

THE OHIO STATE UNIVERSITY
OFFICIAL PROCEEDINGS OF THE
THIRTEENTH MEETING OF THE
WEXNER MEDICAL CENTER BOARD

Columbus, Ohio, August 25, 2015

The Wexner Medical Center Board met on Wednesday, August 25 at the Richard M. Ross Heart Hospital, Columbus, Ohio, pursuant to adjournment.

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Minutes of the last meeting were approved.

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August 25, 2015 meeting, Wexner Medical Center Board

Dr. Wadsworth, called the meeting of the Wexner Medical Center Board to order on Tuesday, August 25, 2015 at 9:03am

Present: William G. Jurgensen, Cheryl L. Krueger, Corbett A. Price, Stephen D. Steinour, John F. Wolfe, Jeffrey Wadsworth, Michael V. Drake, Sheldon M. Retchin, Geoffrey S. Chatas, E. Christopher Ellison, and Marti C. Taylor. Leslie A. Wexner and David B. Fischer were late.

Ms. Link:

Good morning everyone. I would to convene the meeting of the Wexner Medical Center Board and note that a quorum is present. The minutes of the June meeting of the Wexner Medical Center Board were distributed to all members and if there are no additions or corrections, the minutes are approved as distributed.

First I'd like to call on Dr. Sheldon Retchin for the CEO (chief executive officer) update.

Dr. Retchin:

Thank you. We're going to put up the scorecard, but before we start, I want to make a couple of announcements about happenings around the Medical Center. First, a couple of days ago we successfully performed the first High Intensity Focused Ultrasound. The procedure itself is called HIFU. This is a focused ultrasound in the brain that actually creates a lesion and in this case was used to treat a patient with a central tremor. It uses 1,000 ultrasound probes to be able to do this and it's a remarkable procedure.

There are only four centers in the country now performing this procedure. Dr. Vibhor Krishna, a recent recruit from Toronto, performed the procedure. This is a landmark event for the medical center and I want to bring it to your attention.

This is one of, as you know, our essential signature programs. We are very pleased.

The second is a part of our network efforts. For that announcement and focus, I'll call on Gail Marsh.

Ms. Marsh:

Hopefully you saw in last week's Columbus Dispatch a nice article by Ben Sutherly on our newest affiliation with Hocking Valley Medical Center in Logan Country. This is an example of what we're going to see today with our telehealth affiliates. Most importantly, our philosophy of working with hospitals across the state of Ohio to keep patients close to home, is really what is garnering us more and more affiliates across the state. Thank you Sheldon.

Dr. Retchin:

Congratulations on those efforts Gail, that's terrific.

Now for my report, Mr. Chair, I'm going to turn to the score card that you see on the screen and is also in your book. Let me go down those individually and explain where we're at.

First is inpatient mortality which has been a note of great success for this medical center. You'll see that in general, in terms of our scorecard, there is a mixture of green and red. We are not shy about presenting both results: those that we've had success in and those that we still have challenges ahead. In inpatient mortality rate, our target for the year was .65 and the year-end, I'm pleased to report, we beat that. That, in essence, is observed over expected. I don't know that it translates exactly as a 35% reduction over what you would expect, but I can tell you nationally this ranks very high and in fact we're

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in the top five among academic health centers in the University Health System Consortium, which is made up of over 100 of the elite academic health centers in the nation. That is a great result as well.

Next is patient satisfaction. Here we've had our work cut out for us. We have made some progress, but we've got a ways to go. The question that is posed and used for this particular scorecard, or element of the score card, is using a number of zero to 10, what number would you use to rate this hospital?

Now, that's the index that we use because it is tied back most successfully in terms of whether patient satisfaction, in general, is reported positively. But below that are a number of different domains and questions that we go forward and look at through the patient experience council on a regular basis under our chief nursing officer's guidance and leadership, Mary Nash.

With four exceptionally strong months of performance in the second half, I am pleased to say that our score has improved from 75% to 75.2%, which is at the 77th percentile. That's a 7% improvement over fiscal year 2014. We still have a long ways to go, but it is an improvement. I think part of that was moving into the new James Cancer Hospital as well as a great focus by Mary in nursing, as well as the physicians and leadership there as well.

President Drake:

Just a quick question? You said the last four months. If you look at this, it is over a year but it could be that things were done in the second half of the year differently than in the first half of the year and when you average the together we get a, the average of those things. Is there a trend or direction, say for the last four months of the year?

Dr. Retchin:

I think more for like the last six months of the year, Dr. Drake, that the improvement was made. Over the last six months we reached the 85th percentile. Mary, do you want to comment on that?

Dr. Nash:

We'll I'm actually going to make the comments in my presentation. I'd be happy to do that.

President Drake:

But it sounds like something you would want to be able to say twice, so it's ok.

Dr. Nash:

You're exactly right in the fact that in the last six months we have had the opportunity to have our score at the 85th percentile and our goal is the 90th percentile. Seventy nine percent of the patients have to say that they would give us a nine or a 10, 77% for 85th percentile. We know that we have two percentile points, or 2%, to go to the next percentile.

Dr. Retchin:

Further improvements have been made across all dimensions in fiscal year 2015 compared to fiscal year 2014 and that includes nurse communication, doctor communication, and cleanliness. A lot of the domains have had improvement. We have a ways to go and lots of work to do there as well. I think the biggest opportunities are in responsiveness and in quiet. That's one of the questions that is included in the domain

and often times, because of semi-private rooms, that becomes a difficult effort. We do note in those hospitals which have private rooms that that is a much higher score.

On the outpatient scores, the CG-CAHPS (Clinician & Group Consumer Assessment of Healthcare Providers and Systems) survey is a relatively new measurement that we've been using and is not required reporting yet. In terms of the performance itself we're relatively flat, but we are at 91% in terms of performance. That falls short of our goal of 95%. The band width there tends to get a bit narrow on some of these, but we're still hard at work, in terms of improving it. We continue to focus on all dimensions on the outpatient side: doctor communication, office staff, timely appointments, particularly an area we want to focus on, and test results follow up, which is a major issue on the outpatient side. That will also be reported later in the public session.

Let me move on to the rankings for *U.S. News & World Report*. This year we increased the number of specialties that we ranked in the top 50; from five in fiscal year 2014 to seven in fiscal year 2015. This is out of 16 specialties. This puts us in the top 1% of hospitals nationwide. Again, a point of great pride but not exactly where we want to be. We want to continue to strive forward in that.

We have two that are back in the top 50 that joined the five in fiscal year 2014. One of those is an area of great emphasis for us, neurosciences. I am pleased to note that neurology and neurosurgery have joined the top 50 and diabetes and endocrinology, which are areas of focus for us at the college, as well in the practice plan.

The following specialties increased in the rankings: cancer moved up six spots to 24, cardiology and heart surgery moved up three spots to 31, otolaryngology, an area where we have a specialty ranked in the top 20, which could get us into the honor roll, moved up one spot to 14, nephrology moved up four spots to 31, and urology is at 33.

What you want to look at, in terms of the rankings, are those areas or specialties that are on deck in the batting circle that might be able to move up. We have GI (gastrointestinal), geriatrics, orthopedics, pulmonology, and rehab that were not ranked in the top 50, but were identified as high performing programs, and are probably on the bubble. You have to dig a little bit deeper to be able to tell that.

In front of you is an analysis of the rankings in hard copy and has a title sheet to it. I won't project it up there, you can look at it at your leisure. You can see the weights that are given in terms of patient safety, the process of delivering care, the structure or the resources that relate to care, including imagining availability, and then reputation score and outcomes. There are different weights that are given. We continue to focus like a laser on the methodology and I would say for most specialties that methodology rings true. Mr. Steinour.

Mr. Steinour:

Sheldon, could I ask for comment on the cancer rankings and insights around that?

Dr. Retchin:

That's a good question. I think that the answer to that is probably reflected in the validity and confirmation of rankings overall. The methodology often times is generic in terms of, for example, mortality, patient safety, that particular specialty may be handicapped because of the entire house. I would stack up our cancer endeavors in terms of patient care, research, and education against anybody in the country. The *U.S. News & World Report* is simply, I guess, one aspect of the ranking. You could look at NCI (National Cancer Institute) funding, you could look at other elements, and I think our cancer program is easily a top 10. I don't know, Mike?

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Dr. Caliguri:

Thank you, Sheldon. Well said and I appreciate that.

I think that the biggest challenge we have in moving up in *U.S. News & World Report* rankings for cancer is our reputational score. Reputational score accounts for a sizable fraction of the number, it's probably 30% - 40% of the votes, and it is highly disproportionate. We are the youngest cancer center on the map actually. Most of the highly ranked centers are literally over or close to 100 years old. The James Cancer Hospital is 25 years old. It is a matter of working harder to build our national and international reputation.

The way this is done is physicians come on and vote: "What is the top three places you would send your cancer patient to?" and those physicians are largely on the coasts and that's the way that goes. Working harder to create a broader market appeal to those outside of our region is going to be critical. That is the big thing that we could really work on and I think, to Sheldon's point, we have the guns to do that. Now it's marketing the incredible discoveries and treatments, et cetera, that we have here.

President Drake:

I would like to make a comment that I make that I always think of when we're talking about these rankings. I make them more often than maybe you want to hear. I am in a lot of groups where these things are looked at.

There are two types of rankings. There are objective rankings that look at things that should actually have as your goals that you've achieved and can compare yourself with others on those metrics. That is a very useful thing to do. And, there are subjective rankings that mean nothing. You look at the objective rankings and then you add something else to it and you get the subjective ranking. To me it then becomes meaningless, it's an interesting guess.

We are doing it on the sports pages now, deciding how we're going to end up in football season this year. Last year we know, because we used the objective rankings of playing the games and seeing the one that meant something. Now, it's a semi-educated guess that either does mean something or it doesn't. *U.S. News & World Report*, in particular, rank to sell magazines. They end up with rankings that look about what you think the rankings ought to be before you buy the magazine, or else you wouldn't buy the magazine because it's not right. All of their rankings are tailored to come out to be about what people think before they go to buy the magazine. I honestly think that there are some parts of, not so much in this, but there's parts of it in the college rankings that are perverse. They treat you for high tuition and small classes, or they reward you for things like that and they're really not in the interest of what's good for the country. They motivate behavior, I think, in a bad way.

I don't like these honestly. I think that they can lead you in the wrong direction. They tend not to be entirely unconnected with what's true, but they have subtle things that are woven, and as Mike was saying, a reputational rank. Reputational rank means that certain places are always going to be at the top and that that counts for something. When I look at these often I strip that away and then recalculate the rankings in my mind, and you get something that is more tied to things that mean something.

Last thing I'll say is that when groups like this, of this size that are on the inside like the AAU (Association of American Universities) and others, we are thinking about this for public consumption, then their ranking list and we always strip out the reputational ranks, and the popularity ranks, we look at what our goals are and then we get a good idea of how we're doing. We will talk a little about that a little later on today and we'll get an idea of what it, what the cancer center and cancer program look like from the inside out, and it's a different picture.

Dr. Retchin:

Thank you. That steals the thunder a little bit for me to announce that we're ranked number one in Columbus. But, as Michael suggests, the rankings can ring true. I will say the rankings are used by students often in terms of making choices, not so much by patients necessarily. Some could argue or debate on that and tie it back, but I do think it's an important source of pride. You want to be in the rankings more than you don't, but with that said I think some of the subjective elements do play into it as everybody has suggested.

Let me move on to the next category which is financial viability. This was our strongest year ever in terms of growing cash and fund reserves. We ended the year at 87 days, up from 69 days a year ago, improving our balance sheet measurably. I think it's a note of, not only strong pride, but recognition of the leadership we've had with Pete Geier and his colleges, in terms of bringing us into a much stronger position as we look forward. We've got a lot more work to do there as well, but that was all green.

We also include day's cash on hand in terms of a balance sheet for the physician faculty group practice, OSUP (Ohio State University Physicians). Day's cash grew in excess of budget expectations. We had actually targeted at 52.5 days and we are just shy under 65 days. All and all a great improvement on the balance sheet.

This all goes hand in hand in terms of revenue enhancement and scale. Our revenue, per adjusted admission, was up 7.3% and over budget by 6.6%. A lot of things went into that, including the contracts that we have been a part of over the last five to six years and moving into the James Cancer Hospital. The revenue per adjusted admission really was all green as well.

The development dollars exclude the Office of Sponsored Programs and is marked that way. Our total development dollars came in shy of the \$100 million goal by about \$11 million. There are a number of factors that played into that, and I will note a couple of large gifts will now come in fiscal year 2016. The efforts have been extraordinary, particularly areas like neuro. Patty and her group are to be congratulated. It has been a strong year in development, but there's more work to do there as well.

In terms of cost management, we had targeted some areas of cost management as part of fiscal year 2015. The expense per adjusted admissions was up only 3.6% over last year. It was up, but in terms of the trajectory, we bent the cost curve. We absorbed the cost of the new hospital and the move in. This was a stellar performance in term of managing costs. In terms of cost management, I'm very pleased to report that that was green for fiscal year 2015.

On research our total NIH (National Institutes of Health) awards were \$95.5 million, very close to target of \$97 million. The federal research environment has been a bit harsh. The pay line continues to be challenging. Also, not reflected in here, are a couple of payments in fiscal year 2014 that one of which would of spilled over into fiscal year 2015, thereby making fiscal year 2014 a little bit of an anomaly. If you compare it to fiscal year 2013, our increase in NIH awards, Chris I believe, was up 22%.

Dr. Ellison:

That is correct.

Dr. Retchin:

It is a little bit of anomaly that we actually decreased a bit in fiscal year 2015 compared to fiscal year 2014, but I think our overall trajectory is very good.

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We continue to submit proposals to the NIH in great number. We submitted 399 in fiscal year 2014, up to 474 proposals submitted in fiscal year 2015. An important element to track as part of our research portfolio.

In education excellence, the *U.S. News and World Report* rankings for 2015: we jumped 3 spots from 34 to 31. We continue to make progress among the elite medical schools in the country.

We also improved our performance in terms of education, our undergraduate GPA (grade point average) increased to 3.77 from 3.73 in one year, and our faculty student ratio continues to improve, we're now at 2.1 from 2.3. Sounds small, but those are big numbers in terms of the elements of our College of Medicine for students who want to select and have other opportunities for selecting medical schools.

In talent management a census faculty and staff satisfaction survey will be conducted later in the year. We continue to look at that as an important part of our work force engagement.

I will answer any questions Mr. Chair.

Dr. Wadsworth:

Questions for Dr. Retchin?

What would be your reasonable aspiration for NIH funding going forward?

Dr. Retchin:

That is a good question. We had a target this year of \$97 million. I think a reasonable target, and we can talk about that, is about \$105 million in NIH awards.

Dr. Ellison:

I think given the pay lines and discussion with the vice dean of research, we've actually targeted \$97 million in NIH funding, but for total funding \$200 million, which is an increase over this past year of about \$3 million. I think the pay line is just so tight. I think we'll be challenged to get over \$100 million. If we do it'll be great.

We know that we have some early wins in the process. We have some early acknowledgements of awards that will put wind in the sails as we move toward the end of this fiscal year.

Dr. Retchin:

And the question, in follow up Dr. Wadsworth, is whether just looking at the NIH is the appropriate metric for us to be judging our research success. As you know we continue to focus on NSF (National Science Foundation) and DOD (Department of Defense). Maybe it is total federal awards or total research overall. We will be looking at that as a scorecard.

Dr. Wadsworth:

Oh good. You will include that in the future?

Dr. Retchin:

Yes.

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Dr. Wadsworth:

That would be insightful, thank you.

Any other questions?

President Drake:

One tiny comment. I know we have the 2019 goal of top 10 public medical schools in *U.S. News and World Report*. Chris, I saw a note from you. How are we doing there?

Dr. Ellison:

We are ranked number 11 in public medical schools. We were ranked number 31 this past year. We moved up three spots compared to all medical schools in the rankings and moved up I think one spot in public to 11. Our goal, this next year, is to be top 10 public and top 30 overall ranking. We feel confident that we can reach that this year.

(See Attachment I for background information, page 27)

Dr. Wadsworth:

Let's move to the next agenda item. We welcome Mr. Wexner. He told me to keep chairing this.

Accreditation requirements. Dr. Retchin.

Dr. Retchin:

If you will turn behind the tab on Patient Care Services. The Plan for Patient Care Service is required by the Joint Commission. Andy, do you want to comment on this?

Dr. Thomas:

Thank you, Dr. Retchin. These are documents from both University Hospitals as well as the James Cancer Hospital, given the two provider numbers. There relatively standard documents are updated annually. Over the past year with changes in space and some services that are provided, it's updated to reflect that.

These have been reviewed by the Quality and Professional Affairs Committee prior to coming today, as well as by the Medical Staff Administrative Committees of both hospitals.

PLAN FOR PATIENT CARE SERVICES

Resolution No. 2016-17

University Hospitals

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

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

WHEREAS the University Hospitals plan for inpatient and outpatient care describes the integration of clinical departments and personnel who provide care and services to patients

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at The Ohio State University Hospital, Richard M. Ross Heart Hospital, Harding Hospital, and University Hospital East; and

WHEREAS the plan of care and scope of services for The Ohio State University Hospital, Richard M. Ross Heart Hospital, Harding Hospital, and University Hospital East were approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board on July 22, 2015 and are being recommended to the Wexner Medical Center Board for approval:

NOW THEREFORE

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

(See Attachment II for background information, page 28)

PLAN FOR PATIENT CARE SERVICES

Resolution No. 2016-18

Arthur G. James Cancer Hospital

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

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

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

WHEREAS the plan of care and scope of services for the Arthur G. James Cancer Hospital was approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board on July 22, 2015 and are being recommended to the Wexner Medical Center Board for approval:

NOW THEREFORE

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

(See Attachment III for background information, page 40)

Ms. Link:

Can I have a motion to approve the Plans for Patient Care Service?

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

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Dr. Wadsworth:

Thank you. We are now on item four which is Amendments to the *Bylaws of The Ohio State University Wexner Medical Center Board*.

You have in front of you a proposal for several changes. There are a number of updates to the bylaws that will be considered at the Governance Committee meeting of the Board of Trustees later this week, and I want to briefly update the board on these updates.

The first set of changes involves the medical staff chapter of the bylaws. This chapter has been revised to reference the Quality and Professional Affairs Committee. It also clarifies in the section that whether our medical staff governing and enforcing actions, that these are separate from medical staff appointments.

There are also some updates for temporary privileges. The language change clarifies that this is a delegated responsibility from the board to the chief medical officer and the director of medical affairs for each hospital. This language is also being aligned with the Joint Commission standard that allows temporary privileges to go up to 120 days. This was increased to 120 from the previous 90 days.

These are important changes that have been vetted and brought forward. The Joint Commission also now requires the process for the composition of the Medical Staff Administrative Committee, MSAC, to be approved by the governing body and that membership selection also needs to include for the removal of members. Language has been added to that effect.

The title for the executive vice president has been updated. I think you missed a trice for bringing some of these issues to our attention because they're important to make these changes, and bring us into accord. That is the first set of changes.

The second, are more general changes to the bylaws that were established for the Wexner Medical Center Board. We are rescinding three sections that are either outdated or duplicated and we're also proposing the addition, as you will see today, of the individual hospital chief executives and the CEO of the health system, as ex-officio nonvoting members. Adding all hospitals CEOs and the CEO of the health system will allow the board to have more complete input from its business units at the board level. Many of them already participate in our work and these individuals bring a wealth of knowledge and experience to the table.

As the bylaws relate to chair of the Wexner Medical Center Board's term, we are recommending a continuance of the current structure to the Governance Committee later this week. These changes are supported by the president and the CEO of the medical center. There will be a formal motion in this meeting to recommend these to the university board for approval after the year-end financials and the budget are presented.

I'll take any questions.

Hearing none, we will proceed later this week to move these forward where they'll be discussed in the Governance Committee and by the full trustees. Any questions?

**AMENDMENTS TO THE BYLAWS OF THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER BOARD**

Resolution No. 2016-19

Synopsis: Approval of the attached amendments to the *Bylaws of the Ohio State University Wexner Medical Center Board*, is proposed.

WHEREAS the University Board of Trustees approved the creation of The Ohio State University Wexner Medical Center Board at its August 2013 meeting; and

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

WHEREAS the Quality and Professional Affairs Committee of the Wexner Medical Center Board recommended the proposed amendments to the Chapter 3335-101 of the *Bylaws of the Ohio State University Wexner Medical Center Board* on July 22, 2015:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby recommends to the Board of Trustees the approval of the attached amendments to the *Bylaws of the Ohio State University Wexner Medical Center Board*; and

BE IT FURTHER RESOLVED, That the Wexner Medical Center Board hereby recommends to the Board of Trustees that the currently enacted *Bylaws of the Ohio State University Wexner Medical Center Board*, Ohio Administrative Code Chapters 3335-99, 3335-103, and 3335-104 be rescinded.

(See Attachment IV for background information, page 51)

Dr. Wadsworth:

Thank you very much.

We now move to Mr. Geier to report on the year-end financials.

Mr. Geier:

Thank you Dr. Wadsworth. I would like to close out fiscal year 2015 with a couple of comments and then move into requesting approval of the fiscal year 2016 budget for the consolidated health system.

Many of these numbers will be familiar with the committee, the trends that we had all year pretty much continue to the end. Backing up a year, in terms of our thinking at the time and the budget, there were three areas, I think, we were all concerned about.

One was the timing of the tower opening and the magnitude of that task and the uncertainty of the impact, particularly in respect to cost and volume.

The second was the opening and possible destruction of the new emergency room, which has gone very, very well. At that time we were really at the beginning, maybe a quarter of the way into, our operating efficiency activity and measures. At that time, it was difficult to predict how they would end up impacting the financial statements.

Going down to admissions, all of the hospitals are on budget. We missed it by 400 and that was in the Harding Hospital. I think we talked about how the length of stay in our psychiatric hospital has increased dramatically. Much of that is due to the access issues, now people with Medicaid and Medicaid expansion. I know Amanda Lucas and her team are working to get that length of stay down. Had they been on budget, our admissions number would have been right on budget.

Surgical volume is very strong in Ross Heart Hospital on an outpatient basis. University Hospital East, the Ambulatory Surgery Center, and the James Cancer Hospital were at about 15,000 inpatient surgeries and about 25,000 outpatient, a trend that has continued the last couple of years.

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Our ED (emergency department) visits, as you remember we were under budget about 6 months into it, in 7 months we were worried about, and again the opening of the new ED, that seems to be working now. We have some throughput issues that we are working through with Dr. Thomas' leadership. For the last couple of months, the budget for University Hospitals' emergency department has been above.

We ended the year up about 6% over budget on emergency visits. That is important because we get about 40% of our admissions through the emergency room. To break down the two emergency rooms, University Hospital has about 72,000 and University Hospital East has about 52,000. When you adjust for the activities, and Dr. Retchin touched on this, the revenue per adjusted admission, we ended the year up a little bit over on expenses and there were really two things that drove that. One was being over budget \$10 million on depreciation. That was really driven by when we estimated we would get the building and take it into service. We actually thought we would take it in January and begin depreciating it. It was done in December and started depreciating a month early, so we were off by about \$10 million. Obviously that will be queued up this year.

Drug expenses were over about \$25 million. A lot of that driven is by cancer drugs, specialty pharmacy, but that's offset with revenue. We absorbed about \$35 million in expenses over budget, still came in right on top of budget. We ended the year with an operating EBIDA (earnings before interest, depreciation, and amortization) at 19%, as Sheldon said, we were able to grow our cash balances from a year ago by about \$100 million and end the year at 87 days with a debt service coverage of 6.4.

Dr. Wadsworth:

Mr. Geier, obviously a very strong financial performance, year over year. Could you comment on the sustainability and growth going forward?

Mr. Geier:

I don't think you'll see this quantum leap in the bottom line going forward. I think, as you'll see in the budget, it's much more normalized. I don't think we'll see much of this. Obviously it was in volume. I think we'll see in the budgets next year a pick up in the James Cancer Hospital capacity, but the other hospitals are pretty much at capacity now. I think there will be a little more normalized growth.

We're still going hard at the cost side. I think one of the challenges going forward is being able to hold the cost number that we have. That is going to be one of the biggest challenges and resist that tendency to add back and let it slip back in. I think there will be growth as you'll see in the budget. I would not predict this kind of improvement year over year.

Dr. Wadsworth:

Good, thank you.

Mr. Geier:

This is by hospital. What our expectations were and where they came in. There is a different story for every one of these. This was not in your packet all though it was passed out at your place. You can see University Hospital had a strong year, very, very strong cost control in the volumes held, particularly through the transition. The Ross Heart Hospital, I think, had a bit of a positive surprise in surgical volume, that we had budgeted, but exceeded budget. That obviously helped James Cancer Hospital moving into their new facility. You can see this growth, it was quite strong and should continue next year.

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For University Hospital East, you can see the impact of the volume and University Hospital East was very, very full. Tremendous surgical activity, but also the impact of Medicaid expansion on reimbursements, which is again, something we did not know the impact when we did the budget. We will have another strong year this year.

Harding Hospital did better than budget. It is a very tough patient base. Reimbursements are not good. We also have a short stay area down in the emergency department that is housed in Harding Hospital's expenses and that probably is about \$2 million in expenses, but it benefits the whole system.

Ambulatory, which is our care point and our ambulatory surgery centers, continue to grow. Our employed physician practices, this is basically primary care, orthopedics, and neurosurgery, that is their professional component, it's not the hospital piece. They do show a loss and we'll spread that throughout the whole system. This is to give you a sense of how each one of these units did this year relative to the budget.

Any questions? We are wrapping this up and turning it over to PricewaterhouseCoopers, who we coordinate with for the audit, and that's underway.

(See Attachment V for background information, page 55)

Dr. Wadsworth:

Any questions?

President Drake:

I have a comment on Harding Hospital and the length of stay issue, Medicaid expansion, and a sort of a macro trend, I think, to think about.

Chronic mental illness, difficulty in succeeding in life, and poverty all modify each other. We have a circumstance where we are having Medicaid expansion for people who were out of the system and had no place to go. Some fraction of that population are going to be people who have chronic mental illness issues. They are so severe that they keep them, that that's the reason they're in poverty. I would expect the length of stay issues to have upward pressure because we're now getting into a population that has a difficult time being functional. I wouldn't expect that population to be the same as the average population. I think that we should be thoughtful about that when we're making our projections.

Dr. Wadsworth:

Thank you.

Mr. Geier:

I would like to turn to the budget for the health system for fiscal year 2016. This will be something we'll be asking approval for. I know Steve wants to make a comment. We have reviewed this a couple of times at the Finance Committee and made some changes and modifications to it. I will run through the assumptions on the payers.

We are assuming that Medicaid expansion will continue and provide us a positive impact in the budgets. Whatever our contract rates are on commercial contracts, we load those right into the budget, whatever we have, we put in there. We've got admissions, about 2.9% on the inpatient side and 3.8% in outpatient. The outpatient number is probably a little lower than we've had in the past. We're hitting capacity and we don't bring any new capacity on until the following year. The Sports Medicine Facility does not open until the end of the fiscal year.

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Surgical growth, 1.4%. If you remember, we pulled that back. At one of our prior meetings, we discussed, it was close to 4%. We had some concerns over bringing on some new surgeons and how well they would ramp up. From the last budget draft that the board saw we actually pulled about \$20 million out of the bottom line. That is a potential upside for us if we can do better.

We haven't done much to the case mix index with ICD10 (International Statistical Classification of Diseases and Related Health Problems). We are going to have to see how the impact to our own coding occurs which happens on October 1. We think we're good shape.

Length of stay hasn't changed, although we're in the process of, in October, implementing a new patient bed flow management system called TeleTracking, which is designed to bring the patients into the transfer center much more smoothly through the ED to get them placed in their beds. We're hopeful that as that system is fully implemented, and many of the physicians in this room are part of that project, that we'll begin to lower our length of stay, help unclog the ED, and have better patient flow and patient placement into beds.

The number of beds in the budget is 1,300. That is the number we ended with this year, and includes the beds in the James Cancer Hospital that have opened. We don't have any of the 90 beds in the Brain and Spine Center. Those don't really open until June or July of next year.

From an expense standpoint, we have a 2% merit increase. If you look at the budget, salaries are up about \$60 million, about \$30 million of that is in the merit pool, another \$30 million is the full year impact of hiring from the James Cancer Hospital opening. And we have some new programs, we have opened, I think this morning, more beds in University Hospital.

Benefits are up 17%. There are a couple of one time things in there. We have been working with Geoff and AJ at the university on getting caught up on our internal benefit rate. Some of this has to do with legacy hiring some of the physicians into the university and hiring some of the physicians into the health system. They came from OSUP with a lower benefit rate. Now they have a higher benefit rate in the university. We had to get this calibrated and caught up. There was about \$8 to \$10 million in this budget relative to catching up that benefit rate in conjunction with the university benefit.

Drug costs are up about 8%. That is after adjusting for volumes of the specialty pharmacy. I think we've talked about this, this will be the first full year of interest expense and depreciation up about 47% at 19%.

About \$176 million in capital expenditures and I'll go through a slide to detail the capital expenditures. The funding will be about \$126 million from cash flow, \$10 million from development, that's the Crane gift, and \$40 million from internal university loans, to fund. But again, I have a schedule in here that we'll go through.

And then we plan, which is the same level as this year, our medical center investments, which are supported academic clinical programs that the college and OSUP are budgeted, at \$140 million.

Dr. Wadsworth:

I may have missed it, but on benefits, you know in industry we're seeing a huge shift to lower monthly payments, much higher upfront costs, how is this matching with those trends?

Mr. Geier:

It's very high, we're high compared to our peers, particularly hospital peers. We're in the state system so when you take the health, the retirement, and paid time off, as I said our benefit rates are about 33% to 34%. In other places they're 23% and 24%. In the pure hospital business, makes us uncompetitive from a benefit cost standpoint and an employee expense standpoint. I would say it's a bigger issue to tackle at some point.

Dr. Retchin:

Yes. We have talked about this before. If you compare us to the local environment, there may be a delta there. Deltas are pretty large to estimate. You have a number of individuals, virtually the entire workforce, in a defined benefit plan. Moving to that would, while it could save money, would be very difficult and it takes time to move employees into a different plans.

Mr. Price:

In an essence, it impacts the overall cost structure, and as we look at these managed care plans, it's going to make us not competitive. While we may enroll in these managed care plans, they may not use the institution as a result of it.

Dr. Retchin

It is a cost we have had to absorb. There are a number of costs that academic health centers like ours bare. This is one of those that is, I think, more indicative or more reflective of a state plan environment.

Dr. Wadsworth:

Ok.

Dr. Retchin:

And we have not moved to paid time off (PTO), we still have sick days and vacation days. It is not a PTO situation.

Mr. Geier:

When we take our assumptions and put them together, you can see the consolidated budget for next year calls for an increase in the bottom line of \$323 million to \$346 million and an operating EBIDA of 20%. Days cash, we are projecting at 92 days and debt service coverage well within our lower limit of four to one. We take a little bit of a bend back on the expense per adjusted admission and that's something we're going to keep taking a look at only because we're absorbing this full year of depreciation, interest, payroll, in the new hospital. It is something the team is talking about all the time. We think we can do a little bit better than that.

From the balance sheet standpoint, you can see the days cash increasing \$461 million to \$541 million. You'll also see the other reserve move from \$146 million to \$205 million. That is driven by two items.

ICD10, which is a conversion of the physician coding system, is going to happen in October. It is hard to tell what's going to happen. We think we are well prepared but we want to put some reserves away in case we see a slowdown in cash flow. We actually have \$40 million in that balance sheet reserved for ICD10 if we get a payment. We think we're well prepared, we think the large payers are well prepared, but we have many small payers, we don't know if they're going to be prepared. We actually use an outside consultant to help us get a range of what we could expect. And as you can imagine it's

all over the board, other academic medical centers aren't doing anything, some are being very, very conservative on their reserves. We put a reserve in there of \$40 million for that. We will know by, probably next March or April, whether we actually need it or not and the receivable should come back. There is a bit of a timing issue.

The other, we put \$10 million in there. There's a timing issue relative to the collection of the fundraising portion on the project. If you remember, in the financing for the \$1.1 billion was \$100 million from the HRSA (Health Resources and Services Administration) Grant, about \$925 million in bonds, and \$75 million in development. Those pledges are spread out over three to four years, but we've got to pay the bills now as we close the project out. We put that cash aside, we'll pay it as they come in over the next three to four years, and we'll replenish it. That is why you see this other reserve go up, basically cash reserves.

Debt. You might ask why that doesn't go down. We are paying down the bond debt, but we're also, as you'll see, borrowing some internal loans to fund the Arlington and CarePoint, about \$40 million. Our debt picture doesn't change year over year, it stays about \$838 million.

Cash flow. I won't talk about fiscal year 2015. The budget will have a cash flow of \$486 million. The major categories that you'll see: \$52 million for debt payment, we were paying the interest on the construction loan now that we've taken possession of the building and we're paying the loan down; we don't have capitalized interest; \$80 million to grow five days cash; I talked about the cash transfer, the designated funds for ICD10; medical center investments, about \$133 million, those are specifically two departments; \$7 million for College of Medicine, those are reserves that Dr. Retchin and Dr. Ellison and I have talked about, they're not designated right now. You'll see at the end of the year in fiscal year 2015 we actually moved \$20 million over to the College of Medicine, undesignated, and I think for future strategic use, again for future plans that the college would have. Then cap ex of \$126 million.

To break the down the capital expenditures slide, the sources and uses of capital. Crane Sports Medicine Facility is \$10 million of development funds. We will borrow \$15 million for a 20-year loan from the university and then \$20 million of cash from operations, which is in the cash flow statement for the \$45 million project. For the Arlington CarePoint, a \$25 million loan from the university, payable over 20 years, and then \$5 million out of cash from operations for the equipment. We have about \$101 million of what we're calling "routine capital," in that is a \$17 million for the brain and spine hospital and then \$84 million in these major categories: selected projects and equipment, some infrastructure and renovation, what we call unit directed funds. Each hospital CEO has a capital reserve that they can spend in the hospital as they need. And then \$10 million in contingency. As things come up, pieces of equipment break, we've got to replace it that day and that's the \$84 million in selected projects and equipment.

We have an internal process, we have capital allocation committee for the \$84 million, all the CEOs and CFOs (chief financial officers) sit on it. We meet once a month and have criteria to reprioritize: life safety issues first and then financial returns, strategic investment. The capital allocation process for the projects and equipment is reviewed internally with the leadership team.

With that, this completes my presentation of the health system budget for fiscal year 2016.

Dr. Wadsworth:

This is going to be voted on. This is the budget for fiscal year 2016, consistent with our university budget.

Are there any other questions before we vote to approve the budget?

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Mr. Steinour:

Jeff if I could add we've had several meetings with the Finance Committee. David has participated and Mike Gasser has been involved. There has been a good exchange with Pete, Geoff, and Sheldon, along the way.

(See Attachment VI for background information, page 57)

Dr. Wadsworth:

If there are no further questions.

Ms. Link:

May I have a motion to recommend the Amendments to the *Bylaws of the Wexner Medical Center Board* and the Fiscal Year 2016 Budget?

Upon motion of Dr. Wadsworth, seconded by Mr. Price, the Wexner Medical Center Board members adopted the foregoing motion by unanimous voice vote.

Dr. Wadsworth:

The last topic within the public session is an outreach update by Ms. Marsh and Dr. Ali. Thank you.

Ms. Marsh:

Thank you, Dr. Wadsworth. At every board meeting, we've made a commitment to share with you a new innovative technology that we use to improve health care across the state of Ohio. You've seen Dr. Rezaei's brain chip, or neuromodulation. Last meeting you saw Dr. Kaeding's cartilage grown from a patient's own cells. Today we're proud to bring you an update on our telemedicine or what we call our virtual health initiative that is run across the state of Ohio.

I would like to take an opportunity now to introduce the two presenters: Dr. Victor Trianfo is joining us from Marysville Memorial Hospital in Union County and is one of our most valuable partners in the state. You won't be able to see him yet but Dr. Trianfo can you hear us?

Dr. Trianfo:

Yes.

Ms. Marsh:

Welcome and thank you for joining us this morning. Dr. Trianfo is the chief medical officer at Memorial Health and he did his medical school training at Ohio University in Athens and was actually one of our chief residents in family medicine here at Ohio State.

To my left, good friend and exceptional doctor, Dr. Naeem Ali. Dr. Ali is the medical director of University Hospital and works closely with Andy Thomas. Dr. Ali did his training, medical school training, residency training, he was a chief resident for us as well here at Ohio State, and he's been on the faculty since that time. I won't say how old he is.

I would also like to introduce our two robots behind me. Without these robots we wouldn't be able to have a virtual health initiative or telemedicine. On the right is the iRobot. This robot will move itself, will drive itself, and has an internal GPS. On the left is a more mobile robot that is moved by a caregiver.

These robots are in our affiliate hospitals and then back on our side is one of our specialists. Most often a stroke neurologist is back here at Ohio State using these robots to help with the care of a patient somewhere else in the state of Ohio. The robots you'll see here, they look like screens, why wouldn't you just have an iPad or a screen? They have special capabilities: stethoscopes to look at the vitals of patients; special cameras to look into the eyes of the patient, usually in an ER (emergency room) at another hospital; and documentation capabilities, the information that's used with the robot is immediately put into the electronic medical record and is updated not only at our partner hospital medical record, but at ours.

Why are we interested in telemedicine at Ohio State? First and foremost, our partner hospitals are asking us for this. Their objective is to keep the patient close to home, close to family, but still provide the highest quality care, and telemedicine does just that. But more importantly, for the services that we're using it for, it is improving the timeliness of care. A stroke patient, I think as most of you know, needs a clot busting drug administered in a timely manner to alleviate the stroke symptoms. That is the most common. Time is brain, I think we use the term here with the medical staff. On a routine basis, even last week, I heard another story of a 20 some year old women in eastern Ohio who went into the ER of one of our affiliate hospitals with stroke symptoms, immediately was connected by their ER docs to our stroke neurologists via telemedicine, administered TPA (Tissue Plasminogen Activator) in 58 minutes, and recovered with no signs of stroke. It is affecting people's lives every day.

We have telemedicine in our own hospital as well. Related to the conversation and the point that Dr. Drake made, we use telepsych between our University Hospital East and our main Harding Hospital so that our psychiatrists can immediately access psychiatric patients, not only on the main campus here, but in the University Hospital East. We found that previously about 40% of the psychiatric patients coming into the University Hospital East ER were admitted and now it's only 25%. They are treated, assessed, and they're sent to an appropriate place. And it has reduced the length of stay. Elizabeth Sealy is here from our University Hospital East and I know she's seen the impact of reducing the length of stay within the ER.

We also use it for burn services. We are the only burn center in this part of the state. We are using it so the burns coming in from farms and industry across the state into Ers, our burn specialists can immediately asses the severity of the burn and whether or not to move the patient here to the burn center or take care of them there.

But, primarily it's used in stroke as we already talked about. We have 27 sites across the state that have these robots that are connected back to Ohio State where we're providing care. This is the largest stroke network in the state, larger than some of our friends up north.

At this point I'd like to turn it over to Dr. Trianfo and Dr. Ali to demonstrate this great capability.

(See Attachment VII for background information, page 61)

Dr. Ali:

Thank you, can everybody hear me ok? I'm going to introduce Dr. Trianfo to start with here. We are displaying, great. We are on one of these mobile robots. I want to emphasize that one of the things that we think is of real value is this personal, almost a stand-in for you as a surrogate physician. Dr. Trianfo, welcome to the OSU Wexner Medical Center Board.

Dr. Trianfo:

Thank you.

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Dr. Ali:

Can you give us a few thoughts about what the role of telemedicine has been for you at Memorial and what that's been like?

Dr. Trianfo:

Well thank you very much and good morning members of the board. As was mentioned I'm Dr. Victor Trianfo and I'm the chief medical officer here at Memorial Health. We are located in Marysville, Ohio, and we have had a long relationship with Ohio State, specifically along the lines of neurology, cardiology, pulmonary and critical care medicine. As a community hospital, we're very excited to participate in today's event and demonstrate this technology and the benefit that it provides a community hospital.

Dr. Ali:

Vic, do you feel like you have any kind of illustrations of high value cases where you've gotten a lot of value out of this kind of interaction? And can you talk a little bit about where these robots really are positioned for you?

Dr. Trianfo:

We have a 12 bed emergency room. The robot is located here at our emergency department, readily available 24/7, 365 days. This is very important to a community hospital. When we only have one specialist, or one area being covered, we often lack the specialties that an institution like Ohio State can provide. It's going be hard for us to recruit a neuro-radiologist or a neuro-specialist, and having this available allows us to have that available to our patients all the time.

Recently, let me share an example in which telemedicine was available here in our community and made a difference. A local gentlemen presented to our hospital who had symptoms of a stroke. Our wellness center and our marketing departments have provided information to our community of how patients are supposed to react when they are presented with symptoms of stroke. While this individual wasn't 100% sure that he was having a stroke, he knew something was wrong and the take home message was "when something's wrong, come to the hospital, let us help figure it out with you."

The patient presented, our emergency department was activated, a stroke alert was called, the patient was evaluated by the emergency room physician and immediately a consultation was undertaken with a representative from Ohio State's neurology and neurovascular service. The patient was evaluated by that physician via the technology that's provided with us here today that we're demonstrating. A decision was made to provide the clot busting agent that Gail spoke of earlier. It was provided in a timely fashion and that was very important. The entire event took less than 20 minutes, when the target and the benchmark in our community and around the nation is 60 minutes. To be able to provide that care in a timely fashion was extremely important.

Dr. Ali:

That's a really powerful example Vic. Maybe what we can do right now is demonstrate some of the functionality that might have been used in that same kind of encounter and what the patient interaction would be like. How about you go ahead and introduce our patient and we can demonstrate some of the exam techniques.

Dr. Trianfo:

I have with us today Mr. Cox. He is the gentleman who is going to participate in today's demonstration for the board. He is not a real patient.

Dr. Ali:

As I'm entering the room, and to illustrate for you guys, I want to emphasize the personal aspect of this. Entering into a room, may or may not be with the presence of that physician. Quite often I find, in this kind of technology, that's of huge value to connect directly with that clinician. But you can also get a lay of the land by scanning the room, seeing if there are other family members there or other folks there, just like you would as you're entering into that room. And then, addressing the patient and having all that ability to connect with them. Dr. Trianfo and I could have a specific conversation about what it is that he's interested in and then we can proceed to doing a simulated exam. Vic, why don't we go ahead and proceed. First I'll start with the visual examination and then if you want to help us to get ready for the eye exam, ok?

Earlier versions of video technology have been a little bit frustrating, because we can all sit in front of a TV and talk with someone. I think I inadvertently showed you some of the power of the magnification earlier. There is the ability to focus in on specific areas and particularly in the stroke exam, the idea that you can focus in on very subtle findings on the eye exam, really to the extent that you can actually measure pupil dilatation and pupillary changes, is really impressive.

Now if you want to show that flashlight from the side you can actually see down to the level of the responsiveness of that pupil and how it's moving. Bill is moving so I have to move with him. There you go. It gives you an idea of that magnitude. As you've already noted there's a little bit delay in the audio but it's fairly tight and makes those kinds of conversations reasonable in a clinical setting here.

Another thing that I'll do, and being a critical care provider, is a lot of input that necessary to me that's visual. Vic if you wouldn't mind, I'm going to focus on this monitor up here. In addition, I make the analogy that often we get these kinds of communications in a verbal way. If you think about how dull email is relative to a personal verbal conversation, I think of these video interactions very similar to the magnitude of difference. When you're talking with someone and just hearing their words as opposed to talking with them and primarily looking at this data, in this case being the heart rhythm that's displayed on the monitor, the oxygen saturation curve. In fact, if you even wanted to look at subtleties of whether there is specific abnormalities related to the telemetry strip, you can get a quick sense of where you need to go in the next interaction. You're not duplicating tests, you're not asking them to do additional things, you're gaining this all by a visual interaction, which really makes it just as if you were at the bedside with that partner of yours looking at the case.

Vic I wonder if we could get use of the stethoscope? At this point I'm only highlighting one of the other aspects of the technology. We've got two of these that we'll go through and we'll illustrate for you.

Right now I'll switch over to our stethoscope mode and I'll turn, we'll get that started. And why don't we go ahead and listen to your breathing. That wave of sound is really something that we hear, and I'm very reassured. Bill, congratulations your lung sounds are normal.

Now we're going to try to listen to the heart tones. I think you can hear the drum beat under there. For me, as a critical care provider or perhaps as a stroke consultant, it's sufficient to be able to hear major abnormalities.

You also do hear a little bit of ambient noise and in this setting we would normally move into the room, close the door, and moderate that environment. Let me turn off the stethoscope here. Vic do you have any comments about exam technique that you've found have been useful through this robotic telemedicine?

Dr. Trianfo:

I have. Most of the time, this is used in our emergency department on an acute basis, but the technology lends itself to the emergency room and inpatient environments. It also lends itself to the ACC (Ambulatory Care Center) clinic. Ohio State University is a reservoir of some of the greatest specialists in the country. But like a library, a book cannot sit on the shelf, it has to be brought out to the community to be used, and this technology allows those experts to move down into the community and to assist me in the care of patients.

Dr. Ali:

Vic that's great. I want to demonstrate one other thing here. In this simulated encounter, the nice thing is that we're all engaged together. I do want to highlight one extra difference. If you wouldn't mind picking up the handset.

There are times when we're all trying to capture this in layman's terms, in terms of connecting to our patients, we want to make sure we speak in terms they understand; that's an important principle of medicine. But there is a mode through this private communication that Vic and I can have a peer to peer conversation and I can say things like you know "Vic I think there's some major concern here, I've tried to be as cautious as I can in my prediction, but in respect to the patient I think you should advise them in this direction." He and I can have an exchange. Vic, have you had an occasion to use this and can you imagine situations where you would have private communications that you want to have?

Dr. Trianfo:

Yes I think it's very important for us to be able to speak. At this time the patient cannot hear what I'm saying, we can interact both on a professional level, or on a personal level. It is very important that this modality be available to us.

Dr. Ali:

I am going to switch off the handset now. I think the idea to demonstrate there obviously picking up a phone in front of the patient is not exactly the way to achieve that, but on the other hand, it does provide that avenue for really flexible communication that you would do in the hallway outside of the room in a normal consultation.

Vic, I think that's most of the technology we wanted to demonstrate, do you have any thoughts? I think one area that I was specifically interested in is if you had anecdotes about how the patients themselves and family react to this robotic interaction.

Dr. Trianfo:

That was a concern for us initially. We're a small community for the Dublin area for workers at Honda as well as at Scotts, two of our major employers here in the area, but technology is prevalent throughout the community. Everyone seems to have a cellphone and texting throughout the day, even our older patients are aware of the technology that's available to them. They utilize their cell phones to contact their children and grandchildren and we have not had any negative impact of the technology. The robot was named here in Maryville, Sheldon, after the TV show.

Dr. Ali:

You can't see but he's smirking right now.

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Dr. Retchin:

To bring life to an otherwise robotic process.

Dr. Trianfo:

Yes.

Dr. Ali:

Alright, well thank you very much for those comments. I think, for the room here I'm going to comment on two things. To amplify that family experience, one of our critical care physicians had the opportunity, when Memorial had a critical care doctor who could not round in the ICU (intensive care unit) that weekend, to do robotic rounds in the intensive care unit, and had the opportunity to have an end of life discussion with family members. I can say from that experience I think people react to this relatively positively.

The only other thing I'll add, there's a lot of talk about electronic monitoring in remote sites to improve care and I think that's a very important aspect of delivering improved health care to the broader community, but I will say as an academic physician, this kind of connection remotely has some resonance with me. When I talk to our faculty and our medical staff about the values of this, when they think about the old platforms where it's a fixed area, you had to have the patient move to you, it had to be scheduled to work, and that doesn't feel like a real interaction. I think this kind of interaction really simulates what I do in practice and resonates with the academic physician, particularly when you have the ability to expand your expertise across the state as opposed to across this building.

Ms. Marsh:

Vic, can you stay with us for a minute or two to see if there's any questions from the board?

Dr. Trianfo:

Certainly.

Dr. Wadsworth:

I have a question. Some of you may remember the notorious diagnoses by Senator Bill Frist which represents a low point of technology, I can't resist saying that. Where are we on the technology curve here? In other words, where's the technology going, in terms of resolution, additional equipment, and is there a constant track with acceptance by patients, as we get more and more technology into there.

Ms. Marsh:

Let me introduce two other people. Karen Jackson is our director of telemedicine here at the Medical Center and Tom Blinko is our executive director of outreach. I am going to let them talk about where the technology is going with telemedicine.

Ms. Jackson:

I will speak to that. It continues to evolve. Even with the relationship we have with this vendor, since 2013, it continues to improve, expand, what are the capabilities, as far as both resolution and timeliness. One of the things that they're going to be rolling out is a new connection to RAPID (Rapid processing of Perfusion and Diffusion), which, and I'm not a stroke expert, is an expedited analysis of what's happening in the brain and trying to figure out what part's salvageable or not. They are working with the company and this

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could go out to our remote hospitals. That is an example for using the technology and people are used to it. They expect it more than it is a surprise.

Mr. Blinko:

One other comment about the technology. I think you're seeing a greater integration of data from all different sources. One of the capabilities we currently have is pulling up images in real time, CT (Computerized Tomography) scans, X-ray images, MRIs (Magnetic Resonance Imaging), those types of things in real time. Dr. Ali, sitting at a computer, can be looking at integrating all of these things at once. As the technology has grown and expanded, it has started to bring more and more data and information that's appropriate into the collaboration platform formed by this technology.

Dr. Wadsworth:

Have there been any liability issues you have to anticipate and take care of as a result of doing, tele-diagnoses.

Mr. Blinko:

I personally don't believe there's been any major ones but I'm not 100% sure of the relationships that are set up. The practitioners that practice there get credentialed at both sites, and so that quality is managed there, and it's been very smooth to do that, but I'm not aware of any major problems that have been introduced as a result of that.

Dr. Thomas:

You're exactly right, we've not. People were on the phone doing this before. It is not like there hasn't been connections. To Tom's point, this is an additional set of data, video, visual, and actually detailed data from EKGs (electrocardiogram) and other things, CT scans as opposed to giving someone advice over the phone, it's a next step forward.

Ms. Marsh:

It's important to point out that on our end we've dedicated only subspecialists to be on our side. Some other networks might have nurse practitioners that do the assessment first and then contact a specialist. We feel the quality is better with our specialists on this.

Dr. Wadsworth:

Very good, it's very interesting your demonstration. I certainly learned a lot from it. Questions, yes Steve?

Mr. Steinour:

Does this evolve ultimately into transport so you're getting earlier access?

Ms. Marsh:

Yes. For some of these patients, it is determined very early on that the patient needs to be put on a helicopter and flown here.

Mr. Steinour:

No, I'm talking about when they're going into their primary care hospital, wherever that's located.

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Ms. Marsh:

Yes, that's what I'm saying. They might go into one of these 27 places across the state. If we can keep them there and treat them there via telemedicine, then they'll stay there. There are some capabilities that Ohio State has that these hospitals don't have and that determination is made via telemedicine.

Mr. Steinour:

I must not be clear. In transporting to the regional hospital, is there an extension of this telemedicine capability in the ambulance or other environments that they're being transported?

Ms. Marsh:

There is a new Beta test out right now that we're using the mobile version of this technology with EMS (Emergency Management Service) and our MedFlight folks. We have done it now with one MedFlight, we're on MedFlight two. What happens is, back in our ER we have something called medical control for EMS, for ambulance transfers and helicopter transfers. They bring up the patient, they're able to talk to the patient via this same type of mobile technology. It is only being Beta tested.

Mr. Steinour:

Particularly in our environment Jeff, with the resources of the engineering school, Battelle, et cetera, it would seem to me there may be an opportunity to participate somehow in further upstream adoption.

Dr. Wadsworth:

Yes, I am sure. I bet there are trade shows and all sorts of competition going on for the technology advancements. They must find application in remote fields where, you know people are offsite somewhere, maybe on ships or other things where you could eventually use this.

President Drake:

I was going to say, maybe 10 days ago, I was at Wright Patterson Air Force base and looking at the transports, what is available in field, which is quite amazingly advanced, and then what's available during transport. They have a simulator there and they train people for combat. They had a simulator for what happens when people get the cot to the airplane. Things that can be done in stabilizing patients, deciding where they're going to be flown. It's quite amazing and real, and then there are different levels of care they go to stabilization and lifesaving as we move forward and we see this with the conflicts in the Middle East. The survival rate of the soldiers and others who are wounded there is dramatically different than it had ever been in the past because of things are being able to be done remotely through telemedicine, et cetera.

I do have a question, a couple things. On the state of the art as far as latency resolution, bandwidth requirements, where are we there?

Ms. Jackson:

One of the things with bandwidth is that, with this vendor we're able to manage it, it will adjust based on the environment. If we had successful consults with the bandwidth dropping down to 100, it adjusts for it. As far as the resolution change, we're interested in bringing out the best. It continues to improve.

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Mr. Blinko:

Dr. Drake your question is very relevant because if you think about it there are 27 different environments that we're in. That's 27 different network constructions, that 27 different CT scanners. You hit on something that's really crucially important.

Dr. Wadsworth:

We are on schedule here.

Mr. Price:

Where are we with the reimbursement climate for this technology in terms of being compensated?

Ms. Marsh:

Most commercial payers have negotiated reimbursement for telemedicine consults; Medicaid has and Medicare has. It is not comparable necessarily to an onsite visit but it's reasonable.

Mr. Price:

Isn't there a provision regarding Medicare that you have to be designated as a rural hospital in order to be compensated for that. I don't think the compensation is generally across the board. There's a special designation, you want to speak to that?

Ms. Jackson:

That is a really important thing, with Medicare you do have to be in a rural site because that has an impact, and we continue to work with our legislature as far as how to roll that out to other environments. For example, in Columbus, Ohio, you may not get reimbursed for telemedicine although it may have a very significant impact in our community if we were able to use it. That is important.

Mr. Price:

That is something we have to look at very closely because we may not be compensated for some of these activities and, you know, we have to make sure that laws are changed in such a way that we can be compensated. Also managed care companies, in certain cases will not reimburse you for this as well. There is a lot that needs to be done. We need to come back to the serenity of earth in terms of understanding how we're going to pay for some of this technology.

It is outstanding technology, but we have to get the legislation in such a way that we can be compensated for these activities.

Ms. Jackson:

I would add, we are working with our legislators and Congressman Johnson is checking onsite tomorrow, in fact, to talk with us more about telemedicine.

Mr. Price:

Thank you, that's an important point.

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President Drake:

I would love to know more about that, because it's the kind of thing that actually would be useful my conversations with our legislators and I think, they'd be interested in hearing about this, and there'd be opportunities to share this. I would love to know more.

Dr. Wadsworth:

Any other comments? If not, I'd like to thank Gail and Dr. Ali. I would like to thank Dr. Triano. I'd like to thank the patient, although not a real patient. At this point we're going to move into executive session and I'm going to ask Ms. Link to say the appropriate words.

Ms. Link:

The board will now recess into executive session to discussion personnel matters regarding the appointment, employment, and compensation of public officials, to consider business sensitive trade secret matters required to be kept confidential by federal and state statutes and to discuss the purchase and sale of real property.

May I have a motion?

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

Attest:

Leslie H. Wexner
Chairman

Heather Link
Associate Secretary

(ATTACHMENT I)



Final Version
FY15 Year End | Through June 2015

MEDICAL CENTER PERFORMANCE					FY14 Actual	FY15 YE Actual	FY15 Target	Current Status	2019 Target
A. Quality and Service									
1. Inpatient Mortality									
				0.64	0.64	0.65			Top 5 of UHC Hospitals
2. Overall Patient Satisfaction									
2a. Inpatient: HCAHPS									
				73.8%	75.2%	79.0%			Top Decile
2b. Outpatient: CG-CAHPS/Physician Offices Sat									
				91.0%	90.8%	95.0%			Top Decile
3. USNWR Best Hospitals: Number of Specialties Ranked									
				5	7	7			11
4. USNWR Best Hospitals: Number of Specialties in Top 20									
				1	1	2			6
B. Financial Viability									
1. Days Cash on Hand: Health System									
				69.0	87.3	72.0			84.1
2. Days Cash on Hand: OSUP									
				60.8	64.8	52.5			61.6
C. Revenue Enhancement and Scale									
1. Health System Total Operating Revenue per Adjusted Admission									
				\$20,294	\$21,839	\$20,484			\$21,479
2. Development Dollars (excluding OSP)									
				\$99.8M	\$98.9 M	\$100M			\$108 Cumulative
D. Cost Management									
1. Health System Total Operating Expenses per Adjusted Admission									
				\$16,207	\$18,850	\$18,792			\$20,240
E. Research Excellence									
1. Total NIH Awards ¹									
				\$109.0M	\$95.9M	\$97.0M			Top 15 Public
F. Education Excellence									
1. USNWR Best Medical Schools									
				#34	#31	#33			Top10 Public
G. Talent Management									
1. Workforce Engagement: Staff									
				4.05	To be reported 2015	4.15			Top Decile
2. Workforce Engagement: Faculty									
				3.93	To be reported 2015	4.15			Top Decile

Meets or Exceeds goal
 Caution
 Below Goal - Action Needed
 Data Pending
 Data Missing

▲▲▲▲▲
 ▲▲▲▲▲
 ▲▲▲▲▲

1. Total NIH Awards exclude Nationwide Children's awards

Performance Up from last Board report
 No Performance Change from last Board report
 Performance Down from last Board report



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

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

OSU WEXNER MEDICAL CENTER MISSION, VISION AND VALUES

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

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

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

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

PHILOSOPHY OF PATIENT CARE SERVICES

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

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

- assessment and improvement activities; communications through management team meetings, administrative staff meetings, special forums, and leadership and employee education/development;
- h) Maintaining competent patient care leadership and staff by providing education designed to meet identified needs;
- i) Respect for each patient's rights and decisions as an essential component in the planning and provision of care; and,
- j) Staff member behaviors reflect a philosophical foundation based on the values of Ohio State's Wexner Medical Center.

THE HOSPITAL LEADERSHIP

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

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

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

Other leadership responsibilities include:

- a) Communication of the organization's mission, goals, objectives and strategic plans across the organization;
- b) Ensuring appropriate and competent direction, management and leadership of all services and/or departments;
- c) Collaborating with community leaders and organizations to ensure services are designed to be appropriate for the scope and level of care required by the patients and communities served;
- d) Supporting the patient's continuum of care by integrating systems and services to improve efficiencies and care from the patient's viewpoint;
- e) Ensuring staffing resources are available to appropriately and effectively meet the needs of the patients served and to provide a comparable level of care to patients in all areas where patient care is provided;
- f) Ensuring the provision of a uniform standard of patient care throughout the organization;

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- g) Providing appropriate job enrichment, employee development and continuing education opportunities which serve to promote retention of staff and to foster excellence in care delivery and support services;
- h) Establishing standards of care that all patients can expect and which can be monitored through the hospital's performance assessment and improvement plan;
- i) Approving the organizational plan to prioritize areas for improvement, developing mechanisms to provide appropriate follow up actions and/or reprioritizing in response to untoward and unexpected events;
- j) Implementing an effective and continuous program to improve patient safety;
- k) Appointing appropriate committees, task forces, and other forums to ensure interdepartmental collaboration on issues of mutual concerns and requiring interdisciplinary input; and,
- l) Supporting patient rights and ethical considerations.

ROLE OF THE CHIEF NURSING OFFICER

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

The Chief Nursing Officer ensures the following functions are addressed:

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

DEFINITION OF PATIENT SERVICES, PATIENT CARE AND PATIENT SUPPORT

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

- **Access in:** emergency process, admission decision, transfer or admission process, registration and information gathering, placement;
- **Treatment and evaluation:** full scope of services; and,

- **Access out:** discharge decision, patient/family teaching and counseling, arrangements for continuing care and discharge.

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

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

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

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

SCOPE OF SERVICES / STAFFING PLANS

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

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

- recognized standards or practice guidelines, when available (the complex or high level technical skills that might be expected of the care providers).

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

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

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

STANDARDS OF CARE

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

Patients of the Hospitals can expect that:

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

communication, supports technological advancements and maintains patient safety.

Patient Assessment:

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

Coordination of Care:

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

STANDARDS of COMPETENT PERFORMANCE/STAFF EDUCATION

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

CARE DELIVERY MODEL

The care delivery model is guided by the following goals:

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

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

PATIENT RIGHTS AND ORGANIZATIONAL ETHICS

Patient Rights

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

Organizational Ethics

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

- Services and capabilities offered meet identified patient and community needs and are fairly and accurately represented to the public.
- Adherence to a uniform standard of care throughout the organization, providing services only to those patients for whom we can safely care for within this organization. The hospitals do not discriminate based upon age, ancestry, color, disability, gender identity or expression, genetic information, HIV/AIDS status, military status, national origin, race, religion, sex, sexual orientation, or veteran status.
- Patients will be billed only for care and services provided.

Biomedical Ethics

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

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

INTEGRATION OF PATIENT CARE AND SUPPORT SERVICES

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

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

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

CONSULTATIONS AND REFERRALS FOR PATIENT SERVICES

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

INFORMATION MANAGEMENT PLAN

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

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

PATIENT CARE ORGANIZATIONAL IMPROVEMENT ACTIVITIES

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

PLAN REVIEW

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

Appendix A: Scope of Services: Patient Support Services

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

DEPARTMENT	SERVICE
CASE MANAGEMENT	As part of the health care team, provides world class personalized care coordination and resource management with patients and families.
CHAPLAINCY AND CLINICAL PASTORAL EDUCATION	Assists patients, their families and hospital personnel in meeting spiritual needs through professional pastoral and spiritual care and education.
CLINICAL ENGINEERING	Routine equipment evaluation, maintenance, and repair of electronic equipment, evaluation of patient owned equipment.
COMMUNICATIONS AND MARKETING	Responsible for developing strategies and programs to promote the organization's overall image and specific products and services to targeted internal and external audiences. Handles all media relations, advertising, internal communications, special events and publications.
DIAGNOSTIC TESTING AREAS	Provides tests based on verbal, electronic or written order. Preliminary report via phone or electronic patient record. Permanent reports in patient record.
DIAGNOSTIC TRANSPORTATION	Provision of transportation services for patients requiring diagnostic, operative or other ancillary services.
EARLY RESPONSE TEAM (ERT)	Provides timely diagnostic and therapeutic intervention before there is a cardiac or respiratory arrest or an unplanned transfer to the Intensive Care Unit. Consists of a Critical Care RN and Respiratory Therapist who are trained to help patient care staff when there are signs that a patient's health is declining.
EDUCATIONAL DEVELOPMENT & RESOURCES	Provides and promotes ongoing development and training experiences to all member of the OSU Wexner Medical Center community; provides staff enrichment programs, organizational development, leadership development, orientation and training, skills training, continuing education, competency assessment and development, literacy programs and student affiliations.
ENDOSCOPY	Provides services to patients requiring a nonsurgical review of their digestive tract.
ENVIRONMENTAL SERVICES	Provides quality monitoring for routine housekeeping in patient rooms. Routine housekeeping of nursing unit environment. Additional services upon request: extermination, wall cleaning, etc.

DEPARTMENT	SERVICE
EPIDEMIOLOGY	Enhance the quality of patient care and the work environment by minimizing the risk of acquiring infection within the hospital setting.
FACILITIES OPERATIONS	Provide oversight, maintenance and repair of the building's life safety, fire safety, and utility systems. Provide preventative, repair and routine maintenance in all areas of all buildings serving patients, guests, and staff. This would include items such as electrical, heating and ventilation, plumbing, and other such items. Also providing maintenance and repair to basic building components such as walls, floors, roofs, and building envelope. Additional services available upon request.
FISCAL SERVICES	Works with departments/units to prepare capital and operational budgets.
HUMAN RESOURCES	Serves as a liaison for managers regarding all Human Resources information and services; assists departments with restructuring efforts; provides proactive strategies for managing planned change within the Health System; assists with Employee/Labor Relations issues; assists with performance management process; develops compensation strategies; develops hiring strategies and coordinates process for placements; provides strategies to facilitate sensitivity to issues of cultural diversity; provides HR information to employees, and establishes equity for payroll.
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 and visitors. Clinical nutrition assessment and consultation are available in both inpatient and outpatient settings. The Department provides food service to inpatients and selected outpatient settings in addition to operating a full-service cafeteria and acts as a liaison for vending and sub-contracted food services providers.
PATIENT ACCESS SERVICES	Coordinates registration/admissions with nursing management.
PATIENT EXPERIENCE	Develops programs for support of patient relations and customer service, and includes front-line services such as information desks.

DEPARTMENT	SERVICE
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.
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.
PULMONARY DIAGNOSTICS LAB	Provides service to patients requiring an evaluation of the respiratory system. Performs Pulmonary Function Testing to assess the functional status of the respiratory system. Bronchoscopy and other diagnostic/interventional pulmonology procedures are performed to diagnose and/or treat abnormalities that exist in the airways, lung parenchyma or pleural space.
QUALITY AND OPERATIONS IMPROVEMENT	Provides an integrated quality management program and facilitates continuous quality improvement efforts throughout the medical center.
RESPIRATORY THERAPY	Provide all types of respiratory therapeutic interventions and diagnostic testing, by physician order, mainly to critically ill adults and neonates, requiring some type of ventilator support, bronchodilator therapy, or pulmonary hygiene, due to chronic lung disease, multiple trauma, pneumonia, surgical intervention, or prematurity.
REHABILITATION SERVICES	Physical therapists, occupational therapists, speech and language 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	Handles issues associated with licensing and regulations, such as EPA and fire regulations.

DEPARTMENT	SERVICE
SECURITY	Provides a safe and secure environment for patients, visitors, and staff members by responding to all emergencies such as workplace violence, fires, bomb threats, visitor/staff/patient falls, Code blues (cardiac arrests) in public places, internal and external disasters, armed aggressors, or any other incident that needs an emergency response.
SOCIAL WORK SERVICES	Social Work services are provided to patients/families to meet their medically related social and emotional needs as they impact on their medical condition, treatment, recovery and safe transition from one care environment to another. Social workers provide psychosocial assessment and intervention, crisis intervention, financial counseling, discharge planning, health education, provision of material resources and linkage with community agencies. Consults can be requested by members of the treatment team, patients or family members.
VOLUNTEER SERVICES	Volunteer Services 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. Volunteer Services manage the patient mail & flower room, cultural support volunteer program, and the pet visitation program. Volunteer Services serve as a liaison for the Service Board auxiliary which annually grants money to department-initiated projects than enhance the patient and family experience.



Revised: May 2015
MSAC Approval: June 2015
QPAC Approval: July 2015
Board Approval:

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

PLAN FOR PROVIDING PATIENT CARE SERVICES

Prepared by: **ADMINISTRATION**

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

THE HOSPITAL'S MISSION, VISION, AND VALUES

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

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

Values: Excellence, Collaborating as One University, Integrity and Personal Accountability, Openness and Trust, Diversity in People and Ideas, Change and Innovation, Simplicity in Our Work, Empathy, Compassion, and Leadership. Each of the three elements of The James Cancer Hospital's Mission contributes to the strength of the other two elements. The James' patient centered care is enhanced by the teaching and research programs, while patient service both directly and indirectly provides the foundation for teaching and research programs. This three-part mission and a staff dedicated to its fulfillment distinguish The Arthur G. James Cancer Hospital and Richard J. Solove Research Institute as a Comprehensive Cancer Center and as one of the nation's premier cancer treatment centers.

Philosophy of Patient Care Services

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

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

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

Hospital Leadership

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

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

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

Other leadership responsibilities include:

- Communication of the organization's mission, goals, objectives and strategic plans across the organization;
- Ensuring appropriate and competent direction, management and leadership of all services and/or departments;
- Collaborating with community leaders and organizations to ensure services are designed to be appropriate for the scope and level of care required by the patients and communities served;

- Supporting the patient's continuum of care by integrating systems and services to improve efficiencies and care from the patient's viewpoint;
- Ensuring staffing resources are available to appropriately and effectively meet the needs of the patients served and to provide a comparable level of care to patients in all areas where patient care is provided;
- Ensuring the provision of a uniform standard of patient care throughout the organization;
- Providing appropriate job enrichment, employee development and continuing education opportunities which serve to promote retention of staff and to foster excellence in care delivery and support services;
- Establishing standards of care that all patients can expect and which can be monitored through the hospital's performance assessment and improvement plan;
- Approving the organizational plan to prioritize areas for improvement, developing mechanisms to provide appropriate follow up actions and/or reprioritizing in response to untoward and unexpected events;
- Implementing an effective and continuous program to improve patient safety;
- Appointing appropriate committees, task forces, and other forums to ensure interdepartmental collaboration on issues of mutual concerns and requiring interdisciplinary input; and,
- Supporting patient rights and ethical considerations.

Role of the Executive Director, Patient Services and Chief Nursing Officer

The Executive Director, Patient Services and Chief Nursing Officer is a member of the Executive Leadership Team and is under the direction of the Senior Executive Director, Administration of the hospital. The Executive Director, Patient Service and Chief Nursing Officer has the requisite authority and responsibility for directing the activities related to the provision of care services in those departments defined as providing care to patients. The Executive Director, Patient Services and Chief Nursing Officer ensures the following functions are addressed:

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

Definition of Patient Services, Patient Care and Patient Support

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

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

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

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

Nursing Care (nursing practice) is defined as competently providing all aspects of the nursing process in accordance with Chapter 4723 of the Ohio Revised Code (ORC), which is the law regulating the Practice of Nursing in Ohio. The law gives the Ohio Board of Nursing the authority to establish and enforce the requirements for licensure of nurses in Ohio. This law, also, defines the practice of both registered nurses and licensed practical nurses. All activities listed in the definitions, including the supervision of nursing care, constitute the practice of nursing and therefore require the nurse to have a 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 patients' care needs (includes services most frequently provided such as procedures, services, etc.);
- The scope and complexity of patient care needs (such as most frequent diagnosis)
- The appropriateness, clinical necessity and timeliness of support services provided directly or through referral contact;
- The extent to which the level of care or service meets patient needs (hours of operation if other than 24 hours a day/7days a week and method used for ensuring hours of operation meet the needs of the patients to be served with regard to availability and timeliness);
- The availability of necessary staff (staffing plans); and
- Recognized standards or practice guidelines, when available (the complex or high level technical skills that might be expected of the care providers).

Staffing plans for patient care service departments are developed based on the level and scope of care provided, the frequency of the care to be provided, and a determination of the level of staff that can most appropriately (competently and confidently) provide the type of care needed. Nursing units are staffed to accommodate a projected average daily patient census. Unit management (including nurse manager and/or charge nurse) reviews patient demands to plan for 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 James Cancer Hospital follows the Staffing Guidelines set by the American Nurses Association. In addition, we utilize staffing recommendations from various specialty nursing organizations, including ANCC, AACN, AORN, OCN, and others.

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

Standards of Care

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

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

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

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

Patient Assessment:

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

Coordination of Care:

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

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

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

Standards of Competent Performance/Staff Education

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

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

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

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

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

Care Delivery Model

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

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

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- Physicians, nurses, pharmacists, respiratory therapist, patient care resource managers and many other disciplines collaborate and provide input to patient care.
- The patient and family will be involved in establishing the plan of care to ensure services that accommodate their needs, goals and requests.
- Streamlining the documentation process will enhance patient care.

Patient Rights and Organizational Ethics

Patient Rights

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

Organizational Ethics

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

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

Biomedical Ethics

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

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

Integration of Patient Care and Support Services

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

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

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

Consultations and Referrals For Patient Services

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

Information Management Plan

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

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

Patient Organization Improvement Activities

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

Plan Review

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

Appendix A: Scope of Services: Patient Support Services

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

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

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

(ATTACHMENT IV)

OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER BOARD BYLAWS

Chapter 3335-101 Medical Staff

3335-101-01 General.

No change

3335-101-02 Medical staff.

For purposes of this chapter, the words "medical staff" shall include all physicians, psychologists, podiatrists, and dentists who are authorized to attend patients in any medical care facility or program administered by the university Wexner medical center, and may include such other [health care](#) professionals as the medical staff bylaws designate.

3335-101-03 Medical staff organization.

The organization of the medical staffs of the university Wexner medical center shall discharge those duties and responsibilities assigned to them by the university Wexner medical center board and is subject to the approval and authorization of the university Wexner medical center board. Those duties and responsibilities include the following purposes:

- (A) No change
- (B) To recommend, through the appropriate medical staff administrative committee, to the [quality and](#) professional affairs committee of the university Wexner medical center board the appointment or reappointment of an applicant to the medical staff of university hospitals or the James cancer hospital, the clinical privileges such applicant shall enjoy in the facilities of or associated with university hospitals or the James cancer hospital, and appropriate professional review action that may be necessary in connection with any member of the medical staff.
- (C) No change
- (D) To establish and enforce medical staff bylaws, ~~and establish specific~~ rules and regulations governing actions of members of the medical staffs ~~and practitioners~~ [granted clinical privileges](#).

3335-101-04 Medical staff bylaws.

The medical staff organization shall recommend to the [quality and](#) professional affairs committee and the university Wexner medical center board amendments to medical staff bylaws, rules, and regulations that set forth [by](#) the medical staff organization and the governance process for maintaining such bylaws, rules, and regulations to accomplish the purposes set forth in rule 3335-101-03 of the Administrative Code. When such medical staff bylaws, rules, and regulations are adopted by the university Wexner medical center board and the Ohio state university board of trustees, they shall become effective and be part of the medical staff bylaws, rules, and regulations of the medical center and the hospital and other facilities to which they apply. The medical staff organizations shall also be responsible for reviewing these bylaws, rules, and regulations periodically and recommending appropriate revisions to the [quality and](#) professional affairs committee and university Wexner medical center board.

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 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 persons/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, acting as members of and on behalf of the university Wexner medical center board, are delegated the responsibility by the university Wexner medical center board to grant of temporary clinical privileges. ~~The granting of temporary privileges shall be limited to situations which fulfill 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 ninety-one hundred and twenty days.

3335-101-06 Medical staff administrative committees.

- (A) Purpose. The medical staff administrative committee for the university hospitals medical staff and the medical staff administrative committee for the James cancer hospital each shall establish and maintain means of accountability to the university Wexner medical center board, in accordance with their respective medical staff bylaws. Each medical staff administrative committee shall concern itself primarily with the quality of medical care within the facilities of, or associated with, the university Wexner medical center. Each medical staff administrative committee shall receive and act upon all medical staff committee reports and make recommendations regarding medical staff status and clinical privileges to the university Wexner medical center board, through the board's quality and professional affairs committee. Other specific duties of the medical staff administrative committee are identified in the medical staff bylaws.
- (B) Composition. The composition of the medical staff administrative committee of the university hospitals medical staff shall be determined in accordance with the university hospitals medical staff bylaws and the chief medical officer of the medical center shall serve as chair of the university hospitals medical staff administrative committee. The composition of the medical staff administrative committee of the James cancer hospital medical staff shall be determined in accordance with the James cancer hospital medical staff bylaws and the James cancer hospital director of medical affairs ~~chief of the medical staff~~ shall serve as chair of the James cancer hospital medical staff administrative committee. Any members may be removed from the medical staff administrative committee in accordance with the medical staff bylaws. Replacement or additional members may be appointed to the medical staff administrative committees in accordance with the medical staff bylaws and subject to review/renewal on a yearly basis to maintain the medical staff administrative committee's constituency.
- (C) Meetings. Each medical staff administrative committee shall meet monthly. Minutes of the meetings shall be provided available to all members of the the university Wexner medical center board and the quality and professional affairs committee of the university Wexner medical center board, the senior executive vice president for health sciences, the dean of the college of medicine, the dean of the college of

dentistry, and the deans of other professional colleges whose faculty have appointments on the medical and dental staffs.

3335-101-07 Hospitals clinical departments.

- (A) Appointment of the chief of each clinical department of each hospital as defined in Chapter 3335-104 of the Administrative Code is subject to approval by the university Wexner medical center board on the recommendation of the dean of the applicable professional college and the senior-executive vice president for health sciences. All such appointments shall be periodically reviewed by the university Wexner medical center board. Any vacancy in the position of chief of a clinical department may be filled on an interim basis by the dean of the appropriate professional college, after consultation with the university Wexner medical center board. (In standard practice, the chief of a clinical department will be the chair of the corresponding academic department.)
- (B) No change
- (C) The senior-executive vice president of health sciences shall recommend a candidate for the appointment of the chief medical officer of the medical center to the university Wexner medical center board and the Ohio state university board of trustees. The Ohio state university board of trustees shall appoint the chief medical officer of the medical center. The chief medical officer of the medical center shall report to the vice president for health services, the senior-executive vice president for health sciences and to the university Wexner medical center board. In matters relating to medical care in the university hospitals, members of the clinical departments of the university hospitals are accountable to the clinical chiefs, and medical directors who are accountable to the chief medical officer of the medical center.
- (D) No change
- (E) The senior-executive vice president for health sciences shall appoint a medical director for each of the university hospitals, university hospitals east, Harding hospital, and Ross heart hospital. The medical director of each hospital shall report to the chief executive officer or executive director of the respective hospital, to the chief medical officer of the medical center, and to the university Wexner medical center board. In matters relating to medical care in the hospitals, members of the clinical departments of the hospitals are accountable to the clinical chiefs, who are accountable to the medical directors.
- (F) The senior-executive vice president for health sciences shall appoint a director of medical affairs for the James cancer hospital who shall be the chief medical officer of the James cancer hospital. The director of medical affairs shall report to the chief executive officer of the James cancer hospital, ~~the James cancer hospital board~~ and to the university Wexner medical center board. In matters relating to medical care in the James cancer hospital, members of the clinical departments of the hospitals are accountable to the clinical chiefs, who are accountable to the director of medical affairs.
- (G) The chief medical officer of the medical center, the director of medical affairs of the James cancer hospital and the medical directors of each hospital shall each be a physician and shall maintain an appointment as an attending staff member of his or her respective medical staff. The chief medical officer of the medical center, medical directors of each hospital and director of medical affairs shall have authority as conferred by the senior-executive vice president for health sciences and the university Wexner medical center board; including the responsibility for clinical research and education programs and services, supervision of patient and

clinical activity; and responsibility for the clinical organization of his or her respective hospital. The chief medical officer of the medical center and director of medical affairs shall direct and supervise the medical staff quality assurance, utilization review, and credentialing activity. The chief medical officer of the medical center, medical directors of each hospital and director of medical affairs shall 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.

(ATTACHMENT V)



Financial Highlights

June 2015
Peter E. Geier



The Ohio State University Wexner Health System Operating and Financial Highlights

FOR THE YTD ENDING: JUNE 30, 2015

	ACTUAL	BUDGET	BUDGET % VAR	PRIOR YEAR	PY % VAR	ANNUAL BUDGET
Inpatient Admissions	58,211	58,621	-0.7%	57,024	2.1%	58,621
Patients in Beds including Obs Area	76,088	75,662	0.6%	73,522	3.5%	75,662
Patient Discharges	57,946	57,987	-0.1%	56,913	1.8%	57,987
Total Surgeries	40,951	38,721	5.8%	38,381	6.7%	38,721
Outpatient Visits	1,664,152	1,626,653	2.3%	1,592,483	4.5%	1,626,653
ED Visits	125,327	124,002	1.1%	117,977	6.2%	124,002
Adjusted Admissions	108,362	108,604	-0.2%	104,719	3.5%	108,604
Oper. Rev. / Adj. Admit	\$ 21,839	\$ 20,484	6.6%	\$ 20,348	7.3%	\$ 20,484
Expense / Adj. Admit	\$ 18,850	\$ 18,792	-0.3%	\$ 18,199	-3.6%	\$ 18,792
(in millions)						
Operating Revenues	\$ 2,366.5	\$ 2,224.7	6.4%	\$ 2,130.8	11.1%	\$ 2,224.7
Total Expenses	\$ 2,042.6	\$ 2,040.8	-0.1%	\$ 1,905.8	7.2%	\$ 2,040.8
Gain from Operations	\$ 323.9	\$ 183.9	76.2%	\$ 225.0	44.0%	\$ 183.9
Excess Rev. Over Exp.	\$ 324.4	\$ 185.2	75.1%	\$ 227.8	42.4%	\$ 185.2
Y/E Target						
Operating EBIDA Margin	19.7%	14.1%	14.1%	14.6%		
Days Cash on Hand	87.3	72.0	72.0	69.0		
Debt Service Coverage	6.4	4.4	4.4	7.8		



FY15 Preliminary Results

Draft

Gain/Loss from Operations	Budget 2015	Preliminary 2015
UH	\$27,558	\$66,551
Ross	\$12,942	\$23,272
James	\$162,187	\$229,321
East	\$1,945	\$22,058
Harding	(\$3,331)	(\$2,041)
Ambulatory	\$6,803	\$8,697
Physician Practices	(\$24,257)	(\$23,381)
Shared Services	\$0	(\$988)
Gain/Loss from Operations	\$183,847	\$323,489

(ATTACHMENT VI)



The Ohio State University Wexner Medical Center FY16 Budget

August 25, 2015



The Ohio State University Health System



Assumptions FY16 Budget

Draft

Factor	Assumptions & Explanation
Payors	Medicaid expansion continues to provide positive impact.
Admissions/Outpatient Visits	2.9% inpatient growth and 3.8% in outpatient growth
Surgeries	1.4% growth
Case Mix Index	1.79 vs. 1.77 in 2015
Length of Stay	6.1 Days
Total Beds	1,300 with Brain & Spine beds to become available late FY2016

Assumptions FY16 Budget

Draft

Factor	Assumptions & Explanation
Salary	2% merit increase
Benefits	17% increase (34% of salaries)
Drugs	Adjusting for volumes and new specialty pharmacy— drug costs up 8%
Interest Expense	Increase \$13.6M or 47%
Depreciation	Increase \$22.6M or 19%
Capital Expenditures	\$176M (\$126M from operations, \$10M from development, and \$40M from University loans)
Medical Center Investments (cash transfers to the College of Medicine and Faculty Group Practice)	\$140M

FY16 Health System Budget

	Preliminary 2015	Budget 2016
OPERATING STATEMENT		
Total Operating Revenue	\$ 2,366,710	\$ 2,620,249
Operating Expenses		
Salaries and Benefits	1,061,050	1,165,536
Supplies	263,539	287,971
Drugs and Pharmaceuticals	206,807	262,967
Services	269,653	276,779
Depreciation	114,335	136,962
Interest	28,856	42,511
Other	98,981	101,237
Total Expenses	\$ 2,043,221	\$ 2,273,962
Gain/Loss from Operations	\$ 323,489	\$ 346,286
Financial Metrics		
Total Revenue per AA	\$ 21,840	\$ 23,289
Total Expense per AA	\$ 18,855	\$ 20,211
Total Expense per AA (excl Depr & Int)	\$ 17,534	\$ 18,616
Operating EBIDA Margin	19.7%	20.1%
Days Cash on Hand	87.4	92.5
Debt Service Coverage	6.4	5.8

Balance Sheet

(in thousands)

	Preliminary 2015	Budget 2016
Balance Sheet		
Assets		
Cash	\$ 461,866	\$ 541,364
Accounts Receivable & Other Current Assets	365,579	400,225
Property, Plant, Equipment - net of Depreciation	1,428,185	1,470,932
Other	146,826	205,126
Total Assets	\$ 2,402,456	\$ 2,617,647
Liabilities & Fund Balance		
Current Liabilities	\$ 320,599	\$ 328,463
Debt	838,032	839,110
Fund Balance	1,243,825	1,450,074
Total Liabilities and Fund Balance	\$ 2,402,456	\$ 2,617,647

Statement of Cash Flow from Operations

Draft

	FY 15 Preliminary	FY 16 Budget
Sources of Cash:		
Excess of Revenues over Expenses	\$ 323,489	\$ 346,286
Depreciation	114,335	136,962
Interest, Other and Non Operating, net	593	3,260
Total Sources of Cash	\$ 438,417	\$ 486,508
Uses of Cash:		
Change in Working Capital	\$ 7,089	\$ 29,874
Long Term Debt Payments	48,840	52,836
Capitalized Interest on MCE construction	14,487	-
Cash Growth (Days Cash)	115,447	79,498
Cash transfers from designated (to) funds	63,778	58,300
Medical Center Investments	116,888	133,000
Transfers to the College of Medicine	20,000	7,000
Capital Expenditures	51,888	126,000
Total Uses of Cash	\$ 438,417	\$ 486,508

FY16 Health System Capital Budget

Draft

Sources of Capital Funds	
For Crane Sports Medicine	
Development Funds	\$ 10,000
Internal University Loan	15,000
Cash from Operations	20,000
Crane Sports Medicine	45,000
For Arlington CarePoint	
Internal University Loan	25,000
Cash from Operations	5,000
Arlington CarePoint	30,000
For Routine Annual Capital	
Cash from Operations	101,000
Funds Available	\$ 176,000
Uses of Capital Funds	
Crane Sports Medicine (includes \$10M for OR build out)	\$ 45,000
Arlington CarePoint	30,000
Brain and Spine	17,000
Select projects and equipment replacement	84,000
Funds Used	\$ 176,000

HS capital expenditures include:	
Sports Medicine	\$45M
Arlington	\$30M
Brain and Spine	\$17M
Projects & equipment	\$84M

Selected Projects and Equipment	
Major Equipment	20,000 (Patient Beds, Bi-plane angiography, Ross refresh)
Infrastructure, Renovation	22,500 (Five Electrical upgrades, Surg Path renovation, OR Hybrid)
Unit directed funds	18,000 (Unit renovations, clinical equipment)
IT and analytics	13,500 (Epic changes, Cost Accounting, System Support)
Contingency/Opportunities	10,000
	84,000

Outreach and Regional Telemedicine

Gail B. Marsh, Chief Strategy Officer

Naeem Ali MD, Chief Medical Officer, University Hospital

Victor Trianfo DO, Chief Medical Officer, Memorial Health

August 25, 2015



What is telemedicine?

Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status. –American Telemedicine Association

Regional telemedicine is a collaboration platform that engages in-person physicians and nurses, relevant patient information, faculty with specialized expertise, and the patient, with the objective of assessing and improving the patient's health in their current location.

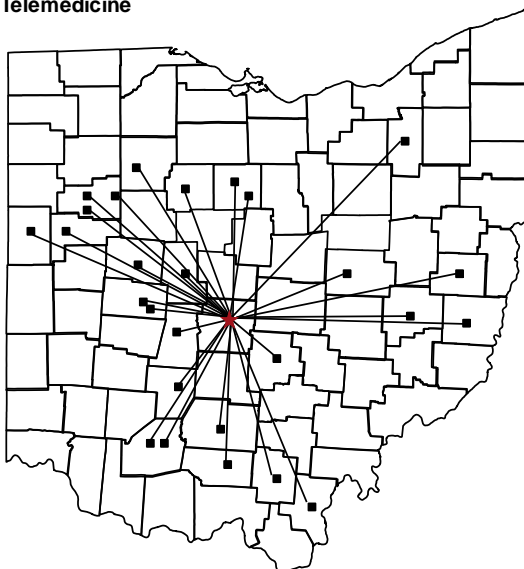
Why are we interested in telemedicine?



- Developed based upon need identified by regional providers
- Keeps patients close to home
- Lower cost, high value care
- Time-sensitive specialized assessment, treatment plan, and care

Clinical Area	Initiated	Locations	Encounters
Psychiatry	April 2013	UHE	1,463
Burn	December 2013	18	20
Stroke	May 2011	26	2,341
Emergency Medical Services	Entering stage II beta testing with MedFlight		

Telemedicine



Telemedicine demonstration



August 28, 2015 meeting, Board of Trustees