 home football games in FY 2023 compared to 6 in FY 2024, as well as changes in the number of premium football games and changes in sponsorship agreements. FY 2024 Student Life revenue is projected to increase $6.0 million from FY 2023 based on a 3.0% increase in housing and dining rates for new first-year students and return to normal for Ohio Union conferences and meetings. Business Advancement is projecting a $10.2 million increase from FY 2023, reflecting an additional stadium concert in FY 2024 and return to normal operations for the Blackwell Hotel.

Revenue sources in educational departments consist largely of clinical operations in colleges such as Dentistry, Optometry, and Veterinary Medicine and non-college departments such as Recreational Sports and Student Health Services. Sales and Services are expected to decrease 5.7% in FY 2024 due to a decline in Technology Commercialization Office (TCO) royalties within Enterprise for Research, Innovation and Knowledge.

## Advancement Sources

| $ thousands | FY22 Actuals | FY23 Forecast | FY24 Plan | CAGR FY22-FY24 | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|
| Current Use Gifts | $174,362 | $143,564 | $166,000 | -2.4% | $22,436 | 15.6% |
| Endowment Distributions | $323,532 | $347,727 | $363,182 | 6.0% | $15,455 | 4.4% |
| **Total Advancement Sources** | **$497,894** | **$491,291** | **$529,182** | **3.1%** | **$37,891** | **7.7%** |

Gifts from alumni, friends, grateful patients, and the rest of Buckeye Nation continue to be directed to our students, faculty, campuses, and future potential. In FY 2024, the university's goal for "New Fundraising Activity" is $625 million, which is equal to the goal used in the FY 2023 Forecast. New Fundraising Activity includes gifts, pledges, and certain private contracts. The Office of Advancement fully expects to deliver results in line with expectations. Dollars are being raised by engaging a variety of constituents including students, faculty, staff, alumni, friends, corporate partners, and private foundations.

To display an operating financial plan, only the cash sources that can be used immediately against operating expenses are presented. These include current use gifts and endowment distributions.

### Current Use Gifts

In the FY 2024 Financial Plan, current use gifts are expected to increase by $22.4 million compared to the updated goal used in the FY 2023 Forecast. FY 2022 was a record (outlier) year for fundraising and receipts. Advancement fundraising goals for FY 2023 Forecast and FY 2023 Financial Plan were deliberately lower than FY 2022 actuals accordingly.

### Endowment Distributions

Endowment distributions are the spendable portion of annual distributions from the Long-Term Investment Pool (LTIP), which totals $7.38 billion as of FY 2023 and includes gifted endowment funds of $2.74 billion, designated funds of $2.90 billion, and operating funds of $1.74 billion that have been invested for long-term institutional stability. The investment team has built a portfolio of specialized investment teams around the world to implement the university's investment strategy and to be responsive to changing market conditions. The LTIP is expected to gain $518 million before fees at an 8.0% return in FY 2024 and is projected to have an ending market value of $7.82 billion at the end of FY 2024.

For the operating budget, spendable endowment distributions of $363 million for FY 2024 are anticipated. Distribution per share was calculated based on projected market values through June 2023.

## Interest Income

Interest income on cash, short and intermediate-term investments is budgeted at $59.1 million for FY 2024. This projection reflects an increase in short-term rates due to economic conditions.

# Chapter 5 | University Operating Plan | Uses

## Salaries and Benefits

| $ thousands | FY22 Actuals | FY23 Forecast | FY24 Plan | CAGR FY22-FY24 | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|
| Faculty | $577,317 | $591,131 | $633,137 | 4.7% | $42,006 | 7.1% |
| Staff | $915,300 | $994,049 | $1,052,661 | 7.2% | $58,612 | 5.9% |
| Students | $146,208 | $156,813 | $157,452 | 3.8% | $639 | 0.4% |
| **Total Salaries** | **$1,638,825** | **$1,741,992** | **$1,843,250** | **6.1%** | **$101,258** | **5.8%** |
| Benefits | $471,656 | $503,840 | $548,920 | 7.9% | $45,080 | 8.9% |
| **Total Personnel** | **$2,110,481** | **$2,245,832** | **$2,392,170** | **6.5%** | **$146,338** | **6.5%** |

### Salaries

Salary expense is expected to increase by $101.3 million or 5.8% over FY 2023. The plan for FY 2024 includes a 3% increase in faculty and staff annual merit compensation pool, which accounts for $44.7 million of the increase. Beyond salary increases, additional investments in human capital are largely driven by strategic investments in academic excellence and market wage pressures, as detailed below.

***Strategic Investments: Academic Excellence*** – With the goal of supporting academic excellence through faculty investments supporting teaching and research, the FY 2024 Plan includes incremental investments of $18.9 million for faculty salary and benefits, with an additional $18.3 million for start-up packages across numerous colleges. Colleges with planned investments in faculty compensation of $2.0 million or greater in FY 2024 include the College of Arts and Sciences ($6.9 million); the College of Medicine ($2.8 million); the College of Engineering ($2.8 million); and the College of Food, Agricultural, and Environmental Sciences ($2.2 million). Across all colleges, 140 net new faculty positions are assumed.

***Market Wage Pressures –*** Wage pressures accounted for in the FY 2024 Plan are a result of both internal and external market factors. The implementation of Career Roadmap for staff in Autumn 2022 is resulting in FY 2024 planned growth beyond the 3% merit pool, as the annual impact of compensation adjustments will be fully realized in FY 2024, while only a portion was realized in FY 2023 due to the mid-year implementation. Additionally, the raise-to-minimum for employees identified as part of the Career Roadmap salary re-banding has created compression issues that colleges and support units are reprioritizing resources to address. While faculty were not included as part of the Career Roadmap analysis, the FY 2024 Plan includes funding designated to support market-based equity adjustments for faculty. As the external labor landscape remains highly competitive, the university is facing pressures in counter-offer salary adjustments to retain existing employees, in addition to extending competitive salary offers for open positions to attract new talent.

### Benefits

Benefits consist of several different pools of costs, including retirement plans, medical plans, educational benefits, and life insurance benefits. For the forecast and budget, benefits are estimated based on the composite benefit rate applied to salaries by employee type (e.g., full-time faculty vs. part-time staff vs. students). Actual expenses may be more or less than the amount collected through the rates and vary from year to year. The composite benefit rate-setting process takes these yearly variations into account.

Total benefit costs are expected to increase by $45.1 million or 8.9% over FY 2023, to $548.9 million. This increase is primarily driven by annual merit compensation pool and composite benefit rate increases as well as strategic hiring. Benefit rate increases for FY 2024 are driven by an 8% increase in the medical plan component; these rates will continue to reflect controlled employer medical costs and historical over-collection against the expense. Benefits expense increases are also proportionate to the increases in salaries detailed above.

Controlled employer medical costs are driven by benefits plan changes that reflect recent trends in moving to consumerism. Employer medical costs are also driven by tightened controls over benefits administration and decreased inpatient and outpatient utilization from enhanced medical management processes. Benefits include the university's contribution to employee retirement plans, various medical, dental, vision, life and disability plans, employee and dependent tuition plans, and university expenses related to compulsory plans, such as workers' compensation and unemployment compensation.

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

***Medical Plan*** - The university is self-insured for employee health insurance. FY 2024 medical plan costs are budgeted based on historical cost trend data, projected employee eligibility, and expected plan changes associated with governmental regulations and plan design.

## Student Financial Aid

| $ thousands | FY22 Actuals | FY23 Forecast | FY24 Plan | CAGR FY22-FY24 | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|
| Student Aid \| Institutional | $201,670 | $193,711 | $202,211 | 0.1% | $8,500 | 4.4% |
| Student Aid \| Departmental | $76,771 | $76,137 | $71,546 | -3.5% | ($4,591) | -6.0% |
| Student Aid \| Endowment and Development | $43,342 | $50,943 | $52,621 | 10.2% | $1,678 | 3.3% |
| Student Aid \| Athletic | $27,733 | $36,149 | $37,504 | 16.3% | $1,355 | 3.7% |
| Student Aid \| Federal | $123,343 | $60,716 | $65,421 | -27.2% | $4,705 | 7.7% |
| Student Aid \| State | $16,886 | $18,882 | $18,882 | 5.7% | ($0) | 0.0% |
| **Total Student Aid** | **$489,745** | **$436,537** | **$448,185** | **-4.3%** | **$11,647** | **2.7%** |
| **Fee Authorizations** | **$130,040** | **$130,348** | **$129,350** | **-0.3%** | **($998)** | **-0.8%** |

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

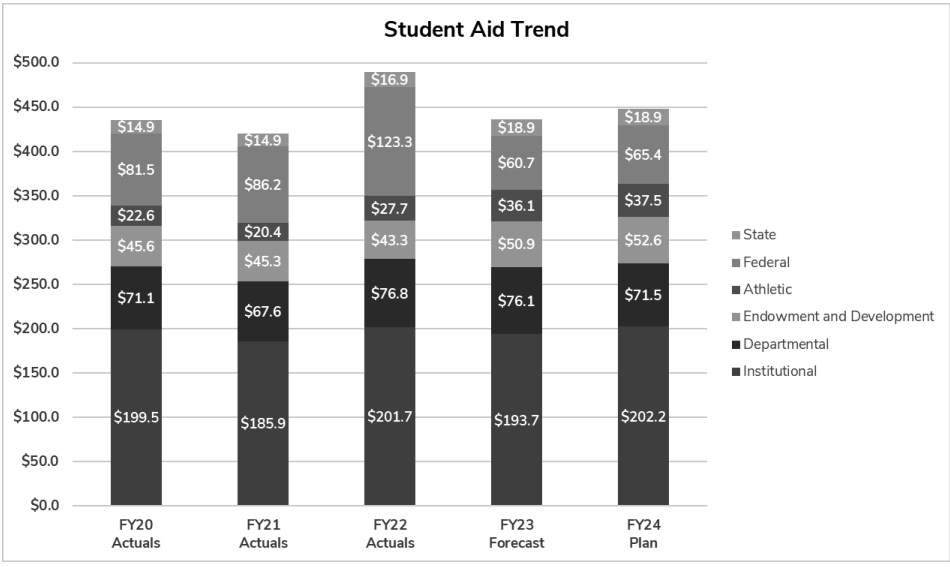
The financial aid plan seeks to advance two specific goals for the university: to invest in the quality, quantity, and diversity of students to continue to advance Ohio State as a leading national flagship public research university; and to invest in students to fulfill the role as a land grant university for the State of Ohio, whereby college access is afforded to those students with limited resources. The university continues to support both goals and develop the appropriate balance in moving the university toward eminence. Fundraising efforts are also underway through various initiatives.

## FY 2024 FINANCIAL PLAN

Since FY 2015, the university has increased financial aid to support 56,000 low- and moderate-income families by more than $305 million through FY 2023.

Ohio State expects to distribute a total of $448.2 million of financial aid, excluding graduate fee authorizations, to students in FY 2024. Sources for financial aid include federal and state programs, gifts and endowments and institutionally funded aid. The university financial statements present a portion of financial aid, in accordance with GASB accounting requirements, as an allowance against gross tuition and, in the case of athletic and room and board scholarships, an allowance against sales and services of auxiliary enterprises.

The increased budget of $11.6 million of Total Student Aid for FY 2024 includes a $1.5 million inflationary increase, a historic increase in Federal Pell grants (up to a $500 increase per student) that results in a $5 million increase, as well as a $7.0M increase in institutional aid, compared to FY 2023 Forecast. It should be noted that the FY 2024 institutional financial aid funding level is not an increase when compared to the original FY 2023 Plan and reflects a return to historical spending levels, after an unplanned decline in FY 2023. The FY 2024 state funded financial aid projection was finalized prior to the approval of the FY 2024-25 state operating budget. Student Financial Aid is currently awaiting final guidance issued by the Ohio Department of Higher Education that will provide more insight on the positive impact to need-based Ohio students enrolled in FY 2024. Any increase in OCOG revenues will have a corresponding increase in student financial aid expenses, not yet included in the FY 2024 Plan.



## Fee Authorizations

Fee authorizations are provided to students holding graduate student appointments to pay for graduate tuition and fees. Total university fee authorization expense is expected to remain flat, with a total of $129.4 million planned in FY 2024.

## Supplies and Services

Supplies and services expenses are comprised of several discrete categories, including the following: Cost of Sales, Supplies, Services, Travel, Utilities, Other Expense and Non-Capitalized Equipment, all offset by Intra-University Revenue. Additionally, this category includes expenses related to the institutional response to COVID-19 in FY 2022.

| $ thousands | FY22 Actuals | FY23 Forecast | FY24 Plan | CAGR FY22-FY24 | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|
| Cost of Sales | $125,794 | $132,698 | $137,399 | 4.5% | $4,701 | 3.5% |
| Supplies | $128,465 | $153,054 | $163,170 | 12.7% | $10,116 | 6.6% |
| Services | $487,549 | $480,232 | $488,537 | 0.1% | $8,305 | 1.7% |
| Travel | $24,773 | $71,160 | $71,796 | 70.2% | $636 | 0.9% |
| Utilities | $172,088 | $180,297 | $188,471 | 4.7% | $8,173 | 4.5% |
| Other Expense | $259,015 | $198,159 | $197,097 | -12.8% | ($1,062) | -0.5% |
| Investment Expenses | $70,865 | $67,307 | $67,000 | -2.8% | ($307) | -0.5% |
| Non-Capital Equipment (< $5k) | $49,038 | $88,955 | $101,955 | 44.2% | $13,000 | 14.6% |
| Intra-University Revenue | ($277,786) | ($211,515) | ($208,012) | -13.5% | $3,504 | -1.7% |
| **Total Supplies and Services** | **$1,039,801** | **$1,160,347** | **$1,207,412** | **7.8%** | **$47,065** | **4.1%** |

Overall, supplies and services expenses are projected to increase $47.1 million or 4.1% over FY 2023 to $1.2 billion. In response to global macroeconomic trends, we are planning for general inflation of 3.0%, which yields an increase of approximately $35 million. While FY 2023 experienced a significant increase in travel from FY 2022 due to a return to normal post-COVID, travel expenses are expected to remain relatively flat in FY 2024. The remaining increase is attributable to strategic investments by colleges and support units. The largest area of investment is in support of research growth and faculty, particularly in the College of Medicine and the College of Arts and Sciences, which accounts for a total $12.1 million increase after inflation.

## University Debt Service

The proceeds of debt issuances have been utilized to fund major construction projects, including the Wexner Medical Center expansion, student housing construction and refurbishments, and significant campus infrastructure improvements and academic facility construction and enhancements. A portion of the consolidated debt service budget is aligned with the Health System based on its internal loan amortization schedules, with the remainder attributed to the university. The university's portion of the consolidated debt service is expected to decrease $29.2 million from FY 2023 to approximately $83.2 million in FY 2024, driven by debt restructuring. In April 2023, the University issued $328.8M in variable-rate refunding bonds, which have been swapped into a fixed-rate of 1.23% by leveraging swap agreements entered in May 2020. See Chapter 8 for additional details on current capital projects.

# Chapter 6 | Health System Operating Plan

In order to consolidate the University with the Health System, we format the Health System budget into a sources and uses view as provided below:

| Total Sources ($ thousands) | FY22 Actuals | FY23 Forecast | FY24 Plan | CAGR FY22-FY24 | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|
| Sales & Services \| Health System | $4,181,644 | $3,995,697 | $4,331,152 | 1.8% | $335,455 | 8.4% |
| Interest Income | - | $15,025 | $32,767 | > 1,000% | $17,743 | 118.1% |
| **Total Sources** | **$4,181,644** | **$4,010,722** | **$4,363,920** | **2.2%** | **$353,198** | **8.8%** |

| Total Uses ($ thousands) | FY22 Actuals | FY23 Forecast | FY24 Plan | CAGR FY22-FY24 | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|
| **Total Personnel Expense** | **$1,654,822** | **$1,850,328** | **$1,989,846** | **9.7%** | **$139,518** | **7.5%** |
| Supplies, Services & Other | $1,880,468 | $1,676,423 | $1,840,314 | -1.1% | $163,891 | 9.8% |
| Debt Service | $103,270 | $117,233 | $113,125 | 4.7% | ($4,108) | -3.5% |
| **Total Non-Personnel Expense** | **$1,983,738** | **$1,793,656** | **$1,953,439** | **-0.8%** | **$159,783** | **8.9%** |
| **Total Uses** | **$3,638,560** | **$3,643,984** | **$3,943,284** | **4.1%** | **$299,300** | **8.2%** |
| Sources Less Uses, Operating | $543,084 | $366,738 | $420,635 | | | |
| **Total Capital-Related Sources** | **$259,974** | **$410,940** | **$330,488** | | | |
| **Total Capital-Related Uses** | **$710,720** | **$783,666** | **$652,829** | | | |
| Sources Less Uses, Capital | ($450,745) | ($372,726) | ($322,341) | | | |
| Sources Less Uses, Capital and Operating | $92,339 | ($5,988) | $98,294 | | | |

The managerial Income Statement view provided on behalf of the Health System is provided below:

| Health System ($ thousands) | FY22 Actuals | FY23 Forecast | FY24 Plan | CAGR FY22-FY24 | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|
| **Total Operating Revenue** | **$3,816,536** | **$3,995,697** | **$4,331,152** | **6.5%** | **$335,455** | **8.4%** |
| **Operating Expenses** | | | | | | |
| Salaries & Benefits | $1,721,204 | $1,850,328 | $1,989,846 | 7.5% | $139,518 | 7.5% |
| Supplies | $423,060 | $469,523 | $498,820 | 8.6% | $29,297 | 6.2% |
| Drugs & Pharmaceuticals | $510,658 | $542,704 | $618,888 | 10.1% | $76,184 | 14.0% |
| Services | $399,278 | $405,697 | $454,807 | 6.7% | $49,110 | 12.1% |
| Depreciation | $187,800 | $218,174 | $242,307 | 13.6% | $24,133 | 11.1% |
| Interest | $42,275 | $44,443 | $41,879 | -0.5% | ($2,564) | -5.8% |
| University Overhead | $74,793 | $74,157 | $78,581 | 2.5% | $4,424 | 6.0% |
| Other Expenses | $59,387 | $68,028 | $71,337 | 9.6% | $3,309 | 4.9% |
| **Total Expenses** | **$3,418,455** | **$3,673,054** | **$3,996,465** | **8.1%** | **$323,411** | **8.8%** |
| Gain/Loss from Operations | $398,081 | $322,643 | $334,687 | | | |
| **Medical Center Investments** | **($190,419)** | **($229,071)** | **($240,361)** | **12.4%** | **($11,290)** | **4.9%** |
| **Investment Income** | **($726)** | **$26,463** | **$26,943** | **> 1,000%** | **$480** | **1.8%** |
| **Other Gains (Losses)** | **$119,974** | **$162,905** | **$30,223** | **-49.8%** | **($132,682)** | **-81.4%** |
| Excess of Revenue over Expenses | $326,910 | $282,940 | $151,492 | | | |

## FY 2024 FINANCIAL PLAN

The margin for the OSU Health System is budgeted at $151.5 million for FY 2024. The operating budget is set at a level to achieve the organization's strategic and long-range financial plan goals and provides the necessary margin to invest in clinical programs, strategic capital and provide debt service coverage. The operating budget for FY 2024 anticipates continued growth in both inpatient and outpatient activities, with the cancer program, new ambulatory services and surgical specialties being the leading contributors. The budget also includes assumptions around healthcare reform impacts on reimbursement. In addition, the budget continues to incorporate payer mix changes resulting from an aging population with shifts to Medicare. Included in the budget is the Health System's continued investment in Medical Center initiatives ($240 million). The budget provides a Total Margin percentage of 3.5% and earnings before interest, taxes, depreciation, and amortization (EBITDA) margin of 10.1%.

### Revenue Drivers

Overall revenue is budgeted to increase 8.4% compared to a 4.7% increase in FY 2023. Inpatient discharge growth is budgeted at 5.5% above FY 2023. Growth is projected across numerous specialties with reductions in length of stay assumed to drive additional capacities. Outpatient activity is expected to grow 4.2% in total. The outpatient growth is being driven by the continued ramp-up of the Outpatient Care New Albany and Dublin facilities and opening of the James Outpatient Care facility.

The overall payer mix continues to see growth in Medicare and decreases in managed care. Overall, Medicare rates will increase by approximately 2%. Managed care plan migration to Medicare due to the aging population is anticipated at 2% in FY 2024. Managed care arrangements are negotiated through the end of FY 2024 and, in some cases, into FY 2025. Inflation, quality driven outcomes and risk-based contracts are the primary drivers in ongoing negotiations with payers and are reflected in the modeled reimbursement rates. The payment increases for managed care contracts are on average 5% in rate growth, while governmental payer base rates are anticipated to increase 1-2%.

### Expense Drivers

Total operating expenses will grow by 8.8% compared to the prior-year growth of 7.4%. Drug costs are increasing 14.0% with 5.0% due to inflation, and the remaining impact is primarily due to growth in infusions and increased cancer drug utilization. Operating expenses, excluding drugs, depreciation and overhead, are budgeted to grow 7.7%, of which 3.4% will be activity driven and 4.3% rate driven. Annual salary merit increases are budgeted at 3% and an additional 2% is planned in the budget relating to market increases for employee retention and recruitment. Benefit rates are expected to increase 4.0% from FY 2023. Revenue enhancement and expense efficiency initiatives will continue to be an emphasis to mitigate pressures around inflationary expense impacts on labor, supplies and drugs.

# Chapter 7 | OSU Physicians Operating Plan

In order to consolidate the University with the OSU Physicians (OSUP), we format the OSUP budget into a sources and uses view as provided below.

| Total Sources ($ thousands) | FY22 Actuals | FY23 Forecast | FY24 Plan | CAGR FY22-FY24 | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|
| Sales & Services \| OSU Physicians | $758,874 | $866,101 | $943,215 | 11.5% | $77,114 | 8.9% |
| Net Transfers from OSU Health System | $118,155 | $137,253 | $153,934 | 14.1% | $16,681 | 12.2% |
| **Total Sources** | **$877,029** | **$1,003,354** | **$1,097,149** | **11.8%** | **$93,795** | **9.3%** |

| Total Uses ($ thousands) | FY22 Actuals | FY23 Forecast | FY24 Plan | CAGR FY22-FY24 | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|
| **Total Personnel Expense** | **$627,794** | **$642,813** | **$692,079** | **5.0%** | **$49,266** | **7.7%** |
| Supplies, Services & Other | $230,000 | $355,445 | $399,040 | 31.7% | $43,595 | 12.3% |
| **Total Non-Personnel Expense** | **$230,000** | **$355,445** | **$399,040** | **31.7%** | **$43,595** | **12.3%** |
| **Total Uses** | **$857,794** | **$998,257** | **$1,091,119** | **12.8%** | **$92,862** | **9.3%** |
| Sources Less Uses, Operating | $19,235 | $5,097 | $6,030 | | | |

The managerial Income Statement view provided on behalf of the OSU Physicians is provided below:

| OSU Physicians ($ thousands) | FY22 Actuals | FY23 Forecast | FY24 Plan | CAGR FY22-FY24 | FY23-FY24 $ Diff | FY23-FY24 % Diff |
|---|---|---|---|---|---|---|
| **Revenue** | | | | | | |
| Net Patient Revenue | $614,375 | $625,970 | $693,167 | 6.2% | $67,197 | 10.7% |
| Other Revenue | $143,826 | $236,343 | $246,448 | 30.9% | $10,105 | 4.3% |
| Medical Center Investments | $118,155 | $137,253 | $153,934 | 14.1% | $16,681 | 12.2% |
| Interest Income | $673 | $3,788 | $3,600 | 131.3% | ($188) | -5.0% |
| **Total Revenue** | **$877,029** | **$1,003,354** | **$1,097,149** | **11.8%** | **$93,795** | **9.3%** |
| **Expenses** | | | | | | |
| Provider Salaries & Benefits | $627,794 | $642,813 | $692,079 | 5.0% | $49,266 | 7.7% |
| Non-Provider Salaries & Benefits | $136,829 | $186,741 | $209,951 | 23.9% | $23,210 | 12.4% |
| Other Expenses | $93,171 | $168,704 | $189,089 | 42.5% | $20,385 | 12.1% |
| Depreciation | $9,935 | $4,861 | $5,013 | -29.0% | $152 | 3.1% |
| Interest | $3,339 | $236 | $243 | -73.0% | $7 | 3.0% |
| **Total Expenses** | **$871,068** | **$1,003,354** | **$1,096,375** | **12.2%** | **$93,022** | **9.3%** |
| Change in Net Assets | $5,961 | - | $774 | | $774 | n/a |

Total revenue is budgeted to increase $93.8 million or 9.3% over FY 2023. Total operating revenue includes net patient revenue and other operating revenue associated with physician services. Net patient revenue is budgeted to increase $67.2 million or 10.7% over FY 2023 due to faculty recruitment, increased clinical productivity, and expansion of services through opening Outpatient Care West Campus and continued growth at Outpatient Care Dublin and Outpatient Care New Albany. Other operating revenue and MCI are budgeted to increase $26.6 million due primarily to support for and growth in specific healthcare service lines.

Total expenses are expected to increase by $93.0 million. Expense categories with the largest increases were physician salaries & benefits and staff salaries & benefits. Expenses are included for staff, supplies and depreciable equipment in preparation for opening Outpatient Care West Campus. Growth in staff salaries includes investment in the expansion of services and service locations including new Community Outreach practices. Generally, the amount of time for a new practice to reach full profitability is approximately 2-3 years.

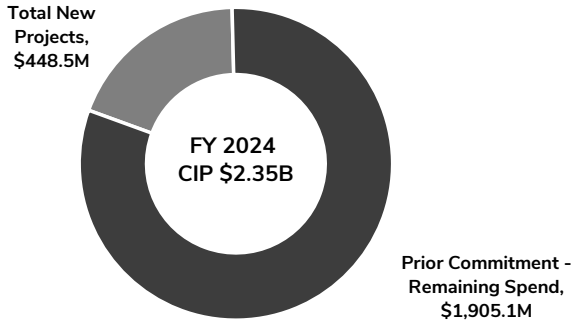
## FY 2024 FINANCIAL PLAN

Work continues to increase revenue growth through several initiatives. In addition, expense control measures continue to evolve to help keep controllable costs, such as the number of staff, supplies, and services, in line with revenue changes. Annual salary merit increases are budgeted at 3% and an additional 2% is planned in the budget relating to market increases for employee retention and recruitment. Benefit rates are expected to increase 4.0% from FY 2023. The budget also includes assumptions about the inflationary impact on supplies and offsetting supplies expense mitigation strategies. These assumptions are aligned with the Health System.

# Chapter 8 | Capital Investment Plan FY 2024-28

The university is planning to invest more than $2.35 billion through FY 2028 in strategic physical plant projects as detailed in the FY 2024-28 Capital Investment Plan. Each year, Ohio State completes a robust capital planning process resulting in a comprehensive Capital Investment Plan that reflects all capital investments across six campuses and the Wexner Medical Center, regardless of funding source. Each project is evaluated for alignment with strategic, physical, and financial plans prior to inclusion in the Capital Investment Plan. This integrated approach ensures that capital investments support the strategic mission of the university.

The Capital Investment Plan captures the spend on all capital projects, defined as projects over $200,000, that are in various stages of implementation or are anticipated to begin in FY 2024. The following chart reflects the capital plan through FY 2028. Of the total $2.354 billion, $1.905 billion is remaining spend on projects previously committed and $0.449 billion is on new projects beginning in FY 2024. The remaining spend reflects the active strategic capital projects including the Wexner Medical Center Inpatient Hospital. The total for new spend includes the projects for which state capital funding has been requested.



## FY 2024 FINANCIAL PLAN

### Prior Commitment Remaining Spend

| Capital Priority | Projected Capital Expenditures | | | | | |
|---|---|---|---|---|---|---|
| $ millions | FY 2024 | FY 2025 | FY 2026 | FY 2027 | FY 2028 | Total |
| A&S - Arts District | $ 9.9 | $ 2.1 | - | - | - | $ 11.9 |
| A&S - Celeste Lab Renovation | $ 8.4 | $ 7.0 | $ 1.4 | - | - | $ 16.8 |
| COE - BMEC Phase 2 | $ 11.6 | $ 50.6 | $ 19.6 | $ 1.1 | - | $ 82.9 |
| COE - CAR Bus Testing Facility | $ 3.3 | $ 9.2 | $ 5.3 | $ 5.3 | $ 2.9 | $ 25.9 |
| COM - Interdisciplinary Health Sciences Center | $ 32.5 | $ 12.1 | $ 0.7 | - | - | $ 45.2 |
| EHE - Campbell Hall Renovation | $ 4.1 | $ 22.5 | $ 32.0 | $ 0.3 | - | $ 58.8 |
| ERIK - Energy Advancement and Innovation Center | $ 11.6 | $ 2.7 | - | - | - | $ 14.3 |
| ERIK - Pelotonia Research Center | $ 19.6 | $ 13.9 | - | - | - | $ 33.4 |
| FOD - Cannon Drive Relocation - Phase 2 | $ 15.5 | $ 27.5 | $ 10.9 | - | - | $ 54.0 |
| FOD - Elevator Safety Repairs and Replacements | $ 3.1 | $ 1.6 | - | - | - | $ 4.7 |
| FOD - Roof Repairs and Replacements | $ 1.3 | $ 3.3 | - | - | - | $ 4.6 |
| LIB - Library Book Depository Phase 3 | $ 3.5 | $ 0.7 | - | - | - | $ 4.2 |
| Newark - Founders Hall Enhancements | $ 3.0 | $ 19.4 | $ 1.1 | - | - | $ 23.4 |
| Nursing - Jane E Heminger Hall and Newton Renovation | $ 5.3 | $ 0.3 | - | - | - | $ 5.6 |
| Vet Med - Equine Arena | $ 3.2 | $ 6.1 | - | - | - | $ 9.2 |
| WMC - Inpatient Hospital | $ 402.0 | $ 299.7 | $ 141.5 | $ 68.5 | - | $ 911.7 |
| WMC - James Outpatient Care | $ 41.7 | $ 32.4 | $ 2.6 | - | - | $ 76.7 |
| WMC - Loading Dock Expansion and Renovation | $ 8.2 | $ 6.1 | $ 0.4 | - | - | $ 14.6 |
| WMC - Martha Morehouse Facility Improvements | $ 10.4 | $ 8.4 | - | - | - | $ 18.7 |
| WMC - Outpatient Care New Albany | $ 3.3 | - | $ 1.9 | - | - | $ 5.2 |
| WMC - Outpatient Care Powell | $ 2.8 | $ 1.3 | $ 7.6 | $ 7.2 | $ 1.0 | $ 19.9 |
| Wooster - Fisher Auditorium Renovation | $ 0.4 | $ 4.1 | $ 3.5 | - | - | $ 8.0 |
| Roll Up Other Projects | $ 227.9 | $ 155.3 | $ 65.8 | $ 5.7 | $ 0.4 | $ 455.2 |
| **Total Prior** | **$ 832.5** | **$ 685.9** | **$ 294.3** | **$ 88.1** | **$ 4.3** | **$ 1,905.1** |

### New Projects Beginning in FY 2024

| Capital Priority | Projected Capital Expenditures | | | | | |
|---|---|---|---|---|---|---|
| $ millions | FY 2024 | FY 2025 | FY 2026 | FY 2027 | FY 2028 | Total |
| **Anticipated Spend for CIP Changes** | **$ 10.0** | - | - | - | - | **$ 10.0** |
| **Roll up of Small Infrastructure RDM Projects** | **$ 15.3** | **$ 14.4** | **$ 8.5** | **$ 2.5** | **$ 4.8** | **$ 45.6** |
| **Small Programmatic Cash Ready** | **$ 12.2** | **$ 20.1** | **$ 10.0** | **$ 0.7** | - | **$ 43.1** |
| **WMC - Roll up of Multiple Cash Ready** | **$ 197.7** | - | - | - | - | **$ 197.7** |
| **New Major Projects** | **$ 19.4** | **$ 58.1** | **$ 42.8** | **$ 25.8** | **$ 6.3** | **$ 152.2** |
| A&S - Biological Sciences Building Upgrades | $ 0.4 | $ 2.4 | $ 5.3 | $ 4.7 | $ 2.3 | $ 15.0 |
| A&S - Department of Economics Relocation | $ 0.8 | $ 3.1 | $ 3.5 | $ 2.3 | $ 0.3 | $ 10.0 |
| CFAES - Multispecies Animal Learning Center - Waterman | $ 4.2 | $ 15.3 | $ 17.4 | $ 11.2 | $ 1.7 | $ 49.8 |
| ERIK - Battery Cell Research and Demonstration Center | $ 1.2 | $ 4.9 | $ 7.0 | $ 5.3 | $ 1.7 | $ 20.0 |
| VET - VMC PET/CT Space Renovation | $ 1.3 | $ 3.6 | $ 1.6 | - | - | $ 6.5 |
| WMC - Inpatient Hospital Endo/Bronch/Admin Suite | $ 8.0 | $ 18.0 | $ 1.0 | - | - | $ 27.0 |
| WMC - James Cellular Therapy Lab | $ 1.3 | $ 3.8 | $ 1.7 | - | - | $ 6.8 |
| WMC - James Outpatient Care Buildout | $ 1.3 | $ 3.8 | $ 1.7 | - | - | $ 6.8 |
| WMC - Magnetic Resonance Linear Accelerator & Housing | $ 0.9 | $ 3.2 | $ 3.6 | $ 2.3 | $ 0.3 | $ 10.3 |
| **New Projects Beginning in FY24** | **$ 254.6** | **$ 92.6** | **$ 61.3** | **$ 28.9** | **$ 11.1** | **$ 448.5** |

## Capital Plan Funding Sources

Capital projects are funded with a variety of sources, including state capital appropriations, fundraising, debt proceeds, current year operating margins and existing cash from units and central university. As discussed previously, operating margins can be highly restrictive, and only certain funds are available for capital uses. As projects are completed, restricted dollars such as state capital appropriations and private capital gifts typically are used first, followed by existing cash, depending on the project or funding plan. Each project requiring debt must have a specific funding plan completed and approved before inclusion in the capital plan. For the FY 2024-2028 Capital Investment Plan, the following represents the sources identified to fund the new projects.

| Unit Type ($ millions) | Local | State | Fundraising | Grant | Partnership Funding | University Debt | Grand Total | % by Unit |
|---|---|---|---|---|---|---|---|---|
| Academic Support | $ 71.4 | $ 10.0 | $ 19.0 | $ 4.8 | $ 16.0 | $ 15.2 | $ 136.4 | 30% |
| Athletics | $ 14.3 | - | $ 2.7 | - | - | - | $ 17.0 | 4% |
| Infrastructure | $ 13.4 | - | - | $ 8.1 | $ 0.5 | $ 7.5 | $ 29.4 | 7% |
| Regional Campuses | $ 0.2 | - | - | - | $ 2.5 | - | $ 2.6 | 1% |
| Student Life | $ 14.5 | - | - | - | - | - | $ 14.5 | 3% |
| Wexner Medical Center | $ 248.6 | - | - | - | - | - | $ 248.6 | 55% |
| **Grand Total** | **$ 362.3** | **$ 10.0** | **$ 21.7** | **$ 12.9** | **$ 18.9** | **$ 22.7** | **$ 448.5** | **100%** |
| % by Fund Source | 80.8% | 2.2% | 4.8% | 2.9% | 4.2% | 5.1% | 100.0% | |

# Chapter 9 | Economic Impact of Ohio State

The university's economic impact on the state of Ohio provides important context to understand the FY 2024 Financial Plan. To quantify Ohio State's current economic impact in Ohio, the Enterprise for Research, Innovation and Knowledge (ERIK) commissioned an analysis of the regional and statewide economic impact in collaboration with units and colleges across the university. The report accounts for the ripple effects of spending by employees, students and visitors on retail purchases, restaurant meals, hotel occupancy, events and other goods and services that filter through the economy and support jobs. The figures below represent the data for FY 2019 as it was the most recent pre-pandemic year for which university financial data, student and visitor spending data, and industry sector economic data was available.

The FY 2019 analysis showed that The Ohio State University generates $19.6 billion annually in economic impact for the state of Ohio – which equates to more than $2.244 million in economic impact every hour.

Ohio State's research enterprise, medical complex, construction projects, athletics events and status as Ohio's fifth-largest employer combined to support more than 116,819 jobs generating over $7.5 billion in labor income in Ohio.

The total economic impact is attributed to Ohio State's six campuses, academic medical complexes, and the Department of Athletics. The analysis estimated that the Columbus campus alone generated $9.7 billion in industry output, supporting 61,243 jobs, and stimulating $327.9 million in state and local tax revenue. The Wexner Medical Center generated $9.4 billion, directly supported nearly 52,294 full- and part-time jobs resulting in $318.3 million of state and local tax revenue.

Alongside $8.5 billion in operational and capital expenditures, The Ohio State university is estimated to stimulate $341.8 million in student spending, and $585.5 million in visitor spending in the state of Ohio. Overall, every dollar of state investment in The Ohio State University has leveraged $31 of economic impact.


The Ohio State University is made up of the Columbus campus, four regional campuses in Lima, Mansfield, Marion, Newark, and the Wooster Campus, which includes the Agricultural Technical Institute (ATI) and the Ohio Agricultural Research and Development Center (OARDC). The university also has a presence in all 88 Ohio counties in the form of OSU Extension offices and numerous farms and research facilities throughout the state.

# Appendix A | Student Fees

## Columbus Undergraduate Fees

**Columbus Campus**
**Typical Annual Undergraduate Fees by Cohort (Autumn and Spring Terms)**

| Resident | Continuing, enrolled between August 2015 and July 2017 | Cohort 2020-2021 | Cohort 2021-2022 | Cohort 2022-2023 | Cohort 2023-2024 |
|---|---|---|---|---|---|
| Instructional Fees | $ 9,351 | $ 10,615 | $ 11,018 | $ 11,525 | $ 11,826 |
| General Fees | $ 390 | $ 401 | $ 416 | $ 458 | $ 524 |
| Student Activity Fee | $ 75 | $ 80 | $ 80 | $ 80 | $ 80 |
| Student Union Fee | $ 149 | $ 149 | $ 149 | $ 149 | $ 149 |
| Rec Fee | $ 246 | $ 246 | $ 246 | $ 246 | $ 253 |
| COTA Fee | $ 27 | $ 27 | $ 27 | $ 27 | $ 27 |
| **Total Tuition and Fees** | **$ 10,238** | **$ 11,518** | **$ 11,936** | **$ 12,485** | **$ 12,859** |
| Housing (Rate I) | $ 7,876 | $ 8,874 | $ 9,096 | $ 9,514 | $ 9,798 |
| Dining (Gray 10) | $ 3,790 | $ 4,152 | $ 4,256 | $ 4,452 | $ 4,584 |
| **Total** | **$ 21,904** | **$ 24,544** | **$ 25,288** | **$ 26,451** | **$ 27,241** |

| Non-Resident Domestic | Continuing, enrolled between August 2015 and July 2017 | Cohort 2020-2021 | Cohort 2021-2022 | Cohort 2022-2023 | Cohort 2023-2024 |
|---|---|---|---|---|---|
| Instructional Fees | $ 9,351 | $ 10,615 | $ 11,018 | $ 11,525 | $ 11,826 |
| General Fees | $ 390 | $ 401 | $ 416 | $ 458 | $ 524 |
| Student Activity Fee | $ 75 | $ 80 | $ 80 | $ 80 | $ 80 |
| Student Union Fee | $ 149 | $ 149 | $ 149 | $ 149 | $ 149 |
| Rec Fee | $ 246 | $ 246 | $ 246 | $ 246 | $ 253 |
| COTA Fee | $ 27 | $ 27 | $ 27 | $ 27 | $ 27 |
| Non-Resident Surcharge | $ 25,506 | $ 25,506 | $ 25,506 | $ 25,506 | $ 25,506 |
| **Total Tuition and Fees** | **$ 35,744** | **$ 37,024** | **$ 37,442** | **$ 37,991** | **$ 38,365** |
| Housing (Rate I) | $ 7,876 | $ 8,874 | $ 9,096 | $ 9,514 | $ 9,798 |
| Dining (Gray 10) | $ 3,790 | $ 4,152 | $ 4,256 | $ 4,452 | $ 4,584 |
| **Total** | **$ 47,410** | **$ 50,050** | **$ 50,794** | **$ 51,957** | **$ 52,747** |

| Non-Resident International | Continuing, enrolled between August 2015 and July 2017 | Cohort 2020-2021 | Cohort 2021-2022 | Cohort 2022-2023 | Cohort 2023-2024 |
|---|---|---|---|---|---|
| Instructional Fees | $ 9,351 | $ 10,615 | $ 11,018 | $ 11,525 | $ 11,826 |
| General Fees | $ 390 | $ 401 | $ 416 | $ 458 | $ 524 |
| Student Activity Fee | $ 75 | $ 80 | $ 80 | $ 80 | $ 80 |
| Student Union Fee | $ 149 | $ 149 | $ 149 | $ 149 | $ 149 |
| Rec Fee | $ 246 | $ 246 | $ 246 | $ 246 | $ 253 |
| COTA Fee | $ 27 | $ 27 | $ 27 | $ 27 | $ 27 |
| Non-Resident Surcharge | $ 25,506 | $ 25,506 | $ 25,506 | $ 25,506 | $ 25,506 |
| International Surcharge | $ 1,932 | $ 2,928 | $ 2,928 | $ 2,928 | $ 2,928 |
| **Total Tuition and Fees** | **$ 37,676** | **$ 39,952** | **$ 40,370** | **$ 40,919** | **$ 41,293** |
| Housing (Rate I) | $ 7,876 | $ 8,874 | $ 9,096 | $ 9,514 | $ 9,798 |
| Dining (Gray 10) | $ 3,790 | $ 4,152 | $ 4,256 | $ 4,452 | $ 4,584 |
| **Total** | **$ 49,342** | **$ 52,978** | **$ 53,722** | **$ 54,885** | **$ 55,675** |

Undergraduate tuition and fee rates reflected above do not include program specific, special or technology fees that may be assessed based on major or program of study. For more information see: https://registrar.osu.edu/feetables/mainfeetables.asp

## Regional Campus and ATI Undergraduate Fees

| Undergraduate Cohort | Instructional Fees | General Fees | Resident Total | Non-Resident Surcharge | Non-Resident (Domestic) Total |
|---|---|---|---|---|---|
| AGRICULTURAL TECHNICAL INSTITUTE | | | | | |
| Continuing, enrolled prior to August 2017 | 3,507.00 | 116.50 | **3,623.50** | 12,753.00 | **16,376.50** |
| Cohort 2017-2018 | 3,644.40 | 114.00 | **3,758.40** | 12,753.00 | **16,511.40** |
| Cohort 2018-2019 | 3,690.00 | 114.00 | **3,804.00** | 12,753.00 | **16,557.00** |
| Cohort 2019-2020 | 3,819.00 | 118.00 | **3,937.00** | 12,753.00 | **16,690.00** |
| Cohort 2020-2021 | 3,975.50 | 123.00 | **4,098.50** | 12,753.00 | **16,851.50** |
| Cohort 2021-2022 | 4,126.50 | 127.50 | **4,254.00** | 12,753.00 | **17,007.00** |
| Cohort 2022-2023 | 4,316.50 | 133.50 | **4,450.00** | 12,753.00 | **17,203.00** |
| Cohort 2023-2024 | 4,446.00 | 137.50 | **4,583.50** | 12,753.00 | **17,336.50** |
| LIMA, MANSFIELD, MARION, NEWARK - UNDERGRADUATE | | | | | |
| Continuing, enrolled prior to August 2017 | 3,525.00 | 116.50 | **3,641.50** | 12,753.00 | **16,394.50** |
| Cohort 2017-2018 | 3,662.40 | 114.00 | **3,776.40** | 12,753.00 | **16,529.40** |
| Cohort 2018-2019 | 3,708.00 | 114.00 | **3,822.00** | 12,753.00 | **16,575.00** |
| Cohort 2019-2020 | 3,838.00 | 118.00 | **3,956.00** | 12,753.00 | **16,709.00** |
| Cohort 2020-2021 | 3,995.50 | 123.00 | **4,118.50** | 12,753.00 | **16,871.50** |
| Cohort 2021-2022 | 4,147.50 | 127.50 | **4,275.00** | 12,753.00 | **17,028.00** |
| Cohort 2022-2023 | 4,338.50 | 133.50 | **4,472.00** | 12,753.00 | **17,225.00** |
| Cohort 2023-2024 | 4,468.50 | 137.50 | **4,606.00** | 12,753.00 | **17,359.00** |

Undergraduate tuition and fee rates reflected above do not include program specific, special or technology fees that may be assessed based on major or program of study. For more information see: https://registrar.osu.edu/feetables/mainfeetables.asp

# Graduate and Professional Fees

| Program | Instructional | General | Student Activity | Student Union | Recreation | COTA | Distance Education | Resident Total | Non-Resident Surcharge | Non-Resident Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Masters & PhD - Columbus | 6,257.50 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 6,748.40 | 13,865.00 | 20,613.40 |
| Masters & PhD - Online - Columbus | 6,257.50 | 239.00 | | | | | 100.00 | 6,596.50 | 200.00 | 6,796.50 |
| Masters & PhD - Regional | 6,223.00 | 129.50 | - | - | - | - | - | 6,352.50 | 13,865.00 | 20,217.50 |
| Doctor of Audiology | 6,257.50 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 6,748.40 | 13,865.00 | 20,613.40 |
| Master of Speech-Language Pathology | 6,257.50 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 6,748.40 | 13,865.00 | 20,613.40 |
| Graduate Minor in Business for Health Sciences | 11,644.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 12,134.90 | 5.00 | 12,139.90 |
| Master of Accounting | 15,728.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 16,218.90 | 13,865.00 | 30,083.90 |
| Master of Business Administration (MBA) | 14,876.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 15,366.90 | 13,865.00 | 29,231.90 |
| Master of Business Administration - Working Professional | 12,592.00 | 164.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 13,007.90 | 11,816.20 | 24,824.10 |
| Master of Business Administration - Working Professional Online | 12,592.00 | 164.00 | - | - | - | - | 100.00 | 12,856.00 | 200.00 | 13,056.00 |
| Master of Human Resource Management (MHRM) | 8,505.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 8,995.90 | 12,227.23 | 21,223.13 |
| Specialized Masters in Business - Finance | 27,632.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 28,122.90 | 5.00 | 28,127.90 |
| Master of Business Administration - Executive | 28,071.60 | 164.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 28,487.50 | 5.00 | 28,492.50 |
| Master of Business Operational Excellence (MBOE) | 17,521.60 | 164.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 17,937.50 | 5.00 | 17,942.50 |
| Specialized Master of Business - Analytics | 13,666.00 | 239.00 | - | - | - | - | 100.00 | 14,005.00 | 200.00 | 14,205.00 |
| Master of Supply Chain Management | 9,592.00 | 239.00 | - | - | - | - | 100.00 | 9,931.00 | 200.00 | 10,131.00 |
| Micro-Certification in FinTech Fundamentals | 7,560.00 | 239.00 | - | - | - | - | 100.00 | 7,899.00 | 200.00 | 8,099.00 |
| Certificate in Business Strategy for IT Leaders | 11,176.00 | 239.00 | - | - | - | - | 100.00 | 11,515.00 | 200.00 | 11,715.00 |
| Dentistry - Rank 1 | 21,880.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 22,370.90 | 24,571.00 | 46,941.90 |
| Dentistry - Rank 2 | 18,408.00 | 164.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 18,823.90 | 21,789.00 | 40,612.90 |
| Dentistry - Rank 3 | 18,408.00 | 164.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 18,823.90 | 21,789.00 | 40,612.90 |
| Dentistry - Rank 4 | 18,408.00 | 164.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 18,823.90 | 21,789.00 | 40,612.90 |
| Master of Engineering Management (MEM) | 8,560.00 | 239.00 | - | - | - | - | 100.00 | 8,899.00 | 200.00 | 9,099.00 |
| Master of Global Engineering Leadership (MGEL)-DL | 8,560.00 | 239.00 | - | - | - | - | 100.00 | 8,899.00 | 200.00 | 9,099.00 |
| Professional Master of Structural Engineering | 8,560.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 9,050.90 | 13,865.00 | 22,915.90 |
| Cybersecurity Offense and Defense Graduate Certificate | 9,360.00 | 239.00 | - | - | - | - | 100.00 | 9,699.00 | 200.00 | 9,899.00 |
| Cybersecurity Studies: Design and Implementation Graduate Certificate | 9,360.00 | 239.00 | - | - | - | - | 100.00 | 9,699.00 | 200.00 | 9,899.00 |
| Master of Ag and Extension Education | 7,172.00 | 239.00 | - | - | - | - | 100.00 | 7,511.00 | 200.00 | 7,711.00 |
| Masters of Translational Data Analytics (PSM-TDA) | 9,530.00 | 239.00 | - | - | - | - | 100.00 | 9,869.00 | 200.00 | 10,069.00 |
| Doctor of Jurisprudence (J.D.) | 16,552.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 17,042.90 | 7,626.00 | 24,668.90 |
| Master in Study of Law (MSL) - Part Time | 7,436.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 7,926.90 | 7,626.00 | 15,552.90 |
| Master in Study of Law (MSL) - Full Time | 9,544.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 10,034.90 | 7,626.00 | 17,660.90 |
| Medicine - Rank 1 | 15,062.00 | 164.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 15,477.90 | 12,460.00 | 27,937.90 |
| Medicine - Rank 2 | 15,062.00 | 164.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 15,477.90 | 12,460.00 | 27,937.90 |
| Medicine - Rank 3 | 15,062.00 | 164.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 15,477.90 | 3,333.00 | 18,810.90 |
| Medicine - Rank 4 | 15,118.00 | 164.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 15,533.90 | 3,333.00 | 18,866.90 |
| Master of Dietetics and Nutrition (MDN) | 6,257.50 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 6,748.40 | 13,865.00 | 20,613.40 |
| Master of Genetic Counseling | 9,568.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 10,058.90 | 7,120.50 | 17,179.40 |
| Doctor of Occupational Therapy | 6,556.00 | 164.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 6,971.90 | 10,737.90 | 17,709.80 |
| Doctor of Physical Therapy | 6,520.00 | 164.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 6,935.90 | 11,253.50 | 18,189.40 |
| Doctor of Nursing Practice: In-person | 7,780.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 8,270.90 | 13,865.00 | 22,135.90 |
| Doctor of Nursing Practice: Online | 7,780.00 | 239.00 | - | - | - | - | 100.00 | 8,119.00 | 200.00 | 8,319.00 |
| Doctor of Nursing Education: In-person | 7,780.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 8,270.90 | 13,865.00 | 22,135.90 |
| Doctor of Nursing Education: Online | 7,780.00 | 239.00 | - | - | - | - | 100.00 | 8,119.00 | 200.00 | 8,319.00 |
| Master of Science in Nursing: In-person | 7,780.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 8,270.90 | 13,865.00 | 22,135.90 |
| Master of Science in Nursing: Online | 7,780.00 | 239.00 | - | - | - | - | 100.00 | 8,119.00 | 200.00 | 8,319.00 |
| Optometry - Rank 1 | 14,149.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 14,639.90 | 10,528.00 | 25,167.90 |
| Optometry - Rank 2 | 14,149.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 14,639.90 | 5.00 | 14,644.90 |
| Optometry - Rank 3 | 12,561.00 | 164.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 12,976.90 | 5.00 | 12,981.90 |
| Optometry - Rank 4 | 12,561.00 | 164.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 12,976.90 | 5.00 | 12,981.90 |
| Pharmacy - Rank 1 | 13,033.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 13,523.90 | 14,005.60 | 27,529.50 |
| Pharmacy - Rank 2 | 13,033.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 13,523.90 | 5.00 | 13,528.90 |
| Pharmacy - Rank 3 | 13,033.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 13,523.90 | 5.00 | 13,528.90 |
| Pharmacy - Rank 4 | 13,033.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 13,523.90 | 5.00 | 13,528.90 |
| Master of Public Health | 6,257.50 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 6,748.40 | 13,865.00 | 20,613.40 |
| Program for Experienced Professionals | 6,257.50 | 239.00 | - | - | - | - | 100.00 | 6,596.50 | 200.00 | 6,796.50 |
| Master of Health Administration | 8,400.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 8,890.90 | 12,976.00 | 21,866.90 |
| Master of Social Work - In-Person | 6,257.50 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 6,748.40 | 13,865.00 | 20,613.40 |
| Master of Social Work - Online | 6,257.50 | 239.00 | - | - | - | - | 100.00 | 6,596.50 | 200.00 | 6,796.50 |
| Veterinary Medicine - Rank 1 | 17,068.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 17,558.90 | 20,865.00 | 38,423.90 |
| Veterinary Medicine - Rank 2 | 17,068.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 17,558.90 | 5.00 | 17,563.90 |
| Veterinary Medicine - Rank 3 | 17,068.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 17,558.90 | 5.00 | 17,563.90 |
| Veterinary Medicine - Rank 4 | 17,068.00 | 239.00 | 37.50 | 74.40 | 126.50 | 13.50 | - | 17,558.90 | 5.00 | 17,563.90 |

Graduate and professional tuition and fee rates reflected above do not include program specific, special or technology fees that may be assessed based on major or program of study. For more information see: https://registrar.osu.edu/feetables/mainfeetables.asp

# Housing Rates

**The Ohio State University**
**Proposed Housing Rates for FY 2024**

| Housing Plans | FY 2023 | FY 2024 | $Change | %Change |
|---|---|---|---|---|
| **Columbus Campus (Annual Rates - 2 semesters)** | | | | |
| Rate I | $9,514 | $9,798 | $284 | 3.0% |
| Rate II | $7,926 | $8,162 | $236 | 3.0% |
| Rate IIA | $7,672 | $7,902 | $230 | 3.0% |
| Rate III | $7,408 | $7,630 | $222 | 3.0% |
| **Summer Term Options:** | | | | |
| 4-Week Session - Rate II | $1,982 | $2,040 | $58 | 3.0% |
| 6-Week Session - Rate II | $2,972 | $3,060 | $88 | 3.0% |
| 8-Week Session - Rate II | $3,964 | $4,082 | $118 | 3.0% |
| 4-Week Session - Rate IIA | $1,918 | $1,974 | $56 | 3.0% |
| 6-Week Session - Rate IIA | $2,876 | $2,962 | $86 | 3.0% |
| 8-Week Session - Rate IIA | $3,834 | $3,948 | $114 | 3.0% |
| Summer Term - Rate II | $5,946 | $6,124 | $178 | 3.0% |
| Summer Term - Rate IIA | $5,754 | $5,926 | $172 | 3.0% |
| Stadium Scholars Program | $6,280 | $6,468 | $188 | 3.0% |
| Alumnae Scholarship Houses - single or double w/bath | $7,202 | $7,418 | $216 | 3.0% |
| Alumnae Scholarship Houses - double or triple | $7,046 | $7,256 | $210 | 3.0% |
| German House - 1-person room | $7,306 | $7,524 | $218 | 3.0% |
| German House - 2-person room | $6,800 | $7,004 | $204 | 3.0% |
| **Monthly Housing Rates** | | | | |
| 237 E 17th - mini-single | $980 | $1,008 | $28 | 3.0% |
| 237 E 17th - single | $1,356 | $1,396 | $40 | 3.0% |
| 237 E 17th - supersingle | $1,638 | $1,686 | $48 | 3.0% |
| 237 E 17th - double | $894 | $920 | $26 | 3.0% |
| Gateway - studio | $2,084 | $2,146 | $62 | 3.0% |
| Gateway - 1 bedroom apartment | $2,234 | $2,300 | $66 | 3.0% |
| Gateway - 2 bedroom apartment | $2,176 | $2,240 | $64 | 3.0% |
| Gateway - 3 bedroom apartment | $1,894 | $1,951 | $57 | 3.0% |
| Neil - efficiency | $1,894 | $1,950 | $56 | 3.0% |
| Neil - 4 bedroom | $1,876 | $1,932 | $56 | 3.0% |
| Penn Place - 1 person room | $1,790 | $1,842 | $52 | 3.0% |
| Penn Place - 2 person room | $1,028 | $1,058 | $30 | 3.0% |

**FY 2024 FINANCIAL PLAN**

| ATI | | | | |
|---|---|---|---|---|
| 1-bedroom for 2 (per person) | $7,888 | $8,124 | $236 | 3.0% |
| 2-bedroom for 2 (per person) | $9,378 | $9,658 | $280 | 3.0% |
| 2-bedroom for 4 (per person) | $7,888 | $8,124 | $236 | 3.0% |
| 2-bedroom for 5 (per person - double) | $7,888 | $8,124 | $236 | 3.0% |
| 2-bedroom for 5 (per person - triple) | $6,804 | $7,008 | $204 | 3.0% |
| 3-bedroom for 5 (per person - single) | $8,310 | $8,558 | $248 | 3.0% |
| 3-bedroom for 5 (per person - double) | $7,888 | $8,124 | $236 | 3.0% |
| Private apartment | $9,378 | $9,658 | $280 | 3.0% |

| Newark | | | | |
|---|---|---|---|---|
| 1-person efficiency | $8,834 | $9,098 | $264 | 3.0% |
| 2-person efficiency (per person) | $8,532 | $8,786 | $254 | 3.0% |
| 2-bedroom for 4 (per person) | $8,578 | $8,834 | $256 | 3.0% |
| 3-bedroom for 6 (per person) | $8,084 | $8,326 | $242 | 3.0% |
| McConnell Hall | $8,834 | $9,098 | $264 | 3.0% |

| Mansfield | | | | |
|---|---|---|---|---|
| 2-bedroom for 2 (per person) | $9,014 | $9,284 | $270 | 3.0% |
| 2-bedroom for 4 (per person) | $7,214 | $7,430 | $216 | 3.0% |
| 5-bedroom for 5 (per person) | $7,568 | $7,794 | $226 | 3.0% |
| 5-bedroom for 6 - single (per person) | $7,214 | $7,430 | $216 | 3.0% |
| 5-bedroom for 6 - double (per person) | $6,502 | $6,696 | $194 | 3.0% |

# Dining Rates

**The Ohio State University**
**Proposed Dining Rates for FY 2024**

| Dining Plans | FY 2023 | FY 2024 | $Change | %Change |
|---|---|---|---|---|
| Scarlet Access 14 | $5,302 | $5,460 | $158 | 3.0% |
| Declining Balance | $4,730 | $4,870 | $140 | 3.0% |
| Gray Access 10 | $4,452 | $4,584 | $132 | 3.0% |
| Traditions (formerly "Unlimited") Access | $4,344 | $4,474 | $130 | 3.0% |
| McConnell (Newark) | $3,098 | $3,190 | $92 | 3.0% |
| Carmen 1 | $960 | $988 | $28 | 3.0% |
| Carmen 2 | $1,876 | $1,932 | $56 | 3.0% |
| **Summer:** | | | | |
| Carmen 1 | $960 | $988 | $28 | 3.0% |
| Carmen 2 | $1,876 | $1,932 | $56 | 3.0% |

# Appendix B | Tuition and SSI History (Columbus Campus)

| Fiscal Year | Undergraduate Resident Total | % Change | Undergraduate Non-Resident (Domestic) Total | % Change | Columbus Campus Total SSI (000's) | % Change |
|---|---|---|---|---|---|---|
| **1998** | $3,687 | 6.3% | $10,896 | 5.4% | $297,551 | 5.1% |
| **1999** | $3,906 | 5.9% | $11,475 | 5.3% | $305,161 | 2.6% |
| **2000** | $4,137 | 5.9% | $12,087 | 5.3% | $312,839 | 2.5% |
| **2001** | $4,383 | 5.9% | $12,732 | 5.3% | $317,721 | 1.6% |
| **2002** | $4,788 | 9.2% | $13,554 | 6.5% | $305,389 | -3.9% |
| **2003** | $5,691 | 18.9% | $15,114 | 11.5% | $300,064 | -1.7% |
| **2004** | $6,651 | 16.9% | $16,638 | 10.1% | $299,998 | 0.0% |
| **2005** | $7,542 | 13.4% | $18,129 | 9.0% | $301,898 | 0.6% |
| **2006** | $8,082 | 7.2% | $19,305 | 6.5% | $305,588 | 1.2% |
| **2007** | $8,667 | 7.2% | $20,562 | 6.5% | $314,597 | 2.9% |
| **2008** | $8,676 | 0.1% | $21,285 | 3.5% | $330,269 | 5.0% |
| **2009** | $8,679 | 0.0% | $21,918 | 3.0% | $362,682 | 9.8% |
| **2010** | $8,726 | 0.5% | $22,298 | 1.7% | $391,658 | 8.0% |
| **2011** | $9,420 | 8.0% | $23,604 | 5.9% | $390,830 | -0.2% |
| **2012** | $9,735 | 3.3% | $24,630 | 4.3% | $329,548 | -15.7% |
| **2013** | $10,037 | 3.1% | $25,445 | 3.3% | $331,829 | 0.7% |
| **2014** | $10,037 | 0.0% | $25,757 | 1.2% | $334,394 | 0.8% |
| **2015** | $10,037 | 0.0% | $26,537 | 3.0% | $330,878 | -1.1% |
| **2016** | $10,037 | 0.0% | $27,365 | 3.1% | $341,582 | 3.2% |
| **2017** | $10,037 | 0.0% | $28,229 | 3.2% | $362,654 | 6.2% |
| **2018** | $10,591 | 5.5% | $29,695 | 5.2% | $360,816 | -0.5% |
| **2019** | $10,726 | 1.3% | $30,742 | 3.5% | $359,412 | -0.4% |
| **2020** | $11,084 | 3.3% | $32,061 | 4.3% | $353,396 | -1.7% |
| **2021** | $11,518 | 3.9% | $33,502 | 4.5% | $375,115 | 6.1% |
| **2022** | $11,936 | 3.6% | $35,019 | 4.5% | $376,486 | 0.4% |
| **2023** | $12,485 | 4.6% | $36,722 | 4.9% | $393,035 | 4.4% |
| **2024** | $12,859 | 3.0% | $38,365 | 4.5% | $398,826 | 1.5% |

# APPENDIX XXIII

| | Amount Establishing Endowment* | Total Commitment |
|---|---|---|
| Establishment of Named Designated Chair (University) | | |
| Edgar C. Hendrickson Designated Chair Fund<br>Established August 17, 2023, with a fund transfer by the College of Engineering of college funds and distribution from The Edgar C. Hendrickson Fund; supports a chair in the College of Engineering, Department of Biomedical Engineering. The position holder shall be appointed for a term of five years and reviewed in accordance with the current guidelines and procedures for faculty appointment. Should the position be vacated before the five-year term is completed, a new position holder may be appointed to complete the five-year term. This designated chair position shall cease to exist when annual funding ends. | $157,500.00*<br>As of July 31, 2023 | $787,500.00 |
| Establishment of Named Endowed Fund (University) | | |
| John G. and Patricia N. Kramer Fund for Academic Excellence<br>Established August 17, 2023, with gifts from Dr. John G. (DDS 1957), Mrs. Patricia N. Kramer, their family, and their estate; 10% - reinvested in the endowment principal. Remaining 90% - shall be divided as follows: 50% - College of Dentistry, 25% - Max M. Fisher College of Business, 25% - Michael E. Moritz College of Law to be used for academic excellence as determined by the dean of the respective college. | $145,659.34 | $145,659.34 |
| Glenn College Alumni Society Student Scholarship Fund<br>Established August 17, 2023, with alumni and friends of the John Glenn College of Public Affairs; provides support to undergraduate and graduate students at the John Glenn College of Public Affairs. | $103,909.44 | $103,909.44 |
| Integrated Systems Engineering Department Fund<br>Established August 17, 2023, with gifts from members of the Department of Integrated Systems Engineering Advisory Board; supports the key priorities and strategic initiatives of the Department of Integrated Systems Engineering as recommended by the highest ranking official of the department, in consultation with department leadership. | $102,209.81 | $120,209.81 |
| Establishment of Named Endowed Professorships (Foundation) | | |

| | | |
|---|---|---|
| John & Christine Olsen Professorship in Head and Neck Radiation Oncology<br>Established May 20, 2021, with gifts from Dr. John O. Olsen and Christine E. Olsen; supports a professorship position in OSUCCC – James supporting a faculty physician specializing in head and neck radiation oncology. It is the donors' preference that consideration be given to a faculty physician specializing in head, neck, and brain cancers. If the position is vacant, the annual distribution may be used to support OSUCCC – James as recommended by the highest ranking official(s) in OSUCCC - James or his/her/their designee(s). If at any time the gifted principal balance of the fund reaches the then current minimum required for an endowed chair position, the fund name and purpose shall be revised to support a chair position in OSUCCC – James supporting a faculty physician specializing in head and neck radiation oncology. It is the donors' preference that consideration be given to a faculty physician specializing in head, neck, and brain cancers. If the position is vacant, the annual distribution may be used to support OSUCCC – James as recommended by the highest ranking official(s) in OSUCCC - James or his/her/their designee(s). Revised August 17, 2023. | $1,000,000.00 | $1,000,000.00 |
| John & Christine Olsen Professorship in Head and Neck Surgical Oncology<br>Established May 20, 2021, with gifts from Dr. John O. Olsen and Christine E. Olsen; supports a professorship position in OSUCCC – James supporting a faculty physician specializing in head and neck surgical oncology. It is the donors' preference that consideration be given to a faculty physician specializing in head and neck cancers. If the position is vacant, the annual distribution may be used to support OSUCCC – James as recommended by the highest ranking official(s) in OSUCCC - James or his/her/their designee(s). If at any time the gifted principal balance of the fund reaches the then current minimum required for an endowed chair position, the fund name and purpose shall be revised to support a chair position in OSUCCC – James supporting a faculty physician specializing in head and neck surgical oncology. It is the donors' preference that consideration be given to a faculty physician specializing in head and neck cancers. If the position is vacant, the annual distribution may be used to support OSUCCC – James as recommended by the highest ranking official(s) in OSUCCC - James or his/her/their designee(s). Revised August 17, 2023. | $1,000,000.00 | $1,000,000.00 |
| <u>Establishment of Named Endowed Fund (Foundation)</u> | | |

| | | |
|---|---|---|
| Elizabeth and William Ralston Engineering Scholarship Fund<br>Established August 17, 2023, with gifts from Douglas E. Ralston; provides one or more scholarships to students who are enrolled in the College of Engineering and are studying a major in one of the following departments: 1) Civil, Environmental and Geodetic Engineering 2) Mechanical and Aerospace Engineering 3) William G. Lowrie Department of Chemical and Biomolecular Engineering 4) Electrical and Computer Engineering. Preference shall be given to candidates who are involved in extracurricular activities outside of the classroom such as organized sports teams. The donor desires that when awarding this scholarship special consideration be given to students who are United States citizens or permanent residents. | $823,795.00 | $823,795.00 |
| Earl D. Shurtz Endowed Fund<br>Established August 17, 2023, with gifts from the estate of Earl Shurtz (BS 1956); 50% - reinvested in the endowment principal. 50% - used in a business curriculum for real estate teaching and research at The Ohio State University at Newark. Should there be no real estate teaching and research at Ohio State Newark, the fund may be used in a general business curriculum at Ohio State Newark. | $500,000.00 | $500,000.00 |
| The Molly Caren Agriculture Vice Presidents Excellence Fund<br>Established August 17, 2023, with a gift from Molly Caren (1935 BA) of Columbus, Ohio; 25% - supports the Study Abroad Programs within the College of Food, Agricultural, and Environmental Sciences. The distribution shall be used to assist students from all economic backgrounds with travel expenses. 50% - supports programs identified by the highest ranking official in the College of Food, Agricultural, and Environmental Sciences, or his/her designee, at his/her discretion. 25% - supports the Gwynne Conservation area at the Molly Caren Agriculture Center. The distribution shall be used to support all areas of farm conservation. | $269,527.40 | $269,527.40 |
| Lean Into Leadership Health Care Scholarship Fund<br>Established August 17, 2023, with gifts from the estate of Kathleen L. Sharp; provides one or more scholarships to students who are enrolled in the Max M. Fisher College of Business, are participating in the Master of Business Operational Excellence (MBOE) program, are interested in the healthcare profession, and demonstrate financial need. If no students meet the selection criteria, the scholarship(s) will be open to all students enrolled in the College and participating in the MBOE program. If no students meet the selection criteria, scholarships may be awarded to students who are enrolled in the College and demonstrate financial need with preference given to students who are interested in the healthcare profession. | $226,176.47 | $226,176.47 |
| The Dr. Ronald E. Myers & Kathleen A. Kiefer Endowed Dental Scholarship Fund<br>Established August 17, 2023, with a gift from Dr. Ronald Eugene Myers (BA 1973, DDS 1979) and Kathleen Ann Kiefer (BS 1974, MS 1979) and matching funds from the College of Dentistry; provides one or more scholarships to students enrolled in the DDS program. | $200,000.00 | $200,000.00 |

| | | |
|---|---|---|
| Georganne M. Shockey Undergraduate Scholarship Fund<br>Established August 17, 2023, with gifts from Georganne M. Shockey (BS 1980) and matching funds as part of the Scarlet and Gray Advantage Endowed Matching Gift Program; provides one or more scholarships to undergraduate students who are enrolled in the College of Public Health with preference given to students participating in faculty-led and/or interdisciplinary research. Additional preference shall be given for students participating in research engaging with the Byrd Polar and Climate Research Center. If no students meet the selection criteria, the scholarship(s) will be open to all undergraduate students who are enrolled in the college. | $200,000.00 | $200,000.00 |
| Davison, Bauer and Stanley Families Women's Athletics Scholarship Fund<br>Established August 17, 2023, with gifts from Marilyn Bauer Davison (MS 1975) and Dr. Thomas C. B. Davison (PhD 1977) and matching funds as part of the Scarlet and Gray Advantage Endowed Matching Gift Program; supplements the grant-in-aid costs of an undergraduate student-athlete participating on a women's varsity team with a preference for those participating on the women's basketball team, women's tennis team, women's golf team or the women's rowing team. | $150,235.00 | $150,235.00 |
| The Jean Kauffman Yost Scholars Program Fund<br>Established August 17, 2023, with gifts from Jean Kauffman Yost (MSW 1989) and Robert D. Yost; provides supplemental opportunities to recipients of The Jean Kauffman Yost Pharmacy Scholarship Fund for specialized training and support beyond the classroom to ensure their ability to make the most of their educational experience. Annual distribution may be used for program support and/or provide financial support to students to assist with extracurricular and/or professional development opportunities or to help remove barriers to their ability to access educational experiences. | $150,000.00 | $300,000.00 |
| The Ramaswamy Family Endowed Fund for Breast Cancer Translational Research<br>Established August 17, 2023, with gifts from Dr. Bhuvaneswari Ramaswamy and Dr. Chakravarthi R. Ramaswamy; supports breast cancer translational research as recommended by director of Translational Research within the breast cancer program or his/her designee. | $140,000.00 | $300,000.00 |

| | | |
|---|---|---|
| Robert and Janet Lee Family Fund<br>Established August 17, 2023, with gifts from Robert Eugene Lee (BS 1978) and Janet Matson Lee; provides one or more scholarship(s) to students who are enrolled in the College of Engineering and are majoring in mechanical, electrical and/or computer science engineering. Candidates must demonstrate financial need. The donors desire that when awarding this scholarship special consideration be given to candidates that are members of organizations recognized by the University that are open to all but whose missions seek to advance the need of women in engineering. The donors desire to provide as significant financial support as possible to one eligible recipient annually. Any remaining distribution shall be used to provide as significant financial support as possible to additional eligible recipients. Scholarship(s) are renewable as long as recipient(s) remain in good academic standing. | $125,000.00 | $125,000.00 |
| Bost Family Fellowship Support Fund<br>Established August 17, 2023, with a gift from Glenn Eugene Bost II (JD 1978); supports first or second-year fellows who are enrolled in the Michael E. Moritz College of Law and pursuing work opportunities in the area of entrepreneurial business law for a nonprofit, academic institution other than the college, or similar organizations that advance opportunities in entrepreneurship, business, technology, industry, and/or economic development. If no students meet the selection criteria, support will be open to all fellows in the college. | $122,500.00 | $122,500.00 |
| Bost Family Scholarship Fund<br>Established August 17, 2023, with a gift from Glenn Eugene Bost II (JD 1978); provides one or more scholarships to first-year students who are enrolled in the Michael E. Moritz College of Law and demonstrate financial need. The donor desires that when awarding this scholarship special consideration be given to candidates who have taken at least one year off from school between earning their undergraduate degree and enrolling in the college. If no students meet the selection criteria, the scholarship(s) will be open to all students who are enrolled in the college and demonstrate financial need. Scholarships are renewable as long as recipients remain in good academic standing. | $122,500.00 | $122,500.00 |
| Rick Freuler and John Demel FEH Design Project Support Fund<br>Established August 17, 2023, with gifts from family, friends and colleagues; supports Fundamentals of Engineering - Honors (FEH) design-based projects in the Department of Engineering Education. | $114,804.81 | $114,804.81 |
| John N. King Fund for the Center for Medieval and Renaissance Studies<br>Established August 17, 2023, with gifts from Pauline G. King; supports initiatives and priorities of the Center for Medieval and Renaissance Studies at the discretion of the highest ranking official in the center or his/her designee. Expenditures may include, but are not limited to, student education, the University's membership with The Folger Shakespeare Library, and future programming. | $100,000.00 | $100,000.00 |

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| Kocan Family Fund<br>Established August 17, 2023, with gifts from Jerome Anthony Kocan and Nancy Kocan; supports undergraduate students who are enrolled in the College of Arts and Sciences. Preference shall be given to candidates who demonstrate financial need and are from Trumbull or Mahoning County, Ohio, Mercer County, Pennsylvania, or the state of Alabama. | $100,000.00 | $100,000.00 |
| John and Barbara Morrison Veterinary Medicine Endowed Scholarship Fund<br>Established August 17, 2023, with gifts from John Thomas Morrison (BA 1969) and Barbara Durphy Morrison; provides one or more scholarships to third or fourth-year DVM students who graduated from an Ohio high school and demonstrate financial need. First preference shall be given to candidates who are interested in equine medicine. Second preference shall be given to candidates who are interested in farm animal medicine. If no students meet the selection criteria, scholarship(s) will be open to all third or fourth-year DVM students who graduated from an Ohio high school. | $100,000.00 | $100,000.00 |
| The Newmark Family Endowed Scholarship Fund<br>Established August 17, 2023, with gifts from Dr. Arnold P. Good and Lisa M. Newmark; provides one or more scholarships to MD students who are enrolled in the College of Medicine, demonstrate financial need, and graduated from high school in the state of Ohio with preference given to candidates who graduated from high school in Youngstown. If no students meet the selection criteria, the scholarship(s) will be open to all MD students enrolled in the college. | $100,000.00 | $100,000.00 |
| Ohio Expositions Commission I – Youth Reserve Program Scholarship Fund<br>Established August 17, 2023, with gifts from the Ohio Expositions Commission; provides one or more scholarships to incoming first-year students who are enrolled in the College of Food, Agricultural, and Environmental Sciences, are attending any campus, including The Ohio State University Agricultural Technical Institute, and are current junior exhibitors at the Ohio State Fair. If there are no candidates enrolled in the college, scholarship(s) will be open to students enrolled in any college in the University that otherwise meet the selection criteria above. If no students meet the selection criteria above, the scholarship(s) will be open to all students who are enrolled in the college and are attending any campus, including ATI. | $100,000.00 | $100,000.00 |

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| Carol Zelizer Stoff Endowed Memorial Scholarship Fund<br>Established August 17, 2023, with gifts from Richard A. Stoff; provides one or more scholarships to students who are enrolled in the Michael E. Moritz College of Law, demonstrate financial need, and possess an undergraduate degree from the College of Social Work at The Ohio State University with a minimum 3.0 grade point average on a 4.0 scale upon graduation. Candidates must demonstrate leadership qualities, a commitment to social and economic justice, and aspire for a career in public service. If no students meet the selection criteria, the scholarship(s) will be open to all students who are enrolled in the Michael E. Moritz College of Law, demonstrate financial need, and possess an undergraduate degree from The Ohio State University. The donor desires that when awarding this scholarship special consideration be given for students who have experience living or working in diverse environments. The donor also desires to provide as significant financial support as possible to one eligible recipient. Any remaining distribution shall be used to provide as significant financial support as possible to additional eligible recipients. | $100,000.00 | $100,000.00 |
| The Law Class of 1982 Scholarship Fund<br>Established August 17, 2023, with gifts from the College of Law Classmates of 1982; provides renewable, tuition-only scholarship support to students enrolled in the Michael E. Moritz College of Law who demonstrate financial need and an interest in public service law. | $56,328.67 | $56,328.67 |
| The Adrienne M. Gavula Memorial Scholarship Fund at The Ohio State University College of Social Work<br>Established August 17, 2023, with gifts from family, friends, and colleagues of Adrienne Gavula (MSW 2009); used at the discretion of the highest ranking official in the College of Social Work or his/her designee. The endowment may be revised when the gifted endowment principal reaches the minimum funding level required at that date for a restricted endowment. Thereafter, the annual distribution from this fund shall provide one or more scholarships to MSW1 or MSW2 ranked graduate students who are enrolled in the College of Social Work and demonstrate financial need. Preference shall be given to students who are interested in but not limited to advocacy/social justice, women's rights, and/or domestic violence. It is the group's preference to award to one student. It is the group's intent to provide significant financial support to the scholarship recipients, rather than provide smaller scholarships to several recipients. If no students meet the selection criteria, the scholarship(s) will be open to all students who are enrolled in the college. | $28,505.00 | $28,505.00 |
| <u>Change in Name of Named Endowed Fund (Foundation)</u> | | |
| From: The Sarah Ross Soter Endowed Chair for Women's Cardiovascular Health Research in Women's Cardiovascular Health at OSU Heart Center<br>To: The Sarah Ross Soter Endowed Chair for Women's Cardiovascular Health Research | | |

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| Change in Description of Named Endowed Fund (Foundation) | | |
| The Steven Heath and Sarah Shireen Eddleblute Endowed Scholarship Fund | | |
| The Walt M. Rudin Football Manager's Scholarship Fund | | |
| Total | $6,338,650.94 | 6,338,650.94 |

*Amounts establishing endowments as of June 30, 2023, unless notated otherwise.

**Ohio State philosophy on institutional and leadership statements**
As the state's flagship public, land-grant university and a national higher-education leader, Ohio State is frequently asked to express its position on local and national issues, and to make a public response after tragedies and high-profile events.

News and opinions are shared in real time, and constituents often expect to hear directly from leaders in both public and private institutions. Ohio State also welcomes students, faculty and staff from across the globe and, as a result, events affect people in our community frequently. Whether an institution makes a public statement or remains silent, it does not go unnoticed. As such, Ohio State uses a consistent framework to evaluate if, how and when to make institutional and leadership statements to ensure the university is making decisions based on consistent factors rather than on content or sentiment.

In addition, communications should be proportional to the situation, with our broadest communications tools reserved for the most critical responses. Ohio State issues statements via a campus-wide email or on enterprise social media only on very limited occasions, and only after appropriate socialization with a variety of university leadership and governance bodies, including the Board of Trustees.

Ohio State created and has utilized a standard framework to provide consistency in responses. The framework is used to decide whether the situation:

- directly affects members of the Ohio State community, such that their ability to function in their university roles is significantly impaired.
- is of significant impact to the university and its operations.
- is of importance to the city, region or state, and Ohio State can play a role in sharing important, related information with the public.

**Defining public statements**
A public statement is defined as the written and published official position of the university or representative university leader that is distributed within an appropriate timeline given the situation.

**Evaluating public statements**
While this framework is meant to help evaluate responses through a common lens, standardize institutional responses and ensure that responses are socialized with appropriate stakeholders, each situation is different and will need to be evaluated based on additional factors that will only be known at the time. There are several tenets that must always underlie each evaluation:

- Using Ohio State's Shared Values, as well as the Kalven Report and Chicago Principles, as guiding principles.
- Considering the expertise of university leaders who represent a variety of stakeholders.
- Evaluating each potential statement for the appropriate voice and method of distribution.
- Ensuring that statements are timely and action-oriented, including what the university is doing to resolve the issue or how it is providing support to our community.

Additionally, given Ohio State's broad range of stakeholders, our response or the absence of one will not satisfy all constituents. Members of the university community advocating for a statement, even through demonstrations, is a consideration but should not be the sole reason to issue a statement.

**Planning and response team**
To help facilitate an informed and efficient response, the university convenes a planning and response team to discuss and make a recommendation on the university's response to a variety of issues or events.

The standing group consists of the: provost (or designee); chief of staff, Office of the President; senior vice president and general counsel (or designee); secretary, Board of Trustees; senior vice president for student life (or designee); senior vice president for marketing and communications; associate vice president, university communications; assistant vice president of media and public relations; vice president of government affairs (or designee); and president and CEO of the Ohio State University Alumni Association. Additional leaders or subject matter experts will be included as needed.

This group shares its recommendations with the president, including for socializing with additional stakeholders or the Board of Trustees. In urgent situations, the president may be asked to join the group as the recommendation is being developed. The group meets monthly to proactively plan and discuss ongoing, long-term needs, and any member may convene the group on an as-needed basis for more urgent situations.

**The presidential voice**
The president's voice and platform are powerful and represent the voice of the institution. As such, the president's voice should be reserved for issues and statements that require the highest level of leadership — due either to their impact to our campuses or because they are inextricably tied with the university's ability to fulfill its overarching mission. A statement in the president's voice should be framed with appropriate context to make clear that it is being issued because of its relevance to a public, land-grant, R1, Big Ten, academic institution. It is also appropriate to use the president's platform to amplify the voices of other leaders who bring important perspectives to an issue.

**Ways to support our community beyond making statements**
When members of our community need support, options for responding include:

- Reaching out directly to those affected to check on their well-being or determine what support they may need, including mental health resources.
- Hosting events that allow for the community to gather and be heard, including vigils and forums.
- Holding panel discussions or seminars to provide academic, historical or other factual context in which multiple viewpoints are shared through a facilitated and civil dialogue.
- Providing customizable communications templates to help college and unit leaders frame issues appropriately while speaking directly to their stakeholders.

**First Amendment and Academic Freedom**
This philosophy does not impact any individual's ability to make statements or represent their own, individual views, or the freedom of faculty to teach, conduct research and publish research findings.

However, it must be noted that leaders such as the president, provost, members of President's Cabinet and deans are inextricably tied to the institution, and even statements made in their individual capacity would likely still be viewed as representative of the university. This does not limit their individual First Amendment rights, but it does require an additional level of university coordination before such statements are made. Other members of the university community speaking as individuals in their private capacity should represent their statements as such and should not represent them as statements made on behalf of the university. These statements should not include the name of the university or university marks, or use the individual's position, title or university affiliation unless select identifiers are being listed as part of an academic affiliation demonstrating a field of study, research or scholarly expertise.