THE OHIO STATE UNIVERSITY

OFFICIAL PROCEEDINGS OF THE

SIXTEENTH MEETING OF THE

WEXNER MEDICAL CENTER BOARD

Columbus, Ohio, April 6, 2016

The Wexner Medical Center Board met on Wednesday, April 6 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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April 6, 2016 meeting, Wexner Medical Center Board

Mr. Wexner called the meeting of the Wexner Medical Center Board to order on Wednesday, April 6, 2016 at 9:09am.

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

Mr. Wexner:

I think a quorum is present; we can begin the meeting. The minutes of the January meeting have been circulated, hopefully there are no additions or corrections. If there are none, the minutes can be approved as circulated. Later on in the meeting we're going to have a special presentation by Abigail, who is going to discuss her ACL (Anterior Cruciate Ligament) surgery and the excellent care and therapy that she received from the Wexner Medical Center, a testimonial to the quality of our practice.

Mrs. Wexner:

And the nursing care.

Mr. Wexner:

Continuing on with the progress we're making, let me call on Sheldon for an update.

Dr. Retchin:

Thank you, Les. I'm going to begin this morning with the introduction of Dr. Ken Washburn, the new Director of Adult and Pediatric Transplant programs. I want to parenthetically note that this was the result of the collaboration, with our dean, Chris Ellison, between two great institutions, the Wexner Medical Center and Nationwide Children's Hospital. Beginning in March, Dr. Washburn accepted the role, or assumed the role of Director of Adult and Pediatrics Transplants programs at Ohio State's Wexner Medical Center and Nationwide Children's Hospital. In his role, he will be the executive director of the Ohio State Comprehensive Transplant Center and the Division of Transplantation Surgery as well as Director of the Division of Vision Transplantation of the newly established Abdominal Transplant Program at Nationwide Children's Hospital. He will also be leading a team at Nationwide Children's Hospital to establish a new pediatric liver transplant program. There will be a lot of innovative, new skills and programs introduced to central Ohio, but more importantly, it will extend to a much broader area.

As you know, transplantation is a rare procedure to be needed, even rarer for pediatrics. It will draw, I am sure, patients from around the Midwest and Dr. Washburn's credentials will also draw patients and interest from around the Midwest and beyond. He comes to us from the University of Texas Health Science Center at San Antonio where he served as the Valero President's Distinguished Chair in Transplantation Surgery and Director of the Liver Transplantation. Dr. Washburn, would you stand and be recognized? Welcome. Chris, did you want to make any remarks?

Dr. Ellison:

Thank you. I think this is a great opportunity for collaboration between our institutions and I'd like to thank Nationwide Children's Hospital leadership, Dr. Larry Moss, in particular, and Steve Allen for their collaboration.

Dr. Retchin:

It was a great collaborative effort. Ken, welcome to the Medical Center and we look forward to reports and great work. With that, I am going to turn to the scorecard and I believe that is behind the CEO update tab. First on quality and patient safety, you will notice the short hand is the color coding on the right. In the interest of working towards goals, we are not shy about presenting data where we are missing targets. Allow me to begin with inpatient mortality. While we are missing targets there, the targets were ambitious. We still are outpacing the vast majority of our peers with an actual indexed rate of 72% of UHC average (University HealthSystem Consortium). Going down to PSI, (Patient Safety Index); this is an aggregate figure of a number of quality and patient safety indicators. I am pleased to report we are exceeding the targeted goal and I believe that some of that is in the annotation. This is probably the most concentrated evidence of quality for us and that we are doing well. On readmissions we have our work cut out for us. While we stand with many of our peers in working on readmissions, it is still a problem nationally, for us, and for academic health centers to get that down. Our target was 11.9% and lower is better. Right now we are hovering just below 14%, that is 14% overall in terms of the discharges being readmitted within 30 days. This takes a lot of coordination, and not just with us and what we control, but post-acute care, nursing homes, rehab facilities, and home care. We are working on that because, the future really is coordinating the comprehensive delivery of care across the continuum pre, during, and post-acute care. The CAUDI (Catheter Associated Urinary Tract Infections), which is a standardized infection ratio for urinary tract infections, is good. We are beating target and I continue to point to nursing, as well as the collaborative efforts between physicians, in particular, and other providers with nursing. Allowing nursing to make the judgement or the call about discontinuing Foley catheters is why that is all green and continues to do well. Overall, patient satisfaction, there is continued effort on this and while I think we are doing well, we are still not hitting target. We are within shouting distance in a number of areas with some improvement on doctor communication, nurse communication, which continues to do well and hit target, as well as the outpatient satisfaction and overall on our HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems).

Going over into the research excellence, we continue to track NIH (National Institutes of Health) awards because that is the way many medical schools are judged. There are national rankings that are available as a part of public domain. That does not mean that we do not count and celebrate other awards, particularly other federal awards like from NSF (National Science Foundation), Department of Defense and the like, but NIH awards are really a proxy measure. We are currently ranked 45 among probably around now about 132 medical schools and we want to climb those rankings.

Chris, where we were last year, at $47 million?

Dr. Ellison:

NIH awards are currently at $58 million year-to-date versus $59 million in 2015.

Dr. Retchin:

That continues to be incredibly competitive with the pay line being much, much more difficult than before. That said, we are all playing the same golf course and when it looks at rankings, we are all competing with each other. Our effort to push on that will be a high part of my agenda in the recruitment of the dean and Chris continues to press as the current dean on that.

Dr. Wadsworth:

Question, Sheldon, if I may? There's two ways to grow, one is by organic growth, people getting better. The other is by acquisition. Where is our philosophy vis-à-vis, trying to improve our NIH funding between those two?

Dr. Retchin:

Strategically, I would say, in terms of tempo and growth, it is not going to be organic. You can invest and you will strike oil. I do not know what the odds are in someone who has never been funded. The average age of funding for the first R01 is about 42 now. If you think about somebody coming out of their fellowship, you are looking at a long runway. If that is a principle effort to grow our own, it is a long process. That said, and we can discuss this later on but the packages that we are competing with are expensive. Recruiting someone with two R01s, much less three R01s, which are standards at many places, is very difficult and requires a lot of resources. Funded research outside of industry but certainly funded research, from federal sources, is a costly venture. There is no ROI (Return on Investment) other than the prestige and desire for discovery. You lose, I do not know what figure you might want to use, about 24 cents on the dollar.

Dr. Ellison:

For the AAMC (Association of American Medical Colleges) recently published a paper, 53 cents is what we spent for every dollar of research. We currently have $200 million of total funding so we are spending an additional $100 million a year basically to maintain that.

Dr. Retchin:

It is a calling and certainly high, if not among the highest ambitions that we have.

Dr. Drake:

I have a couple comments. One is that we call that money institutional investment. It is looked at, it is actually monitored, and it is an important thing that all institutions have to do. Spending is one thing, investing is another and I think that is a really important, critical place for us to be investing as an institution because that is something we need to grow. I also want to say to your question, Jeff, you know it is a little bit like the Washington Redskins under George Allen, a generation ago.

Dr. Wadsworth:

I might be in trouble on this one.

Dr. Drake:

I will quickly rescue you. The concept is he moved to the Redskins, the coach. He wanted to win now and he did that by spending a lot on people who had a year or two of prime playing left and that worked for a bit of time but it didn't build a sustained dynasty of success. It is very important and we are always looking to bring in galactic stars to be a wonderful, leading focus of research and that is a great thing, but the quality overall of our faculty are young faculty, our post docs, our residents, and our graduate students. All of that is really important for the long term pedigree of success that we want, so I think that, and I am very interested in making sure we continue doing, taking the long view and growing our culture to be a culture of productive research science.

Dr. Wadsworth:

I am sure it feeds into the teaching excellence because places that do research, teach more interesting work, and I applaud it. I think it is a tough environment and I am interested in that.

Dr. Retchin:

It is a very important area and I always am reticent about following a Dr. Drake metaphor. I want to, as a historical note, because we do want to recruit senior investigators who bring a new thought process and a whole new set of discovery efforts. With George Allen's recruitment to get to the super bowl sooner, I will say, his senior recruits that he brought in were called the "over the hill gang" and I don't want our senior professors to have that moniker but the metaphor works in some ways.

Dr. Wadsworth:

Thank you, I have learned a lot.

Dr. Retchin:

You see *the U.S. News and World Report* ranking and it has slipped a couple of spots from where we were, from 31 to 33. We can dissect that out. Chris?

Dr. Ellison:

Last year we were 31, tied with the University of Iowa and Oregon Health Sciences. Both of those institutions have made major commitments to research. I think the change is largely driven by them moving up in the rankings due to research dollars and us staying the same but basically dropping because we were tied with them.

Dr. Retchin:

I think it is reflective of the discussion we had. It takes a village. *U.S. News and World Report* rankings on hospitals, as you see, is still not out. I mentioned this last time about the workforce engagement results that continue to tick up. While we are only at the 56 percentile, that compares us on a broad brush with community hospitals and the like and is an improvement over where we have been so those were good results. We will go over the financial viability with Mr. Larmore in a few minutes, but there is good news there as well both in terms of operations as well as the balance sheet. Similarly, on the revenue enhancement and scale, I will jump to development dollars and the number there is $65.9 million. Patti do you have any update on that?

Ms. Hill-Callahan:

I do. We are currently year to date at $75.8 million and we are on track to hit the $137 million providing two of our $5 million plus gifts in the pipeline close.

Dr. Retchin:

Yes, and kudos to Patti and her leadership and her team working really hard in conjunction with my office and the leaders at the medical center to make this happen. Particularly, I applaud Mike Caliguiri and his efforts. Lastly, in terms of cost management you see the cost for adjusted admission, again Mr. Larmore will touch on this but I call your attention to the spending per Medicare beneficiary which continues to be a target for us. An area where we need to be focused, not only for being able to participate and attract patients in the marketplace but also because it is part of the value based purchasing program from Medicare. It is real dollars as well as potential dollars and we continue to focus on that across the continuum. That is my report, Mr. Chair.

Mr. Wexner:

Thank you.

Dr. Reid:

Sheldon, if you don't mind, I wanted to go back to the readmissions part and I know readmissions is a sticky thing to really gauge. What part is due to us and what part is due to what happens to the patient after they leave us? Have you seen any trends or are there any specialties where the readmissions rates are higher or are there any ideas that might be on our side of the fence that we can address?

Dr. Retchin:

We do divide it really among five areas including congestive heart failure and I believe total joint. That is actually total joint surgery, so we are focusing on areas because we believe that the trend there is to bundle price so we are responsible for continuing care as well as overall readmissions. There are different performance areas and one of them, along the same note, is in cardiac where we are already participating and demonstrating for our bundled price. Focusing on that, I don't know if we have any early results. Susan or Andy?

Dr. Moffatt-Bruce:

We do know that where there is focus, we are improving our readmissions. In particular, putting the resources in around the cardiac surgery bundles has been incredibly helpful. Now, we are focusing on joints and because, obviously, it is an area that has a high readmission rate, even if they go to a nursing home. It doesn't matter if they go home or to a nursing home, they still come back again. That is starting to trend our downward readmissions. Lastly, looking at our patients with chronic disease, COPD (Chronic Obstructive Pulmonary Disease), pneumonia, patients that have multiple medical problems, we are finding, and Andy is leading this with one of our team members, that when they come into hospital, they need a place to be seen post-care, post-acute. Does that look like a transition clinic? Is it a home visit? Is it Carepoint East? Directing our attention to the medical hospitalist service that need our support is really where we are going to get the biggest improvements going forward. A lot of that is around refining the socioeconomic status of the patients and what they have at their disposal in the community and partnering with the community workers. For example, the PACT (Partners Achieving Community Transformation) on the east side is an initiative that Elizabeth and team have been working on, bringing it all together and shining a light on it.

Mrs. Wexner:

Are we able to look at our peer information? Do they divide that out so we understand where we are versus best in class? Do we have areas where we know how to improve?

Dr. Moffatt-Bruce:

We can look relative to our academic peers and relative to our Medicare peers. We can break all of that out and that is what Andy and the team members are doing.

Dr. Thomas:

For the past four years, we have data going back to national comparative data and we have beat the national average on heart failure, but, we have not beat the national average on the other ones. This year, for our first six months of data, it is not perfect because we will not have all the Medicare data until the summer, we are beating the national average through the first half of the year on everything except a few myocardial

infarctions. With the focused efforts we have seen some movement. The issue with this particular metric is this is all patients and all payers, so when we look at CMS (Centers for Medicare and Medicaid Services) and focused areas where the penalty programs have been before and where our energy has been put, we have seen some progress over time, both compared to local competitors as well as regional and national competitors. This metric looking at all patients and all payers has lead us to now say we need a new business plan around how we manage these people and whether we scale that up payer by payer or diagnosis by diagnosis. You can imagine a couple of more on the forefront, as our strategy would dictate.

Dr. Moffatt-Bruce:

Do note as well that the readmission rates in our academic peers, the UHC cohort, is around 10.5-11%. Even for all cause, 30-day readmission we know best in class, we are not there yet. It is a small number of readmissions that we have to impact but I think, to Andy's point, really looking at all payers, all patients, all challenges will impact that number ultimately.

Dr. Thomas:

The other thing we find, that Sheldon mentioned at the bottom, on a cost per Medicare beneficiary, if you look at where we are compared to the bottom end of the spectrum to get any points in the value based purchasing system, Susan correct me, about $600 per patient is that cost differential. If you think about reducing readmissions, that cost gets spread across all of your patients. Reducing readmissions helps on that metric. It also helps on length of stay that Mark will talk about in a second in terms of bed capacity, it is a win all around.

Dr. Reid:

We have a team of people who look at this, unbundle it, and focus in on it?

Dr. Moffatt-Bruce:

Absolutely.

Dr. Retchin:

It is a major focus and I do think that, you do not have to own the post-acute care sector that you are discharging patients to, whether it is an independent rehabilitation facility, a skilled nursing facility, or even home care. You do not have to own that. Basically, you are renting it, if you will, through your patients' expenditures, but you do have to have a collaborative, coordinated effort and you have to hold them accountable for the business, and that is what we are trying to do.

(See Attachment XIX for background information, page 225)

Mr. Wexner:

Any other questions? Mark.

Mr. Larmore:

Good morning, everyone. To present numbers for the month of February and for the eight months ending, February 16, 2016. On page two and three of the presentation are a couple quick snapshots of where we stand and this is on a year-to-date basis. You can see high admissions, slightly behind our budget 1.5% but we have seen a 3% growth year over year.

Surgeries are to the right of that, and we are slightly ahead of budget 1% and if you split that we are about half a percent behind on inpatient surgeries and 1.9% ahead of budget on ambulatory surgery compared to prior year we have actually seen 3% growth there and that is about 1% on the inpatient side and 4.5% on the outpatient side. It gives you an idea of where is the book of business. On outpatient visits, a large number, 1.1 million visits, slightly behind budget and actually we added a page we will get to on page 7 and it breaks that out because it is such a big number. What makes up those categories and we are, again, seeing growth of year-over-year of 3.5%.

The worked hours per adjusted, and I know Jerry asked last meeting to adjust the last page on this. We actually put the calculation in there so you can see how we do it. You can see we are over budget and above prior year on this and certainly a big driver of this has been our length of stay. You will see when I get to the detail that we have seen an increase of about a quarter a day in the length of stay. If you look at capacity, it's probably 40 or 45 beds with capacity and the opportunity for about 2,500 discharges. We are filling the beds and of course the worked hours reflect that we're taking care of the patients in the bed, but we are using up that capacity that we budgeted for.

On page 3, you can see the operating revenue to date is .4% off budget and about 11% ahead of prior year. The controllable costs, so that would be all of our costs with the exception of capital costs and overhead allocations from the university, were positive to budget and given the opening of the new James Hospital and the growth of the entire enterprise we did expect to see our expenses grow year-over-year about 9.5%. The bottom line is about 5%, almost 6% ahead of budget and 13% ahead of prior year, which is good news and our days' cash on hand has grown considerably so we are at 14%, 15% ahead of our budget, about 27% ahead of last year. When I get to the balance sheet I'll talk about the cash growth there.

If you flip to page 4, this is the month of February and the first time that we had volume activity. You can see, most volume activity is fairly close to budget, again, the admissions trail. I would say, there is demand out there but the challenge is getting everyone in with the house being so full especially Monday through Friday. That is a constant work in progress and I would say we are no different than any other health system, especially the academics. They are full and length of stay is always an ongoing challenge. A little better performance on length of stay, you know, the number I quoted was a quarter day, so the month had better length of stay and actually a very good month on case mix. You will see that in our numbers on the next page, 0.12 doesn't look like a big number but has a pretty big financial impact and then our adjusted admissions are 119 ahead of target, so 1.3% and our revenue is 1.1% ahead of our budget and expenses were a little heavy in the month of February.

Slide 5 is the detail to the financial close, you can see that on the bottom, we had an $18 million month. The budget was $19 million, so about $1 million off budget. If you stay on that variance column, you can see, I said the case mix had a good impact on the month so even though we were slightly behind on discharge volume, the case mix picked that up. We also had, when we look at the volume mix between hospitals, Ross had a good month on volume as did the James which are higher revenue facilities, so about $5.1 million positive on revenue and the not so good news is $5.9 million, almost $6 million over on expenses.

When I look at the expense categories, the supplies, drugs, and pharmaceuticals, we can tie back to the volume that came through the house. We can tie the cost of those cases, which are higher cost cases back to the overspend on expenses on drugs and pharmaceuticals. I said the James volume was positive so it would be infusion drugs, which are costly but we get paid for them so that's good news. We have both the expense variance and the positive revenue variance and then, this year, we have had a number of hemophiliacs in the house which require a lot of clotting factor which is outrageously expensive. That is a big driver in the month and on the year to date basis how much of that is the factor costs. The good news is that the majority of payers do

pay us for that factor. On the services we are $1.8 million over budget and when I look at this I would say about half of that is attributable to spending in the month and about half of that is still some of the noise and process that we are trying to put in place throughout the system where invoices come in and they do not necessarily make it through to finance on a timely basis. We need a little improvement on that process to make sure expenses are hitting the month. I estimate about half of that $1.8 million should have actually come through.

Dr. Drake:

Mark, just a quick question, I think, just for the board, you mentioned the cost of factor for a hemophiliac. I think those numbers always surprise people the first time they hear them.

Mr. Larmore:

We actually had one, not in this month, and we had one factored patient earlier in the year that actually, on a cost of drug basis, to us was almost $2 million just for that clotting factor.

Dr. Drake:

That is extraordinarily expensive.

Mr. Steinour:

Is that recoverable, Mark?

Mr. Larmore:

Depending on the payer but the majority of the payers, we do get paid on it.

Dr. Wadsworth:

So this delta down, this 14% on drugs and pharmaceuticals, I do not fully understand the recovery part. Is that the piece you cannot recover?

Mr. Larmore:

It is not, no. The 14% is the overspend compared to our budget so that $2.4 million is part of the $5 million positive variance on the revenue side, so we can bill and collect for it.

Mr. Steinour:

Is any of that related to stock, if you will, stocking up now that you have brought the James or other changes in the way drug and pharmacy is managed?

Mr. Larmore:

No, all that inventory was done prior. We would actually, as we stocked up, put it into a balance sheet inventory account so it is not filling the James with inventory.

Dr. Drake:

Steve, the concept of a specialty pharmacy and when we first were expanding and moving to that, was the one-time expense to get your basic provision, but then it should be a steady flow through.

Mr. Larmore:

Just one other comment on the drug costs, we are going back on the 340b program. It is a program the government has to allow us to buy drugs at manufacturer costs. There is an amazing amount of regulation that is on that program and the health system had come off that program a few years ago because they felt they were not compliant with it, which was the right move. We have made the adjustments and are building the staff to make sure that we have compliance and will come back on to that program July 1, and that will produce quite a bit of savings for us. The James is actually not eligible for it because of its PPS exempt status but the rest of that opportunity will start again in July so that will be good news for us.

Mr. Wexner:

One of the things that, I do not know whether it can be estimated, but I am curious because we are thinking about the future. When you look at occupancy, is there some judgement that perhaps all of you could make on what capacity you wish you would have because we are limited by the number of beds we have and we are at a very high occupancy rate? The question that I am asking myself is, are we short 20 beds or are we short 120 beds? I cannot calculate it but I think when we are thinking about new facilities, we will look at our actual occupancy, not against the number that might have been the potential in estimating the futures.

Mr. Larmore:

A couple of pieces to that. If you look, most of the literature says the hospital runs most efficiently around an 80-85% occupancy. It does not usually happen at academic centers but I think as we look to the next plan, we look at how many beds we should build or replace. Part of that is what occupancy do we want to run at and then what is the cost to build those beds as we go through the program.

Mr. Wexner:

So if you look back at February, can you make a guess, or is that an unfair question?

Dr. Caliguri:

If you look over the months, our slope is very clear thus far that when we have beds, we fill them. There is a slope, a rate, at which we are filling them so we could look out five years and predict, to your point, of what we would have liked to have had.

Mr. Wexner:

The question I'm asking, Mike, is a different question. When you look at February, because it happened, and you know who is calling up, maybe you wish it was 10 beds we wish we had more in February, maybe we wish we had 25. I could look at a slope that would show the trend but I am trying to get a sense of real time demand.

Ms. Marsh:

If we look at what has been boarding in our emergency room overnight and our transfers that we have been holding out there, this is an estimate of course, I would say 30 more beds over the last couple of months.

Dr. Retchin:

With one caveat, how you solve the need for more capacity is a different answer and there are two ways. One is to increase the number of beds that you actually build out which brings with it the fixed costs that you have to allocate. The other way is to be more

efficient. Either way, even if we are planning on new beds, there is a runway on that which has a pretty significant lead time. We need to gear up for that by being optimally efficient.

Dr. Drake:

Let me add another complicating factor. As we build beds and as we use beds in a more efficient fashion, generally, our performance will improve and we will become more attractive. There is a cycle that goes in a virtuous way, so in fact, where you would like to be is a sweet spot where that you are always pushing your capacity because you have shown a better option as you have more capacity.

Mr. Wexner:

If I am understanding, you do not want to have excess capacity, you have to be efficient with the capacity you use.

Dr. Drake:

Efficiency drives demand.

Mr. Wexner:

Yes, I am trying to get a gauge.

Mr. Larmore:

Ideally, you have that 15%, you know the 85% to 100% capacity as a way to flex up on that. I talked about the length of stay so that is 40 beds every day that if we think like to stay down, that is invaluable. If you look back at the last plan, when we agreed to build the James, the idea was that there were going to be units shut down in the University Hospital and those units are back open, so right now we have both the brain and spine hospital with all four floors open with 118 beds of capacity on and then at the last meeting we agreed to move forward with building out the 72 beds in the James tower. We have more capacity coming on, so I think this will be a big test to see if that demand is there to fill that and we think it is.

Ms. Krueger:

The interesting question is like a missed opportunity cost, not only of current but three to five years out. I remember when we were looking at the James five or six years ago and we were trying to figure out what the budget was going to be and what the number of rooms should be and we thought we would have more than enough. As you invest in reputation, as you invest in, especially, the Wexner Medical Center, you are going to continue to attract more and more and so what is the projection five years from now for the medical center and how do you think about it? What are the factors that we can garner that we could make smart guesses, or smart forecasts based on a certain set of criteria? I'm not sure we are there yet.

Mr. Larmore:

That all leads into the next long term strategic plan that looks at where we stand today. We are recruiting a couple of new chairs and each one of those come in with an idea, a big recruitment need of new physicians. Certainly we have to have the capacity both in the surgical case, the ORs (operating rooms), and the bays to bring patients on board. That will definitely be a key piece of the long term plan that will be coming forward later this year.

Mr. Jurgensen:

Mark, if we are down, if we are below budget in all the volume metrics but we are above budget in operating revenue, is that all explained by the delta in case mix?

Mr. Larmore:

Part of it is case mix and part of it is items such as the mix of the cases. I said that the Ross volume was good in the month so our average payment per case was…

Mr. Jurgensen:

It makes me wonder whether or not we are tracking all the right things. In other words, volume metrics, surgeries, and out-patient visits are not the sole explainer of revenue. What else better explains deltas in revenue other than volume?

Mr. Larmore:

It is types of cases and the case mix. It is a little bit more complicated because of the James; case mix does not impact the James reimbursement.

Mr. Jurgensen:

I am wondering if beyond case mix index, if there is another set of performance criteria that really end up mattering and how do those things find their way?

Mr. McQuaid:

That is a good point. The types of cases are very important. We had more transplant cases, for example, significant revenue margin on those cases.

Mr. Larmore:

It is amazing that a small number of cases can drive that revenue considerably in one month.

Dr. Drake:

There is a bit of a fluctuation on it. We mentioned hemophilia so we could have a couple of hemophiliac patients which would change a month dramatically and then maybe we would have 10 in a year and two of them in a month and that would cause that bit of a bump. The long term trends are important to look at as well.

Mr. Jurgensen:

We had the flip of this in a way in our company and paying attention to our medical claims costs. We were tracking a lot of volume related things. If we wanted to know what was going to get us premature deliveries, every premature delivery we had was a $1 million in our workforce. That then cost us to spend a lot more time on that issue and if we had followed the frequency of volume of claims we did not get at what was the real underlying driver. This is the reverse or the flip of that.

Mr. McQuaid:

It is the quality of earnings within each payer. It is really drilling down, particularly as we look at Medicare, managed care, and understanding how we manage those as we move to value based purchasing, bundled payment, and we own the continuum of care 90 days out. All of those costs of drilling down into the quality within each payer would be important.

Mrs. Wexner:

For long term strategic plan, you need to understand this because you want to know where you wisely make your investments. In some cases, that is in order to permit our mission in others. That is the balance we really need to drill down into.

Mr. Larmore:

Let us move to the year to date, which is page six in your book. Most of these statistics are fairly close to budget. There is a .22 variance on length of stay and then overall you can see our case mix is up about 4% year to date. On the bottom, the good news is, our operating revenue per adjusted admission is up ahead of budget and the expenses are actually just slightly over. A positive impact on the bottom line.

Ms. Vilagi:

Do you know if there is a correlation between the length of stay and readmissions, that if we were improving the length of stay, maybe we might have higher readmissions into the hospital?

Dr. Thomas:

Halie, in the end, if you push that too far on the margin, you can certainly get that as an issue and it is a concern that we have. When you look at it globally, that is one way to analyze it, but with any individual patient, it is a little bit easier to see that relationship. It is a concern that we push length of stay drastically too long but we are not at that point yet. As Mark said, we are about .2 days over what we think would be optimal for an academic medical center. We were under the national average numbers but we have a long way to go.

Mr. Larmore:

Page seven in your book, is a new page where we broke out the ambulatory volume. You can see most items are fairly close to budget on a year to date basis. I would say one question that people usually ask is on the bottom. You have physician visits, so remember that the departments that are deemed in the specialty care network, which is anesthesia, ortho, neurosurgery, maternal fetal medicine, plus the primary care network are included in the hospital numbers. That is why you have physician visits here. All other departments are within the physician LLCs.

Across the bottom, you can see we are at $123 million bottom line. We are budgeted to be at $116 million, so we are $7 million better than budget. Last year at this point we were at $109 million. If you convert that to a margin, last year we were about 7.2% and we are at 7.32% this year. Just on the variance column, on $1.7 billion in revenue, we are within $6 million of it, so fairly close. On expense controls, with the exception of the drugs and pharmaceuticals, just the factor patients alone were $5.3 million of that $10 million variance. It gives you an idea of the cost of the factor. Any questions on the year-to-date bottom line?

Page nine is the balance sheet. This is comparing June to June close last year through February. You can see that on the change column, growth and cash, $124 million which I discussed in our increase in days' cash. Out of the $449 million in current assets, $365 million of that is accounts receivable and out of the $80 million increase, $66 million of that is accounts receivable increase. I am not thrilled with this, but this is the end of the ICD10 conversion, so not only did we have to be ready to bill that way, but every payer, including the government, had to be ready to pay us through that system. When I look at that $66 million, about $24 - $25 million of that is revenue growth that you would expect keeping the days consistent through the time period. The Medicare growth is about $15 million and then United Healthcare, which we have struggled with a little bit is

about $10 million of that. The good news is we set out cash targets each month based on 90 days prior and in the month of March, we actually exceeded our cash goal by $44 million. We are starting to see the money come in from the payers and my expectation is it will drop considerably in March. The current liability is up $71 million.

Mr. Steinour:

Are we far enough into the revenue cycle then to know that we had a good conversion? That we are not stacking up some disputes on the receivable side?

Mr. Larmore:

I think we have finally come through that. We have unusual contracts here. We have a prison unit and to try to get the prison system to pass and it is almost a monthly meeting with them.

Mr. Steinour:

That is great.

Mr. Larmore:

The bad news is that they are actually going to expand the number of coding opportunities in the ICD10, so they continue to make it more and more complicated to bill and collect.

Mr. Jurgensen:

This is the first time in quite a while that all the places that I frequent where I see somebody ahead of plan on investments. Nobody is ahead of plan on investments this year, unless it is all volume. Unless it is the amount of money invested. But rates of return?

Mr. Larmore:

Where are you looking, Jerry?

Mr. Jurgensen:

I'm on page eight.

Dr. Retchin:

He is looking at the balance sheet, income from investments, is that right?

Mr. Larmore:

The way investments are, the cash that is on the health system is invested with the university. The university pays the health system a fixed rate on the cash that is there and the cash balances have grown in the last couple of years. That is the only reason why this has not fluctuated.

Mr. Jurgensen:

Is it all in volume?

Dr. Retchin:

They are not invested in variable instruments/equities. It is all paper, right?

Mr. Larmore:

It is a fixed rate.

Mr. Jurgensen:

If it is between the investments and you that is the case. The money actually is invested in things that are not going up.

Mr. Larmore:

The fixed rate is .4%.

Mr. Chatas:

This is cash in short term investments, so it is all volume.

Mr. Jurgensen:

Thank you. I wish I had the secret formula.

Mr. Larmore:

If there are no other questions on the balance sheet, page ten is the medical center. We have now rolled in the College of Medicine and the practice plan, from a bottom line standpoint, not a dramatic difference. There is a $119 million bottom line and the budget was $123 million. The health system, you will see on the next page was ahead of budget. The health system was struggling a little to budget on both the College of Medicine and the health plan but both are improving year over year. You can see the statistics on the bottom; the OSUP (Ohio State University Physicians, Inc.) encounters and we are actually pretty close to budget, about 7% growth, year-over-year. We are seeing volume growth and I think most of the challenge on the physician group has been on the expense side and Chris and I have been dealing with that.

Page eleven; the top third is what I reported on through the health system, about $7 million positive variance and the physician group is about $7 million behind its budget, but it is an improvement year-over-year. The College of Medicine is about $5 million behind. Remember, the College of Medicine operates on a cash basis. If they budgeted a gift towards a project and the gift comes in a little later than expected, it will show variances where both the top two, the health system and the practice plan are on an accrual basis. As long as we know in that example that we are going to receive it, we would accrue that so it is a little mixed bag as we put these together.

On page twelve is the balance sheet. The dramatic change here would be bringing all the restricted assets within the College of Medicine, predominantly, endowment funds and specific purpose funds onto the books. That is $500 million, so it increases as a combined medical center, whose total net assets is about $2 billion if you add them together. This month, I actually put in the slide that shows you how the balance sheets break out on page 13 and we had not shown that prior.

The last slide in the packet, slide 14, is the calculation that we go through for the adjusted admission. We do it at charges, so the assumption is that your charges are based on the difficulty of the case, or the outpatient procedure. Then we divide that by inpatient admissions to give a normalized number. It is a good measure that many health systems use, so that is good information. That is the highlight as of February. Any questions?

Mr. Wexner:

I was thinking, in our business we have financial periods, so we have the close. I have a point of view that you never want to run out of cash. We build an annual cash projection and then it is updated to me every week. Depending on what we are actually doing, it gets reprojected every week so it is a constant cycle of are we on the cash budget and how does it project. I do not know whether that would be useful but, to me, it would be useful in the health system. I do not know whether you do that internally because if we are only looking at cash, now we are looking with February closes, but presumably, you know how much cash you have today.

Mr. Larmore:

We target our cash. We have a cash target every month and that looks at what the revenue was 60 to 90 days prior and then every week I get a flash report that says what percentage of that target in cash we have collected. That is how I monitor it. Monthly, I look at our capital spend compared to what we expected and I know that this year the capital budget came out late so we were actually spending slower than normal. We are building some cash because capital spend is behind, but that will catch up at some point.

Mr. Wexner:

Right now, we are ahead of our cash projection today.

Mr. Larmore:

We are.

Mr. Wexner:

And then if you looked out a month, or two, or three, we are on it, or probably we will be ahead of it.

Mr. Larmore:

If my assumption is that we catch up on capital and our bottom line is pretty close to where our budget is, we should come back in line with that. There was a lot of focus on that in the past, on growing cash by five days, six days a year and Geoff and I have talked about how that impacts the credit rating on the university when he talked to the rating agencies. From my standpoint, a little less focus on that and more on the bottom line on the health system, but certainly we monitor it. We have grown much more than that targeted five, six, seven days that was the benchmark in the past few years.

Mr. Wexner:

The board might think about whether on a regular basis we see the cash projections because they would be more current than the financial closings.

Mr. Steinour:

Les, we have asked for an expanded package from Mark, going forward. That would certainly be an area for Mark to do. Could you comment further, back on page 11, the growth year over year on expenses for physician practice, please.

Mr. Larmore:

We are $7.5 million over our target and about 7% above prior year. When I look at the provider piece of that, it is $4 million out of that $7 million variance. One of the things in OSUP in prior years, incentive payments got paid out in the next year and there was a

mixed practice as to whether they knew what they were and whether they were accrued or not. We have moved to a quarterly estimation as to how the performance of each department is going and whether there will be a performance bonus paid. There is a couple million dollars that, just by that practice change, is part of that variance that is in there. Now it is consistent through all the departments, so when you look at this year I had the tail of some of the departments for fiscal year 2015 hitting here and then I have the accruals for this year. My guess would be half of that variance is that change but it is just not physician's salaries. They have the same issues with drug purchases and med supplies, if their volume is up, we would see more cost on that. $4 million out of the $7.5 million is salary.

Mr. Steinour:

For the year, where you have a catch up of accrual plus the carryover, the carryover would be variance but for the year, will this be back in line?

Mr. Larmore:

The expenses will not come back to the budget. I do not expect further negative variance based on changing the practice on accruing the incentives. When we looked at, Chris and I have cohorts that are the leads that are involved in departments. The challenge is that when we took the snapshot as of the end of December, halfway through the year, the practices were doing really well and we saw some great performance on that. We have seen January and February expenses creep up so we have already met with them and tried to cap some of that growth that is there.

Dr. Ellison:

The other thing is that we are ahead on physician hiring to meet the needs of the medical center, particularly hospitalists, where we have the hospital based services in the institution that are staffed by in-house physicians 24 hours a day, not with residents. We have had to increase the number of physicians in order to provide coverage for those services and we are up currently close to 80 hospitalists to provide coverage for these beds both in University Hospitals as well as the James. That is also a driver of some of the expenses that are higher than what we had projected.

(See Attachment XX for background information, page 226)

Mr. Larmore:

Any other questions? Okay, thanks.

Mr. Wexner:

Sheldon, back to you.

Mrs. Wexner:

I think you have one more question.

Dr. Reid:

This may be on what you are about to talk about. Les was asking about how many more beds were we to waive our wand, and you had mentioned that it's beds but it's also efficiency, you know, getting beds turned over and so forth. I recalled some years back seeing some very sophisticated software that could track when a bed was empty but not cleaned yet and how to place people. Do we utilize something like that or how do we maximize our efficiencies?

Dr. Retchin:

That is a great question and there is a long answer and a short answer. The short answer is we have recently installed a software to which you are referring. It is a teletracking system that provides real time as well as aggregate data on utilization. That information, Janet, fed back to the point of service, is extraordinarily useful. Imagine flying blind in the night and you are only on instruments. Now we are flying blind without instruments, we are flying with instruments. Andy, do you want to make a quick comment?

Dr. Thomas:

We are actually, to Sheldon's point, still learning how to use the system effectively as a day to day management tool. We had the vendor that we bought the system from came back 60 days out from the implementation and look at our pros, cons, benefits, practices, and various areas we need to improve. We got that back at the end of February. We are now going back to fine tune a lot of those practices. For example, we used to have nurses or nurses aid on the floor to take patients down to the car. We have now hired up our transporters and we now have a better way with this software to manage them. It is a much less destructive thing to have a transporter come get the patient and take them down so that staff member does not need to. Little tweaks like that but also larger tweaks about that turnaround time for housekeeping and supervisors to make sure that people are doing it in 40 minutes instead of 48 minutes. It is huge at the margin change to get beds available earlier in the day.

Dr. Reid:

I am glad we have it because there are huge economic pluses for us as well as patient pluses so I'm glad we have invested in it.

Dr. Thomas:

The end of the beginning of the implementation, now that we have the tool, it is a matter of the day-to-day blocking.

Dr. Retchin:

It would be interesting to know if we have sort of a critical last mile issue where measuring the time gap between when the patient is ready to go to when the attending, or whoever's case it is. My hunch is that is part of the culprit.

Dr. Thomas:

That is exactly what we are experiencing with the system.

Dr. Retchin:

Institutions are facing this across the country, but without the software. Taking the data and acting on it is really important with the discipline. Any other questions?

Dr. Reid:

No, that is it. Thank you.

Mr. Jurgensen:

It would be interesting to see how many times, requiring whoever's case it is, to say, "okay, you can go home." It would be interesting to see how many times they ever say no. If the answer is never, then we need to ask ourselves, what value is being added by

putting that step in the process? Back to the satisfaction, sitting there and waiting three or four hours when you are ready to go and you have been in, is a killer.

Dr. Thomas:

Those are exactly the processes that now we can better manage in a real time fashion.

Dr. Reid:

Because you can see who has gotten the discharge order.

Dr. Retchin:

The real science in this is anticipating the discharge. That is where you really gain it. The earlier the better in the cycle and I think that is where we really need to get some traction. Great questions, great comments. In the interest of time, I am going to move to a couple of votes. If you go behind the rules and regulations tab, you will find resolutions and full sets of medical staff rules and regulations for both the University Hospitals and The James. This requires a roll call vote and because this is delegated authority to the Medical Center Board, I will ask the secretary to call the roll.

RULES AND REGULATIONS
***OF THE MEDICAL STAFF* OF UNIVERSITY HOSPITALS**
Resolution No. 2016-80

Synopsis: Approval of the *Rules and Regulations of the Medical Staff* of the Ohio State University Hospitals, is proposed.

WHEREAS the *Rules and Regulations of the Medical Staff* of the Ohio State University Hospitals were approved by the University Hospitals Bylaws Committee; and

WHEREAS the *Rules and Regulations of the Medical Staff* of the Ohio State University Hospitals were approved by the University Hospitals Medical Staff Administrative Committee; and

WHEREAS the *Rules and Regulations of the Medical Staff* of the Ohio State University Hospitals were approved by the Quality and Professional Affairs Committee on February 18, 2016:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the *Rules and Regulations of the Medical Staff* of the Ohio State University Hospitals.

(See Attachment XXI for background information, page 233)

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***RULES AND REGULATIONS OF THE MEDICAL STAFF* OF THE ARTHUR G. JAMES CANCER HOSPITAL AND RICHARD J. SOLOVE RESEARCH INSTITUTE**
Resolution No. 2016-81

Synopsis: Approval of the *Rules and Regulations of the Medical Staff* of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, is proposed.

WHEREAS the *Rules and Regulations of the Medical Staff* of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute were approved by the James Bylaws Committee; and

WHEREAS the *Rules and Regulations of the Medical Staff* of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute were approved by the James Medical Staff Administrative Committee; and

WHEREAS the *Rules and Regulations of the Medical Staff* of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute were approved by the Quality and Professional Affairs Committee on February 18, 2016:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the *Rules and Regulations of the Medical Staff* of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute.

(See Attachment XXII for background information, page 251)

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

Dr. Retchin:

> Thank you and on the next tab are amendments to *the Bylaws for the Wexner Medical Center Board*. Just a notation on this, while it is just a very quick voice vote, it is very important. This allows the CEO of the Health System, in this case, David McQuaid, to be appointed to the Quality and Professional Affairs Committee and it is in our interests to have Mr. McQuaid, not only at the table, but also deeply engaged. Having new board members, which I am pleased we are going to be adding, our focus has to be straight up into quality and getting board engagement and leadership involved. It is important, so this is a voice vote. Heather?

AMENDMENTS TO THE *BYLAWS OF*
THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER BOARD
Resolution No. 2016-82

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

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

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

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves and recommends the attached Amendments to the *Bylaws of the Ohio State University Wexner Medical Center Board* to the Board of Trustees for approval.

(See Attachment XXIII for background information, page 271)

The Wexner Medical Center Board members adopted the foregoing motion by unanimous voice vote.

Dr. Retchin:

Those are the two issues. I will skip ahead to the next one but, if you will turn behind the approval for professional services and construction contracts. I turn to Jay on this.

Mr. Kasey:

We are bringing to you today two projects that we would like your approval to move forward with some level of funding. The first one is in regards to trying to anticipate the needs of parking as the phase one Cannon Drive relocation moves forward. We have 1,900 spots as you know in the polo lots down by the river. There are medical center leadership and some campus leadership that have been wrestling with the citing of garage or surface lots to replace those sites. We would like to request a $600,000 planning funding to bring in a criteria parking architect to work with the internal team to help set the stage for how those sites will be replaced, working with the medical center's need for how its employees are going to be managed. That is a request for planning. You will see a very significant figure for the potential construction costs, which would be in anticipation of two garages. Two garages of about 1,000 cars each is a placeholder for what might come as we try to anticipate over the next year or two the replacement activity for those 1,900 car spots. That is the first one and I can go to the second. The second is the construction of two hybrid ORs (operating room). Marti is going to describe them clinically and then I can take the construction questions.

Ms. Taylor:

Two hybrid operating rooms. One is an existing EP (electrophysiology) lab that is on the second floor here in the Ross. That will be converted to be a hybrid room. As they are doing procedures and there is something needed for the patients, the patient would not have to move to the operating room. This specifically relates to our lead extractions and the volumes of lead extractions that we do in the electrophysiology labs. This is a conversion of that lab and then the other is a seventh operating room. We have six ORs right now in the Ross. This is a seventh operating room in the Ross that also would be a hybrid room, so as technology changes or surgeons are doing more and more minimally invasive work and structural heart work, specifically valvular work, this is the type of technology needed for that. It is a traditional operating room with advanced imaging equipment in the room.

Mr. Kasey:

The request is for funding of both the planning and construction of those rooms. I will give you a brief background to let you know that this project started and was designed in July 2014. At that time, it was anticipated to be a $2.6 million single room OR renovation with the availability of a $2 million gift. The leadership expanded this to a two room hybrid OR option and that gift came in September 2014. Then there was a period of quiet redesign equipment selection. The contractor was brought on to work around a very difficult construction site, both in the Ross active OR site and on the roof of the Ross OR and the estimate then grew to $3.9 million in November 2014. Since that time, 18 months later, there was a new bid done which anticipated both the design and site access issues and staging issues. With time and escalation and the difficulty of the project, the new estimate now is $6 million. This was a concern of ours. We rebid it and got that $6 million bid in December. We rebid and at the middle of February came back with essentially the same bid from other subcontractors. Our request now is a solid bid at $6 million to fund these two ORs. Marti and I can have questions on this.

Mr. Wexner:

I got lost in the numbers. The original estimate and approval was for $2.6 million for one. Now we have two and we have a $2 million gift.

Mr. Kasey:

We had a $2 million gift to add to that.

Mr. Wexner:

So the $6 million nets to $4 million?

Mr. Kasey:

There was an initial internal estimate of $3.9 million which the contractor, the construction management contractor accepted and went into design. When it came out of design for the build out of this room, it was a $6 million design development bid estimate. We have a hard estimate now from the subcontractor at $6 million.

Mrs. Wexner:

You have a gift against it, the $2 million. On this type of investment, do we look at rates of return or time to capture?

Mr. Larmore:

The construction costs on the two rooms is the $6 million number. Then the gift is being used for the equipment piece of it which is expensive. When I look at it, I look at an $8 million total project on a fully loaded basis. We have a four year return and if I look out on a marginal basis we have about a year and a half return so it is a good return on the overall investment.

Mr. Kasey:

Those are our two projects today.

Mr. Jurgensen:

One question back on the parking for a second. How did the outsourcing process work with the parking arrangement?

Mr. Kasey:

We anticipated three years ago that the polo lot would be lost, so we put in a bank, 2,000 spots, actually 2,200 spots that we would not be charged against if we eliminated or chanced. We are now ready to pull the trigger on that and CampusParc is working with us to site and size these garages, but it will probably not be the case that CampusParc would be responsible for building these garages because these are already in their revenue stream and expectations.

Dr. Retchin:

This requires a vote for approval.

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

Resolution No.2016-83

Approval to Enter Into/Increase Professional Services Contracts
Medical Center Parking Garage(s)
Ross - 4th Floor Hybrid OR

Approval to Enter Into Construction Contracts
Ross - 4th Floor Hybrid OR

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

WHEREAS in accordance with the attached materials, the university desires to enter into/increase professional services contracts for the following projects:

	Prof. Serv. Approval Requested	Total Project Cost	
Medical Center Parking Garage(s)	$0.6M	$50.6M	auxiliary funds
Ross - 4th Floor Hybrid OR	$0.7M	$6.0M	auxiliary funds

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

	Construction Approval Requested	Total Project Cost	
Ross - 4th Floor Hybrid OR	$5.3M	$6.0M	auxiliary funds

NOW THEREFORE

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

(See Attachment XXIV for background information, page 272)

The Wexner Medical Center Board members approved the foregoing motion by unanimous voice vote.

Dr. Retchin:

> Those are approved. We have one more item. In each of the board meetings I try to bring an aspect of the medical center to the board in the interest of more insight in our direction. This time, I wanted to call attention and describe, in modest detail, our graduate medical education program, both in size and scope. I do not know if there are many industries in the country where one competitor trains the workforce for another and that is true for us. We not only train for the workforce for central Ohio and greater Ohio. Being the largest public training program for post graduate, we invest in that. While there are some federal and state dollars that help with this, I have to tell you, the gap is large and getting larger. Parenthetically, in the balanced budget amendment of 1997, 19 years ago, the federal government capped expenditures, declared a moratorium on the growth of residency programs through Medicare, and it has expanded since that time.

You will see some information on that dramatically nationally as well as at Ohio State. I am going to introduce Scott Holliday. I believe he is going to carry this. Scott is newly appointed. Scott, how long have you been in the role as Director of Graduate Medical Education?

Dr. Holliday:

About six months.

Dr. Retchin:

Actually he is a veteran of Graduate Medical Education and he is going to give us a few facts and figures.

Dr. Drake:

Just to comment on the 1997 cap, that was based on the projection for a 2,000 physician glut in the country so it is a fascinating thing that the data have shown not to be accurate.

Dr. Holliday:

Thank you. I did bring some demonstrations with me today. Dr. Beal and Dr. Taylor are residents and fellows in our programs and they can talk a little bit about their experiences as well and I appreciate their time with us. Graduate Medical Education, GME, as we tend to call it, like we use a lot of acronyms around this place, is additional training after medical school. I use medical school as kind of the lump sum to gather everything but we do have people who went to other type of professional schools within our graduate medical education. We have dentists, podiatrists, and medical physicists. We have different people who have done different training programs and then come here for additional specialty training to differentiate into their final practice model. This includes interns, which is the first year of residency; residency, which is the main training; and then fellowship is additional training after residency to get a little bit more subspecialty guidance in what the career is. There is a lot of variability in that training time based on specialties and I added a few examples here on this slide. Someone going into family medicine, general and internal medicine, or general pediatrics would have a one-year internship, that first year of residency, and then two additional years of residency for their complete training to become a generalist in one of those areas. By contrast, general cardiologists would have that internship and then two years of residency, they would be associated with general internal medicine or general pediatrics. If they are a pediatric cardiologist they will need an additional fellowship time of three years to become that cardiologist. Radiologist is four years and neurosurgery is seven years, our longest individual training program that we have in graduate medical education.

Dr. Wadsworth:

Is this fairly standard internationally?

Dr. Holliday:

It is not standardized internationally. This is much more U.S. and Canada based. There are differences in those models across the world.

Dr. Wadsworth:

If someone comes to this country from somewhere else, how does that kind of background get evaluated?

Dr. Holliday:

That is based on what the standards are within the country where they come from and then agencies within the U.S. will then decide if that is comparable training. They may need additional training here in the U.S. based on what those skills are.

Dr. Wadsworth:

Thank you.

Dr. Holliday:

I have this slide here which is an overview of residencies and fellowships and how that process works. When I think of residencies, I think of those being the pipeline specialties that feed into the different types of practice.

We have our undergraduate medical education, those are our allopathic graduates of our medical schools such as here at Ohio State, our osteopathic graduates in the U.S., U.S. students who go to medical schools abroad, and international medical students who come here for additional training. They can enter into a pipeline type program or a program that gives initial accreditation, certification, or training. I have the bulk of those listed there on the slide everything from internal medicine, anesthesiology, pediatrics, et cetera. From those pipeline programs, once those are completed, people can go into practice as that specialist or can continue on in additional GME and fellowships and develop additional subspecialty in areas of practice.

There are several organizations that accredit residency training programs and fellowship training programs here in the U.S. The bulk of them that we deal with is the ACGME or the Accreditation Council for Graduate Medical Education based in Chicago that oversees U.S. residencies and fellowships. There are many other accrediting organizations though. Some of the individual boards will do the accreditation. The American Board of Obstetrics and Gynecology is one that still manages many of the accreditations of their specialties. There are others, as I mentioned, we have people who are not in medicine; dental accreditation, psychology accreditation, the United Council for neurologic subspecialties is one that accredits many of the programs after the initial training in neurology. These organizations set the requirements for graduate medical education so they will say for each individual program these are what the minimum expectations are and it is the responsibility of us in GME to follow those while still trying to be innovative and really train our residents and fellows to be outstanding physicians.

Then we have some fellowships that are unaccredited. You might ask why we have unaccredited fellowships and many times these are the cutting edge type training programs designed to give a very subspecialized practice plan. An example of that is our cardiothoracic surgery program here has a fellowship in mechanical circulation. That is not something that someone is going to practice a lot but that is going to have an extra added expertise related to the operative and perioperative care of patients that are on mechanical circulation to help them be better in their field.

This is a look at the numbers of our training programs at The Ohio State University Wexner Medical Center. We have 23 accredited residency programs for a total of 582 trainees. We have 41 fellowship programs for 147 fellows and those are the accredited. Other accredited boards and non-accredited for a total of about 805 trainees that we have here at Ohio State.

The training of residents and fellows involves direct patient care with supervision. We want to introduce these folks that have come from medical school to getting experience in taking care of patients while they are getting their education. They are coming here to work but they are also still students in some regard. They are working double duty and are working up to 60-80 hours a week in patient care with direct supervision from their

attending physicians while also studying to ensure they are meeting expectations for knowledge in their specific field. All of these programs have a program director who is a physician who oversees the training within the program.

This graph shows U.S. residency programs are growing and the graph goes to 2014. Roughly, there are about 120,000 residents and fellows per academic year. That number increased by about 535 for 2015, so not a big increase from 2014 to 2015, but you can see the number of residents has increased and the folks in the primary or pipeline specialties make up the bulk of those, almost 100,000 of those positions.

I would like to finish off talking about some of the innovations that we are doing here at Ohio State. This is the exciting part when it comes to graduate medical education and I can probably talk a long period of time about this but I will try to keep it succinct. We have great simulation facilities and when we bring residents and fellows in to train, we will spend a lot of time with them early on to talk about developing some of the skills that are necessary for their everyday career. You see in the photo; we have some pictures of Dr. Wyatt who is one of our otolaryngologists in pediatrics working with a simulation tool that allows him to simulate surgery on a temporal bone. Using this equipment, they can practice and show them the skills of the physician and how to do the procedures. They can walk them through the processes and give them real time guidance before they are operating on patients. They can help the fellows hone those skills when they see areas of concern or deficits.

We use our simulation center, not just for procedural skills, but we also use it to teach communication and how teams work in real life in the hospital. Bringing groups together that will be working together in units is important. We have a Master's in Medical Science program that many of our fellows participate in to develop those physician scientists who have interests in research careers as you mentioned earlier today. We want to build those careers and those folks within as well as outside. We have our Masters in Medical Science program to help provide some of those skills for some of our trainees.

(See Attachment XXV for background information, page 274)

Dr. Wadsworth:

Could I just ask a question about the philosophy of retaining people here?

Dr. Holliday:

It varies from year to year but 10% to 20% of our trainees and others go to other places. There have been many studies that show that a lot of folks end up at least a relative geographic area from where they trained so we are proudly feeding a lot into our community as well. The folks that we train are taking care of our patients in our community. We also send people throughout the country so it is variable based on what they want to do and what the demand is within the organization. As we start to look, not so much for primary residencies, but as we look into some of those very subspecialized fellowships, we very much pay attention to whether we have a need here at Ohio State for these folks and who would fit that need. We use that in recruiting.

Ms. Marsh:

Dr. Wadsworth, I will add to what Dr. Holliday said, that we also try to match our graduates with our affiliate hospital needs across the state of Ohio. Folks that are already affiliated with us somehow, we try to match their needs to who is graduating.

Dr. Wadsworth:

The objective is not to keep everybody that is trained here. It is a mix of training for the community and then retaining some people for areas we are particularly interested in and so on.

Dr. Drake:

Part of the philosophy Jeff is our primary mission. Our organic primary mission is to create people who have the talent to serve the community broadly so there would have to be an intertie there.

Mr. Jurgensen:

How do we think about the economics of all of this? I always heard that this is sort of a really big issue for academic medical centers because no payer wants to pay for this. What does the economics of all of this look like at the end of the day? What does it cost and where does the money come from? What is the future of all of this if nobody wants to pay? We cannot have a medical profession that is not trained.

Dr. Retchin:

That is a great question, Jerry. I would say that it would be a very interesting answer because it depends on how you count. The philosophy of the program itself has transformed over the last 15 years from a service to an educational program.

Dr. Drake:

That is a really important point; is it a service or an educational program primarily? I think it is an extraordinarily important philosophical point and it has to do with the utilization of these young trainees and who they are here for. I think great programs are focused on training the trainees to be the best person he or she can be when they go out to the world. There is a problem, which was the case 50 years ago, 100 years ago, a lot of places, where they were labor and used inappropriately. Great training programs, like The Ohio State University, need to be, primarily a training enterprise.

Mr. Jurgensen:

Because this is part of our tripartite reason, that there has to be a clinical implication in terms of the people who are overseeing the residents and the fellows, it cannot possibly be as productive clinically because there are not enough hours in the day to pay attention to the residents and the fellows and see patients. The paying system only wants to pay for the clinical side of things. Nobody wants to pay for it. The government does not want to pay for this, insurance companies do not want to pay for this, patients do not want to pay for this. How does that model work?

Dr. Retchin:

If you count the dollars, even with the cap, remember, the support for this program really comes through Medicare and Medicaid. The private payers have never created a premium on that. I have always embedded that in terms of the premium rates, but increasingly they attack prices. I am not sure how you completely fund this and we will bring some numbers back. I know where I came from the subsidy was huge.

Mr. Jurgensen:

I mean it would seem like it would put a lot of heat on. Do we really need three years of this to happen or do we call it a day at two, or one?

Mr. McQuaid:

It gets to the point that academic medical centers around the concept of funds flow, medical center investment, mission based formula, around education, around research, around clinical, how we break that down per physician, and how that allocation comes across. It is at the center of the conversation of affordability going forward. Historically, the clinical enterprise could support that.

Mr. Jurgensen:

Medical center investment is code for cross subsidation so. Eventually, we need a radically different model. The country needs a radically different model for this.

Dr. Retchin:

I am not sure I want to be the first patient to be operated on by a neurosurgeon after one year of training, but let me just ask you, Scott, I don't know if you can reflect on this but, what is about the night call for a general internal medicine resident?

Dr. Holliday:

In fact, that whole call is a very different model. It is much more night float, so shift work and evening calls are spread out through the day. It is much different from when we trained when it was 36-40 hours in a row or more to where we have people doing 24 to 26 hour shifts, which is probably about the maximum. The most is 24 plus four that is allowed by the ACGME. It is a different model than what was used before with more coverage of people that are, in theory, more fresh at night to come in to take better care.

Dr. Retchin:

Work week?

Dr. Holliday:

Work week is between 60 and 80 hours a week.

Dr. Retchin:

It is a huge week compared to what you would think, but all the concerns about fatigue have cut back on all of that. All that has financial implications, so you are spot on.

Mrs. Wexner:

What is the subsidy that this requires?

Mr. Larmore:

I do not have the number on the top of my head but it is fully loaded. Our net investment into this is tens of millions of dollars. It is a community benefit that we are definitely providing, teaching and the academics.

Mrs. Wexner:

20? 30? Just order of magnitude, what would you guess.

Dr. Thomas:

It depends on how you count the revenue that comes in. There are two streams. There is direct GME, which is for the direct cost. That is where we get substantially harmed by the cap because we are well above the cap and then the indirect, which is meant to

compensate the hospital for residents potentially ordering more tests than a fixed reimbursement system with DRG (Diagnosis-Related Group) payments. Also, we get slightly more complex patients than the average hospital and the DRG system does not reflect that, so if you take all of those dollars, we are in the black. The IME (Indirect Medical Education) is not meant fully to cover the direct costs so the formula that we use is half the IME and all of the DME (Direct Medical Education) as the revenue. If you look at that with our expenses, we vacillate back and forth between a little in the red and little in the black on any given year, but that is Medicare and Medicaid combined. Medicaid has been threatening some of those dollars in the past year but it is a large number of dollars. I agree with Mark, it is a big expense and we would be happy to bring those dollars back and have a more direct discussion.

Dr. Reid:

It is important to know what is the cost, there is no doubt about that. I want to caution us that if we know the cost and make value judgements based on only the cost, we might be falling short. This is a challenge for all academic medical centers, there's no doubt. Some are merging with for-profit centers. The strategic planning process will help us be able to take the cost and put it in perspective with the university's mission. We have to know the answers to all of the specifics, but then we also have to look at the total and figure out where all of this fits. I do have a quick question for you. In terms of what our mission is as a land grant university and what happens with residents and interns, how is it that we address the health needs of rural residents? Do we use telemedicine?

Dr. Holliday:

We do have telemedicine. We also have some of our trainees who go out to our communities and provide care in local areas either with some of our partner institutions or some in prison medicine and other areas where they are actually going out to the patients.

Dr. Reid:

We really are serving the state and all of its different populations when we train people. To the 80-hour work week and the number of hours that residents work, there was some legislation at some point that says you can't work 90 hours and still take care of patients. Is that still true and if so, how, when you say 80 hours, do we balance that against quality of care.

Dr. Holliday:

Definitely that is a continuing conversation. It is not legislation here in Ohio for the 80-hour work week, it is actually regulated by the accrediting body, the ACGME that says 80 hours. Some states have gone and said that the regulations are for our state, that you can only work so many hours. New York is 60 hours with the Bell Commission. What that has been rolled into in 2003 initially, and then 2011, are the duty hours for training programs that are accredited so that they have to fall within that 80-hour work week.

There are other stipulations, maximum number of hours in a row and that changes based on year of training. First year out, they give you less continual hours as you are adjusting or adapting to that role to try to reduce accidents or injuries related to fatigue. The challenges with that is there is more hand off, so you are handing off care between more providers and there is risk for errors with that too. The first study looking at post duty hours in a large, randomized study was in the surgical realm and it just came out about six weeks ago. It showed that, maybe, if we were more flexible with that 80 hours and it was not a rigid cut off, there may not be more errors associated with that. There is another study ongoing in internal medicine to look at those exact same issues. My suspicion is we have not heard the last of those rules related to duty hours and those will be tempered based on the data we have coming in.

Dr. Drake:

Here is the comment more broadly on this. It is a great question. We have looked at the continuum of medical education which starts with our medical students and then goes through our post-doctoral fellows and the cost per person for the system to support that varies dramatically. It goes from extraordinarily expensive to in fact, cost positive in many cases. Medical students are extraordinarily expensive to train. If you were going to break out what it costs to train one, it is a whopping big number but it is seen as a great societal good and an important thing for us.

Residencies, depending on what the service is and what they are doing, have changed a bit between first year residents and primary care and senior residents in surgical specialties. We can actually produce and support volume. I operated thousands of times with residents and they actually helped me to do work and it was a great thing. The senior trainees, about ready to go out, were positive, and the ones at the very beginning were extraordinarily time consuming. When you get the post-doctoral fellows, you really can get to junior specialty faculty like people, particularly, towards the end who can be a great benefit. Then there is the intrinsic value of the engagement of the faculty in the enterprise in the teaching and doing our best on a daily basis. There is great evidence to show that faculty and teaching institutions, by nature, are more engaged and actually have greater work satisfaction and by doing that. We actually get a bit of a premium there on what keeps the faculty coming to work and the intrinsic value of the work. The net of the training programs is extraordinarily valuable and that is why academic medical centers are such attractive places. The best outcomes, internationally, come from academic medical centers et cetera. That is why most of us choose academic medical centers for our own care. All of that is a part of the teaching and training mission, so it is actually a very good thing to be involved in.

The numbers look different depending on which part of it you look at, but it is like our athletic programs. There is excellence in many different areas. Some have better returns on investment but it is not done for the finances. It is really done to make sure that our entire enterprise meets our basic missions. We really appreciate that. Not that I have an opinion on this.

Dr. Retchin:

Thanks, Scott. I do want to comment as we go into executive session just to thank the board. I do not know if you feel the same as I do, but every single board meeting, the board engagement gets sharper and sharper, and the questions you continue to ask are just incredibly insightful.

Dr. Reid:

I want to thank on behalf of us, our two guests.

Dr. Beal:

I am a second year general surgery resident and I am in my first year of the Master in Medical Science program pursuing a Master's in how to do research. I work in a lab and I moonlight here. I serve as the Chair of the House Staff Quality Forum working with Dr. Moffatt-Bruce and her team on engaging residents in our quality and patient safety process. I serve on the resident advisory council and I also take care of patients. Dr. Holliday and Dr. Retchin had asked us to come to give a slice of what our experience as residents here is like and after Montoya introduces himself, we are happy to answer any questions about the resident experience.

Dr. Taylor:

I am from Mississippi and I went to medical school on the East coast. A few years ago, Dr. Holliday and I became acquainted. He was my former program director and so I did Med PEs (pulmonary embolism) here. As you all attest to the fact that my very first year of training, Dr. Holliday saw every single patient, but as I got more efficient, towards the end of my Med PEs, I was more independent and able to see more patients with less oversight. The clinic ran more efficiently where I could have two of my patients seen and out the door and they did not have to wait around for an hour as opposed to the first year, each patient would take 30 to 45 minutes. I did moonlighting as Eliza does and would help the attending. I would be there at night seeing patients, admitting patients, and doing all the orders. That way when the patients came in the morning, they would see the attending physician as a very fresh face, not fatigued, and they would actually trust us. Now I am an interventional cardiology fellow and one of the things that I have been doing is still moonlighting at one of our outreach hospitals, Southeastern Ohio Regional Medical Center, helping provide influx of those patients from Cambridge, Ohio back to the Columbus area so that we do not have our competition basically taking those patients away from us. It is very important that we continue training programs because they do go out into the community and do outreach. They also provide stimulation and as the workforce gets more senior and they start to think about stepping out of the workforce. Knowing a trainee that you have had hands on experience with for four to five years and knowing someone that you can entrust the legacy of Ohio State and to maintain that legacy is also very important because they have been here for eight, nine, ten years doing their training. They know them. To speak to the other reasons why medical residency and training programs are important is also mentorship. As I said, I came from Mississippi. I came through a lot of pipeline programs. Dr. Holliday has encouraged us to do volunteer work through the MedPeace program, Dr. Caligiuri also has had a lot of our workshops at his house, doing residency engagement. Wherever I go, I will still reflect on my time here at Ohio State and speak very highly of the place.

Very high quality care at a minimal investment, very good with what you put in. Some of our competing hospitals have residency and training programs because they realize that the upfront investment on the first year is going to be relatively high but that second, third, and fourth year is going to be quite well recuperated. In St. Louis and in Chicago, they do have residency and training programs because they see the value in this, so I think that we should definitely continue all of the training programs and that helps to boost our reputation of what we do.

Dr. Drake:

Thank you.

Dr. Retchin:

May I have a motion to go into executive session?

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

Attest:

Leslie H. Wexner	Heather Link
Chairman	Associate Secretary

(ATTACHMENT XIX)

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

FY16 YTD | Through February 2016

MEDICAL CENTER PERFORMANCE	FY15 Actual	FY16 YTD Actual	FY16 Target	Current Status
A. Quality and Service				
1. Quality and Patient Safety				
1a. Inpatient Mortality[1]	0.84	0.72	0.68	▼
1b. PSI-90 (Patient Safety Index)[2]	2.84	0.66	0.62	▲
1c. Overall Readmission[3]	13.2%	13.6%	11.6%	▼
1d. CAUTI (Standardized Infection Ratio)[4]	1.18	0.68	0.68	▲
2. Overall Patient Satisfaction[5]				
2a. Inpatient HCAHPS	76.2%	77.6%	79.8%	◆
2b. Outpatient CG CAHPS/Physician Office Satisfaction	90.6%	91.2%	88.0%	▲
2c. HCAHPS Doctor Communication	81.1%	81.6%	83.0%	▼
2d. HCAHPS Nurse Communication	80.0%	81.8%	81.0%	◆
B. Research Excellence				
1. Total NIH Awards[6]	$[illegible]	$[illegible]	$[illegible]	▲
C. Education Excellence				
1. USNWR Best Medical Schools Ranking	#[illegible]	#[illegible]	#[illegible]	▼
D. Clinical Excellence				
1. USNWR Best Hospitals - Number of Specialties Ranked	7	Reported July 2016	10	[illegible]
2. USNWR Best Hospitals - Number of Specialties in Top 20	1	Reported July 2016	2	[illegible]
E. Talent Management				
1. Workforce Engagement: Staff[7]	[illegible]	[illegible] Percentile	[illegible]	◆
F. Financial Viability				
1. Net Medical Center Operating Margin (and %)[8]	$[illegible] (7.7%)	$[illegible]	$[illegible]	▲
2. Days Cash on Hand: Health System	87.1	102.5	82.5	▲
3. Days Cash on Hand: OSUP + College of Medicine	[illegible]	95.8	[illegible]	▲
G. Revenue Enhancement and Scale				
1. Health System Total Operating Revenue per Adjusted Admission	$21,[illegible]	$22,[illegible]	$22,[illegible]	▲
2. Development Dollars (Including FMF)	$[illegible]	$[illegible]	$[illegible]	▲
H. Cost Management				
1. Health System Total Operating Expenses per Adjusted Admission	$[illegible]	$[illegible]	$[illegible]	▼
2. Spending per Medicare Beneficiary[9]	0.[illegible]	0.[illegible]	0.[illegible]	◆

Green: Met or Exceeds Goal
Yellow: Caution
Red: Below Goal / Action Needed
White: Data Pending

▲ Performance Up from last Board report
◆ No Performance Change from last Board report
▼ Performance Down from last Board report

1. Inpatient Mortality data through January 2016
2. PSI-90 data through [illegible]
3. Overall Readmission through December 2015
4. CAUTI [illegible] through September 2015 [illegible]
5. Overall Patient Satisfaction data through January 2016 [illegible]
6. Total NIH Awards [illegible]
7. Workforce Engagement [illegible]
8. Net Operating Margin [illegible]
9. Spending per Medicare Beneficiary data through December 2014 [illegible]

Data Definitions for Quality and Patient Safety Measures:

Inpatient Mortality: [illegible]

PSI-90 (Patient Safety Index): [illegible]

Overall Readmission: [illegible]

CAUTI (Standardized Infection Ratio): [illegible]

Inpatient HCAHPS: [illegible]

Outpatient CG CAHPS/Physician Office Satisfaction: [illegible]

HCAHPS Doctor Communication: [illegible]

HCAHPS Nurse Communication: [illegible]

(ATTACHMENT XX)

Health System Financial Summary

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

The Ohio State University Health System
Financial Highlights
For the YTD ended: February 29, 2016

Admissions	
Budget	-1.5%
Prior Yr	3.0%
Actual	39,381
Budget	39,974
Prior Yr	38,235

Surgeries	
Budget	1.0%
Prior Yr	3.1%
Actual	27,625
Budget	27,350
Prior Yr	26,795

O/P Visits	
Budget	-0.7%
Prior Yr	3.5%
Actual	1,131,553
Budget	1,139,384
Prior Yr	1,093,031

Worked Hrs / Adjusted Admit	
Budget	-1.4%
Prior Yr	-5.0%
Actual	197
Budget	194
Prior Yr	187

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

The Ohio State University Health System
Financial Highlights
For the YTD ended: February 29, 2016
($ in thousands)

Operating Revenue	
Budget	-0.4%
Prior Yr	11.2%
Actual	$1,683,448
Budget	$1,689,538
Prior Yr	$1,514,348

Controllable Costs	
Budget	0.9%
Prior Yr	-9.5%
Actual	$1,282,193
Budget	$1,293,220
Prior Yr	$1,170,934

Excess Revenue over Expense	
Budget	5.9%
Prior Yr	13.3%
Actual	$123,235
Budget	$116,326
Prior Yr	$108,740

Days Cash on Hand		
Budget	14.7%	
Prior Yr	26.7%	
Actual	102.5	$589M
Budget	89.4	$514M
Prior Yr	80.9	$465M

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

1

The Ohio State University Health System
Consolidated Activity Summary
For the MTD ended: February 29, 2016

OSUHS

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
CONSOLIDATED ACTIVITY SUMMARY						
Activity						
Admissions	4,764	4,884	(120)	-2.5%	4,529	5.2%
Surgeries	3,425	3,453	(28)	-0.8%	3,262	5.0%
Outpatient Visits	141,727	142,520	(793)	-0.6%	130,161	8.9%
Average Length of Stay	6.24	6.12	(0.12)	-1.9%	6.24	0.0%
Case Mix Index (CMI)	1.90	1.78	0.12	6.9%	1.76	8.4%
Adjusted Admissions	9,154	9,035	119	1.3%	8,404	8.9%
Operating Revenue per AA	$ 23,339	$ 23,083	256	1.1%	$ 22,626	3.2%
Operating Expense per AA	$ 20,105	$ 19,707	(398)	-2.0%	$ 19,357	-3.9%

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

1

The Ohio State University Health System
Consolidated Statement of Operations
For the MTD ended: February 29, 2016
(in thousands)

OSUHS

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	$ 213,649	$ 208,551	$ 5,098	2.4%	$ 190,147	12.4%
Operating Expenses						
Salaries and Benefits	91,144	90,936	(208)	-0.2%	82,783	-10.1%
Supplies	25,079	23,550	(1,529)	-6.5%	18,059	-38.9%
Drugs and Pharmaceuticals	19,574	17,144	(2,430)	-14.2%	17,278	-13.3%
Services	23,485	21,683	(1,802)	-8.3%	20,888	-12.4%
Depreciation	11,585	11,395	(190)	-1.7%	10,875	-6.5%
Interest	3,494	3,525	31	0.9%	3,573	2.2%
Other	9,684	9,820	136	1.4%	9,215	-5.1%
Total Expense	184,045	178,053	(5,992)	-3.4%	162,671	-13.1%
Gain (Loss) from Operations (pre MCI)	29,604	30,498	(894)	-2.9%	27,476	7.7%
Medical Center Investments	(11,671)	(11,667)	(4)	0.0%	(11,407)	-2.3%
Income from Investments	182	107	75	70.1%	216	-15.7%
Other Gains (Losses)	-	-	-	---	-	---
Excess of Revenue over Expense	$ 18,115	$ 18,938	$ (823)	-4.3%	$ 16,285	11.2%

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

1

The Ohio State University Health System
Consolidated Activity Summary
For the YTD ended: February 29, 2016

OSUHS

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
CONSOLIDATED ACTIVITY SUMMARY						
Activity						
Admissions	39,381	39,974	(593)	-1.5%	38,235	3.0%
Surgeries	27,625	27,350	275	1.0%	26,795	3.1%
Outpatient Visits	1,131,553	1,139,384	(7,831)	-0.7%	1,093,031	3.5%
Average Length of Stay	6.33	6.10	(0.22)	-3.6%	6.08	-4.0%
Case Mix Index (CMI)	1.85	1.78	0.07	3.8%	1.78	3.9%
Adjusted Admissions	73,684	74,348	(664)	-0.9%	70,713	4.2%
Operating Revenue per AA	$ 22,847	$ 22,725	122	0.5%	$ 21,415	6.7%
Operating Expense per AA	$ 19,947	$ 19,918	(29)	-0.1%	$ 18,596	-7.3%

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

1

The Ohio State University Health System
Consolidated Outpatient Visit Summary
For the MTD & YTD ended: February 29, 2016

MONTH							YEAR TO DATE					
ACTUAL	BUDGET	ACT-BUD VAR	BUDGET % VAR	PRIOR YEAR	PY % VAR	CATEGORY	ACTUAL	BUDGET	ACT-BUD VAR	BUDGET % VAR	PRIOR YEAR	PY % VAR
2,165	2,095	70	3.3%	1,985	9.1%	**Surgeries**	17,166	16,854	312	1.9%	16,428	4.5%
8,788	9,599	(811)	-8.5%	8,124	8.2%	**ED Visits**	75,727	76,359	(632)	-0.8%	73,083	3.6%
10,482	10,211	271	2.7%	9,087	15.4%	**Procedures**	81,227	81,223	4	0.0%	75,458	7.6%
359	308	51	16.6%	130	176.2%	Cath Lab	2,536	2,450	86	3.5%	1,953	29.9%
222	217	5	2.4%	192	15.6%	EP Lab	1,701	1,725	(24)	-1.4%	1,605	6.0%
381	362	19	5.1%	296	28.7%	Interventional Radiology	2,936	2,883	53	1.8%	2,577	13.9%
3,588	3,609	(21)	-0.6%	2,843	26.2%	Radiation Oncology	28,374	28,708	(334)	-1.2%	21,430	32.4%
5,932	5,715	217	3.8%	5,626	5.4%	All Other	45,680	45,458	222	0.5%	47,892	-4.6%
34,849	35,068	(219)	-0.6%	31,935	9.1%	**Clinic Visits**	278,222	278,947	(725)	-0.3%	277,642	0.2%
32,403	32,634	(231)	-0.7%	29,686	9.2%	Clinic/Office Visits	258,795	259,592	(797)	-0.3%	258,612	0.1%
2,446	2,433	13	0.5%	2,249	8.8%	Chemo Visits	19,427	19,355	72	0.4%	19,032	2.1%
11,025	10,900	125	1.1%	9,561	15.3%	**Rehab Services**	86,278	86,708	(430)	-0.5%	77,708	11.0%
13,511	13,416	95	0.7%	12,293	9.9%	**Radiology**	106,332	106,716	(384)	-0.4%	101,139	5.1%
21,852	22,166	(314)	-1.4%	21,002	4.0%	**Lab**	176,952	176,323	629	0.4%	168,915	4.8%
1,936	1,920	16	0.8%	1,698	14.0%	**Pharmacy**	15,295	15,273	22	0.1%	15,552	-1.7%
5,454	5,009	445	8.9%	4,967	9.8%	**Other OP Visits**	40,598	39,843	755	1.9%	41,038	-1.1%
31,665	32,136	(471)	-1.5%	29,509	7.3%	**Physician Visits**	253,756	261,139	(7,383)	-2.8%	246,068	3.1%
141,727	**142,520**	**(793)**	**-0.6%**	**130,161**	**8.9%**	**TOTAL OUTPATIENT VISITS**	**1,131,553**	**1,139,384**	**(7,831)**	**-0.7%**	**1,093,031**	**3.5%**

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

The Ohio State University Health System
Consolidated Statement of Operations
For the YTD ended: February 29, 2016
(in thousands)

OSUHS

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	**$ 1,683,448**	**$ 1,689,538**	**$ (6,090)**	**-0.4%**	**$ 1,514,348**	**11.2%**
Operating Expenses						
Salaries and Benefits	**757,333**	**769,263**	**11,930**	**1.6%**	**687,363**	**-10.2%**
Supplies	**182,035**	**189,686**	**7,651**	**4.0%**	**174,805**	**-4.1%**
Drugs and Pharmaceuticals	**152,605**	**142,482**	**(10,123)**	**-7.1%**	**126,450**	**-20.7%**
Services	**179,888**	**181,249**	**1,361**	**0.8%**	**175,449**	**-2.5%**
Depreciation	**92,554**	**91,632**	**(922)**	**-1.0%**	**63,977**	**-44.7%**
Interest	**27,881**	**28,518**	**637**	**2.2%**	**14,417**	**-93.4%**
Other	**77,502**	**78,044**	**542**	**0.7%**	**72,541**	**-6.8%**
Total Expense	**1,469,798**	**1,480,874**	**11,076**	**0.7%**	**1,315,002**	**-11.8%**
Gain (Loss) from Operations (pre MCI)	**213,650**	**208,664**	**4,986**	**2.4%**	**199,346**	**7.2%**
Medical Center Investments	**(93,358)**	**(93,327)**	**(31)**	**0.0%**	**(91,259)**	**-2.3%**
Income from Investments	**1,574**	**853**	**721**	**84.5%**	**1,102**	**42.8%**
Other Gains (Losses)	**1,369**	**136**	**1,233**	**906.6%**	**(449)**	**404.9%**
Excess of Revenue over Expense	**$ 123,235**	**$ 116,326**	**$ 6,909**	**5.9%**	**$ 108,740**	**13.3%**

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

The Ohio State University Health System
Consolidated Balance Sheet
As of: February 29, 2016
(in thousands)

	February 2016	June 2015	Change
Assets			
Cash	$ 453,662	$ 330,141	$ 123,521
Current Assets	448,738	368,518	80,220
Assets Limited as to Use	255,343	255,029	314
Property, Plant & Equipment - Net	1,375,755	1,420,127	(44,372)
Other Assets	33,349	21,019	12,330
Total Assets	$2,566,847	$2,394,834	$ 172,013
Liabilities & Net Assets			
Current Liabilities	$ 339,977	$ 268,237	$ 71,740
Other Liabilities	51,883	47,338	4,545
Long-Term Debt	809,708	839,232	(29,524)
Net Assets - Unrestricted	1,365,279	1,240,027	125,252
Net Assets - Restricted	-	-	-
Total Liabilities & Net Assets	$2,566,847	$2,394,834	$ 172,013

OSU Wexner Medical Center
Combined Statement of Operations
For the YTD ended: February 29, 2016
(in thousands)

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	$2,052,169	$2,060,781	$ (8,612)	-0.4%	$1,861,544	10.2%
Operating Expenses						
Salaries and Benefits	1,076,697	1,087,502	10,806	1.0%	991,000	-8.6%
Supplies	198,420	206,494	8,074	3.9%	189,988	-4.4%
Drugs and Pharmaceuticals	170,121	158,576	(11,545)	-7.3%	142,502	-19.4%
Services	233,486	228,021	(5,465)	-2.4%	225,562	-3.5%
Depreciation	100,702	98,883	(1,819)	-1.8%	70,994	-41.8%
Interest/Debt	35,530	36,562	1,031	2.8%	22,290	-59.4%
Other Operating Expense	89,460	92,564	3,104	3.4%	84,202	-6.2%
Medical Center Investments	28,739	28,739	0	0%	33,261	13.6%
Total Expense	1,933,155	1,937,342	4,187	0.2%	1,759,800	-9.9%
Excess of Revenue over Expense	$ 119,014	$ 123,440	$ (4,425)	-3.6%	$ 101,745	17.0%
Financial Metrics						
Adjusted Admissions	73,684	74,348	(664)	-0.9%	70,713	4.2%
OSUP Physician Encounters	1,565,515	1,565,538	(23)	0.0%	1,459,982	7.2%
Operating Revenue per AA	$ 22,847	$ 22,725	$ 122	0.5%	$ 21,415	6.7%
Total Expense per AA	$ 19,947	$ 19,918	$ (29)	-0.1%	$ 18,596	-7.3%

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

OSU Wexner Medical Center
Combined Statement of Operations
For the YTD ended: February 29, 2016
(in thousands)

	ACTUAL	BUDGET	ACT-BUD VARIANCE	BUDGET % VAR	PRIOR YEAR	PY % Var
Health System						
Revenues	$1,683,448	$1,689,538	$ (6,090)	-0.4%	$1,514,348	11.2%
Expenses	1,560,213	1,573,212	12,999	0.8%	1,405,608	-11.0%
Net	123,235	116,326	6,909	5.9%	108,740	13.3%
OSUP						
Revenues	$ 260,725	$ 259,928	$ 797	0.3%	$ 241,358	8.0%
Expenses	252,168	244,617	(7,552)	-3.1%	234,909	-7.3%
Net	8,557	15,311	(6,755)	44.1%	6,449	-32.7%
COM/OHS						
Revenues	$ 107,996	$ 111,315	$ (3,319)	-3.0%	$ 105,838	2.0%
Expenses	120,774	119,512	(1,262)	-1.1%	119,279	-1.3%
Net	(12,778)	(8,197)	(4,581)	-55.9%	(13,441)	4.9%
Total Medical Center						
Revenues	$2,052,169	$2,060,781	$ (8,612)	-0.4%	$1,861,544	10.2%
Expenses	1,933,155	1,937,342	4,187	0.2%	1,759,800	-9.9%
Net	119,014	123,440	(4,425)	-3.6%	101,745	17.0%

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: February 29, 2016
(in thousands)

	February 2016	June 2015	Change
Cash	$ 588,668	$ 460,071	$ 128,597
Current Assets	683,159	627,127	56,032
Assets Limited as to Use	255,343	255,029	314
Property, Plant & Equipment - Net	1,496,226	1,548,833	(52,607)
Other Assets	420,407	394,701	25,706
Total Assets	$ 3,443,803	$ 3,285,761	$ 158,042
Current Liabilities	$ 378,578	$ 323,391	$ 55,187
Other Liabilities	51,883	47,338	4,545
Long-Term Debt	924,779	965,218	(40,440)
Net Assets - Unrestricted	1,615,280	1,467,995	147,285
Net Assets - Restricted	473,283	481,818	(8,535)
Liabilities and Net Assets	$ 3,443,803	$ 3,285,761	$ 158,042

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

OSU Wexner Medical Center
Combined Balance Sheet
As of: February 29, 2016
(in thousands)

	February 29, 2016				June 30, 2015			
	Health System	OSUP	COM	Medical Center Total	Health System	OSUP	COM	Medical Center Total
Cash	$ 453,662	$ 74,127	$ 60,879	$ 588,668	$ 330,141	$ 74,065	$ 55,865	$ 460,071
Current Assets	448,738	57,665	176,756	683,159	368,518	64,270	194,339	627,127
Assets Limited as to Use	255,343	-	-	255,343	255,029	-	-	255,029
Property, Plant & Equipment - Net	1,375,755	24,845	95,626	1,496,226	1,420,127	26,139	102,567	1,548,833
Other Assets	33,349	981	386,077	420,407	21,019	4,185	369,496	394,701
Total Assets	$ 2,566,847	$ 157,618	$ 719,338	$ 3,443,803	$ 2,394,834	$ 168,659	$ 722,268	$ 3,285,761
Current Liabilities	$ 339,977	$ 38,601	$ -	$ 378,578	$ 268,237	$ 54,223	$ 930	$ 323,391
Other Liabilities	51,883	-	-	51,883	47,338	-	-	47,338
Long-Term Debt	809,708	19,445	95,626	924,779	839,232	23,419	102,567	965,218
Net Assets - Unrestricted	1,365,279	99,573	150,429	1,615,280	1,240,027	91,016	136,952	1,467,995
Net Assets - Restricted			473,283	473,283			481,818	481,818
Liabilities and Net Assets	$ 2,566,847	$ 157,618	$ 719,338	$ 3,443,803	$ 2,394,834	$ 168,659	$ 722,268	$ 3,285,761

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

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

The Ohio State University Health System
Calculation of Adjusted Admissions

Adjusted admissions serves as an overall volume indicator and presents a productivity metric that accounts for both inpatient and outpatient activities.

	YTD FEB ACTUAL	
REVENUE		
Unrestricted revenues, gains and other support:		
Inpatient Routine	$552,438,032	B
Inpatient Ancillary	1,669,379,744	C
Outpatient Routine	11,378,273	
Outpatient Ancillary	1,990,964,966	
Professional Fees	188,812,263	
OP Routine-Purch Svc Rev	252,108,447	
IP Routine (Purch Svc Rev)	583,093,893	D
Total Patient Revenue	**$5,248,175,619**	A
Admissions less Normal NB	**39,381**	E
Adjusted Admissions	**73,684**	

CALCULATION OF ADJUSTED ADMISSIONS

$$\frac{\text{Total Patient Revenue [A]}}{\text{I/P Routine [B]} + \text{I/P Ancillary [C]} + \text{IP Routine (Purchased Svc Rev) [D]}} \text{ (X) Admissions less Normal NB [E]}$$

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

(Attachment XXI)

BACKGROUND

MEDICAL STAFF RULES AND REGULATIONS
The Ohio State University Hospitals

84-01 Ethical pledge.

(A) Each member of the medical staff and health care providers with clinical privileges shall pledge adherence to standard medical ethics, including:

(1) Refraining from fee splitting or other inducements relating to patient referral;

(2) Providing for continuity of patient care;

(3) Refraining from delegating the responsibility for diagnosis or care of hospitalized patients to a medical or dental practitioner or other licensed healthcare professional who is not qualified to undertake this responsibility or who is not adequately supervised;

(4) Seeking consultation whenever necessary; and

(5) Never substituting physicians without the patient's knowledge or appropriate consent.

(Board approval dates: 11/4/2005, 8/31/2012)

84-02 Admission procedures.

(A) Except in an emergency, in the interest of assignment to the appropriate service area, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated by the patient's attending physician or other licensed healthcare professional who is appropriately credentialed by the hospital and under the supervision of the collaborating medical staff member. The request for admission shall also include the following information:

(1) Any facts essential for the protection of the general hospital population against unnecessary exposure to infectious and other communicable diseases.

(2) Any information which shall warn responsible hospital personnel of any tendency of any patient to try to commit suicide or to injure others because of mental disturbance.

(3) Any information concerning physical condition or personality idiosyncrasy which might be objectionable to other patients who might be occupying the same or adjoining rooms.

(B) In the event that a patient is presented to the hospital with an illness, emotional problem, or condition which is the result of alcoholism or drug abuse and which substantially impairs the patient's affairs and social relationships (including indications of self-harm such as attempted suicide or suicidal gestures), it is the responsibility of the attending physician to provide for a proper comprehensive plan of care, including emergency care.

If a patient with a mental disorder is treated in the hospital for a medical condition, it shall be the responsibility of the attending physician to notify hospital or medical staff personnel of the existence of the mental or substance disorders and to order such precautionary measures as may be necessary to assure protection of the patient and the protection of others whenever a patient might be a source of danger.

It shall also be the attending physician's responsibility to address the underlying mental health or substance abuse problem and when indicated, refer the patient to an appropriate or dedicated facility dealing with alcoholism/drug abuse or mental health problems.

(Board approval dates: 9/6/2002, 9/18/2009)

84-03 Attending assignment.

(A) All patients entering university hospitals who have not requested the services of a member of the medical staff of university hospitals to be responsible for their care and treatment while a patient therein shall be assigned to a member of the attending staff of the clinical division or service concerned with the treatment of the disease, injury, or condition which necessitated the admission of the patient to university hospitals. This shall also apply to the transfer of patients within the clinical divisions or services of the university hospitals.

(B) Alternate attending medical staff member coverage. Each member of the medical staff shall designate on his or her medical staff application one or more members of the attending or courtesy medical staff who have accepted this responsibility and who shall be called to attend his or her patients if the responsible attending medical staff member is not available. The chief of the medical staff member's clinical department or the medical director or his designee shall have authority to contact any member of the medical staff and arrange for coverage should the attending medical staff member and the alternate be unavailable. If the chief of the medical staff member's clinical department or the medical director or his designee is unavailable, the emergency department physician on duty is responsible for arranging appropriate medical coverage until the attending medical staff member is available to care for the patient.

(Board approval dates: 9/6/2002, 3/5/2003)

84-04 Consultations.

(A) Consultation requirements.

When a patient care problem is identified that requires intervention during the hospital stay that is outside the attending or courtesy medical staff member's area of training and experience, it is the responsibility of the attending or courtesy medical staff member or his or her designee, who is appropriately credentialed by the hospital, to obtain consultation by the appropriate specialist. The consultation may be ordered by the responsible medical practitioner, a member of the limited staff, or another licensed healthcare professional with appropriate clinical privileges as designated in these rules and regulations. If a consultation is ordered prior to ten a.m., the consult shall occur on the same business day. If a consultation is ordered after ten a.m., the consult shall occur within twenty-four hours. Irrespective of consultations each patient is continuously assessed and reassessed and his or her plan for care is modified as necessary.

(B) Responsibility to monitor consultations.

It is the duty of the medical staff through its clinical departmental chiefs and the medical staff administrative committee to assure that members of the staff comply in the matter of requesting consultations as needed.

(C) Consultation contents.

A satisfactory consultation shall include examination of the patient, examination of the medical record, and a written opinion signed by the consultant that is made a part of such record. If operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

(Board approval dates: 9/6/2002, 11/4/2005, 6/6/2008, 9/18/2009, 4/8/2011)

84-05 Privileges for giving orders.

(A) Definition of "patient orders."

A patient order(s) is a prescription for care or treatment of patients. An order can be given verbally, electronically or in writing to qualified personnel identified by category in paragraph (C) of this rule, and shall be authenticated by the licensed medical practitioner. Patient orders may be given initially, renewed, discontinued or cancelled. Throughout these rules and regulations, the word “written” and its grammatical derivatives, as used to describe a non-verbal order, refer to both written and electronically entered orders.

(B) Electronic ordering.

Electronic orders are equivalent and have the same force as written orders. Electronic orders have been expressly structured to mirror these rules and regulations and all policy guidelines adopted by the medical staff and hospital administration.

(C) Responsible medical practitioner.

The licensed physician, dentist, podiatrist, or psychologist (under medical doctor supervision) member of the medical staff responsible for the care and treatment of the patient is responsible for all orders for the patient. Attending and courtesy medical staff may designate members of the limited staff, or other licensed healthcare professional with appropriate clinical privileges to write or electronically enter orders under their direction. The attending staff member may also designate members of the pre-M.D. medical student group to write or electronically enter orders, but in all cases these orders shall be signed by the physician, dentist, podiatrist, psychologist, or designated limited staff member who has the right of practice of medicine, dentistry, psychology, or podiatry, and who is responsible for that patient's care. All non-verbal orders must be authenticated by the medical practitioner prior to the execution of the order(s) by the hospital or outpatient nursing staff or other professional groups.

(D) Telephone and verbal orders.

Telephone and verbal orders may be given by the responsible attending physician, dentist, podiatrist, psychologist, member of the limited staff, or other licensed healthcare professional with appropriate clinical privileges only to health care providers who have been approved in writing by title or category by the medical director and each chief of the clinical service where they shall exercise clinical privileges, and only where said health care provider is exercising responsibilities which have been approved and delineated by job description for employees of the hospitals, or by the customary medical staff credentialing process when the

provider is not an employee of the hospitals. Lists of the approved titles or categories of providers shall be maintained by the chief medical officer. Verbal orders should be utilized infrequently. The individual giving the verbal or telephone order must verify the complete order by having the person receiving the information record and “read back” the complete order to assure the quality and safety of patient care. The job description or delineated privileges for each provider must indicate each provider's authority to receive telephone or verbal orders, including but not limited to the authority to receive orders for medications. The order is to be recorded and authenticated by the approved health care provider to whom it is given as "verbal order by," or "V. O. or T. O. by," recording the licensed healthcare practitioner's name and the time of the order. All verbal orders for D.E.A. schedule II controlled substances, patient seclusion, or patient restraint must be authenticated within twenty-four hours by signature of a licensed physician, dentist, podiatrist, psychologist, or designated limited staff member, or other licensed healthcare professional with appropriate clinical privileges. Verbal orders for directives of urgent issues that cannot be addressed by the prescriber’s order entry are encouraged to be signed electronically within 48 hours, but must be authenticated within 21 days by a licensed physician, dentist, podiatrist, psychologist, limited staff member, or other licensed healthcare professional with appropriate privileges.

(E) Standing orders.

Standing orders for medications are only approved in emergency situations. All other standing orders must developed, approved, used and monitored in strict compliance with the standing orders medical staff policy approved by the medical staff administrative committee and hospital administration.

(F) Preprinted orders.

Preprinted order forms for patients must be reviewed, dated, timed and signed by a responsible medical practitioner, a limited staff member, or other licensed healthcare professional with appropriate privileges before becoming effective.

(G) Investigational drug orders.

Evidence of informed patient consent must be available to a nurse or pharmacist before an investigational agent is ordered and administered. Investigational drugs may be ordered only upon authorization of the principal or co-investigator or other delegated physician, dentist, psychologist, or podiatrist named in FDA forms 1572 or 1573. Registered nurses or pharmacists who are knowledgeable about the investigational agents may administer the drugs to patients.

(H) Change of nursing service.

"Change of nursing service" means official and physical movement (transfer) of a patient from any permanent care unit to another with or without change in attending physician, dentist, psychologist, or podiatrist or clinical service. Orders effective before transfer must be reviewed, renewed, rewritten or reentered upon transfer by the responsible medical practitioner. The new or renewed orders may be written or electronically entered before or when the patient arrives on the receiving unit and may become effective immediately.

In each case of "change of nursing service," it is the responsibility of the receiving nurse to establish the availability of renewed or new written or electronically entered orders. Prior orders shall remain in effect until new orders are available. This should be done within eight hours of transfer.

(I) Transfer of clinical service.

Transfer of clinical service means transfer of full patient responsibility from one attending physician, dentist, psychologist, or podiatrist to another; the patient may remain on the same unit or a "change of nursing service" may also occur. Admission of a patient from an emergency service to the hospital as an inpatient involves "transfer of clinical service."

For the purposes of writing or electronically entering orders, two essentials of "transfer of clinical service" are necessary:

(1) The initial transfer order must indicate the release of responsibility and control of the patient, pending acceptance by the receiving service. The order may read "transfer (or admit) to Dr., thoracic surgery service."

(2) Transfer of service may be completed only by the receiving service writing or electronically entering an order to the effect "accept in transfer (or admission) to Dr., cardiology service."

Orders effective before the transfer must be renewed, rewritten or reentered upon transfer by the responsible medical practitioner, a limited staff member, or other licensed healthcare professional with appropriate privileges. The new or renewed orders may be written or electronically entered before or at the time of transfer, and may become effective immediately. It is the responsibility of the receiving nurse to establish the availability of new or renewed orders. If new orders are unavailable, then the nurse may continue previous orders and immediately notify the responsible medical practitioner.

(J) Patient orders and the "covering" medical practitioner.

"Coverage" of patient responsibilities for another physician, dentist, psychologist, or podiatrist for a brief period of time does not constitute or require "transfer of clinical service" unless so desired and agreed upon by the physician, dentist, psychologist, or podiatrist and patient.

(K) Hospital discharge/readmission orders.

Hospital discharge from standard inpatient units or day care units to outpatient status requires appropriate discharge orders. Readmission to any inpatient unit requires new, rewritten/reentered or renewed orders by the responsible medical practitioner, a limited staff member, or other licensed healthcare professional with appropriate privileges.

(L) Orders in emergency vehicles.

These rules and regulations apply to university hospital's owned and/or manned emergency care and retrieval vehicles.

(M) Do not resuscitate order.

Do not resuscitate orders must be written or electronically entered in strict compliance with the comprehensive policy guidelines published by the medical staff administrative committee and hospital administration. See hospital policy 03-24.

(N) Hospital admission/observation orders.

Hospital admission/observation requires appropriate admission/observation orders. Admission to any inpatient unit or placing a patient in observation status requires new, rewritten/reentered or renewed orders by the responsible physician,

limited staff member or other licensed healthcare practitioner with appropriate clinical privileges and under the supervision of the collaborating physician.

(Board approval dates: 9/6/2002, 6/4/2004, 5/6/2005, 11/4/2005, 2/2/2007, 6/6/2008, 9/18/2009 4/8/2011)

84-06 Death and autopsy procedures.

(A) Every member of the medical staff shall be actively interested in securing autopsies whenever possible. No autopsy shall be performed without written consent, permission, or direction as prescribed by the laws of Ohio.

(B) All autopsies shall be performed by an attending pathologist with hospital privileges or other attending practitioner who is qualified to perform autopsies. The attending pathologist or his or her designee, who is appropriately credentialed by the hospital, shall have the responsibility of informing the patient's attending physician or designee, who is appropriately credentialed by the hospital, that a proper consent for the performance of an autopsy has been obtained. The anticipated time for the autopsy shall also be reported at this time.

(C) Criteria for autopsy requests include the following:

(1) Coroner's cases when the coroner elects not to perform an autopsy. The county coroner has jurisdiction for performing an autopsy when death is the result of violence, casualty, or suicide, or occurs suddenly in a suspicious or unusual manner. When the coroner elects not to perform an autopsy, a request for an autopsy shall be made pursuant to paragraph (A) of this rule.

(2) Unexpected or unexplained deaths, where apparently due to natural causes or due to those occurring during or following any surgical, medical, or dental diagnostic procedures or therapies.

(3) Undiagnosed infectious disease where results may be of value in treating close contacts.

(4) All deaths in which the cause of death is not known with certainty on clinical grounds.

(5) Cases where there is question of disease related to occupational exposure.

(6) Organ donors (to rule out neoplastic or infectious disease).

(7) Cases in which autopsy may help to allay the concerns of the family or public regarding the death and to provide assurance to them regarding the same.

(8) Deaths in which autopsy may help to explain unknown or unanticipated medical complications to the attending.

(9) Deaths of patients who have participated in investigational therapy protocols.

(10) Deaths in which there is a need to enhance the education and knowledge of the medical staff and house staff. The attending practitioner shall be notified of the autopsies performed by the pathology department.

(D) When an autopsy is performed, provisional anatomic diagnosis should be recorded in the medical record within three days and the complete protocol should be made a part of the record within sixty days.

(Board approval dates: 9/6/2002, 11/2/2007, 9/18/2009)

84-07 Disaster plan.

A civil, military, natural emergency or disaster, may be declared by the medical director and executive director of university hospitals or their designees. The comprehensive planning for triage and treatments of patients presenting for urgent or emergency care shall be the responsibility of the medical director. The departments of emergency medicine and the department of surgery shall be charged with the primary responsibility for trauma patient care.

Upon order of the medical director, patients may be discharged, transferred to another hospital, or moved to other health care facilities in order to make more room for critical ill or injured patients. The medical director and the executive director may participate in local or regional emergency or disaster plans as may be appropriate to save lives and provide adequate medical care and treatment.

(Board approval date: 9/6/2002)

84-08 Emergency care.

(A) Level of services

The emergency department offers level I comprehensive care 24 hours/day. Emergency medical services are provided to any patient requiring appropriate care in the university hospitals emergency department, university hospitals east emergency department or for any pregnant patient in the university hospitals labor and delivery triage unit that provides care 24 hours/day. No patient shall be arbitrarily transferred to another hospital if university hospitals have the capability of proceeding with the necessary care.

(B) Organization

The respective department/unit shall be directed by a physician member of the attending medical staff, known as the medical director. An acting director shall be designated and authorized to perform the functions of the director when the director is not available. Both shall be board certified or eligible in emergency medicine and shall have at least three years training or experience.

(C) Coverage

All patient care is the responsibility of attending, courtesy A and community affiliate medical staff. Medical coverage may be provided by limited staff under supervision by the attending, or courtesy A members of the medical staff. Medical screening examinations shall be performed by members of the medical staff or his/her designee appropriately credentialed by the hospital and under the supervision of the collaborating medical staff member. When a consultation or arrangement for admission is referred to specialty service, the member of the attending medical staff to whom the consult is directed shall be notified of the findings by the limited staff and concur in the treatment plan and disposition of the patient. This shall be recorded in the electronic medical record. When limited staff are unavailable or unable to provide the appropriate level of services, the attending staff member shall be contacted directly by the emergency department staff physician for provision of

necessary and appropriate care. (Sec. bylaws 3335-43-07-B)

(D) Policies.

Written policies in each emergency department and in the labor and delivery triage unit shall be developed by the medical director in consultation with appropriate services. These shall be reviewed at least annually and approved by the medical staff or its representatives and the hospital administration. These shall be revised as needed and dated at time of last review.

(E) Records

Records shall be maintained on all patients in accordance with the rules of the Joint Commission for a level I service. The emergency record shall be incorporated into the permanent hospital electronic medical record.

(Board approval dates: 9/6/2002, 9/18/2009)

84-09 Surgical case review.

Surgical case review shall be performed as part of the hospital's peer review and quality improvement activity on an ongoing basis, at least monthly, by each department/division (as appropriate) regularly doing surgical procedures. The review shall include indications for surgery and all cases in which there is a major discrepancy between preoperative and postoperative (including pathologic) diagnoses. Discrepancies between the clinical impression and tissue removed during a surgical procedure are identified by pathology and then referred to the appropriate department performing surgical procedures for review. A screening mechanism based on predetermined criteria may be established for cases involving no specimens. Written records of the evaluations and any action taken shall be maintained in the quality and operations improvement division, available to the medical director or the director's designee and the clinical department chairperson or their designee.

(Board approval dates: 9/6/2002)

84-10 Tissue disposition.

All tissue and foreign bodies removed during a surgical procedure shall be sent to the pathology laboratory for examination except for the following categories. These exceptions may be invoked by the attending surgeon only when the quality of care is not compromised by the exception, when another suitable means of verification of the removal is routinely employed, and when there is an authenticated operative or other official report that documents the removal. The categories of specimens that may be exempted from pathological examination are the following:

(A) Specimens that by their nature or condition do not permit fruitful examination, such as cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure;

(B) Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements;

(C) Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary;

(D) Foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives;

(E) Specimens known to rarely, if ever, show pathological change, and removal of which is highly visible postoperatively, such as the foreskin from the circumcision of a newborn infant;

(F) Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics; and

(G) Teeth, provided the number, including fragments, is recorded in the medical record.

(Board approval date: 9/6/2002)

84-11 Committees and policy groups.

In addition to the medical staff committees, the medical staff shall participate in the following hospital monitoring functions: infection control, clinical quality management, safety, disaster planning, and in other leadership council advisory policy groups.

(Board approval date: 9/6/2002)

84-12 Medical records.

(A) Each member of the medical staff shall conform to the medical information management department policies, including the following:

(1) Medical Record contents

The attending medical staff member shall be ultimately responsible for the preparation of a complete medical record of each patient. The medical record may contain information collected and maintained by members of the medical staff, limited staff, other licensed healthcare professionals, medical students or providers who participate in the care of the patient in an electronic or paper form. This record shall include the following elements as it applies to the patient encounter:

(a) Identification and demographic data including the patient's race and ethnicity.

(b) The patient's language and communication needs.

(c) Emergency care provided to the patient prior to arrival, if any.

(d) The legal status of patients receiving mental health services.

(e) Evidence of known advance directives.

(f) Statement of present complaint.

(g) History and physical examination.

(h) Any patient generated information.

(i) Provisional diagnosis.

(j) Documentation of informed consent when required.

(k) Any and all orders related to the patient's care.

(l) Special reports, as those from:

(i) The clinical laboratory, including examination of tissues and autopsy findings, when applicable.

(ii) Signed and dated reports of nuclear medicine interpretations, consultations, and procedures.

(iii) The radiology department.

(iv) Consultants.

(m) Medical and surgical treatments.

(n) Progress notes.

(o) Pre-sedation or pre-anesthesia assessment and plans of care for patients receiving anesthesia.

(p) An intra-operative anesthesia record.

(q) Postoperative documentation records, including the patient's vital signs and level of consciousness; medications, including IV fluids, blood and blood components; any unusual events or postoperative complications; and management of such events

(r) Postoperative documentation of the patient's discharge from the post-sedation or post-anesthesia care area by the responsible licensed independent practitioner or according to discharge criteria.

(s) A post-anesthesia follow-up report written within forty-eight hours after surgery.

(t) Reassessments and revisions of the treatment plan.

(u) Every dose of medication administered and any adverse drug reaction.

(v) Every medication dispensed to an inpatient at discharge.

(w) Summary and final diagnosis as verified by the attending medical staff member's signature.

(x) Discharge disposition, condition of patient at discharge, and instructions given at that time and the plan for follow up care.

(y) Any referrals and communications made to external or internal providers and to community agencies.

(z) Any records of communication with the patient made by telephone or email or patient electronic portal.

(2) Deadlines and sanctions.

(a) A procedure note shall be entered in the record by the responsible attending medical staff member or the medical staff member's designee, who is appropriately credentialed by the hospital, immediately upon completion of an invasive

procedure. Procedure notes must be written for any surgical or medical procedures, irrespective of their repetitive nature, which involve material risk to the patient. Notes for procedures completed in the operating rooms must be finalized in the operating room information system by the attending surgeon. For any formal operative procedures, a note shall include preoperative and postoperative diagnoses, procedure(s) performed and description of each procedure, surgeon(s), resident(s), anesthesiologist(s), surgical service, type of anesthesia (general or local), complications, estimated blood loss, any pertinent information not included on the O.R./anesthesia record, preliminary surgical findings, and specimens removed and disposition of each specimen. Where a formal operative report is appropriate, the report must be completed immediately following the procedure. The operative/procedure report must be signed by the attending medical staff member. Any operative/procedure report not completed or any procedure note for procedures completed in the operating rooms not completed in the operating room information system by ten a.m. the day following the procedure shall be deemed delinquent and the attending medical staff member responsible shall lose operating/procedure room and medical staff privileges the following day. The operating rooms and procedure rooms will not cancel cases scheduled before the suspension occurred. Effective with the suspension, the attending medical staff member will lose all privileges to schedule elective and add-on cases. The attending medical staff member will only be allowed to schedule emergency cases until all delinquent operative/procedure reports are completed. All emergency cases scheduled by suspended medical staff members are subject to the review of the medical director and will be reported to the suspended medical staff members' chief of the clinical department and the medical director by the operating room staff. Affected medical staff members shall receive telephone calls from the medical information management department indicating the delinquent operative/procedure reports.

(b) Progress notes must provide a pertinent chronological report of the patient's course in the hospital and reflect any change in condition, or results of treatment. In the event that the patient's condition has not changed, and no diagnostic studies have been done, a progress note must be completed by the attending medical staff member or his or her designated member of the limited medical staff or practitioner with appropriate privileges at least once every day.

Each medical student or other licensed health care professional progress note in the medical records should be signed or counter-signed by a member of the attending, courtesy, or limited staff.

(c) Birth certificates must be signed by the medical staff member who delivers the baby within one week of completion of the certificate. Fetal death certificates and death certificates must be signed and the cause of death must be recorded by the medical staff member with a permanent Ohio license within 24 hours of death.

(d) Outpatient visit notes and letters to referring physicians, when appropriate, shall be completed within three days of the patient's visit.

(e) All entries not previously defined must be signed within ten business days of completion.

(f) Queries by clinical documentation specialists requesting clarification of a patient's diagnoses and procedures will be resolved within five business days of confirmed notification of request.

(g) Office visit encounters shall be closed within one week of the patient's visit.

(3) Discharges

(a) Patients shall be discharged only on written or electronically entered order of the responsible medical staff member, limited staff member, or other licensed healthcare professional with appropriate clinical privileges. At the time of ordering the patient's discharge or at the time of the medical staff member's next visit to the hospital (if the attending medical staff member has authorized a member of the limited staff to sign the order of discharge), the attending medical staff member shall see that the record is complete. The attending medical staff member or his or her designee, who is appropriately credentialed by the hospital, is responsible for verifying the principal diagnosis, secondary diagnoses principal procedure, and other significant invasive procedures in the medical record by the time of discharge. If a principal diagnosis cannot be determined in the absence of outstanding test results, the attending medical staff member or his or her designee, who is appropriately credentialed by the hospital, must record a "provisional" principal diagnosis by the time of discharge.

(b) The discharge summary for each patient must be completed by the responsible attending medical staff member or the medical staff member's designee, who is appropriately credentialed by the hospital, before the patient's discharge or transfer to a non-OSU health system facility. All other discharge summaries must be completed by the responsible attending medical staff member or the medical staff member's designee, who is appropriately credentialed by the hospital, within three days of discharge. Electronic discharge instructions will suffice for the discharge summary if they contain the following: hospital course including reason for hospitalization and significant findings upon admission; principal and secondary diagnoses; relevant diagnostic test results; procedures performed and care, treatment and services provided to the patient; condition on discharge; medication list and medication instruction; the plan for follow-up tests and studies where results are still pending at discharge; coordination and planning for follow-up testing and physician appointments; plans for follow-up communication, and instructions.

(c) A complete summary is required on all patients who expire, regardless of length of stay.

(d) Any discharge summary must be signed by the responsible attending medical staff member.

(e) All medical records must be completed by the attending medical staff member or, when applicable, by the attending medical staff member's designee, who is appropriately credentialed by the hospital, within twenty-one (21) days of discharge of the patient. Attending medical staff members shall be notified prior to suspension for all incomplete records. After notification, attending medical staff members shall have their admitting and operative scheduling privileges suspended until all records are completed. A list of delinquent incomplete records, by attending medical staff members, shall be prepared and distributed by the medical information management department once each week. If an attempt is made by the attending medical staff member, or the attending medical staff member's designee, who is appropriately credentialed by the hospital, when applicable, to complete the record, and the record is not available, the record shall not be counted against the attending medical staff member. Medical staff members who are suspended for a period of longer than one hundred twenty (120) consecutive days are required to appear before the practitioner evaluation committee.

(f) Records which are incomplete, more than twenty-one (21) days after discharge or the patient's visit are defined as delinquent.

(4) Confidentiality.

Access to medical records is limited to use in the treatment of patients, research, and teaching. All medical staff members are required to maintain the confidentiality of medical records. Improper use or disclosure of patient information is subject to disciplinary action.

(5) Ownership.

Medical records of hospital-sponsored care including pathological examinations, slides, radiological films, photographic records, cardiographic records, laboratory reports, statistical evaluations, etc. are the property of the hospital and shall not be removed from the hospital's jurisdiction and safekeeping except in accordance with a court order, subpoena, or statute.

(6) Records storage and security.

In general, medical records shall be maintained by the hospital. Records on microfilms, paper, electronic tape recordings, magnetic media, optical disks, and such other acceptable storage techniques shall be used to maintain patient records for twenty-one (21) years. In the case of readmission of the patient, all records or copies thereof from the past twenty-one (21) years shall be available for the use of the attending medical staff member or other health care providers.

(7) Informed consent documentation.

(a) Where informed consent is required for a special procedure (such as surgical operation), documentation that such consent has been obtained must be made in the hospital record prior

to the initiation of the procedure. Such documentation shall be incompliance with the hospitals policy and procedure manual section 03-27.

(b) In the case of limb amputation, a limb disposition form, in duplicate, must be signed prior to the operation.

(8) Sterilization consent.

Prior to the performance of an operative procedure for the expressed purpose of sterilization of a (male or female) patient, the attending medical staff member shall be responsible for the completion of the legal forms provided by the hospital and signed by the patient. Patients who are enrolled in the Medicaid program must have their forms signed at least 30 days prior to the procedure. Informed consent must also be obtained from one of the parents or the guardian of an unmarried minor.

(9) Criteria changes.

The medical information management department shall define the criteria for record completion subject to the approval of the medical staff.

(10) Entries and authentication.

(a) Entries in the medical record can only be made by staff recommended by the medical information management department subject to the approval of the medical staff.

(b) All entries must be legible and complete and must be authenticated, timed and dated promptly by the person, identified by name and discipline, who is responsible for ordering, providing, or evaluating the service furnished.

(c) The electronic signature of medical record documents requires a signing password. At the time the password is issued, the individual is required to sign a statement that she/he will be the only person using the password. This statement will be maintained in the department responsible for the electronic signature system.

(d) Signature stamps may not be used in the medical record.

(Board approval dates: 9/6/2002, 3/5/2003, 6/4/2004, 5/6/2005, 11/4/2005, 2/2/2007, 11/2/2007, 6/6/2008, 9/18/2009, 4/8/2011, 8/31/2012)

84-13 Operating room committee.

(A) The operating room committee shall have representation from clinical departments using the operating room, the medical director of the operating room, nursing, director of the operating room, the operating room coordinator, and hospital administration. The committee is appointed by the medical director in consultation with the executive director of university hospitals. The committee shall meet at least quarterly and carry out the following duties:

(1) Insure that surgical privileges have been delineated for each member of the medical staff who uses the operating rooms.

(2) Develop written policies and procedures concerning the scope and

provision of care in the surgical suite in cooperation with the departments and services concerned.

(3) Consider problems in operating room functions brought to its attention by any of its members.

(4) Monitor medical staff compliance with operating room policies established for patient safety, infection control, and smooth functioning of the operating rooms.

(5) Develop and make recommendations to the medical staff administrative committee regarding conduct of medical staff in the operating rooms.

(6) Maintain written records of actions taken, and results of those actions, and make these available to each committee member, the vice president for health sciences, the medical director, the executive director, and the associate executive directors.

(7) The operating room committee shall be a hospital committee and be appointed in accordance with policies and procedures of the Ohio state Wexner medical center board.

(B) Each member of the medical staff shall conform to the policies established by the operating room committee, including the following:

A member of the attending surgical staff shall be present in person during surgical procedures and a member of the attending anesthesiology staff shall be present in person during anesthetization, shall be familiar with the progress of the procedure, and be immediately available at all times during the procedure.

(Board approval dates: 9/6/2002, 5/14/2010)

84-14 Pharmacy and therapeutics committee.

The pharmacy and therapeutics and drug utilization committee shall be appointed in conformity with these bylaws and have representation from medical staff, nursing, pharmacy department, and hospital administration. The majority of members shall be members of the medical staff. The committee shall meet at least quarterly and carry out the following duties:

(A) Review the appropriateness, safety, and effectiveness of the prophylactic, empiric, and therapeutic use of drugs, including antibiotics, through the analysis of individual or aggregate patterns of drug practice.

(B) Provide the medical and hospitals staff with information and advice concerning the proper use of drugs and related products. Monitor and evaluate those drugs which are most prescribed, known to present problems or risks to patients, and which constitute a critical part of a patient's specific diagnosis, condition or procedure.

(C) Consider the welfare of patients as well as education, research and economic factors when analyzing the utilization of drugs and related products.

(D) Advise on the use and control of experimental drugs.

(E) Develop or approve policies and procedures relating to the selection, distribution, use, handling, and administration of drugs and diagnostic testing materials.

(F) Review all significant untoward drug reactions.

(G) Maintain the Formulary of Accepted Drugs with review of proposed additions and deletions and review of use of non-formulary drugs within the institution.

(H) Maintain written reports of conclusions, recommendations, actions taken, and the results of actions taken, and report these at least quarterly to the medical staff administrative committee.

(I) Create sub-committees, as follows: pharmacy and therapeutic and drug utilization executive sub-committee; formulary sub-committee; antibiotic usage sub-committee; medical safety and policy sub-committee; and the therapeutic drug monitoring sub-committee.

(J) The therapeutic drug utilization monitoring sub-committee shall:

(1) Establish methods by which serum blood levels may be used to improve the therapeutic activity of drugs.

(2) Establish programs to educate health care providers to the appropriate methods of monitoring the therapeutic effect in drugs via serum drug assays.

(3) Provide guidance to the therapeutic drug monitoring service at university hospitals.

(4) Recommend the development of policies and procedures to the pharmacy and therapeutic and drug utilization executive sub-committee.

(Board approval dates: 4/7/2000, 9/6/2002)

84-15 Transfusion and isoimmunization committee.

(A) The transfusion and isoimmunization committee shall be appointed pursuant to these bylaws and include representation from physicians of the clinical departments frequently using blood products, nursing, transfusion service, and hospital administration. The majority of members shall be members of the medical staff. The committee shall meet at least quarterly and carry out the following duties:

(1) Evaluate the appropriateness of all transfusions, including the use of whole blood and blood components.

(2) Evaluate all confirmed or suspected transfusion reactions.

(3) Develop and recommend to the medical staff administrative committee policies and procedures relating to the distribution, use, handling, and administration of blood and blood components.

(4) Review the adequacy of transfusion services to meet the needs of patients.

(5) Review ordering practices for blood and blood products.

(6) Provide a liaison between the clinical departments, nursing services, hospital administration, and the transfusion service.

(7) Use clinically valid criteria for screening and more intensive evaluation of known or suspected problems in blood usage.

(8) Keep written records of meetings, conclusions, recommendations, and

actions taken, and the results of actions taken, and make these available to each committee member and to the medical staff administrative committee.

(B) Each member of the medical staff shall conform to the policies established by the transfusion and isoimmunization committee, including the following:

(1) All pregnant patients admitted for delivery or abortion shall be tested for Rh antigen.

(2) No medication may be added to blood or blood products.

(Board approval dates: 4/7/2000, 9/6/2002, 6/4/2004)

84-16 Standards of practice.

(A) Surgical schedules shall be reviewed by the attending surgeon prior to the day of surgery. Attending surgeons must notify the operating room prior to the first scheduled case that they are physically present in the hospital and immediately available to participate in the case. Attending surgeons may accomplish this by being physically present in the operating room or by calling the operating room to notify the staff of such immediate availability. The operating room must be informed of the attending surgeon's availability prior to anesthetizing the patient. The only exception is in an emergency situation, where waiting might compromise the patient's safety.

(B) All medical staff members must abide by the quality and safety protocols that may be defined by the medical staff administrative committee and the Wexner medical center board.

(C) Inpatients must be seen daily by an attending physician with no exceptions to provide the opportunity of answering patient and family questions.

(Board approval date: 4/8/2011)

84-17 Mechanism for changing rules and regulations.

(A) These rules and regulations may be amended pursuant to the medical staff bylaws section 3335-43-13.

(B) Amendments so accepted shall become effective when approved by the Ohio state Wexner medical center board.

(C) These rules and regulations shall not conflict with the rules and regulations of the board of trustees of the Ohio state university.

(D) Each member of the medical staff and those having delineated clinical privileges shall have access to an electronic copy of the rules and regulations upon finalization of the approved amendment changes.

(Board approval date: 4/8/2011)

84-18 Adoption of the rules and regulations.

These rules and regulations shall be adopted by the medical staff administrative committee and forwarded for approval in the same fashion as provided in Section 84-16.

(Board approval date: 4/8/2011)

84-19 Sanctions.

Each member of the medical staff shall abide by policies approved by the medical staff administrative committee and by the Ohio state university hospitals. Failure to abide may result in suspension of some or all hospital privileges.

(Board approval date: 4/8/2011)

(Attachment XXII)

BACKGROUND

MEDICAL STAFF RULES AND REGULATIONS
Arthur G. James Cancer Hospital and Richard J. Solove Research Institute

01 Ethical Pledge.

(A) Each member of the medical staff and health care providers with clinical privileges shall pledge adherence to standard medical ethics, including:

(1) Refraining from fee splitting or other inducements relating to patient referral;

(2) Providing for continuity of patient care;

(3) Refraining from delegating the responsibility for diagnosis or care of hospitalized patients to a medical or dental practitioner or other licensed healthcare professional who is not qualified to undertake this responsibility or who is not adequately supervised;

(4) Seeking consultation whenever necessary; and

(5) Never substituting physicians without the patient's knowledge or appropriate consent.

(Board approval dates: 7/7/2006, 8/31/2012)

02 Admission procedures.

(A) Except in an emergency, in the interest of assignment to the appropriate service, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated by the patient's attending physician a member of the attending staff, limited staff member or other licensed healthcare professional who is appropriately credentialed by the hospital and under the supervision of the responsible medical staff member. The request for admission shall also include the following information:

(1) Any facts essential for the protection of the general hospital population against unnecessary exposure to infectious and other communicable diseases.

(2) Any information which will warn responsible hospital personnel of any tendency of any patient to commit suicide or to injure others because of mental disturbance.

(3) Any information concerning physical condition or personality idiosyncrasy which might be objectionable to other patients who might be occupying the same or adjoining rooms.

(B) It shall be the responsibility of the attending physician to notify hospital or medical staff personnel of the existence of mental or substance disorders and to order such precautionary measures as may be necessary to assure protection of the patient and the protection of others whenever a patient might be a source of danger. The attending physician is responsible to provide a comprehensive plan of care, including emergency care.

(Board approval date: 9/18/2009)

03 Attending assignment.

(A) All patients entering the Arthur G. James cancer hospital and Richard J. Solove research institute (CHRI) who have not requested the services of a member of the medical staff to be responsible for their care and treatment while a patient therein shall be assigned to a member of the attending staff of the service concerned with the treatment of the disease, injury, or condition which necessitated the admission of the patient to the CHRI. This shall also apply to the transfer of patients within the services of the CHRI.

(B) Alternative attending medical staff member coverage.

Each division shall have a plan for medical coverage. Each member of the medical staff shall designate on his or her medical staff application one or more members of the attending or limited medical staff who have accepted this responsibility and who shall be called to attend his or her patients if the responsible attending medical staff member is not available, the director of medical affairs, section chiefs, department chair or his designee shall have authority to contact any member of the medical staff and arrange for coverage should the attending medical staff member and the alternate be unavailable.

(C) In the case of a medical or psychiatric emergency involving a patient, visitor or CHRI staff member in an inpatient or outpatient setting, any individual who is a member of the medical staff or who has been delineated privileges is permitted to do everything possible to save the life or prevent serious harm regardless of the individual's staff status or clinical privileges.

(Board approval dates: 11/4/2005, 2/11/2011)

04 Consultations.

(A) Consultation requirements.

When a patient care problem is identified that requires intervention during the hospital stay that is outside the medical staff member's area of training and experience, it is the responsibility of the medical staff member or his or her designee (with appropriate credentials) to obtain consultation by the appropriate specialist. The consultation may be ordered by the responsible medical practitioner, a member of the limited staff, or another licensed healthcare professional with appropriate clinical privileges as designated in these rules and regulations. If a consultation is ordered prior to 10 a.m., the consult shall occur on the same business day. If a consultation is ordered after 10 a.m., the consult shall occur within twenty-four hours. Each patient is continuously assessed and his or her plan for care if modified as necessary.

(B) Responsibility to monitor consultations.

It is the duty of the medical staff, through its clinical section chief and the medical staff administrative committee, to assure that members of the staff comply in the matter of requesting consultations as needed.

(C) Consultation contents.

A satisfactory consultation shall be rendered within one day of the request and shall include examination of the patient, examination of the medical record, and a written

opinion signed by the consultant that is made a part of such record. If operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

(Board approval dates: 11/4/2005, 7/7/2006, 2/6/2009, 9/18/2009, 4/8/2011)

05 Order writing privileges.

(A) Definition of "patient orders".

(1) A patient order(s) is a prescription for care or treatment of patients. An order can be given verbally, electronically or in writing to qualified personnel identified by category in paragraph (C) of this rule and shall be authenticated by the licensed medical practitioner, a member of the limited staff, or another licensed healthcare professional with appropriate clinical privileges. Patient orders may be given initially, renewed, discontinued or cancelled. Throughout these rules and regulations, the word “written” and its grammatical derivatives, as used to describe a nonverbal order, refer to both written and electronically entered orders.

(2) Electronic orders are equivalent and have the same authority as written orders. Electronic orders have been expressly structured to mirror these rules and regulations and all policy guidelines adopted by the medical staff and hospital administration.

(B) Responsible medical practitioner.

All patient care is the responsibility of the attending, associate attending, clinical attending, or community associate attending staff. Coverage may be provided by the limited staff or another licensed healthcare professional with appropriate clinical privileges under supervision. The licensed physician, dentist, podiatrist, or psychologist (under medical doctor supervision) with appropriate clinical privileges responsible for the hospitalization or outpatient care, and treatment of the patient is responsible for all orders for the patient. Attending, associate attending and clinical medical staff may designate members of the limited staff, or other licensed healthcare professionals with appropriate clinical privileges to write or electronically enter orders under their direction. The attending staff member may also designate members of the pre-M.D. medical student group to write or electronically enter orders, but in all cases these orders shall be signed by the physician, dentist, psychologist, podiatrist, or designated limited staff member who has the right to practice medicine, dentistry, psychology, or podiatry and who is responsible for that patient's care prior to the execution of the order. Supervising physicians may delegate to a medical staff member (who is appropriately credentialed) the ability to relay, enter, transcribe or write orders for routine laboratory, radiologic and diagnostic studies under their direction, but, in all cases, the order shall be co-signed by the supervising physician within 24 hours of the order being written. Community associate staff coverage may be provided by the limited staff under supervision.

(C) Telephone and verbal orders may be given by the responsible attending physician, dentist, podiatrist, psychologist, member of the limited medical staff, or other licensed healthcare professionals with appropriate clinical privileges only to health care providers who have been approved in writing by title or category by the director of medical affairs and each chief of the clinical service where they will exercise clinical privileges, and only where said health care provider is exercising responsibilities which have been approved and delineated by job description for employees of the hospital, or by the customary medical staff credentialing process when the provider is not an employee of the hospital. Lists of the approved titles or

categories of providers shall be maintained by the director of medical affairs. Verbal orders should be utilized infrequently. The individual giving the verbal or telephone order must verify the complete order by having the person receiving the information record and "read back" the complete order to assure the quality and safety of patient care. The job description or delineated privileges for each provider must indicate each provider's authority to receive telephone or verbal orders, including but not limited to the authority to receive orders for medications. The order is to be recorded and authenticated by approved health care provider to whom it is given as "verbal order by _____," or "V.O. or T.O. by _____," giving the licensed healthcare practitioner's name and the time of the order, followed by the approved health care provider's signature and date, and read back in its entirety to the ordering physician, dentist, psychologist, podiatrist, designated limited staff member, or other licensed healthcare professionals with appropriate clinical privileges. All verbal orders for DEA schedule II controlled substances, patient seclusion, or patient restraint must be authenticated within twenty-four (24) hours by signature of a licensed physician, dentist, podiatrist, psychologist, or designated limited staff member or other licensed healthcare professionals with appropriate clinical privileges. Verbal orders for directives of urgent issues that cannot be addressed by the prescriber's order entry are encouraged to be signed electronically within 48 hours, but must be authenticated within twenty-one (21) days by signature by a licensed physician, dentist, podiatrist, psychologist, limited staff member, or other licensed healthcare professionals with appropriate clinical privileges.

(D) Standing orders.

Standing orders for medications are only approved in emergency situations. All other standing orders must be developed, approved, used and monitored in strict compliance with the standing orders medical staff policy approved by the medical staff administrative committee and hospital administration.

(E) Preprinted orders.

Preprinted order forms for patients must be reviewed, dated, timed and signed by a responsible medical practitioner, a limited staff member, or other licensed healthcare professionals with appropriate clinical privileges before becoming effective.

(F) Investigational drug orders.

Evidence of informed patient consent must be available to a nurse or pharmacist before an investigational agent is ordered and administered. Investigational drugs may be ordered only upon authorization of the principal or co-investigator or other delegated physician, dentist, or podiatrist named in FDA forms 1572 or 1573. Registered nurses or pharmacists who are knowledgeable about the investigational agents may administer the drugs to patients.

(G) Change of nursing service.

Level of care is defined as the type and frequency of medical and nursing interventions required to appropriately manage the medical and nursing care requirements of the patient. "Change of level of care" means official and physical movement (transfer) of a patient from an inpatient or observation care unit providing one level of care to another providing a different level of care, with or without change in attending physician, dentist, psychologist or podiatrist or clinical service. Orders effective before transfer must be reviewed, renewed or rewritten upon transfer by signature of a responsible medical practitioner. The new or renewed orders may be written or electronically entered before or when the patient arrives on the receiving unit and may become effective immediately.

In each case of "change of nursing service," it is the responsibility of the receiving nurse to establish the availability of renewed or new written or electronically entered orders. Prior orders will remain in effect until new orders are available. This should be done within eight hours of transfer.

(H) “Transfer of clinical service” means transfer of full patient responsibility from one attending physician, dentist, psychologist or podiatrist to another; the patient may remain on the same unit or a change in patient care area may also occur. Admission of a patient from an emergency service to the hospital as an inpatient involves "transfer of clinical service."

For the purposes of order writing or electronically entering orders, two essentials of "transfer of clinical service" are necessary:

(1) The initial transfer order must indicate the release of responsibility and control of the patient, pending acceptance by the receiving service. The order may read "transfer (or admit) to Dr., head and neck service."

(2) Transfer of service may be completed only by the receiving service writing an order to the effect "accept in transfer (or admission) to Dr., head and neck service."

Orders effective before the transfer must be renewed or rewritten upon transfer by signature of a responsible medical practitioner, a limited staff member, or other licensed healthcare professionals with appropriate clinical privileges. The new or renewed orders may be written or electronically entered before or at the time of transfer, and may become effective immediately. It is the responsibility of the receiving nurse to establish the availability of new or renewed orders. If new orders are unavailable, then the nurse may continue previous orders and immediately notify the responsible medical practitioner, a limited staff member, or other licensed healthcare professionals with appropriate clinical privileges

(I) Patient orders and the "covering" medical practitioner.

"Coverage" of patient responsibilities for another physician, dentist or podiatrist for a brief period of time does not constitute or require "transfer of clinical service" unless so desired and agreed upon by the physician, dentist, or podiatrist and patient.

(J) Hospital discharge/readmission orders.

Hospital discharge from standard inpatient units or day care unit to outpatient status requires appropriate discharge orders. Readmission to any inpatient unit requires new, rewritten/reentered or renewed orders by signature of the responsible medical practitioner, limited staff member, or other licensed healthcare professional with appropriate privileges and under the supervision of the responsible medical staff member.

(K) Do not resuscitate orders.

The order for do not resuscitate indicating that the patient should not undergo cardiopulmonary resuscitation may be written only by the attending physician or his delegate. Verbal orders for do not resuscitate will not be accepted under any circumstances. The order for do not resuscitate may be rescinded only by the attending physician or delegate and an order must be written to annul said order. Please refer to hospital policy 03-24 do not resuscitate orders for further details.

(L) Hospital admission/observation orders.

Hospital admission/observation requires appropriate admission/observation orders. Admission to any inpatient unit or placing a patient in observation status requires new, rewritten/reentered or renewed orders by the responsible medical practitioner or limited staff member or other licensed healthcare professional with appropriate privileges and under the supervision of the responsible medical staff member.

06 Death procedures.

(A) Every member of the medical staff shall be actively interested in securing necropsies in every death on their service. No autopsy shall be performed without written consent, permission, or direction as prescribed by the laws of Ohio.

(B) The death of a patient in the hospital within twenty-four hours of admission must be reported to the proper legal authorities under the laws of Ohio.

(C) When a necropsy is performed, provisional anatomic diagnosis should be recorded in the medical record within three days and the complete protocol should be made a part of the record within sixty days.

(D) Criteria for autopsy requests include the following:

(1) Coroner's cases when the coroner elects not to perform an autopsy. The county coroner has jurisdiction for performing an autopsy when death is the result of violence, casualty, or suicide, or occurs suddenly in a suspicious or unusual manner. Deaths occurring during surgery or within twenty-four (24) hours of admission to the hospital are also coroner's cases, and the decision whether to autopsy is the coroner's responsibility. When the coroner elects not to perform an autopsy, a request of an autopsy shall be made pursuant to paragraph (A) of this rule.

(2) Unexpected or unexplained deaths, where apparently due to natural causes or due to those occurring during or following any surgical, medical, or dental diagnostic procedures or therapies.

(3) Undiagnosed infections disease where results may be of value in treating close contacts.

(4) All deaths in which the cause of death is not known with certainty on clinical grounds.

(5) Cases where there is question of disease related to occupational exposure.

(6) Organ donors (to rule out neoplastic or infectious disease).

(7) Cases in which autopsy may help to allay the concerns of the family or public regarding the death and to provide assurance to them regarding the same.

(8) Deaths in which autopsy may help to explain unknown or unanticipated medical complications to the attending.

(9) Deaths of patients who have participated in investigational therapy protocols.

(10) Deaths in which there is a need to enhance the education and knowledge of the medical staff and house staff. The attending practitioner shall be notified of the autopsies performed by the pathology department.

(E) When an autopsy is performed, provisional anatomic diagnosis should be recorded in the medical record within three days and the complete protocol should be made a part of the record within sixty days.

(Board approval date: 11/4/2005)

07 Emergency preparedness.

(A) Emergency care.

Emergency care is considered to be treatment rendered to stabilize the patient prior to transport to the Ohio state university hospital's emergency department or other appropriate facility as the patient's condition dictates.

(B) Disaster preparedness.

In case of a civil, military, natural emergency or disaster, patients may be discharged from the CHRI, moved to other community hospitals, or moved to other facilities made available for the care and treatment of patients, by the order of the director of medical affairs of the CHRI or the director of medical affairs designated agent, to preserve life and health, to make room for more critically ill or injured patients sent to the hospitals from a disaster area or for the purpose of saving lives and to provide adequate medical care and treatment.

(Board approval dates: 11/4/2005, 2/6/2009)

08 Surgical case review (Tissue committees).

Surgical case review shall be performed on an on-going basis by each department regularly doing surgical procedures in conjunction with the clinical quality management committee. The review shall include indications for surgery and all cases in which there is a major discrepancy between preoperative and postoperative (including pathologic) diagnoses. Discrepancies between the clinical impression and tissue removed during a surgical procedure are identified by pathology and then referred to the appropriate department for review. A screening mechanism based on predetermined criteria may be established for cases involving no specimens. Written records of the evaluations and any action taken shall be maintained in the quality and operations improvement department, and be available to the director of medical affairs, the CHRI section chief, department chairperson or their designees.

(Board approval date: 11/4/2005)

09 Tissue disposition.

All tissue and foreign bodies removed during a surgical procedure shall be sent to the pathology laboratory for examination except for the following categories. These exceptions may be invoked by the attending surgeon only when the quality of care is not compromised by the exception when another suitable means of verification of the removal is routinely employed and when there is an authenticated operative or other official report that documents the removal. The categories of specimens that may be exempted from pathological examination are the following:

(A) Specimens that by their nature or condition do not permit fruitful examination, such as cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure;

(B) Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements;

(C) Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary;

(D) Foreign bodies (for example bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives.

(E) Specimens known to rarely if ever show pathological change, and removal of which is highly visible postoperatively.

(F) Teeth, provided the number including fragments is recorded in the medical record.

(G) Specimens for gross only examination.

(H) Medical devices. Soft tissue accompanying medical devices may be submitted for microscopic examination if deemed appropriate by the pathologist.

(I) Foreign bodies that are hard and cannot be decalcified. Accompanying soft tissue may be submitted for microscopic examination if deemed appropriate by the pathologist.

(J) Portions of bone removed from feet for bunions/hammer toes, if microscopic exam deemed unnecessary by pathology.

(K) Portions of rib removed for operative exposure only and not designated "disposal only." At the pathologist's discretion, marrow samples from such ribs may be submitted for microscopic examination.

(L) Nasal bone and cartilage removed for deviated septum (does not apply if deviation due to neoplastic or inflammatory process). If soft tissue accompanies nasal bone and cartilage, it may be examined at pathologist's discretion.

(Board approval date: 11/4/2005)

10 Medical records.

(A) Each member of the medical staff shall conform to the following medical information management department policies:

(1) Medical Record contents

(a) The attending physician is ultimately responsible for the preparation of a complete medical record for each patient. The medical record may contain information collected and maintained by members of the medical staff, limited staff, other licensed healthcare professionals, medical students or providers who participate in the care of the patient. This record shall including the following elements as it applies to the patient encounter:

(i) Identification demographic data including the patient’s race and ethnicity.

(ii) The patient's language and communication needs.

(iii) Emergency care provided to the patient prior to arrival, if any.

(iv) The legal status of patients receiving mental health services.

(v) Evidence of known advance directives.

(vi) Statement of present complaint.

(vii) History and physical examination.

(viii) Any patient generated information.

(ix) Provisional diagnosis.

(x) Documentation of informed consent when required.

(xi) Any and all orders related to the patient's care.

(xii) Special reports, as those from:

(a) The clinical laboratory, including examination of tissues and autopsy findings, when applicable.

(b) Signed and dated reports of nuclear medicine interpretations, consultations, and procedures.

(c) The radiology department.

(d) Consultants as verified by the attending medical staff member's signature.

(xiii) Medical and surgical treatments.

(xiv) Progress notes.

(xv) Pre-sedation or pre-anesthesia assessment and plans of care for patients receiving anesthesia.

(xvi) An intra-operative anesthesia record.

(xvii) Postoperative documentation records, the patient's vital signs and level of consciousness; medications, including IV fluids, blood and blood components; any unusual events or postoperative complications; and management of such events.

(xviii) Postoperative documentation of the patient's discharge from the post-sedation or post-anesthesia care area by the responsible licensed independent practitioner or according to discharge criteria.

(xix) A post anesthesia follow up report written within forty eight (48) hours after surgery by the individual who administers the anesthesia.

(xx) All reassessments and any revisions of the treatment plan.

(xxi) Every dose of medication administered and any adverse drug reaction.

(xxii) Every medication dispensed to an inpatient at discharge.

(xxiii) Summary and final diagnosis as verified by the attending physician's signature.

(xxiv) Discharge disposition, condition of patient at discharge, instructions given at that time and the plan for follow up care.

(xxv) Any referrals and communications made to external or internal providers and to community agencies.

(xxvi) Any records of communication with the patient made by telephone or email or patient electronic portal.

(xxvii) Memorandum copy of the death certificate when applicable.

(2) Deadlines and sanctions

(a) A procedure note shall be entered in the record by the responsible attending medical staff member or the medical staff member's designee (who is appropriately credentialed) immediately upon completion of an invasive procedure. Procedure notes must be written for any surgical or medical procedures, irrespective of their repetitive nature, which involve material risk to the patient. Notes for procedures performed in the operating rooms must be finalized in the operating room information system by the attending surgeon. For any formal operative procedures, a note shall include pre-operative and post-operative diagnoses, procedure(s) performed and description of each procedure, surgeon(s), resident(s), anesthesiologist(s), surgical service, type of anesthesia (general or local), complications, estimated blood loss, any pertinent information not included on the O.R./anesthesia record, preliminary surgical findings, and specimens removed and disposition of each specimen. Where a formal operative procedure report is appropriate, the report must be completed immediately following the procedure. The operative/procedure report must be signed by the attending medical staff member. Any operative/procedure report not completed or any procedure note for procedures completed in the operating rooms not completed in the operating room information system by 10:00 a.m. the day following the procedure shall be deemed delinquent and the attending medical staff member responsible shall lose

operating/procedure room and medical staff privileges the following day. The operating rooms and procedure rooms will not cancel cases scheduled before the suspension occurred. Effective with the suspension, the attending medical staff member will lose all privileges to schedule elective cases. Affected medical staff members shall receive telephone calls from the medical information management department indicating the delinquent operative/procedure reports.

(b) Progress notes must provide a pertinent chronological report of the patient's course in the hospital and reflect any change in condition or results of treatment. A progress note must be completed by the attending medical staff member or his or her designated member of the limited medical staff or practitioner with appropriate privileges at least once every day. Each medical student or other licensed health care professional progress note in the medical records should be signed or counter-signed by a member of the attending, courtesy, or limited staff.

(c) Birth certificates must be signed by the medical staff member who delivers the baby within one week of completion of the certificate. Fetal death certificates and death certificates must be signed and the cause of death must be recorded by the medical staff member with a permanent Ohio license within 24 hours of death.

(d) Outpatient visit notes and letters to referring physicians, when appropriate, shall be completed within three days of the patient’s visit.

(e) All entries not previously defined must be signed within ten (10) business days of completion.

(f) Queries by clinical documentation specialists requesting clarification of a patient’s diagnoses and procedures will be resolved within five business days of confirmed notification of request.

(g) Office visit encounters shall be closed within one week of the patient’s visit.

(3) Discharges

(a) Patients shall be discharged only on written or electronically entered order of the responsible medical staff member, a limited staff member or other licensed healthcare professional with appropriate clinical privileges. At the time of ordering the patient’s discharge or at the time of next visit to the hospital, if the attending medical staff member has authorized a member of the limited medical staff to sign the order of discharge, the attending medical staff member is responsible for certifying the principal diagnosis, secondary diagnosis, principal procedure, and other significant invasive procedures in the medical record by the time of discharge. If a principal diagnosis cannot be determined in the absence of outstanding test results, the attending medical staff member must record a "provisional" principal diagnosis by the time of discharge.

(b) The discharge summary for each patient must be completed by the responsible medical staff member who is appropriately credentialed or the member's designee (who is appropriately credentialed) before the patient's transfer to a non-OSU facility. All other discharge summaries must be completed by the responsible attending medical staff member or the member's designee, who is appropriately credentialed by the hospital, within three days of discharge. Electronic discharge instructions will suffice for the discharge summary if they contain the following: hospital course including reason for hospitalization and significant findings upon admission; principal and secondary diagnoses; relevant diagnostic test results; procedures performed and care, treatment and services provided to the patient; condition on discharge; medication list and medication instruction; the plan for follow-up tests and studies where results are still pending at discharge; coordination and planning for follow-up testing and physician appointments; plans for follow-up communication, and instructions. A complete summary is required on all patients who expire, regardless of length of stay. Any discharge summary must be signed by the responsible attending medical staff member.

(c) All medical records must be completed by the attending medical staff member or, when applicable, by his/her appropriately credentialed designee within twenty-one (21) days of discharge of the patient. Attending medical staff members who have incomplete records (of patients discharged for more than twenty-one days) assigned to them will have their admitting and operative privileges suspended until all records are completed. A list of delinquent records, by attending medical staff member, will be prepared and distributed by the medical records administrator once each week. The medical staff member will be given one week's notice of an intent to suspend. If an attempt is made by the attending medical staff member, or his/her appropriately credentialed designee when applicable, to complete the record, and the record is not available, the record is not counted against the attending medical staff member until the next list is prepared. Medical staff members who are suspended for a period of longer than one hundred twenty (120) consecutive days are required to appear before the practitioner evaluation committee.

(d) Records which are incomplete greater than twenty-one days after discharge or the patient's visit are defined as delinquent.

(4) Confidentiality.

Access to medical records is limited to use in the treatment of patients, research, and teaching. All medical staff members are required to maintain the confidentiality of medical records. Improper use or disclosure of patient information is subject to disciplinary action.

(5) Ownership.

Medical records of hospital sponsored care are the property of the hospital and shall not be removed from the hospital's jurisdiction and

safekeeping except in accordance with a court order, subpoena, or statute.

(6) Records storage, security, and accessibility.

All patient's records, pathological examinations, slides, radiological films, photographic records, cardiographic records, laboratory reports, statistical evaluations, etc., are the property of the CHRI and shall not be taken from the CHRI except on court order, subpoena or statute duly filed with the medical record administrator or the hospital administration. The hospital administration may, under certain conditions, arrange for copies or reproductions of the above records to be made. Such copies may be removed from the hospital after the medical record administrator or the proper administrative authority has received a written receipt thereof. In the case of readmission of the patient, all previous records or copies thereof shall be available for the use of the attending medical staff member.

In general, medical records shall be maintained by the hospital. Records on microfilms, paper, electronic tape recordings, magnetic media, optical disks, and such other acceptable storage techniques shall be used to maintain patient records for twenty-one (21) years. In the case of readmission of the patient, all records or copies thereof from the past twenty-one (21) years shall be available for the use of the attending medical staff member or other health care providers.

(7) Informed consent documentation.

(a) Where informed consent is required for a special procedure (such as surgical operation), documentation that such consent has been obtained must be made in the hospital record prior to the initiation of the procedure.

(b) In the case of limb amputation, a limb disposition form, in duplicate, must be signed prior to the operation.

(8) Sterilization consent.

Prior to the performance of an operative procedure for the expressed purpose of sterilization of a (male or female) patient, the attending medical staff member shall be responsible for the completion of the legal forms provided by the hospital and signed by the patient. Patients who are enrolled in the Medicaid program must have their forms signed at least thirty (30) days prior to the procedure. Informed consent must also be obtained from one of the parents or the guardian of an unmarried minor.

(9) Criteria changes.

The medical information management department shall make recommendations for changes in the criteria for record completion with approval of the medical staff.

(10) Entries and authentication.

(a) Entries in the medical record can only be made by staff recommended by the medical information management department subject to the approval of the medical staff.

(b) All entries must be legible and complete and must be authenticated, dated and timed promptly by the person, identified by name and credentials, who is responsible for ordering, providing, or evaluating the service furnished.

(c) The electronic signature of medical record documents requires a signing password. At the time the password is issued, the individual is required to sign a statement that she/he will be the only person using the password. This statement will be maintained in the department responsible for the electronic signature.

(d) Signature stamps may not be used in the medical record.

(11) Abbreviations.

Abbreviations, acronyms and symbols appearing on the non-approved abbreviations list may not be used in the medical record.

(Board approval dates: 9/18/2009, 4/8/2011, 8/31/2012)

11 Committees.

In addition to the medical staff committees, the medical staff shall participate in the following hospital and monitoring functions: infection control, clinical quality management, safety, and disaster planning and in other leadership council for clinical quality, safety and service advisor policy groups.

Operating Room Committee

(A) The operating room committee shall have representation from all clinical departments utilizing the operating room. Representation will include: medical director of the CHRI operating room, the section or division chief, or their designee, of: surgery, gynecologic oncology, urology, otolaryngology, radiation oncology, thoracic surgery, surgical oncology, neurological surgery, orthopedic surgery, anesthesia, and plastic surgery; epidemiology/infection control, the medical director of perioperative services for the Ohio state university, the CHRI medical director of quality, the director of perioperative services of the CHRI operating room, the manager of perioperative services, the director of admitting, the operating room coordinator, and the CHRI director of operations. The committee chair will be a CHRI surgeon selected by the nominating committee and shall serve a two-year term beginning on the first of July. The committee shall meet monthly and carry out the following duties:

(1) Develop written policies and procedures concerning the scope and provision of care in the surgical suite in cooperation with the departments and services concerned, including allocation of operating room resources. Allocation of operating room time will be done by the director of medical affairs and approved by the operating room committee.

(2) Monitor quality concerns and consider problems and improvements in operating room functions brought to its attention by any of its members.

(3) Monitor medical staff compliance with operating room policies established for patient safety, infection control, access and throughput, and smooth functioning of the operating rooms.

(4) Maintain written records of actions taken, and results of those actions, and make these available to each committee member, the vice president of health services, the director of medical affairs, and the executive director of the CHRI.

(B) Each member of the medical staff shall conform to the policies established by the operating room committee, including the following:

A member of the surgical attending staff and a member of the anesthesiology staff shall be present in person for crucial periods of surgical procedures and anesthetization, shall be familiar with the progress of the procedure, and be immediately available at all times during the procedure.

Pharmacy and Therapeutics Committee (P & T Committee)

The P & T committee shall be appointed in conformity with the medical staff bylaws and have representation from medical staff, nursing, pharmacy department, and the hospital administration. The majority of members shall be members of the medical staff. The committee shall meet at least quarterly and carry out the following duties:

(A) Review the appropriateness, safety, and effectiveness of the prophylactic empiric and therapeutic use of drugs, including antibiotics, through the analysis of individual or aggregate patterns of drug practice.

(B) Consider the welfare of patients as well as education, research and economic factors when analyzing the utilization of drugs and related products.

(C) Advise on the use and control of experimental drugs.

(D) Develop or approve policies and procedures relating to the selection, distribution, use, handling, and administration of drugs and diagnostic testing materials.

(E) Review all significant untoward drug reactions.

(F) Maintain the Formulary of Accepted Drugs with review of proposed additions and deletions and review of use of non-formulary drugs within the institution.

(G) Maintain written reports of conclusions, recommendations, actions taken, and the results of actions taken, and report these at least quarterly to the medical staff administrative committee.

(H) Create sub-committees, as follows: pharmacy and therapeutic and drug utilization executive sub-committee; formulatory sub-committee; antibiotic usage sub-committee; medication safety and policy sub-committee; and the therapeutic drug monitoring sub-committee.

(I) Establish methods by which serum blood levels may be used to improve the therapeutic activity of drugs.

(J) Establish programs to educate health care providers to the appropriate methods of monitoring the therapeutic effect in drugs via serum drug assays.

(K) Provide guidance to the therapeutic drug monitoring service at the CHRI.

(L) Recommend the development of policies and procedures to the pharmacy and therapeutic and drug utilization executive subcommittee.

Transfusion and Isoimmunization Committee

(A) The transfusion and isoimmunization committee has representation from physicians of the clinical departments frequently using blood products, nursing, transfusion service, and hospital administration. The majority of members shall be members of the medical staff. The committee shall meet at least quarterly and carry out the following duties:

(1) Evaluate the appropriateness of all transfusions, including the use of whole blood and blood components.

(2) Evaluate all confirmed or suspected transfusion reactions.

(3) Develop and recommend to the medical staff administrative committee policies and procedures relating to the distribution, use, handling, and administration of blood and blood components.

(4) Review the adequacy of transfusion services to meet the needs of patients.

(5) Review ordering practices for blood and blood products.

(6) Provide a liaison between the clinical departments, nursing services, hospital administration, and the transfusion service.

(7) Use clinically valid criteria for screening and more intensive evaluation of known or suspected problems in blood usage.

(8) Keep written records of meetings, conclusions, recommendations, and actions taken, and the results of actions taken, and make these available to each committee member and to the medical staff administrative committee.

(B) Each member of the medical staff shall conform to the policies established by the transfusion committee, including the following:

(1) All pregnant patients admitted for delivery or abortion shall be tested for Rh antigen.

(2) No medication may be added to blood or blood products.

Infection Control Committee

(A) The committee members shall be appointed and shall also include representation from nursing, environmental services, and hospital administration. The chairperson will be a physician with experience and/or training in infectious diseases and carry out the following duties.

(1) Oversee surveillance and institute any recommendations necessary for investigation, prevention, and containment of nosocomial and clinical infectious diseases of both patients and staff at all facilities operated by CHRI and subject to TJC standards.

(2) The chairperson of the committee and the hospital epidemiologist, in consultation with the director of medical affairs of the CHRI, will take necessary actions to prevent and control emerging spread or outbreaks of infections; isolate communicable and infectious patients as indicated; and obtain all necessary cultures in emergent situations when the responsible medical staff member is unavailable.

Leadership Council for Clinical Quality, Safety and Service

The leadership council for clinical quality, safety and service shall consist of members appointed pursuant to the university hospital's medical staff bylaws, and shall include the senior vice president for health sciences, the dean of the college of medicine and the chairperson of the professional affairs committee of the Wexner medical center board as ex officio members without a vote, and the director of medical affairs and chief of staff as voting members. The chief quality officer shall be the chairperson of the leadership council for clinical quality, safety and service. The leadership council for clinical quality, safety and service shall authorize policy groups to be formed to accomplish necessary hospital and medical staff functions on behalf of the CHRI and university hospitals.

CHRI representatives on the leadership council for clinical quality, safety and service shall be appointed as provided in the CHRI bylaws.

(A) Duties include:

(1) To design and implement systems and initiatives to enhance clinical care and outcomes throughout the integrated health care delivery systems.

(2) To serve as the oversight council for the clinical quality management and patient safety plan.

(3) To establish goals and priorities for clinical quality, safety and service on an annual basis.

(B) Clinical quality and patient safety committee.

(1) Composition

The members shall include physicians from various clinical areas and support services, the director of clinical quality management policy group, and representation from nursing and hospitals administration. The chairperson of the policy group will be a physician.

(2) Duties

(a) Coordinate the quality management related activities of the clinical sections or departments, the medical information management department, utilization review, infection control, pharmacy and therapeutics and drug utilization committee, transfusion and immunization, and other medical staff and hospital committees.

(b) Implement clinical improvement programs to achieve the goals of the CHRI quality management plan, as well as assure optimal compliance with accreditation standards and governmental regulations concerning performance improvement.

(c) Review, analyze, and evaluate on a continuing basis the performance of the medical staff and other health care providers; and advise the clinical section or department clinical quality sub-committees in defining, monitoring, and evaluating quality indicators of patient care and services.

(d) Serve as liaison between the CHRI and the Ohio peer review organizations through the chairperson of the policy group and the director of clinical quality.

(e) Make recommendations to the medical staff administrative committee on the establishment of and the adherence to standards of care designed to improve the quality of patient care delivered in the CHRI.

(f) Hear and determine issues concerning the quality of patient care rendered by members of the medical staff and hospitals staff, make appropriate recommendations and evaluate action plans when appropriate to the director of medical affairs, the chief of a clinical section or department, or hospitals administration.

(g) Appoint ad-hoc interdisciplinary teams to address hospital-wide quality management plan.

(h) Annually review and revise as necessary the hospital-wide clinical quality management plan.

(i) Report and coordinate with the leadership council for clinical quality, safety and service all quality improvement initiatives.

(C) Clinical resource utilization policy group

(1) Composition

The members shall include physicians from various areas and support services, the director of clinical resource utilization policy group, and representation from nursing and hospitals administration. The chairperson of the policy group will be a physician.

(2) Duties

(a) Promote the most efficient and effective use of hospital facilities and services by participating in the review process and continued stay reviews on all hospitalized patients.

(b) Formulate and maintain a written resource management review plan for hospitals consistent with applicable governmental regulations and accreditation requirements.

(c) Conduct resource management studies by clinical service or by disease entity as requested or in response to variation from benchmark data would indicate.

(d) Report and recommend to the leadership council for clinical quality, safety and service changes in clinical practice patterns in compliance with applicable governmental regulations and accreditation requirements when the opportunity exists to improve the resource management.

(D) Evidence-based practice policy group

(1) Composition

The members shall include physicians from various areas and support services, the director of the practice guidelines policy group, and representation from nursing and hospitals administration. The chairperson of the policy group will be a physician.

(2) Duties

(a) Oversee the planning, development, approval, implementation and periodic review of evidence-based medicine resources (i.e. clinical practice guidelines, quick reference guides, clinical pathways, and clinical algorithms) for use within the CHRI. Planning should be based on the prioritization criteria approved by the leadership council and review should focus on incorporating recent medical practice, literature or developments. Annual review should be done in cooperation with members of the medical staff with specialized knowledge in the field of medicine related to the guidelines.

(b) To report regularly to the leadership council for clinical quality, safety and service for approval of all new and periodically reviewed evidence-based medicine resources for use within the CHRI.

(c) Oversee the development, approval and periodic review of the clinical elements of computerized ordersets and clinical rules to be used within the information system of the CHRI. Computerized ordersets and clinical rules related to specific practice guidelines should be forwarded to the leadership council for clinical quality, safety and service for approval. All other computerized value enhancement for approval. All other computerized ordersets and clinical rules should be forwarded to the leadership council for clinical quality, safety and service for information.

(d) To initiate and support research projects when appropriate in support of the objectives of the leadership council for clinical quality, safety and service.

(e) Oversee ongoing education of the medical staff (including specifically limited staff) and other appropriate hospital staff on the fundamental concepts and value of evidence-based practice and outcomes measurement and its relation to quality improvement.

(f) Regularly report a summary of all actions to the leadership council for clinical quality, safety and service.

(Board approval dates: 11/4/2005, 7/7/2006, 2/6/2009, 9/18/2009, 5/14/2010, 2/11/2011, 4/8/2011)

12 Standards of practice.

(A) Surgical schedules shall be reviewed by the attending surgeon prior to the day of surgery. Attending surgeons must notify the operating room prior to the first scheduled case that they are physically present in the hospital and immediately available to participate in the case. Attending surgeons may accomplish this by being physically present in the operating room or by calling the operating room to notify the staff of such immediate availability. The operating room must be informed of the attending surgeon's availability prior to anesthetizing the patient. The only exception is an emergency situation, where waiting might compromise the patient's safety.

(B) All medical staff members must abide by the quality and safety protocols that may be defined by the medical staff administrative committee and the Wexner medical center board.

(C) Inpatients must be seen daily by an attending physician, with no exceptions, to provide the opportunity of answering patient and family questions.

(Board approval date: 4/8/2011)

13 Mechanism for changing rules and regulations.

(A) These rules and regulations may be amended pursuant to the medical staff bylaws section 3335-111-12.

(B) Amendments so accepted shall become effective when approved by the Ohio state university Wexner medical center board.

(C) These rules and regulations shall not conflict with the rules and regulations of the board of trustees of the Ohio state university.

(D) Each member of the medical staff and those having delineated clinical privileges shall have access to an electronic copy of the rules and regulations upon finalization of the approved amendment changes.

(Board approval dates: 11/4/2005, 9/18/2009, 2/11/2011, 4/8/2011)

14 Adoption of the rules and regulations.

These rules and regulations shall be adopted by the medical staff administrative committee and forwarded for approval in successive order to the following: the professional affairs committee of the Wexner medical center board if it meets prior to the next scheduled Wexner medical center board meeting, and the Wexner medical center board.

(Board approval dates: 7/7/2006, 9/18/2009, 2/11/2011, 4/8/2011)

15 Sanctions.

Each member of the medical staff shall abide by policies approved by the medical staff administrative committee of the CHRI. Failure to abide may result in suspension of some or all hospital privileges.

(Board approval dates: 9/18/2009, 2/11/2011, 4/8/2011)

(Attachment XXIII)

BACKGROUND

3335-97-03 Quality and Professional Affairs Committee.

(A) no change

(B) Composition. The committee shall consist of: no fewer than four voting members of the university Wexner medical center board, appointed annually by the chair of the university Wexner medical center board, one of whom shall be appointed as chair of the committee. The chief executive officer of The Ohio State University Health System; chief medical officer of the medical center; the director of medical affairs of the James; the medical director of credentialing for the James; the chief of the medical staff of the university hospitals; the chief of the medical staff of the James; and the associate dean of graduate medical education shall serve as ex-officio, voting members. Such other members may be appointed by the chair of the university Wexner medical center board, in consultation with the chair of the quality and professional affairs committee.

(C)-(E) no change

(Attachment XXIV)

Project Data Sheet for Board of Trustees Approval

Medical Center Parking Garage(s)

OSU-160625 (CNI# 15000049)

Project Location: Wexner Medical Center

- **approval requested and amount**

professional services	$0.6M

- **project budget**

construction w/contingency	$45.8M
professional services	$4.8M
total project budget	$50.6M

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

- **project schedule**

BoT professional services approval	04/16
design	TBD
construction	TBD

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

- **planning framework**
  - This project will be included in the FY 2017 Capital Plan

- **project scope**
  - construct parking facilities to serve the Wexner Medical Center
  - site or sites to be identified, reviewed and established by Wexner Medical Center and university leadership

- **approval requested**
  - approval is requested to enter into professional services contracts with the Criteria Architect

- **project team**
  University project manager: Al Stazzone
  Criteria AE:
  Design-Builder:

Project Data Sheet for Board of Trustees Approval

Ross - 4th Floor Hybrid OR

OSU-140067 (CNI# 13000164, 14000445)

Project Location: Ross Heart Hospital

- **approval requested and amount**

professional services/construction	$6.0 M

- **project budget**

professional services	$0.7 M
construction w/contingency	$5.3 M
total project budget	$6.0 M

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

- **project schedule**

design/bidding	08/14 - 12/15
BoT approval	04/16
construction	05/16 - 05/17

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

- **planning framework**
  - project is included in the FY 2015 Capital Improvement Plan

- **project scope**
  - construct a 2,400 SF addition on the fourth floor and renovate 2,100 SF on the second floor to create two hybrid operating rooms
  - hybrid ORs allow the opportunity to perform traditional, open surgery and minimally invasive, endovascular procedures on the same patient at the same time
  - the ability to perform imaging studies in the same room eliminates the need to move patients during a procedure and reduces the risk of infection

- **approval requested**
  - project began at $3.9M and has now increased to $6.0M, requiring Board of Trustees approval to increase professional services and enter into construction contracts
  - after bidding, additional funding is needed to accomplish the designed scope

- **project team**

University project manager:	Jack Bargaheiser
AE/design architect:	Perspectus Architecture
CM at Risk	Whiting-Turner Contracting Co.

Graduate Medical Education

Scott A. Holliday, MD, FACP, FAAP
Associate Dean, GME / DIO
Montoya Taylor, MD - Cardiology
Eliza Wright Beal, MD - Surgery

The Ohio State University
Wexner Medical Center

The Ohio State University
Wexner Medical Center

What is GME?

- Additional training after medical school
- Specialized education tailored to future practice
- Internship
- Residency
- Fellowship

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Wide Variability in Required Training

- Family Medicine, General Internist, General Pediatrician = 1 year internship + 2 years residency
- General Cardiologist = 1 year internship, 2 years residency, 3 years fellowship
- Radiologist = 1 year internship, 3 years residency
- Neurosurgeon = 1 year internship, 6 years residency

Overview of Residencies and Fellowships

Pipeline Specialties: Pipeline specialties are those specialties that lead to initial board certification. The net output of physicians over time from the graduate medical education process into clinical practice is determined by the number of positions available in pipeline specialties. These are:

Anesthesiology
Family medicine
Neurological surgery
Obstetrics and gynecology
Otolaryngology
Physical med and rehabilitation
Preventive medicine
Radiology-diagnostic
Thoracic surgery - integrated

Dermatology
Internal medicine
Neurology
Ophthalmology
Pathology-anatomic and clinical
Plastic surgery
Psychiatry
Surgery
Urology

Emergency medicine
Medical genetics
Nuclear medicine
Orthopaedic surgery
Pediatrics
Plastic surgery - integrated
Radiation oncology
Vascular surgery - integrated
Internal medicine/Pediatrics

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Accreditation of GME

Many accrediting bodies

- Accreditation Council for Graduate Medical Education
- Individual specialty boards
- Others (UCNS, ADA, APA, etc…)

These organizations set the requirements for GME training

Some fellowships are unaccredited

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Training Programs at OSUWMC 2016

Program Type	Programs	Trainees
ACGME Accredited Residency	23	582
ACGME Accredited Fellowship	41	147
ACGME TOTAL	64	729
Other Accredited	8	33
Non-Accredited	67	43
Total	139	805

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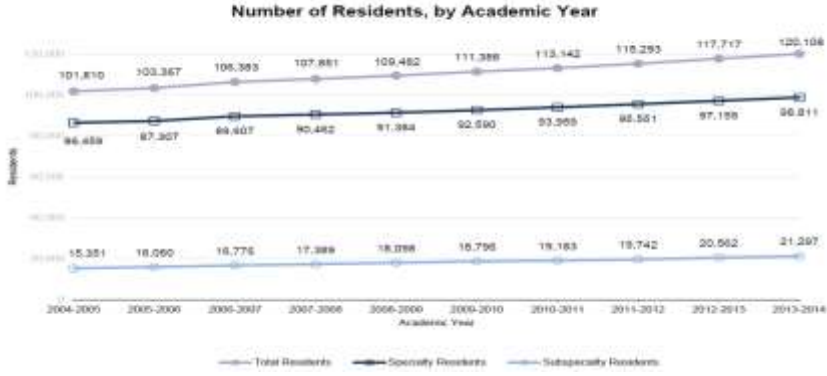
Training of Residents and Fellows

- Direct patient care under supervision of faculty
- Defined educational curriculum developed by the program director
- Minimum requirements set forth by accrediting bodies
- Trainees must balance long hours of work caring for patients while still being an effective student

US Residency Programs are Growing



Educational Innovation

- Simulation
- "Boot Camp"
- MMS Program

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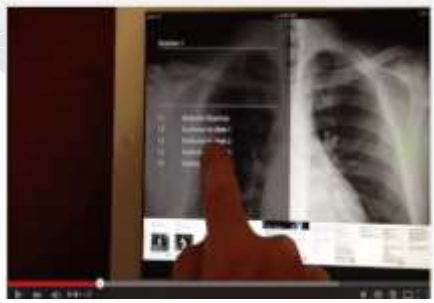

Educational Innovations

- Interactive I-Book curriculum
- Flipped Classroom
- Leadership Development
- Team-based QI
- EIP

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Graduate Medical Education
The Ohio State University Wexner Medical Center

What is Graduate Medical Education?

Graduate medical education (GME) encompasses all medical training after completing medical school or other professional school degree program. The vast majority of trainees in GME are MD's or DO's who have completed medical school and are participating in post-graduate education to pursue a medical specialty or sub-specialty. Other trainees within GME include dentists, podiatrists, psychologists, and medical physicists, to name a few.

Levels of Training

These are people who have completed medical school and are doctors, receiving coordinated on-the-job training and education in the specific field of medicine in which they want to practice.

Internship is the first year of GME training. For most trainees, this is the first year of residency and comes with an increased level of supervision. The intern is also usually the first person called by nursing staff with questions, concerns, or new admissions. In the past, doctors were able to start independent practice as a "general practitioner" after one year of internship. This is rarely done anymore. Some specialties, however, require a one-year general training internship in internal medicine, family medicine, or general surgery prior to starting training in that specialty. The goal of this general year is to give the learner a broad-based experience in the care of patients that is likely to enhance the subsequent specialty training (e.g. anesthesia requires a preliminary training year so that the trainees have a good understanding of the diseases that occur in the patients they will be anesthetizing in their ultimate training program).

Residency is the training that leads to specialty certification. The goal of residency is that the resident will gain supervised experience in caring for the types of patients she/he will see in practice. The resident is given increasing levels of autonomy throughout training in order to make the transition to practice relatively smooth. Residency duration varies by specialty, but most are between three and five years. Neurosurgery is the longest residency at seven years. Upon completion of residency training, a resident can start practice in that general field or pursue additional, sub-specialty training (e.g. a surgery graduate can start practice as a general surgeon after residency or continue training as a fellow in cardiothoracic surgery to become a cardiothoracic surgeon).

Fellowship is the additional training after residency that leads to sub-specialty certification. The time required for this training also varies on the specialty with most ranging from one to three years. Some trainees will choose to do more than one fellowship to gain expertise in very specific subspecialty. An example of this would be a physician who did an internal medicine residency, then a cardiology fellowship and then a cardiac electrophysiology fellowship to specialize in heart rhythm disturbances.

Accreditation of Training Programs

There are multiple groups that accredit residency and fellowship training programs in the U.S. The bulk of training programs are accredited by the Accreditation Council for Graduate Medical Education (ACGME) - headquartered in Chicago, IL. This organization accredits about 9,600 programs nationwide, including nearly all residencies and many fellowships. Other programs are accredited by specialty boards such as the American Board of Obstetrics and Gynecology or by a specialty organization such as the United Council on Neurologic Specialties. These organizations establish minimum requirements that must be met for each accredited training program. Reports and site visits are used to monitor program adherence to the requirements.

Some programs, mostly fellowships, are not accredited by any organization. The accredited programs tend to be common specialties and sub-specialties that have been around for many years, and have a certifying board exam at the end of training. The non-accredited programs tend to be extremely sub-specialized. A good example of this would be our Nephrology - Lupus/Glomerulonephritis/Vasculitis fellowship. This is a kidney specialist that does additional training on specific diseases of the kidney to be a very specialized expert. Other non-accredited fellowships are in cutting-edge fields of medicine. An example of this would be our cardio-thoracic fellowship on mechanical circulation support. Large academic medical centers such as ours, support both types of training programs in order to fulfill the medical needs of the community and advance the practice of medicine for improved patient outcomes.