THE OHIO STATE UNIVERSITY

OFFICIAL PROCEEDINGS OF THE

FIFTEENTH MEETING OF THE

WEXNER MEDICAL CENTER BOARD

Columbus, Ohio, January 27, 2016

The Wexner Medical Center Board met on Wednesday, January 27 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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January 27, 2016 meeting, Wexner Medical Center Board

Ms. Link called the meeting of the Wexner Medical Center Board to order on Wednesday, January 27, 2016 at 9:04am.

Present: Leslie H. Wexner, Jeffrey Wadsworth, William G. Jurgensen, Abigail S. Wexner, David B. Fischer, John F. Wolfe, Michael V. Drake, Sheldon M. Retchin, Geoffrey S. Chatas, E. Christopher Ellison, Michael A. Caligiuri, Amanda N. Lucas, Elizabeth O. Seely, and Marti C. Taylor. Janet B. Reid, Cheryl L. Krueger, Corbett A. Price, and Stephen D. Steinour were absent.

Ms. Link:

Good morning. We are going to convene the meeting of the Wexner Medical Center Board and I'll note that a quorum is present.

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

First, I'll call on Dr. Sheldon Retchin for his CEO (chief executive officer) update.

Dr. Retchin:

Good morning. Before I go over the scorecard for the meeting, I would like to make a few introductions.

As you know, we have continued to recruit for the senior management team and I'm very pleased to introduce a few members who have joined us in the last of couple of months. At the last meeting you met the new CFO (chief financial officer), Mark Larmore, who's no longer in his rookie months and has settled in nicely.

I would like to introduce Mamoon Syed. Mamoon joined us on November 16th and serves as the associate vice president for human resources (HR). He provides strategic HR support and will be focusing on recruiting, effectiveness and efficiency, as well as leading a multidisciplinary HR team, and will work closely with the university's leadership under AJ Douglass. He comes to us from the Children's Hospital and Health Center in San Diego, California. Would you all welcome Mamoon with a warm round of applause? Thank you Mamoon, welcome.

Next is Anne Garcia. Anne started on January 11th and serves as the senior associate vice president for health sciences. Once she is licensed to practice law in Ohio, which will be soon, she will also serve as the senior associate general counsel. She comes to Ohio State from St. Louis University, where she most recently served as senior associate general counsel and executive director of compliance. Would you all welcome Ms. Garcia?

Last, but not least, I would like to introduce David McQuaid. David officially joined the team last week and will serve as the CEO (chief executive officer) of The Ohio State University Health System and chief operating officer (COO) of the Wexner Medical Center. Having most recently served as executive vice president for clinical affairs, president and CEO of Thomas Jefferson University Hospitals in Philadelphia, David's leadership is essential to our success and we welcome David as well.

Collectively, these individuals bring enormous leadership skills. They have been in the business at academic health centers for the majority of their careers and we will work together to advance the missions of the medical center and of course the university. I am thrilled they have joined us and appreciate your welcoming them.

With that I am going to move on to the scorecard that you see on the screen and go through that with you, rather quickly, and then I'll be glad to answer any questions.

First, let's review the category of quality and patient safety. You see that our inpatient mortality rate in the first row sits at .68. The University Hospitals Consortium (UHC) has recently recalibrated their risk model. We are following that as we move into our own measurements. I believe we are still in the top five or six.

Do you have any comments on that Susan?

Dr. Moffatt-Bruce:

Yes. We are number six in UHC right now amongst our academic peers for mortality. We have saved 40% more patients than we were predicted to.

Dr. Retchin:

Yes. We are still among the top in the nation.

President Drake:

I'm sorry, forgive me for interrupting. The .68, is there a different methodology? I know we can fluctuate. Did we fluctuate or is there a different methodology?

Dr. Moffitt-Bruce:

Every year they change the methodology. It was just changed in December and everybody was readjusted around the mean. This means everybody went up a little bit, but our standing stays the same because everybody changed.

President Drake:

Thank you. That was my question.

Dr. Moffitt-Bruce:

Yes sir. Good question. That's a yearly change.

Dr. Retchin:

Next is the patient safety index, which is a consolidated risk adjusted ratio comprised of eight different patient safety indicators. On that note, our number of .66 places us in the top quartile, I believe. Is that right, Susan?

Dr. Moffatt-Bruce:

That number today is .62. There is a correction that should be rendered to that. We are green on that.

Dr. Retchin:

Excellent. On readmissions, you see we still have some work to do. We are at 13.4%, which is actually a little worse than it was in the last fiscal year with a target 11.9%. We're hard at work on that. Most academic health centers around the country are also faced with this issue and it involves, readmissions going from three days prior to admission to 30 days post discharge.

Comments? Susan? Andy?

Mr. Wexner:

I have a question. What is one percent in numbers?

Dr. Thomas:

We have about 60,000 admissions. One percent would be about 600 patients.

Mr. Wexner:

In the period we're measuring, we shifted about a half percent. Is that right? Then would you divide that by 12?

Dr. Thomas:

Divide by 12, yes.

Mr. Wexner:

It's 600. Half would be 300 and then divided by 12. You can do the math because I am making up the numbers.

Dr. Moffatt-Bruce:

The number, it's not a large number of patients that we have to improve upon to get our readmissions down. We are in double digits, we're not in triple digits; 12 to 20 patients. If you look per service, we look at how many patients over the expected numbers and those are small numbers. It is not a huge gap but it's a significant one because everybody in the nation is getting better.

Mr. Wexner:

I didn't know whether half a percent was 1,000 or 12.

Dr. Thomas:

In the focus of penalty areas, we've seen progress over the last four years with focused resources and programs around heart failure, heart attack, joint replacement, pneumonia, and COPD (chronic obstructive pulmonary disease).

This is in all patient numbers. This would be patients that are in for other areas as well. We think we bring some of those same things that we've learned from the Siemens focus penalty areas to all patients will have some success on these metrics. To your point, it's not a large gap to meet our goals.

President Drake:

I have a question about that. I think I brought to this board a while ago, a study that was looking at reasons for admissions in particular categories. The most frequent reasons for readmissions were not hospital or medical or discharge related but rather home circumstance related. I am curious about whether or not our issues are home circumstance or hospital related.

Dr. Moffatt-Bruce

We looked at some of the key areas like heart failure or some of the cardiovascular readmissions. We thought that those patients who went to long care, acute facilities, did better. They actually come back to hospital fairly often so the theory that if they just go to rehab facility is better, doesn't hold up in our patient population. We need to retool

that and look at home care and those opportunities. In the joints, it was an equal readmission rate amongst if they went home or if they went to a long care facility. I think we have opportunities in both of those, wherever we send the patient, but that is the time when we have the most number of variable instances that caused the patients to come back to the hospital.

Mrs. Wexner:

Do we understand which patients we might say we could influence in terms of that after-care versus just medical complications?

Dr. Moffatt-Bruce:

I think we do. I think that we have an understanding, looking at the risk that are well published, that these are the patients that don't have PCPs (primary care physicians), that don't have follow-up, that are on more than 10 medications, or fall into a certain number of co-morbidities.

I think we know who the patients are. I think our strategies still need to be implemented. How do we get the resources to those patients, consistently, so they stay out of hospital?

Dr. Retchin:

Just a comment on that, Susan. I don't know if CMS (Centers for Medicare & Medicaid Services) has resolved this issue about social equivalents.

Dr. Moffatt-Bruce:

They have not.

Dr. Retchin:

A point for the board, one of the national debates is a medical center, like the Wexner Medical Center, that deals with so many people who are of a low socioeconomic status, may not have a secure home to go to, or more importantly, don't have caregivers to be able to transition to a different setting. The debate has been, since this has financial penalty, whether we should actually adjust for that. There are good pros and cons on that.

Dr. Moffatt-Bruce:

Yes. There has been a lot of conversation around that. CMS has not come out with a risk adjustment based on that. I was at the AAMC (Association of American Medical Colleges) last week and they are still trying to push to get that formalized, but it has not come to a conclusion.

Dr. Retchin:

As you can imagine, a hospital in the suburbs where there is a secure family home, it is a lot easier to take care of that patient and keep from readmission.

Mrs. Wexner:

But when you look at academic medical centers, who would be best in class at this?

Dr. Thomas:

One of the ones I have seen prepare or present a lot nationally on this is Rush Medical Center in Chicago. They have developed an integrated case management team.

One of the things I think we have gotten much better at in the last 10 years is case management when the patient is in our doors, in terms of getting them out efficiently, getting them tied into the resources they need. But then to some degree, unless they are seeing one of our primary care doctors, they are a little on their own. That is where there is a heart failure, AMI (acute myocardial infarction), and others. We have built post-discharge resources in place to help manage them after they are out of the hospital. We have not done that with all patients. As Gail's data has shown in the past, a large percentage of our patients come from outside of Franklin County and it's difficult, without some people in place, to help manage those things; to count on doctors that aren't affiliated with us to manage these things well.

Dr. Moffatt-Bruce:

Northwestern University is another institution that has a very strong hospitalist group that works only on the readmissions and how to reduce them in homes and patients coming back to them. A very strong program.

Dr. Retchin:

Thanks and excellent questions and comments.

We are hard at work on this. It is very important and it's a balance of course, on the DRG (Diagnosis-Related Group) effort to get patients out of the hospital but also to keep them from coming back in. It is a very important indicator.

The next row is the catheter associated urinary tract infections. You can see our rate is continuing to decline due to the good work of the physicians, particularly the nursing staff, which we have empowered to be able to make those decisions independently, as they should, and certainly are capable of doing. Congratulations on this rate, which has put us among the top performing leaders.

Next on patient satisfaction. If you look under HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) the November rate came in at a fiscal year high of 79%. Remember, these are nines and 10s in terms of scale. That is at the 89th percentile and it moves our fiscal year-to-date performance to the 83rd percentile, which is above last year at 74th percentile. We are making great progress.

If you look within that, both the Ross and the James are at the 97th percentile nationally. We have continued to focus on our patient satisfaction and patient experience ratings in the hospital and, as you will see in a second, on the outpatient side. You will also hear a little bit about one of those efforts in one of the most difficult settings, which is the emergency medicine department.

Quietness is the only HCAHPS dimension that we've had some difficulty with but it continues to improve year-over-year, moving up and improving on that element.

Going to the outpatient side, we come in for a year-to-date average of almost 91%. That is "yes, definitely"; however, the bandwidth in that area is so narrow that still only puts us about at the 50th percentile. It gets very crowded once you get above 90% "yes", but nonetheless we need to focus on that. You can break it down in terms of elements. Some of those elements are improvements that have been in doctor communication, now at the 56th percentile, continuing to push that.

One of the areas we are focusing on and continue to focus on is test results and communicating test results. This is a very important part of the physician-patient relationship and interaction. Susan or Andy, do you want to comment on that?

Dr. Moffatt-Bruce:

This is a question that asks the patient, "yes or no, did your doctor give you your results to your tests?" It is one that we have been challenged with. I think it is one that we are not proud that we don't have as high of scores because it just doesn't feel right. I think we have all had personal experience with when you get a letter or some sort of communication that is not adequate or what you would want from this medical center. We continue to work on this, I don't think we've cracked the code on this by any means but we have some dedicated resources around this. Eric Forrest, the Medical Director for Ambulatory, is very dedicated to this as is Dr. Welker and Neeraj Tayal in Internal Medicine. This is one that we are going to have to improve on. It's just not satisfactory. Andy?

Dr. Thomas:

I would agree.

Dr. Retchin:

Any comments on the patient portal that could help that?

Dr. Thomas:

MyChart is an ever-growing adoption. We are now up to, I believe, around 140,000 patients.

Dr. Retchin:

And for the Board, that is the electronic health record.

Dr. Thomas:

It is called OSU MyChart for patients to get their results. The reality is that it is probably less than 20% of our total patient population, that we would see in an ambulatory visit in any given year. Even though our numbers have grown, they probably need to continue to grow higher.

We do understand from CMS's perspective, they are changing this question a little bit, which we think will be beneficial. But to be honest, we need to work harder at this, as Susan said, and continue to highlight it with doctors and office staff about how we share information back with patients.

Dr. Moffatt-Bruce:

There is tremendous variability in this space.

Dr. Thomas:

Yes, some are preforming very well and some are not.

Mr. Jurgensen:

Dr. Thomas, on MyChart, we have flags at the end of the results, like high, medium, and low. It is very helpful; but some interpretation of what the numbers are would make it even better.

Dr. Moffatt-Bruce:

I agree. We actually met yesterday with Dr. White from radiology and pathology so that when you get those results we actually flag them as being abnormal and what it actually means for you as a patient. We are working on how to converse that and how to give that to the patients.

Dr. Jurgensen:

It is a great information exchange between medical professionals.

Dr. Moffatt-Bruce:

Right, but not with you as the patient, absolutely.

Dr. Thomas:

There is also another major change that we're doing, Mr. Jurgensen around MyChart. Right now there is an auto-release function for lab test results of four days. The department chairs decided about a month ago that we are going to move that with our IHIS (integrated health information system) upgrade in the spring to essentially, what's called same-day release. It will be in four different batches throughout the day, but as results come in, they'll be sent out literally the same day.

Henry Ford Hospital, Akron Hospital, Children's, and other medical centers are moving to that same-day release. Often times that may mean the patient will get the results before the doctor, but in this case, we think getting the results to the patient more quickly will actually save anxiety for people since the vast majority of these routine tests come back normal.

Right now, a lot of patients are calling on day two because they haven't seen the results yet to only be told "oh yeah, results were all fine." It is an interesting psychological problem, from the patient's perspective, and then a logistics workflow problem from the doctor's perspective. This result will improve the numbers as well.

Mrs. Wexner:

Did you say we would only use this for outpatient services?

Dr. Moffatt-Bruce:

This one measures outpatients but patients that are inpatient also have access to their test results. This measurement is only in the ambulatory setting.

Mrs. Wexner:

You said you have a 20% usage, so is it a question of conversion?

Dr. Thomas:

I have not looked at the percentage of inpatients that have a MyChart account, in terms of the total number of patients. I can get that data for you. I know on the inpatient side, Mrs. Wexner, we actually went live when the new tower opened with MyChart Bedside,

where patients are actually given a tablet when they are admitted, or offered the opportunity to get that, and they can get their results also. We have been doing same-day release since last summer for those patients. We do that now in the cancer tower as well as in our women and infants area. By the end of the calendar year this year, we'll have that rolled out across the entire health system. On the inpatient side, there is the opportunity for patients to get real time results to a tablet we provide to them when they are admitted.

Dr. Retchin:

Any other questions on this? This is a very important element for us to continue to focus on. There is probably nothing more fundamental about an outpatient visit than communication and communicating results. We will keep bringing that back to the board.

I am going to move down to research and total NIH (National Institutes of Health) awards, which tends to be seasonal. There are also some other anomalous elements. You see here that as of December, we were at $36.6 million in NIH funding but with a target of $97 million. Chris, do you want to comment on that?

Dr. Ellison:

Thank you, Sheldon. I think we have had a significant increase in the number of grants submitted. This year, the NIH total submissions are about 233. That puts us ahead half way into the academic year, in terms of total number of grants. Last year, we had 474 NIH grants. I think we are on target to exceed that.

For total proposals, we have over 625 year-to-date submitted. Our total funding year-to-date is over $100 million. This includes all sources, not only NIH.

In addition, if we include NIH sub awards, we're at about $45.5 million and this does not include our cancer center grant which no-doubt will be awarded, we just haven't received the award letter yet. I think that $36 million does not reflect all of the grants that we are expecting to receive. I think it's a timing issue.

Dr. Wadsworth:

Is there a shift in the focus of NIH funding? Could you comment on what the total is that NIH is now spending and whether there is a shift within NIH to areas like the brain or neurosciences?

Dr. Ellison:

I am not sure of that but I do know that the budget is going to be increased by about 6% overall. We do have a significant opportunity to improve in that area.

Dr. Retchin:

I don't know if there has been a fundamental shift in allocation. Mike, do you know?

Dr. Caliguri:

No, not with the majority of the budget, although there are some special initiatives: precision medicine by the president and Vice President Biden is pushing cancer. Other than that I think it is an overall 6% increase across the board.

Dr. Retchin:

Yes, which is the largest in two decades. Great opportunity. Thank you Chris and Mike.

I will skip over the rankings, which as you know, come out on an annual basis although I will be glad an answer comments on that.

On to talent management on the scorecard, as you see there is nothing there but we have some results that are hot off the press.

We had a staff engagement survey that was conducted, the results have come back and I'll ask, in a second, Marti Taylor to comment on it. From my own perspective, we had the highest response rate in, I believe, any survey that had been conducted. The previous was 68%. We had a 71% response rate from staff. This scores are on a one to five scale and I'll ask Marti to comment on that.

Ms. Taylor:

Thanks Sheldon. Yes, we were very pleased with the results, although certainly work to continue. This is administered through Press Ganey and as Sheldon said, we had 71% participation rate, the highest that we've had. It's on a one to five scale and we moved from a 4.05 to 4.15. What we understand from our Press Ganey colleagues is that everyone in the country this last year really moved. We were pleased that we moved from the 23rd percentile in 2013 when the survey was administered to the 56th percentile when we took it. Again, not where we want to be just yet. You can see on our scorecard; we've got a goal to be at the 90th percentile by 2020, but this is a nice increase from the 23rd percentile to the 56th.

Each one of the hospitals and business units increased their performance. As we looked across, the results came out late last week and each of the senior executives saw the results Monday and now will start to go into each one of the departments and look at that.

The way Press Ganey looks at the results with us, is broken into three tiers. We were able to move our tier one departments, which would be our top performers. We doubled the number of departments that were in tier ones. That was great success as well.

Each one of the departments will start to put their action plans together once they see their results. Again this is hot off the press, but pleased with the results, more work to be done.

Dr. Retchin:

Nothing more important than the people, in terms of going forward. Those are good results, but as Marti indicated, still more to do to. Any questions on the engagement survey?

Moving on to the finances and you'll hear more about this from the CFO, Mark Larmore. To refresh the memory of members of the board and those who are here for the first time, this is a consolidated operating margin. This is not just the hospitals and clinics, but also includes the practice plan as well as the college. You can see that our target was 7%. We're almost there, at 6.8%, with a robust consolidated margin across the enterprise, with now 99 days in cash at the health system, and 91 days in cash at the practice plan and college.

Again, we'll have Mark Larmore comment on this to provide more details.

Mr. Wexner:

And just to remind everybody, 100 days is?

Dr. Retchin:

About $7 million a day.

I will now move down to the development dollars of $54.8 million, we're at 40% of goal for the year. That's about at pace for this time of year. Do you have any comments on that Patty?

Ms. Hill-Callahan:

No, the last three years we've had 40% by the end of the December.

Dr. Retchin:

Thanks. Lastly, let me talk about the spending per Medicare beneficiary, which is at the bottom of your page on the scorecard. This represents results from value-based purchasing, and I believe this also includes a window of time for the Medicare spending in terms of attribution. Based on our target, we're about where we were last year. Interestingly, the delta is very small and that works per beneficiary.

Remember of course, that also can increase your readmission rate, it's a delicate balance. We are working on that and keeping our costs down across the board. Any comments or questions?

That's the scorecard, Mr. Chair.

Mr. Wexner:

I'm curious, and maybe it's an unfair question. I think I understand the parts. If you put it all together and if you gave it a letter or a numeric grade, being judgmental, is this a B+ or a C-? How does this feel?

Dr. Retchin:

How does it feel on a grade level? Depends on the day and the framework. I would say for the team, the effort, and the initiative, I give it an A+. For the actual performance, I think it's a B+ or B.

Some of these are very difficult comparisons. With the readmission rate, as I mentioned, you're dealing with a population in an inner-city, urban medical center; very difficult.

In other areas I think we're making great progress, especially in quality and patient safety; certainly in fiscal performance. I give it a solid B to a B+.

(See Attachment XV for background information, page 179)

President Drake:

I am going to vote too. My vote is actually much better than that. I am going to agree with Sheldon in that we set our goals based on our circumstances, which are changing and different from everyone else's. When we look at things on our chart, we have the goal on inpatient mortality, but our goal is to be among the very best in the country. If we set a kind of all comer's goal, looking at all hospitals or all systems and see what is average, then we're way at the top. Not to make this analogy, but it's a little bit like our football team in that we have a standard of an undefeated season as a good season. I

am perfectly happy to have that as a standard as a good way to go, but we have to also remember that the world is really, really large and complicated.

I am going to agree with the A+ effort and I think that it really is a strong effort to move us forward, which is great. But we're also starting in a very narrow band, all the way at the top and working with the most complicated patients in a very complicated way. I agree again exactly with Sheldon in applauding the real efforts of the team, even in the time that I've seen since I've been here. And I also applaud the really lofty goals that we're holding ourselves to, saying we want to be among the nation's leaders in all these areas. I am an easier grader I guess. I think that given our opportunity and our circumstances and looking at the broad world, this team has put forth an incredible effort and we have incredible results on a daily basis. I am very proud of the progress we've made.

Dr. Retchin:

Let the record show.

I do want to re-emphasize Les, the work and effort of the team. When you have a tripartite mission of not only patient care, like community hospitals and health systems, but also discovery and research, and comprehensive education across almost every element of professional training. I think it's an outstanding effort and we compare ourselves with those that don't have those missions.

I am pleased but never satisfied. Other thing I would say about the management team I wouldn't trade them for any team in America, certainly in any of the academic health centers pushing it up stream. Great job.

Mr. Chair, you want to move on to finances?

Mr. Larmore:

We will start with a two-page flash report on some highlights and then we'll talk a little bit about the month of December, which was the last close and puts us halfway through the year, and see where we are year-to-date. The last two slides will combine the activity of the physician practice and the College of Medicine.

On page two of your handout, we're tracking the health system to budget and to prior year. On an admission standpoint, you can see we are slightly behind budget. These are year-to-date 1.6%, but we continue to see growth year-over-year, little over 3%.

On the surgery side, good activity there you can see 1.8% positive to budget and growing at almost 4% to prior year. When you look at 20,000 surgeries, about a third of it is on the inpatient side and two-thirds of it on the ambulatory side.

Outpatient visits are pretty much on budget, but off .7; it is not a huge number, given that the total count is almost 900,000 visits. I would say that we are struggling because patient's length of stay is up. You can see both to our budget and prior year, we're behind our targets.

Mr. Jurgensen:

Mark I don't know what this is. Lower right. What goes into it?

Mr. Larmore:

This is the number of hours worked with our employee base. An adjusted admission takes a weighting of your total inpatient admissions and it weights the ambulatory volume to come up with an adjusted number, a higher number. Then we divide the worked hours by that number, as a constant measure of controlling labor costs.

Dr. Wadsworth:

Is it like a time on project measure? Direct or indirect?

Mr. Larmore:

This is the whole house. For a patient care unit, we look at nursing care hours per day, getting down to that level of detail. A medical surgery unit, it may be five or six hours; in an ICU (intensive care unit) it could be 20 to 24 hours of direct care. It varies throughout the house. This looks at the entire house labor spend.

President Drake:

Is it risk adjusted?

Mr. Larmore:

It is not risk adjusted.

President Drake:

It would seem to me that if we have five ICU admissions or something…

Mr. Larmore:

Yes, if there was a dramatic swing you would see that. The biggest driver of why we are off our projection right now is length of stay.

Mr. Jurgensen:

It just seems to me that it's one of those kinds of measures that can have an unintended consequence, if you actually manage to it. In other words, lower is better right?

Mr. Larmore:

Lower is better. The budget process is looking at the care we're delivering. Again, this is the whole house, but certainly on the patient care units, it looks at the hours of care we're delivering and then our results from a quality standpoint and a satisfaction standpoint. We adjust that in the budget if we feel it's necessary. The target will move as we look at it.

I think, to me, it's a quick snapshot on the whole house, not totally specific to patient care.

Page three measures operating revenue. We are slightly behind budget, .9%, but a considerable growth over prior year. I will remind you that the James Cancer Hospital opened last December, when we look at some of the comparisons to prior year, it's skewed a little bit.

Controllable costs were under budget by 1.5%. The difference between controllable and total is we take the capital costs out of the numbers and look at just the operating costs.

In the prior year, we've seen a 9.3% growth in expenses, again a chunk of that related to opening the new hospital and additional beds.

I will comment that the money that we spoke about at the last meeting, which is called medical center investment, was reported below the line and we've included that since we're combining the practice and the College of Medicine. Last year the numbers were recorded on a cash basis. This year we're recording them on what we expect our annual spend to be in that category. I didn't restate the prior, it would be about a $20 million change. That number would have been $81 million if we were consistent on recording that number. My message is to prior year it's actually about a 20% increase in the bottom line if we consistently reported that. I think that's excellent news.

Days cash on hand, as Sheldon said, has grown from 79 days last year to 99 days. To the right we put the actual dollars that are there. If you go to the balance sheet and add up the cash and current assets, the delta's $120 million, which is money that we've set aside for capital, so we don't include that in our day's cash on hand. If you ask the total amount that's there, it would be $679 million.

Mr. Wadsworth:

So that was the $700 million that we mentioned earlier.

Mr. Larmore:

It's a little less than $700 million.

Mr. Wexner:

If the actual was $559 million and the prior year was $399 million, then we picked up $160 million, right?

Mr. Larmore:

$160 million in cash.

Mr. Wexner:

Right. I thought you said $120 million?

Mr. Larmore:

No. I said the cash, in addition to what here, is cash that's segregated for capital projects, not included in this calculation. I'll point it out when we get to the balance sheet.

Page 4 is the activity for the month. The month of December was a good month. It's interesting, from what I've been told, the first six months from a P&L (profit and loss) standpoint are usually softer than the second six months. I chuckled when my team told me that because in New York was the exact opposite, July through December was better. We will see how that plays out here, but that's been the history.

I won't read the page to you. Good results with being close to budget on admissions and again ahead on surgeries, outpatient visits on budget, which if we look at a year-to-date number we're trailing, so we made up some ground on that.

Length of stay, should say .01 over but you'll see on the year-to-date basis itis improvement on how we were tracking the first five months. When you compare it to the year-to-date we are still showing about a .2 day increase and that is what we're focusing on.

Case mix has grown, .05 to 2.6% and 3.8% over last year. The types of cases we are seeing are more intense by a couple percent in the prior year. We show the expenses per adjusted admission, which we spoke about before, on a monthly basis. We are a little bit short on the revenue side but expenses are under our target more than the revenue, it ends up with a positive result. I wouldn't focus on it, and as I said, the James Cancer Hospital opened last year, On the month, when you compare to prior year, is an odd month given that everybody was moving. I wouldn't spend a lot of time or focus on that.

The next page has the actual P&L for the month. Across the bottom you can see a $16.5 million profit. Budget was about $13 million; about $3.5 million favorable to budget. Here you can see a $3.4 million bottom line. It was a good revenue month. As I stated before, we are trailing a little year-to-date, but about $6 million positive on the revenue side and then a little overspending on the expense side. The bulk of it being in pharmaceuticals and the bulk of that is in cancer related drugs, we're getting paid on that.

Mr. Jurgensen:

In terms of the expense periods year-over-year, this is the principle driver: drugs and pharmaceuticals. It is growing and has for the last couple of years at a pretty alarming rate. What is the strategy?

Mr. Larmore:

Most of it is related to our growth in the oncology area.

Mr. Jurgensen:

Volume over rate?

Mr. Larmore:

We are making on the drugs, the increase in drugs. It is not a bad thing for us. It creates a variance when you look at the revenue and expense, it's in both categories. We opened up a retail pharmacy and we're reporting that in as a net number because otherwise, depending on the activity on a given month, it's big enough that it skews the operations of the hospital. It is a couple million-dollar opportunity on that and we are reporting that as a net number in other revenue.

If we move to the next page, it is our year-to-date. You can see, as I said, from the summary pages, you know about 1.6% behind on admissions but still 3% growth over last year. Surgeries are positive and the outpatient visit I spoke about already. Here's the length of stay I talked about; you can see we're about .2 over year-to-date and a little bit more than almost a quarter a day on the year-over-year comparison. Quarter data doesn't sound like a lot, but there is a lot of capacity that's utilized by that going up.

On the year-to-date P&L bottom line, the health system is at $97.3 million, which is $6 million favorable to budget. For the second column from the right, if you adjusted for the $20 million, you'd be at $81 million, which shows a 21% increase year-over-year. You can see again, because of the volume being short, we are a little behind on the revenue, $12 million over $1.3 billion. Hopefully in the next six months we will make that up. We know where the pharmaceutical spend is, that number being over doesn't bother me. When you look at supplies and salary and benefits, which are the biggest piece of our spend, we're actually tracking below our budget; that's positive.

President Drake:

There are two massive changes that I want to focus on Mark, just from a year ago, before you were here. There are two things that are different, particularly, along with medical center investments, this is now above the line and we are seeing this come out and that wasn't the case a year ago. The number would have been that much more on the bottom line last year because that was in a separate category. The $97 million would have looked like $167 million last year. That is a big change.

The other big change, if you go horizontally across that line and look at the prior year variance, there's been a dramatic decrease in the amount of money in this large category called medical center investments. These were costs that needed to be controlled. That was something that was really, really important for us to focus on although our total number is different because we've now rolled it up above the line.

I know what I said and I apologize on the plus and minus for that one. Sorry, did that come out clearly?

Mr. Larmore:

We did not restate that number in the prior year. It ended last year a little north of $120 million, the amount built into the budget this year was $140. That number would be between $65 and $70 million last year if it had the same process.

Any questions on the year-to-date?

Page eight is the balance sheet and the change from fiscal year end June 2015. You can see the increase in cash, $93 million, which I spoke of. Current assets are up $43 million, $29 million of that is accounts receivable and some of it is the days have gone up a couple days but not dramatically, but certainly the value of a day is more due to the growth in the enterprise. It wasn't only the James Cancer Hospital coming online, but the expectation was the number of patients moved out of UH (University Hospitals) and we thought we'd have less volume there. But, the whole house has filled back up and we are seeing volume growth in both places.

Mr. Wexner:

Mark what is the accounts receivable about? The number of accounts?

Mr. Larmore:

The gross?

Mr. Wexner:

Yes, the gross.

Mr. Larmore:

Out of the $411 million? It's in the low $300 million on a net basis; gross number is much larger. We are at about 46 days in account receivable, which for an academic health center is pretty good, when you compare us to our peers.

Mr. Wexner:

It would seem to me that it would make sense to break out accounts receivable from other because it's so big.

Mr. Larmore:

That is a $29 million increase and the rest of it is intercompany and prepays. Property, plant, and equipment, you see, is down $37 million. We are currently spending less on capital out the door than our depreciation expense. That is why that number is going down, all the liabilities really net with each other. Long term debt was paid down $22 million, about $45 million of debt fees each year, and then certainly the net assets have grown by almost $100 million, which is predominately the bottom line.

Page nine is the consolidated and this includes the College of Medicine and OSUP (Ohio State University Physicians). You can see from a bottom line standpoint almost $160 million, which is pretty much right on budget. The drug and the pharmaceutical number is a larger variance than we saw before because we're seeing that same spending in the practices as we see on the hospital. The growth there, the pharmaceutical costs in the last few years, have been all over the place. A lot of it is the new drugs that are out, but there are a number of drugs that have been generic drugs for years and years and the manufactures of many of them have stopped manufacturing. Once they get down to a small number of manufacture's, they've taken advantaged and raised the price dramatically on those. I think you've seen some of that in the press. That has been a challenge for us that wasn't there in the past. It was usually just the new drugs on the market.

You can see that when you look at year-over-year, the combined entities were $99 million, and we are at $106 million; about a 6.7% increase on the admissions and cost per adjusted admission of the health system, which you saw before. But you can see the OSUP patient encounters, almost $1.2 million in patient encounters for six months. A tremendous amount of volume flows through the practice plan.

Page 10 is broken out into three categories. You can see I reported the health system on the top, at $97 million; OSUP is actually showing a profit of $12 million, which is slightly behind budget but a big improvement over last year of where it was at $3.5 million; and then the College of Medicine is at a small loss of $3.4 million behind budget, but an improvement from last year also from $5.8 to the $3.4.

Mr. Chatas:

Mark, how much of those opportunities led to the increase in the MCI (Medical Center Investment) transfers, does that account for some of that?

Mr. Larmore:

Right now the College of Medicine and OSUP are reflecting MCI at the 15 level. The increase we expected in the 2016 budget is not affecting these numbers. This is really the new look combining all three entities, and then we did the balance sheet too. The health system balance sheet is $2.5 billion. When the physician practice and the College of Medicine is about $890 million absent, we don't have all the restricted funding here that's on a college balance sheet also. We just state the unrestricted operating piece of it.

Mr. Jurgensen:

Mark, I don't know what ratings objective to start from. This is a question for you too, Geoff. Depending on what rating goal for the medical center would be appropriate, and I don't know what that would be, I'm wondering how much more equity the medical center would require if it were a standalone entity. To put both the debt and the cash on hand into some kind of perspective.

Mr. Larmore:

I'll talk about my view on that, on how'd we stand on a health system and then Geoff can because right now the rating is already combined with the university and the debt issues on the university side. I think from a cash investment standpoint, we're low, the 100 days should be probably north of 200 days to maintain a similar credit rating or possibly more. When we do the comparison and looked at if we peeled off just the balance sheet you see here, we would go out at a rating lower then we get through the university, whether it's one tick or two ticks down, that will be determined. I think a chunk of that is, one piece is the quantitative piece of it and the other piece is the qualitative piece of it. Even though they would still take into the account the reputation of the university when they look at it and our programs and our quality, but on a pure quantitative basis, we would take a downgrade.

Mrs. Wexner:

Where do you think it would be?

Mr. Chatas:

Since I was there last week, let me talk a bit about it. Mark's right, on the quantity side they look at three things: your debt service coverage, which we're very strong relatively, we don't have as much debt relative to some others; they look at your total debt, which again isn't very high; and then your days cash on hand. The number they were throwing around was in the high 200 days for its own rating, 270ish days, north of the number Mark said.

When we talked about looking at subordinated debts, if we still issue but issue just to the health system, they were talking somewhere in the single A range. We are AA1 right now. You would probably go down somewhere high single A, mid-single A, I think. That is based on that qualitative piece, the management team, and the overall strategy.

Mr. Jurgensen:

All these things are obviously interlinked; the overall ratings objective will inform capital ratios, days cash on hand, and everything. The fact that we strategically run it as part of the university puts it, to some degree, over a net and allows us to operate with different levels of debt, different levels of cash, and different levels of everything. I think it's just, it's a good thing to know.

Mr. Chatas:

The university has set up a new mechanism for financing. We are seeking approval for a billion-dollar program for the whole university. They are going to allow us to issue debt related to separate entities with its own pricing. Ratings are interesting, but it really is to me about the pricing. When we go to market next month, we will probably have a piece related to our health system. We will know if it does cost ten basis points per year, does it cost a percent? I don't think it's going to be that bad.

Mr. Jurgensen:

But its two edged sword. One edge of the sword is what does debt cost, the other end of the sword is what happens to ROE (return on equity) if you're carrying too much equity. I think maybe down the road it's something we ought to talk about in terms of what is an optimal rating to solve for and why, and then, what are implications.

Mr. Chatas:

I would take it a step back because we're looking at it and we're engaging the financial advisors to look at it right now. I think you start with what your strategy is and then what the structure needs to be to accomplish that and debt doesn't fit into that.

Mr. Larmore:

One of the questions I get asked all the time from the operating team and even general employees is, why does the health system need to make $200 million? Should we be spending that on more staff? I think it is part of our communication plan that says where we're taking the health system and from a capital standpoint, the biggest feeder of our capital program is the bottom line. We have a little under a billion dollars in debt so there is a maximum debt load we'd want to carry. I have set that $200 million as our target as the floor that we want to make each year to feed the capital appetite that's here. I think that's my last slide.

Mr. Wexner:

Any other questions? Mark, thank you.

(See Attachment XVI for background information, page 180)

Dr. Retchin:

Mr. Chair, I'm going to call on Gail Marsh, Chief Strategy Officer, and Mark Larmore to present an authorization for change of name and purpose of the university affiliate. This is the affiliate that was the home for The University Home Care Services Corporation. Gail Marsh?

Ms. Marsh:

Thank you, Sheldon.

In your notebook, there is a tab marked university affiliate with two documents: a resolution and a background page. The Wexner Medical Center proposes to rename and repurpose this university affiliate currently named, The University Home Care Services Corporation, to better align with evolving business needs that the medical center has.

The University Home Care Corporation was established in February 1996 to provide comprehensive home care services. Home care services are primarily nursing services in the home after a patient is discharged. It is recommended that this affiliate be renamed Ohio State Health Inc. and it's stated purpose be modified to include the following: to develop an integrated network for The Ohio State University Wexner Medical Center that furthers its tripartite mission and improves access, quality, and cost of health care for the residents of Ohio and beyond; to provide leadership and funding to manage the medical center's post-acute care network and any associated affiliations or partnerships associated with the post-acute care network, primarily nursing home care, hospice care, rehab care outside of the hospital and is directly related to the conversation we had about managing patients for readmission purposes; to provide grant funding for Ohio State and central Ohio health programs that improve community health outcomes; and to provide grant funding for OSU faculty, staff, and students in the areas of research and training that impact clinically integrated network development and the management of population health.

You can see on the resolution that the entity would continue to meet the policy as established by the Board of Trustees on affiliated entities, would continue to report periodically to the Board of Trustees, and operate in accordance with the policies of

affiliated entities of The Ohio State University. Mark and I are happy to answer any questions.

AUTHORIZATION FOR CHANGE OF NAME AND PURPOSE OF A UNIVERSITY AFFILIATE: THE UNIVERSITY HOME CARE SERVICES CORPORATION

Resolution No. 2016-53

Synopsis: Authorization to change the name and purpose of The University Home Care Services Corporation (hereinafter "TUHCSC") to address the changing business focus of the affiliate, is proposed.

WHEREAS the Board of Trustees adopted the Policy on Affiliated Entities in June 2008 to provide a uniform framework for the establishment and operation of separate entities that are closely affiliated with The Ohio State University (hereinafter "Ohio State" and/or "University"), ensure that such entities serve the best interests of the University, and provide for continuing appropriate oversight by the University and the Board; and

WHEREAS TUHCSC was formed in February, 1996 to provide or make available comprehensive home health care services; and

WHEREAS the executive vice president of health sciences and chief executive officer of the Wexner Medical Center recommends that changes be made to the name and stated purpose of TUHCSC, as more fully described in the accompanying materials, in order to better align the affiliate with its focus and emerging business opportunities:

NOW THEREFORE

BE IT RESOLVED, That the Board of Trustees hereby authorizes the president, the executive vice president of health sciences, and the senior vice president and general counsel to take all actions necessary on behalf of the Ohio State in order to implement the purposes of this resolution, including but not limited to the renaming of TUHCSC as "Ohio State Health, Inc." and to repurpose the affiliate as more specifically stated in the accompanying materials; and

BE IT FURTHER RESOLVED, That in accordance with the Policy on Affiliated Entities, the executive vice president of health sciences is the senior university official charged with oversight of this entity and that TUHCSC, under the name "Ohio State Health, Inc.," shall continue to report periodically to the University and Board of Trustees through the designated senior oversight official; and

BE IT FURTHER RESOLVED, That the entity shall continue to operate in accordance with the Policy on Affiliated Entities, its governance documents including its articles of incorporation, operating and code of regulations; and

BE IT FURTHER RESOLVED, That as appropriate and as directed, trustees, officers, and employees of The Ohio State University are hereby authorized, designated, and directed to serve as directors, managers, officers, employees, and agents of Ohio State Health, Inc., representing the university in such capacities as part of their official duties and responsibilities to the University and entitling them to any immunity, insurance, indemnity, and representation to which trustees, officers, and employees of the University now are, or hereafter may become, entitled.

(See Attachment XVII for background information, page 185)

Dr. Retchin:

We will need a motion and a second and a voice vote.

Mr. Wexner:

May I have a motion to recommend the Authorization for Change of Name and Purpose of a University Affiliate: The University Home Care Services Corporation to the University Board for approval?

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

Ms. Marsh:

Thank you.

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Dr. Retchin:

And finally, Mr. Chair, if you will turn behind the tab in public session labeled quality report.

In the spirit of bringing to the board activities that further the mission of the academic health center and in particular focusing on quality and patient safety and patient experience.

The medical center has a multidisciplinary group that comes together called the patient experience council. At the council, results of patient experience, patient satisfaction, length of stay, and other issues related to the patient experience come before that group. There is a real peer review and interchange of ideas and most recently, the presentation that you are going to hear was presented at patient experience council. I thought it would be useful for the board to see this.

I want you to concentrate on the dramatic results. There is a long way to go but this is an emergency room setting that sees trauma, that sees all kinds of emergent issues that you would usually see in an inner-city academic, urban medical center. The presenters will be Eric Adkins, who is Assistant Professor of Emergency Medicine and Critical Care and is Medical Director of the Emergency Department and Jason Walsh, Director of Nursing for Emergency Services. I would like you to frame the question or the issue that you saw as an opportunity for us. Take it away.

Dr. Adkins:

Thank you, Dr. Retchin. I appreciate everyone giving us the time today to talk with you.

I want to say, before I get started, that one of the opportunities for us or one of our greatest successes, I think, has come because of the relationship that the medical director and the nursing director has in our department. It is really important to show a very collaborative approach and maybe we don’t always have those. So much of the improvements and successes that we’ve had in our unit have been because of the relationship that I have with Jason, as we work together in our leadership team.

I’m going to go over a couple different things with you today and please feel free to stop me along the way if you have questions. There’s going to be some opportunity at the end as well.

We talked to the patient experience council about a number of opportunities and solutions that we've been looking to implement in the emergency department. I'm going to talk to you a little bit about some of the accomplishments and wins that we've had as an emergency department. As you all know, it's been a time of a lot of change and construction at the medical center and from our department of perspective I came on as faculty in 2010 and I haven't known a day without construction in our emergency department until recently when we became whole.

To help understand a little bit about our department and who we are. We are on pace this year for about 78,000 visits, which is up significantly about 12%. We opened the first phase of the department in August 2014 and then moved into the completed department in April 2015. Keep in mind that there's no real advertising that goes on and we used to see 180 patients a day. Our first day we saw 253 patients, which was an amazing achievement by our staff and we had almost no patients who left without being seen that day.

We track our left without being seen rate, and historically we've been in the 6% range or so. That bothers Jason and I because we don't want anybody to come to our emergency department that's seeking care and have to say "I don't want to wait this long and I'm going to go someplace else." We have recently seen, and I'll show you coming forward, our left without being seen rate drop over the last 30 days. We're down to 1%, which was a huge achievement by the team. We know that about 50% of the inpatient admissions come through our emergency department and we can see anywhere from 200 to 250 patients per day, usually depending on the day of the week. Mondays and Tuesdays are some of our busiest, weekends typically are a little bit slower, but we still have some pretty busy weekends. We admit about 35% of the patients that come into the emergency department to the hospital, which will help to drive a lot of the downstream revenue and volume that may come with additional admissions.

At some point during the presentation today, you may hear me talk about boarding. If you haven't heard about an emergency department boarding, it's a national issue. It is an important issue to recognize that boarding is never going to be good for patients. We've come up some solutions about to how to try to fix it and Dr. Thomas and Dr. Alli have been very supportive of us. But this is any time that comes four hours after the decision to admit. Some patients may have to stay for prolonged periods of time.

When I took over in July 2013, we'd be struggling with patient experience. As Dr. Retchin pointed out, we see most people on the worst day, and it's hard to have people have a good experience sometimes on one of their worst days. We've been working a lot with our staff on how we can about improve things.

Recently we've seen a nice trend upwards in the way that patients are experiencing our department, as you can see by the blue bar. These are our November results. We've traditionally hovered between the 8th and 15th percentile range, no one is happy with that, and have been at 80% for satisfaction. It doesn't mean that the care has been bad, it means that it's a tight range that we're competing in. We're competing against other free standing emergency departments and also competing against other community emergency departments that don't have the same type of patient populations or other throughput issues that we may have.

We were very pleased when we saw some of our improvements here in November and we've climbed up to the 39th percentile. It is not where we want to be but it's clearly trending in the right direction and we believe it's because of a number of the interventions that we're making with our staff.

One of the things that our staff have had issues with sometimes is burnout. The burnout rate in medical specialties is the highest in emergency medicine. I don't think that goes just for physicians, I think it goes for everybody who's taking care of people on their

worst days and some of the highest acuity and time sensitive conditions that they'll ever experience.

We started working with two of our patient experience experts, and we named a series called, Potts/Larson, named after Richard Potts and Josh Larson. They've been two wonderful advocates from our patient experience group. We sought out to model a community style patient experience academy. If you go to out to some community emergency departments, they will actually have sessions that they put on and they demand of their staff, their nurses, their doctors, that they all go through this once of a year, about how they connect with patients. How do they show empathy? How do they function better as a team to understand the common goal of the patient having the best possible experience when they come to the department?

We've actually broken this out into eight segments that will roll over the calendar year period and it's going to continue to go on, or hopefully, in perpetuity with some adjustments along the way. As we have members come off the team or come onto the team, if they start midyear, they're going to be exposed to a number of these things. Everybody attends these and our faculty is expected to attend.

When I attended this, I started out the day thinking everything would be okay and I finished that session. It was only a 15-minute session and they keep right to it. At the end of the 15 minutes, one of our technicians was crying and hugging me. She was telling me how sometimes she just didn't know, how she's worked so hard all her life, and the way she was raised. I found it really touching because I felt like the sessions that we're doing is making a difference; where they are starting to understand what they can do differently to better connect with their patients. She is a tough woman. A month ago, she was kind of giving me a really hard time and she comes to me and says "I have to apologize to you" and she's just in tears. The work that Mr. Potts and Mr. Larson are doing is really exemplary.

Mr. Fischer:

Can I ask a question on that slide?

Dr. Adkins:

Yes, sir.

Mr. Fischer:

I read the footnote and I am probably reading it wrong. The overall assessment 39 and the other 7 factors feed to that. But unlike previous time periods, there's none lower than 39 so I was wondering how the overall assessment is 39.

Dr. Adkins:

That would be for the month of November, itself. The blue bar represents just the month of November and the prior months have been where we've struggled.

Mr. Fischer:

Are there other factors feeding in to the overall assessment at 39?

Dr. Thomas:

Mr. Fischer, the way the data is pulled, there's a unique question that is about overall satisfaction. The others are separate questions. It is not an average of all of the other areas. However, there are correlations that we can see in highly correlated areas.

Mr. Fischer:

That answers my question.

Dr. Adkins:

As we continue to focus on staff demeanor and empathy and compassion with our group, we've actually had our staff engage in a number of videos that is a part of the onboarding, as they come on, about how to appropriately walk with patients. In the past, we actually saw some of our staff walking 15 feet in front of patients, kind of like saying "come on, come on" or a tour guide. Now they walk side-by-side with a patient, not necessarily holding their hand, but in some ways they are trying to connect with them on the way back into their rooms and on their way out.

We've started a program related to secret shoppers, where we are actually getting folks who work here at the medical center but are not familiar to our emergency department staff. As you know, there are almost 20,000 people that work here; it's a big place and not everybody knows everybody. We have the shoppers come through and they are paying attention to how are people acting. Are people saying hello?

They are being coached to appear to be lost and someone should come to them and say "do you need help?" As they do that, they're going to find out who is doing it well and they're going to tell us who needs some help and some coaching to be better.

For the first time in my experience, we've had about six months or so of sharing patient experience numbers with our residents. All of our patient experience data has typically come back to us as faculty members. When I get my patient experience data, it's tagged just to me. We have been able to work with the patient experience group to go and get that information related to those residents who also cared for those patients and we're being able to find that there are some residents who didn't know that their patient experience numbers associated with those visits were as bad as they were and they have been very enthusiastic and engaging about how can we learn to do more. To the point at which people like Mr. Larson are coming down and shadowing physicians.

We introduce them as somebody who is interested to see how it is for the patients. They come to us and state that they want to understand what it is like to be a patient, but they are actually watching the health care provider and then giving constructive feedback after four to eight hours of direct observation with them. Something that I think is very unique and that most physicians don't always say, "yes, come over and look over my shoulder." It is something that traditionally has not been welcomed and we've gotten to the point where everybody is so committed to this about making the patient experience better, they're accepting this very openly.

We have a wonderful program where our resident physicians and our nurses are working together to get feedback to better understand each other and how to function as a team.

We are continually investing in our staff. The Daisy Award is something that recognizes nurses for doing outstanding work. If you go to the website, it references the super human work that nurses do and I believe that is true. We have a wonderful group of nursing staff that does super human work every single day when we take care of 230 patients who come in having the worst day of their lives. We've had two of our nurses recently recognized for that.

We've also worked on bringing a greeter to the front. Prior to a year ago, the first thing that you saw when you came into our emergency department, was a security member who was screening them. Now you see folks, like Rob here, with a wheelchair, helping people out of their cars and working to get them in. We have greeters that sit in our lobby for days when we have to have patients in the lobby and they can actually show us how many times they have talked to certain patients. They offer them water, they offer them

blankets if they need it, and if it looks like there is something wrong, they will work with the nursing staff to let them know that this patient is having a hard time or has additional questions.

Then when they actually come back into the rooms, we have patient advocates who go into the room to say “How is everything?”, “How is Dr. Adkins today?”, “How is he as a physician?”, “How is your resident who saw you?”, “How is the nurse?”, “How are things going?” When they find out there is an issue, or somebody feels like their concerns aren’t being addressed or maybe the behavior of that staff member hasn’t been the best, they will come to one of the managers or to the senior physician on duty that day to try to help resolve it at that time instead of waiting to hear about it as a complaint later on.

We’ve done a fabulous new initiative with the white boards in the rooms. As part of the new emergency department, we have white boards that are present and we are counseling our staff so when they go in, they introduce themselves and at the beginning or the end of that moment, they actually write their name on the board, they write what their role is, and they write part of the plan of what is going to happen for that patient. So much is going on at that one moment and people are in pain, they don’t know what is going to happen. It’s easy for them to forget and that method allows the patients to be able to see a little bit of what was said in the room when the doctor or the nurse is gone.

Our leadership team has daily rounding. We go through and look at the environment to ensure that it is clean and that it’s quiet and then we work with individual staff members to talk about what are the hot spots in the department or things we would like for them to focus on, such as closing the doors in our departments to ensure a nice quiet environment for patients and privacy.

Coming up, we’re getting ready to roll out a no pass initiative in which our patients are going to have the expectation that anybody who is working in our emergency department, when an alarm goes off, they should stop walking, go into the room and ask the patient, “are you okay?”. A number of high performing health systems have a system like this and we’ve going to look to pilot this in the emergency department.

You may have heard about teletracking in the past. While that is not necessarily a direct effect on patient experience, it’s had a huge effect for us. When they rolled it out, we started to see opening of the beds and were able to move the patients out of the emergency room, where we are essentially boarding. You can see on the slide, in September 2015, we had 8,000 boarding hours for patients, which is really high. We have seen that come down around 4,000. We are continuing to see that trend go down. We’ve had a little bump up here with some of our length of stay issues but those are being actively addressed.

We recently had one of our high volume days of over 220 patients with a discharge length of stay of under four hours.

Four hours is the magic bell for a lot of patients. No matter what is wrong with them, if you spend more than four hours in the emergency department, we know that based on research from Press Ganey that at that four-hour mark, it’s really hard to recover on service from them. We are seeing an improvement in the efficiency of the staff downstairs, but a lot of that comes when there’s not the other distractions of patients that are already admitted and waiting to go upstairs and the staff can really focus on what their best at, and working in the emergency department.

The left without being seen number dropped from the 7% range to 1.8% and it’s continuing to go downwards.

Mrs. Wexner:

Eric, on the boarding hours, you go from 8,000 to 4,000. Is it 4,000 hours beyond four hours?

Dr. Adkins:

Yes, ma'am.

Mrs. Wexner:

And what realistically would you hope you need to get to get that to fewer hours?

Dr. Adkins:

I think some best practice institutions have minimal number of boarding hours. There are some hospitals that may consider boarding anything after two. Joint Commission considers it four.

Mrs. Wexner:

You could get to zero here and then move it down?

Dr. Adkins:

There are a lot of competing interests about what the right number is as far as that goes. In order to address boarding, we have an obligation to serve the other outlying hospitals that are sending us their transfers. Sometimes you have to make that decision based on "I've got an open bed upstairs, do I bring somebody from Lima who is desperately in need of OSU services and keep the patient in the emergency department?" Those interests will conflict a little bit and sometimes the best thing to do is stay aligned with what is best for the patient and whether it is a patient in our emergency department or a patient we're going to take care of from an outside hospital, that kind of guides that decision, I think.

What I would ask for, and I've heard this talked about a little bit in the meeting so far, is the access to care afterwards. We have some patients who struggle to get in with subspecialists and it may take two months to get in to see a subspecialist and then they have to access the emergency department again. That after part of the ED visit can be very powerful to impact things like reducing the readmission issues which we work a lot with Dr. Moffatt-Bruce on trying to do that, but ensuring that those appointments are readily available. The heart failure has done a great job with trying to manage that and it's been a nice partner in terms of the readmission issue and we've worked out plans to even put their patients in our ED observation unit instead of admitting them so that we don't take on the readmission hit and the cardiologist can see them and send them home.

I receive a daily report of how our emergency department did with capacity. Today at noon, I'll find out how we did yesterday and I am going to be able to see what volume of patients we saw, what was the mix of the acuity, and if there were boarding hours. That is the back door, as I refer to it on the slide, but you know the emergency door is the front door. It is that back door of the ED that will dictate a lot of flow. Building a bigger emergency department doesn't fix those issues and I know some people say, you've got a bigger ED so everything should be better. That doesn't always fix it, it's the ability to move them out because then we can continue to grow the patient volume and bring more into the business of the hospital itself. Having that appropriate inpatient space and the staff to support it and if we can do that consistently on a daily basis, that's where we see our performance doing pretty well.

The thing to remember going forward is that the emergency department has a very vested interest in improving our patient experience and that we are doing a large number of things and trying to improve how our staff interacts with the patients and to improve that connection. We are at a historic low for our left without being seen and we are seeing an upward trend in our patient experience scores, which I believe is from a number of the initiatives that we have been talking about here. We are hopeful that as we continue to move forward, we see that uptrend and we all want to get to that 90th percentile.

President Drake:

A couple of comments. One I am interested in, and particularly the post-ER care and making sure there is a good alignment between the services that patients need when they leave and our ability to provide them in a timely fashion. I think that is a good thing. I won't ask about that, I'll just say that is a very good topic for us to look at, to make sure we don't have a difficult time referring patients to ourselves for things that they need and as you mentioned, causing other visits back to the ER. I think we want to be sure we're being a good receiver but that's just a comment.

The second comment is that I have a greater opportunity than most to hear about how things are going in the emergency room because of what I will call my large family, which is our students.

Dr. Adkins:

Your 60,000 family members.

President Drake:

We have a large family and I mean that in a very serious way. I am called on a more frequent basis than I wish when one of our students has suffered an injury, of one kind or another. I will say that for those students who are treated successfully, I get very good feedback from the families about the interactions they've had with the emergency department and then the hospital in general. Very heartfelt, positive feedback from the families on a routine basis. That also happens in those cases when the outcome has been not positive, that the families have been overwhelmingly grateful for the really high quality and sensitive service that you provide. I hear about this on a regular basis and I want to take a special moment to thank you for that.

Dr. Adkins:

Thank you.

Dr. Retchin:

Other questions or comments?

Dr. Wadsworth:

Yes. This is probably a crazy question; a bunch of people show up at the emergency department. Is there some measure of how many shouldn't be showing up there but should be going somewhere else and what do you do with those people?

Dr. Adkins:

That is an interesting question and that is part of what our staff has struggled with because sometimes people are like, "They shouldn't be here." From my perspective, I've had patients say, "I'm sorry that I'm here" and I tell them that I am glad they are here.

I thank them for coming because there's a couple different options that happen there. They can't access that care somewhere else. Maybe it's urgent care or maybe it's too far. We have people who bring their kids to us because they can't afford the gas to get to Children's. Staff will ask "Why are they here". Sometimes not everybody understands that. I am glad that they come to us so that we have that opportunity. I don't want anyone to have to walk out of our emergency department, even if it's for a splinter, or for a medication refill. If they walk in and say "I'm out of my medication" and we tell them you can get that somewhere else, that's not the right attitude. If they walk in and they are out of their medication and it's to treat them for something that is potentially life threatening, then they aren't taking it and we're not living up to what we're supposed to do as an emergency department.

I think your question is a good one. It doesn't make any sense for someone to walk out the door and go to Ohio Health, or to anything else. We could have other access, other resources within the emergency department or in the health system to help support that but that's silly.

I want to go back to Dr. Drake's comment, two days ago, I saw one of your students and the reason she was in our emergency department is because student health wouldn't take her insurance. I said, "that's crazy", and told her that I am glad she is here and I'm going to help take care of her. I gave her some other information about what to do going forward but it was for a fairly benign complaint.

Dr. Wadsworth:

I think that's a great answer. I think people are inhibited from going as well and so I understand they should default.

Dr. Adkins:

They are scared. They feel like they don't need to be there and I think that we have to find ways to have the appropriate resources to avoid the emergency department so we can take care of the ones we need to because then that starts to influence us from things like ambulance diversion.

We don't want any ambulance diversions and I forgot to highlight it on one of my other slides but we recently went 30 days without ambulance diversion. Hopefully Dr. Thomas is behind me shaking his head and smiling and is happy about that. Jason and I were ecstatic. We were about to start telling the staff, "30 days guys, 30 days". We had periods where Monday through Thursday, we were on diversion six months ago. We had 194 hours of diversion in a month and that's just ridiculous.

Mr. Jurgensen:

I think Jeff's question opens up a big can because when you have aggregate statistics about a department like yours, where the range of what you're seeing is huge, even if I think about boarding hours and that, it depends on what the case is. There's going to be high sensitivity and there's going to be lower sensitivity and if the experience is the emergency room is more like the experience in the patient room, then the boarding hour issue goes away.

What makes it a problem is if there is a level of service that is radically different and I got to get up on the floor because I am going to get better service when I'm on the floor. You have so many different kinds of things in that triage on the front end, the difference between a splinter and something else, is really complicated and being a trauma center adds a degree of complexity to all of this. I think in those aggregate statistics we look at, an aggregate goal setting, I think that is a harder deal in your department because you see everything and it's not all the same.

Ms. Marsh:

Along those lines, Mr. Jurgensen, the emergency medicine leadership has done a great job looking at who is coming in and perhaps, could be treated in another setting even though they go ahead and treat them, and have set up two after hours' clinics, one at Morehouse and one now in Gahanna, which is moving some patients to those lower intensity clinics rather than coming into the ED and especially our health plan members at Ohio State.

Dr. Adkins:

That's a great point and when we opened those, they ate into our lower acuity volume. We knew the fast track type stuff. The funny part is that the total volume coming to the department didn't go down. We saw that we are now seeing more of the moderate complexity or higher complexity patients. They didn't take away our volume, it just got replaced.

There is a portion of patients that I would refer to as, left without being registered. We don't know who they are. If they walk in and see the lobby is full, they leave. Next time on a Friday night, when you're driving down the street and you drive past an Olive Garden and the weather is decent, look outside and see if there is somebody sitting there or if there's people standing out there. Often people might say "oh wait, there's 20 people standing outside of Olive Garden. I want Olive Garden tonight but I'm not going to wait." If you walk into our emergency department and you see 20 people sitting there in the lobby, that may be one person with two family members each, they don't know who the patient is and who the family is, they just go "oh I'm not as sick as I need to be." Back to your point, maybe I don't need to be here. I want to get them the first time they walk in the door.

Mr. McQuaid:

Dr. Adkins, my name is David McQuaid and I am the new CEO for the health system. Today, is my fifth day.

Dr. Adkins:

Welcome!

Mr. McQuaid:

However, on my first day, I wanted to get out and meet people and as I do, every week, and I visited the emergency department. I applaud you for what you're doing.

Dr. Adkins:

I just missed you. I was actually working in our oncology ED, that's something I forgot to highlight. We have a 15-bed space that is dedicated to the care of our oncology patients. That's where I was that day so I missed you.

Mr. McQuaid:

Nice presentation, but I want to follow up on a point that Dr. Drake made, an observation regarding a theme that we're talking about here today. Making the point of the importance of alignment and integration as an operating company and an operating model.

We talked about length of stay, we've talked about readmissions, we've talked about boarding, and we've talked about access to appointments. The opportunity, I believe, that you're making the point on, is how do we create an innovative, new model for case

management. Historically, it's been an inpatient model. The model needs to now bridge to the ambulatory and clinic practices. It needs to bridge 24-hour case managers in the emergency department. I don't know if you have those already.

Dr. Adkins:

We don't have 24-hours but we have about 20.

Mr. McQuaid:

The importance of case managers in these areas to coordinate care. I come from a state that did not have Medicaid expansion. I'm sure there's an impact in the past several years on Medicaid expansion on your numbers. These are also populations that do not have primary care physicians. I think there's a tremendous opportunity here to lead in creating a case management model that can help us help ourselves in many of these areas.

Dr. Adkins:

To your point, there's a hospital down the street that is getting ready to close its doors in a couple of years. When their emergency department closes, you know, we're going to see a portion of those patients showing up here. Mount Caramel, when they move down to Grove City.

Mr. McQuaid:

I look forward to working with you.

Dr. Adkins:

Same here, sir.

Dr. Retchin:

Any other questions?

I think you all probably see why I wanted the board to hear this. It's a great effort to improve quality in an area that often doesn't get that attention because there is, as Mr. Jurgensen pointed out, such a wide spectrum. Congratulations on your efforts and we will look forward to seeing more and better results in the future Eric and Jason. Thanks.

Dr. Adkins:

Thanks.

Mr. Wexner:

You know Eric, what just occurred to me is, from New Albany to the ER here, is about an 18-minute drive. If I went to an ER room that was closer to the house, I'd have a shorter drive time but I might have a longer wait.

The total experience might be short on the drive part but then long on the wait time. I am processing this from integration but also in the marketing because about 45% of the admissions come through the ER. We can increase that absolute number to a bigger number by talking to ambulance drivers or getting people to understand that time to care from home to here is better here than driving a shorter distance and perceived care.

That's just what I was thinking.

Dr. Adkins:

Let me give you some background on that. I think that you're exactly right and we've seen some of this trend as we've done a new initiative with sickle cell and how we take care of the pain. Because our initiative is taking care of their pain sooner in the emergency department, we have been able to cannibalize a little bit of the East sickle cell patient volume and they are coming to main campus. East is closer for them but they are coming to us because they are aware that we have a little bit of a different plan about how they get taken care of from that side.

There's another side. I have many patients, when asked where they are from, state that they are from Cambridge. We are seeing them in the emergency department from an hour and a half away because their community hospitals are doing the best they can, and I always tell the patients that, with the resources they have. But they lose faith in their local outreach because those are smaller hospitals out there and they want to come here. They will come here for us to say that we will see them in the clinic next week. They are happy and they will drive another hour and a half away.

I hear comments such as "thank you very much, I can't believe that you did this for me". Part of that comes back to our case management because we can make those things happen. Somebody can come in worried that they have cancer. They have been told that they chest nodule, a big four centimeter mass in their chest, and they will drive here to be admitted to the James Cancer Hospital.

The James Cancer Hospital has a wonderful diagnostic service for patients that don't have a true diagnosis of cancer but suspect it. Case managers can help make that happen or will set up appointments to be seen in the clinic the next day.

I still think we have some relationships with EMS to work on and the Center for Emergency Medical Services is trying to do that for us but the ambulance drivers in town do know where they get the best care for heart attacks. They know where they get the best stroke care and if they are kind of in that middle, they know that they can walk in because we put our patients directly on the cat scan unit right away.

If you have stroke symptoms, you don't even talk to anybody. We will register you in as Joe Emergent and you lay down on the cat scan table and you go and there's no other questions in order for us to impact our embolic times. The EMS community knows some of that but we still have to soften up the bread and butter patients that are coming in and have EMS want to come back here. Sometimes it comes back, a little bit, to boarding because if they can't go directly to a bed, if we don't have that bed immediately available for them, it influences where they go.

Wonderful points. Thank you.

(See Attachment XVIII for background information, page 186)

Dr. Retchin:

Thank you. Great job.

Ms. Link:

The board will now recess into executive session to discuss personnel matters regarding the appointment and compensation of public officials and to consider business sensitive trade secret matters required to be kept confidential by federal and state statute.

Upon motion of Dr. Wadsworth, 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, Mr. Wolfe, Mr. Fischer, Mrs. Wexner, Mr. Jurgensen, Dr. Wadsworth, and Mr. Wexner.

Attest:

Leslie H. Wexner	Heather Link
Chairman	Associate Secretary

(ATTACHMENT XV)

FY16 YTD | Through December 2015

MEDICAL CENTER PERFORMANCE	FY15 Actual	FY16 YTD Actual	FY16 Target	Current Status	2020 Target
A. Quality and Service					
1. Quality and Patient Safety					
1a. Inpatient Mortality[1]	0.64	0.68	0.66	▼	Top 3 of UHC Hospitals
1b. PSI 90 (Patient Safety Index) [2]	0.64	0.66	0.62	◀▶	TBD
1c. Overall Readmissions [3]	13.2%	13.4%	11.9%	▼	TBD
1d. CAUTI (Standardized Infection Ratio) [4]	1.16	0.62	0.85	▼	TBD
2. Overall Patient Satisfaction [5]					
2a. Inpatient: HCAHPS	75.2%	77.1%	79.4%	▼	Top Decile
2b. Outpatient: CG-CAHPS/Physician Offices Satisfaction	90.8%	90.9%	96.0%	▲	Top Decile
2c. HCAHPS Doctor Communication	81.1%	82.0%	82.8%	▼	Top Decile
2d. HCAHPS Nurse Communication	80.3%	81.1%	81.0%	▼	Top Decile
B. Research Excellence					
1. Total NIH Awards [6]	$95.9M	$36.6M	$97.0M	▲	TBD
C. Education Excellence					
1. USNWR Best Medical Schools Ranking	#31	Reported April 2016	#30	DATA PENDING	Top10 Public
D. Clinical Excellence					
1. USNWR Best Hospitals: Number of Specialties Ranked	7	Reported July 2016	10	DATA PENDING	11
2. USNWR Best Hospitals: Number of Specialties in Top 20	1	Reported July 2016	2	DATA PENDING	7
E. Talent Management					
1. Workforce Engagement: Staff [7]	NA	Reported January 2016	TBD	DATA PENDING	90th percentile
F. Financial Viability					
1. Net Medical Center Operating Margin (and %) [8]	$201M (7.0%)	$106M (6.8%)	$222M (7.0%)	▲	TBD
2. Days Cash on Hand: Health System	87.3	99.3	92.5	◀▶	110.0
3. Days Cash on Hand: OSUP + College of Medicine	84.5	91.1	88.4	▲	80.5
G. Revenue Enhancement and Scale					
1. Health System Total Operating Revenue per Adjusted Admission	$21,839	$22,799	$23,289	▲	$24,419
2. Development Dollars (including OSP)	$124.7M	$54.8M	$137.0M	▲	$260.0M
H. Cost Management					
1. Health System Total Operating Expenses per Adjusted Admission	$18,850	$19,831	$20,211	▼	$21,951
2. Spending per Medicare Beneficiary [9]	0.998	0.998	0.980	◀▶	TBD

1 Inpatient Mortality data through October 2015
2 PSI 90 data through June 2015 - New Metric
3 Overall Readmissions through September 2015
4 CAUTI=Catheter Associated Urinary Tract Infections-data January through June 2015 - New Metric
5 Overall Patient Satisfaction data through November 2015. Doctor and Nurse Comm. new metrics
6 Total NIH Awards exclude Nationwide Children's awards
7 Workforce Engagement to be reported in Jan 2016
8 Net Operating Margin = combined margin of Health System, COM and OSUP - New Metric
9 Spending per Medicare Beneficiary data through December 2014 - New Metric

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

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

Data Definitions for Quality and Patient Safety Measures:

Inpatient Mortality: This measure is expressed as the observed (actual) mortality in the hospital (deaths per 100 patients), compared to the "expected" mortality rate for similar patients at academic medical centers in the United States who participate in the University Healthsystem Consortium's Clinical Data Base.

PSI 90 (Patient Safety Index): It is a composite measure that includes PSI 03 Pressure Ulcer Rate; PSI 06 Iatrogenic Pneumothorax Rate; PSI 07 Central Venous Catheter-Related Blood Stream Infection Rate; PSI 08 Postoperative Hip Fracture Rate; PSI 09 Perioperative Hemorrhage or Hematoma Rate; PSI 10

Overall Readmissions: Estimates of unplanned readmission for any cause to an acute care hospital within 30 days of discharge from a hospitalization.

CAUTI (Standardized Infection Ratio): Measures all patients anywhere in the hospital that develops a catheter-related urinary tract infection.

Inpatient HCAHPS: Percent of patients who gave the hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).

Outpatient: CG-CAHPS/Physician Offices Satisfaction: Shows the percentage of patients when asked "Would you recommend this provider's office to your family and friends?" answered 'Yes, definitely'.

HCAHPS Doctor Communication: How well did the doctors treat with courtesy and respect, listen carefully, explain things

HCAHPS Nurse Communication: How well did nurses treat with courtesy and respect, listen carefully, explain things, answer the call button

(ATTACHMENT XVI)

The Ohio State University Health System

Financial Highlights

For the YTD ended: December 31, 2015
($ in thousands)

Operating Revenue	
Budget	-0.9%
Prior Yr	12.2%
Actual	$1,265,340
Budget	$1,276,937
Prior Yr	$1,127,715

Controllable Costs	
Budget	1.5%
Prior Yr	-9.3%
Actual	$970,616
Budget	$985,319
Prior Yr	$887,911

Excess Revenue over Expense	
Budget	6.5%
Prior Yr	-3.9%
Actual	$97,314
Budget	$91,337
Prior Yr	$101,313

Days Cash on Hand		
Budget	8.2%	
Prior Yr	26.0%	
Actual	99.3	$559M
Budget	91.8	$519M
Prior Yr	78.8	$399M

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

1

The Ohio State University Health System

Consolidated Activity Summary

For the MTD ended: December 31, 2015

OSUHS	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
CONSOLIDATED ACTIVITY SUMMARY						
Activity						
Admissions	5,017	5,081	(64)	-1.3%	4,885	2.7%
Surgeries	3,744	3,604	140	3.9%	3,643	2.8%
Outpatient Visits	145,947	144,962	985	0.7%	140,319	4.0%
Average Length of Stay	6.10	6.09	(0.00)	0.0%	5.90	-3.3%
Case Mix Index (CMI)	1.83	1.78	0.05	2.6%	1.76	3.8%
Adjusted Admissions	9,721	9,410	312	3.3%	9,256	5.0%
Operating Revenue per AA	$ 20,257	$ 20,604	(347)	-1.7%	$ 21,348	-5.1%
Operating Expense per AA	$ 17,381	$ 17,996	615	3.4%	$ 19,569	11.2%

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

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The Ohio State University Health System
Consolidated Statement of Operations
For the MTD ended: December 31, 2015
(in thousands)

OSUHS

OPERATING STATEMENT	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
Total Operating Revenue	$ 219,789	$ 213,793	$ 5,996	2.8%	$ 195,776	12.3%
Operating Expenses						
Salaries and Benefits	98,565	98,163	(402)	-0.4%	92,405	-6.7%
Supplies	23,985	24,585	600	2.4%	25,503	6.0%
Drugs and Pharmaceuticals	21,120	18,080	(3,040)	-16.8%	16,281	-29.7%
Services	22,929	23,914	985	4.1%	21,841	-5.0%
Depreciation	11,439	11,221	(218)	-1.9%	10,701	-6.9%
Interest	3,465	3,549	84	2.4%	3,599	3.7%
Other	10,329	9,748	(581)	-6.0%	8,976	-15.1%
Total Expense	191,832	189,260	(2,572)	-1.4%	179,306	-7.0%
Gain (Loss) from Operations (pre MCI)	27,957	24,533	3,424	14.0%	16,470	69.7%
Medical Center Investments	(11,689)	(11,667)	(22)	0.2%	(13,215)	11.5%
Income from Investments	190	107	83	77.6%	131	45.0%
Other Gains (Losses)	7	10	(3)	---	(25)	---
Excess of Revenue over Expense	$ 16,465	$ 12,983	$ 3,482	26.8%	$ 3,361	389.9%

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

1

The Ohio State University Health System
Consolidated Activity Summary
For the YTD ended: December 31, 2015

OSUHS

CONSOLIDATED ACTIVITY SUMMARY	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
Activity						
Admissions	29,755	30,247	(492)	-1.6%	28,850	3.1%
Surgeries	20,961	20,590	371	1.8%	20,199	3.8%
Outpatient Visits	855,961	861,899	(5,938)	-0.7%	829,790	3.2%
Average Length of Stay	6.28	6.10	(0.18)	-3.0%	6.03	-4.2%
Case Mix Index (CMI)	1.80	1.78	0.02	0.9%	1.76	2.0%
Adjusted Admissions	55,499	56,327	(828)	-1.5%	53,459	3.8%
Operating Revenue per AA	$ 22,799	$ 22,670	129	0.6%	$ 21,095	8.1%
Operating Expense per AA	$ 19,831	$ 19,820	(11)	-0.1%	$ 18,289	-8.4%

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

1

The Ohio State University Health System

Consolidated Statement of Operations

For the YTD ended: December 31, 2015
(in thousands)

OSUHS	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	$ 1,265,340	$ 1,276,937	$ (11,597)	-0.9%	$ 1,125,898	12.4%
Operating Expenses						
Salaries and Benefits	568,175	578,482	10,307	1.8%	515,076	-10.3%
Supplies	134,809	143,487	8,678	6.0%	133,454	-1.0%
Drugs and Pharmaceuticals	115,161	108,301	(6,860)	-6.3%	90,527	-27.2%
Services	134,332	137,521	3,189	2.3%	133,073	-0.9%
Depreciation	69,436	68,681	(755)	-1.1%	42,306	-64.1%
Interest	20,933	21,458	525	2.4%	7,259	-188.4%
Other	57,738	58,454	716	1.2%	54,194	-6.5%
Total Expense	1,100,584	1,116,384	15,800	1.4%	975,889	-12.8%
Gain (Loss) from Operations (pre MCI)	164,756	160,553	4,203	2.6%	150,009	9.8%
Medical Center Investments	(70,022)	(69,994)	(28)	0.0%	(49,042)	-42.8%
Income from Investments	1,198	640	558	87.2%	773	55.0%
Other Gains (Losses)	1,382	136	1,246	---	(427)	---
Excess of Revenue over Expense	$ 97,314	$ 91,335	$ 5,979	6.5%	$ 101,313	-3.9%

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THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

The Ohio State University Health System

Consolidated Balance Sheet

As of: December 31, 2015
(in thousands)

	December 2015	June 2015	Change
Assets			
Cash	$ 423,446	$ 330,141	$ 93,305
Current Assets	411,953	368,518	43,435
Assets Limited as to Use	255,250	255,029	221
Property, Plant & Equipment - Net	1,382,533	1,420,127	(37,594)
Other Assets	27,379	21,019	6,360
Total Assets	$ 2,500,561	$ 2,394,834	$ 105,727
Liabilities & Net Assets			
Current Liabilities	$ 295,978	$ 268,236	$ 27,742
Other Liabilities	47,882	47,338	544
Long-Term Debt	817,337	839,232	(21,895)
Net Assets	1,339,364	1,240,028	99,336
Total Liabilities & Net Assets	$ 2,500,561	$ 2,394,834	$ 105,727

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THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

OSU Wexner Medical Center
Combined Statement of Operations
For the YTD ended: December 31, 2015
(in thousands)

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	$1,547,848	$1,560,422	$ (12,573)	-0.8%	$1,387,585	11.5%
Operating Expenses						
Salaries and Benefits	806,991	817,350	10,359	1.3%	745,884	-8.2%
Supplies	146,596	156,121	9,525	6.1%	145,207	-1.0%
Drugs and Pharmaceuticals	127,906	120,405	(7,502)	-6.2%	102,902	-24.3%
Services	171,150	173,036	1,886	1.1%	170,384	-0.4%
Depreciation	75,974	74,564	(1,410)	-1.9%	47,941	-58.5%
Interest/Debt	26,698	27,491	793	2.9%	13,153	-103.0%
Other Operating Expense	66,625	69,215	2,590	3.7%	63,086	-5.6%
Medical Center Investments	20,269	16,753	(3,516)	-21.0%	(0)	---
Total Expense	1,442,209	1,454,934	12,724	0.9%	1,288,555	-11.9%
Excess of Revenue over Expense	$ 105,639	$ 105,488	$ 151	0.1%	$ 99,030	6.7%
Financial Metrics						
Adjusted Admissions	55,499	56,327	(828)	-1.5%	53,459	3.8%
OSUP Physician Encounters	1,170,800	1,182,347	(11,547)	-1.0%	1,090,313	7.4%
Operating Revenue per AA	$ 22,799	$ 22,670	$ 129	0.6%	$ 21,095	8.1%
Total Expense per AA	$ 19,831	$ 19,820	$ (11)	-0.1%	$ 18,289	-8.4%

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

The Ohio State University
Wexner Medical Center

OSU Wexner Medical Center
Combined Statement of Operations
For the YTD ended: December 31, 2015
(in thousands)

	ACTUAL	BUDGET	ACT-BUD VARIANCE	BUDGET % VAR	PRIOR YEAR	PY % Var
Health System						
Revenues	$1,265,340	$1,276,937	$ (11,597)	-0.9%	$1,127,715	12.2%
Expenses	1,168,026	1,185,602	17,576	1.5%	1,026,402	-13.8%
Net	97,314	91,335	5,979	6.5%	101,313	-3.9%
OSUP						
Revenues	$ 198,824	$ 196,516	$ 2,308	1.2%	$ 181,289	9.7%
Expenses	187,068	183,353	(3,715)	-2.0%	177,799	-5.2%
Net	11,756	13,163	(1,407)	-10.7%	3,490	236.8%
COM/OHS						
Revenues	$ 83,685	$ 86,969	$ (3,284)	-3.8%	$ 80,398	4.1%
Expenses	87,115	85,978	(1,137)	-1.3%	86,168	-1.1%
Net	(3,431)	991	(4,422)	-446.3%	(5,770)	40.5%
Total Medical Center						
Revenues	$1,547,848	$1,560,422	$ (12,573)	-0.8%	$1,389,402	11.4%
Expenses	1,442,209	1,454,934	12,724	0.9%	1,290,372	-11.8%
Net	105,639	105,488	151	0.1%	99,030	6.7%

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

The Ohio State University
Wexner Medical Center

OSU Wexner Medical Center

Combined Balance Sheet

As of: December 31, 2015
(in thousands)

	December 2015	June 2015	Change
Cash	$ 559,946	$ 454,113	$ 105,833
Current Assets	655,510	633,085	22,425
Assets Limited as to Use	255,250	255,029	221
Property, Plant & Equipment - Net	1,507,036	1,548,833	(41,797)
Other Assets	405,249	394,701	10,549
Total Assets	$ 3,382,992	$ 3,285,761	$ 97,231
Current Liabilities	$ 334,383	$ 323,390	$ 10,994
Other Liabilities	47,882	47,338	544
Long-Term Debt	935,982	965,218	(29,236)
Net Assets - Unrestricted	1,590,300	1,467,996	122,304
Net Assets - Restricted	474,444	481,818	(7,374)
Liabilities and Net Assets	$ 3,382,992	$ 3,285,761	$ 97,231

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The Ohio State University
Wexner Medical Center

(ATTACHMENT XVII)

BACKGROUND

1. Overview: The Wexner Medical Center proposes to re-name and re-purpose the University affiliate currently named The University Home Care Services Corporation to better align with its evolving focus and business opportunities.

2. History: The University Home Care Services Corporation ("TUHCSC") is a University-affiliated entity that was formed on February 22, 1996, to provide or make available comprehensive home health care services. On June 24, 1998, TUHCSC became qualified as a tax exempt entity under Section 501(c)(3) of the Internal Revenue Code. All of the current directors of TUHCSC are officers or employees of the University. TUHCSC and the Wexner Medical Center now wish to expand the operations of the affiliate beyond home health care services, and therefore wish to re-name the entity and modify its purpose.

3. Recommendation: It is recommended that the affiliate currently named TUHCSC be renamed "Ohio State Health, Inc.", and that its stated purpose be modified to include the following:

    1. To develop an integrated network for The Ohio State University Wexner Medical Center (OSUWMC) that furthers its tripartite mission of education, research and patient care, and improves access, quality and cost of health care for residents of Ohio and beyond.

    2. To provide leadership and funding to manage OSUWMC's post-acute care network operations and any associated affiliations/relationships that provides services to our patients. Post-acute care will include but is not limited to a 24-hour call service, home care, home infusion, durable medical equipment, short and long term rehab, skilled nursing facilities, and hospice care.

    3. To provide grant funding for OSUWMC and Central Ohio community health programs that improve community health outcomes and further the Wexner Medical Center's mission to improve people's lives.

    4. To provide grant funding to OSUWMC faculty, staff and students for research and training purposes that will enhance the clinically integrated network and/or seek to improve population health.

Patient Experience Council Emergency Services Update

January 2016

Eric Adkins, MD
Jason Walsh, RN

Overview

- Review Opportunities & Solutions
- Accomplishments & Wins
- Additional Support from System

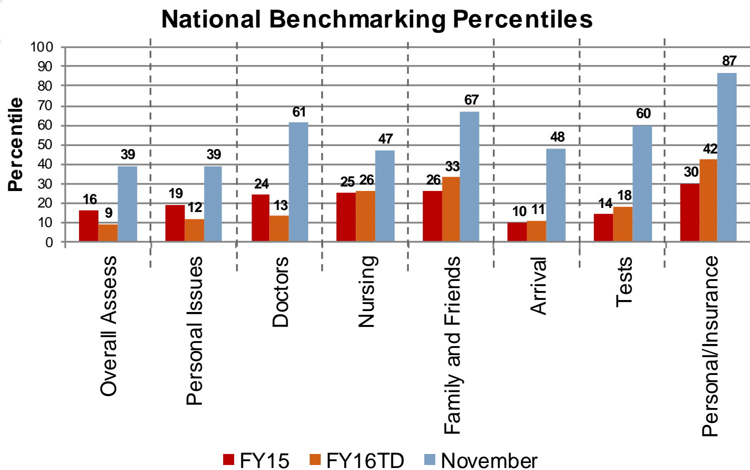
The Ohio State University
WEXNER MEDICAL CENTER

ED demographics

- On pace for 78,000 visits (up 12%)
- 50% of inpatient admissions come through ED
- 200-250 patient per day
- Admission rate 35%
- Boarding
  - Any time 4 hours after decision to admit

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

UH Emergency Services Patient Satisfaction



NOTE: Dimensions are listed from highest to lowest correlation to Overall Assessment

Staff Demeanor – Empathy & Compassion

- Potts/Larson Education Series
  - Rolling curriculum with 8 segments
  - All staff expected to participate

The Ohio State University
WEXNER MEDICAL CENTER

Staff Demeanor – Empathy & Compassion

- Staff Developed Experience Videos
- Secret Shoppers
- Resident Coaching
- MD/RN Collaboration Program
  - 2 way feedback between resident and RN
- Investing in our staff

The Ohio State University
WEXNER MEDICAL CENTER

Communication

- Increased Focus on Positive First Impression
- Welcoming Patients in the AZ with Dedicated Greeter Positions
- Additional Touch Points from ED Advocates

Communication

- White Board Auditing
- Bedside Report
- Purposeful Rounding
  - Management re-enforcing with staff key issues.
- No Pass Initiative

Operational Throughput & Boarding

- TeleTracking Go Live
- 30 days without ambulance diversion
- High Volume Days of >220 patients with Discharge LOS of 4 hours
- Arrival Zone Redesign
- APP/MD in Triage on high volume days

UH ED September 2015 to November 2015:

LWBS: **7.39% to 1.82%**

Admit LOS: **11 hours to 9 hours**

Boarding hours: **8081 to 3991**

Ambulance diversion hours: **154 to 9.4**

The Ohio State University
Wexner Medical Center

Ongoing Support Needed

- Assure access to care
  - After ED visit
- Capacity
  - Backdoor of ED being open
  - Inpatient space, staff (RN & physicians)
  - Consistency

Things to Remember

- Ongoing initiative to improve ED staff connection with patients
- Historical low for left without being seen
- Upward trend in patient experience scores

Thank You

The Ohio State University
Wexner Medical Center