THE OHIO STATE UNIVERSITY

OFFICIAL PROCEEDINGS OF THE

SEVENTEENTH MEETING OF THE

WEXNER MEDICAL CENTER BOARD

Columbus, Ohio, August 31, 2016

The Wexner Medical Center Board met on Wednesday, August 31 at the Richard M. Ross Heart Hospital, Columbus, Ohio, pursuant to adjournment.

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Minutes of the last meeting were approved.

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Ms. Link called the meeting of the Wexner Medical Center Board to order Wednesday, August 31, 2016 at 9:12am.

Present: Leslie H. Wexner, Alex Shumate, Janet B. Reid, William G. Jurgensen, Abigail S. Wexner, Corbett A. Price, 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. David B. Fischer and Cheryl L. Krueger were absent.

Ms. Link:

> Good morning, I would like to convene the meeting of the Wexner Medical Center Board and note that a quorum is present.

Mr. Wexner:

> Before we begin the meeting, and before I get to Sheldon, I would like to say, I think, I was in a funny way, John Wolfe's right hand man. He was always sitting on this side of me and I liked being his helper. The university, the medical center, all of us, and certainly Abigail and I personally, miss him and appreciate the impact that he had on the community. I have worked most of my adult life in the community with John and I have known many of the community leaders and different organizational leaders and John was the most unselfish and the most thoughtful. He was patient and touched so many things in the community. He worked so thoughtfully with a vast amount of impact. For obvious reasons his family cared about The James but they also cared about The Ohio State University and the medical center. When we were organizing this board, John was the first person that I talked to because I did not think that we could be successful without him. For obvious reasons, the newspaper, communications, and advertising were conflicts of interest that he was very concerned about. He was very thoughtful, his attorney, John Zeiger was very thoughtful and with a little pushing, John, for the first time, really got involved. He felt that he could get involved with something of substance like the medical center and I think he leaves an enormous void in the community and leaves that hole, if you would, in our hearts. I was thinking over the last several weeks, just in the medical center, the review of the buildings and trying to sort out things like sports medicine and getting involved in that helped us immensely. Everybody should know that the foundation, the evolution, and the success into the future of the medical center was largely John's work. He built that foundation and I think he gave us something to live up to in terms of teaming and real partnering. He lead his life partnering and being a positive impact on the community, and an unselfish impact. He had a unique way of seeing things in perspective and calmly, but very effectively, getting things done and bringing people together and we will miss him. Hopefully together we can fill a little bit of that spot that he has left for us.

Dr. Retchin:

> I will add my own perspective. When I arrived here a year and a half ago, Les told me to reach out to Mr. Wolfe. When you move to a new area, you do not know names, you do not know personalities, and you do not know the history. John invited me down to the Dispatch, to his office. Those of you who knew John, and I know everybody did, he is a very quiet person. He sat down in the chair and I thought, wow, this is going to be a difficult meeting, I am not sure I have much to say in terms of conversation. How many questions can I ask? I have just been here for a few weeks, what am I going to do? We talked for a few minutes and he was so quiet. I thought well, I will ask him, Mr. Wolfe, could you tell me anything about the medical center? It was like a switch I had turned on, and it reminded me of this rich oral history that I thought to myself, boy, I cannot wait to see the movie. He knew details, down to people and times of the day. His oral history gave me such a perspective, not only of the medical center but of Columbus, The Ohio State University, and the Wolfe Family. He was such a friend. I know that it was a successful meeting because afterwards I got a text from Les and there were three words

that said, “Great meeting. Bravo.” Quiet and a man of few words. John and Anne were wonderful to us when Tracy and I moved here and we will miss them dearly.

President Drake:

Everyone knew him so well and one of the things that has been interesting personally is I have come into communities and met people who have been in the community for a long period of time. There have been then circumstances where something would happen I am then supposed to say something at the service with a room full of people who have known the person for his or her whole life. I always feel entirely illegitimate in talking to people about someone they knew and grew up with. I would say about John Wolfe though that he reminds me of the Yosemite Valley, in that you arrive and you have never been there before, and you are there for a minute and you open your eyes and it is just a magnificent thing and it touches you like you have known it forever, just from the beginning and then it stays with you. Les was mentioning sitting here and saying that John always sat in a position a little bit to the left and as you were saying it Les, I had to remember that he was not actually here. He had such a presence that it is hard to believe that he is gone. I would say that his wisdom and kindness were things that were manifest in the very moment and his support, as Sheldon and Tracy were saying, when we arrived, his support was terrific. His wife Ann had lived in Pizzuti House when she was in high school and they had come over just then to walk around and see what the house was like and have dinner. It was a little bit like a piece of family and such a great presence in Columbus, a great presence in our lives, and then a great presence in the life of the community. It is one of those privileges that we all have, that is hard to get used to not being a part of our lives as the future goes on.

Mr. Wexner:

If anybody else would like to say anything I would be happy to take some time to talk about John.

Mr. Jurgensen:

Les, if I might, it is interesting listening to Sheldon’s story because I had exactly the same story. I do not think I had been in town, maybe a few hours. The first day I was sitting at my desk and the assistant came in and said Mr. Wolfe would like to talk to you. I said, that is great, who is Mr. Wolfe? She explained to me who he was and he called and said do you think you could stop down for lunch? I did and it was probably a three-hour luncheon. He told me everything about my company that my company did not tell me when they were recruiting me. It was all positive and he described this civically-responsible citizen that Nationwide was and what it meant to the city and all of that I learned at that time. My sense of this was that I needed to listen. He was a newspaper man so he liked to report the facts. He liked to be on both sides and think about it the way the newspaper would think about it. He loved to gather points of view and intelligence to inform him on the editorial page. I think he took great personal pride in writing editorials. It was always Columbus first and maybe Children’s Hospital second, and maybe Ohio State third. I am not sure but those are the things he really cared about. He wanted Columbus to be as great of a place as it could be and it certainly is for what that family has done and continues to do for the city. It is amazing. He was a terrific guy.

Mr. Shumate:

I will make a comment as well. To echo the sentiments, I think that John was such a wise person and you always knew that you would get good advice, sound advice, and very thoughtful advice. That is a tradition that hopefully a number of us will continue to embody. That is his legacy for me; to be thoughtful, to really care about the community, really care about people, to be open to other perspectives, and then to wisely execute in a thoughtful manner.

Dr. Wadsworth:

I had a similar experience when I became the CEO of Battelle. I went to see John. In our case, we sat at the opposite ends of a very long conference table in his office. I did not know him of course; he was very quiet spoken but he slowly gave me the history of Battelle in the early 70s which was a little bit fractious at the time. He walked his way through what was successful and what was not and then he asked me what we were doing. I explained we were in career in Japan and he kept bringing it back to Central Ohio. Eventually he said to me, where are you living and I said Upper Arlington and he said, and how do you find that? I said, oh it is wonderful, neighbors bring us cakes and he said, yes that is what we are about, that is who were are, and that is the community. I also loved hearing his political insights, that was one of our favorite moments together. We would ask him or Les would ask him, or somebody would ask him about some political issue and I think as Jerry said, once he started talking, you were going to listen because he had a lot of insights. He was a very special man, a very special family.

Dr. Caligiuri:

John was extremely fond of his cousin, John Wolfe, and of course he, for those of you who may not know, was one of the people that spearheaded the whole movement to establish The James. John, a couple of times, told me the story about how they had everything lined up and we were going to have the first cancer hospital in the Midwest United States, fulfilling Dr. James' dream. His cousin, John, was leading this effort and at that time, he needed a certificate of need, from the city and there was one person who would make that decision and that person was strongly opposed to having a certificate of need feeling that it was hopeless to have a cancer hospital in a city the size of Columbus. John relayed to me how when that was brought to his cousin's attention, that line in the city government was somehow eliminated and things got done. It speaks to his selflessness, his unselfishness, and I am so proud about what his cousin did for the city and how proud he was to, in a sense, carry on with the family tradition which he felt was established by his cousin and doing so much for the city and in my case, so much for The James.

Mr. Wexner:

Andy, I cannot tell whether you are smiling in agreement or have a thought.

Dr. Thomas:

Well, I think it is a great story and I have heard it myself and just to remember John telling it and the joy that he had about. I still remember the night of the opening ceremony at the new building, much less how much he loved the old building, but just the feelings he had and the emotions he had because it was going back generations in his family. The love of The James, and really the love of the whole medical center and the whole university.

Mr. Wexner:

We can move on in the agenda. The doing of the doing.

Dr. Retchin:

I believe the first item, Mr. Chair, is the minutes of the April meeting of the Wexner Medical Center Board. They have been distributed to everybody and if there are no additions or corrections, the minutes are approved as distributed.

Hearing no revisions, we will move on to the second item, the amendments to the *Bylaws and Rules and Regulations for the Medical Staff*. The bylaw changes are largely housekeeping in nature and we have added some clarifying language to ensure

compliance with certain regulations. We also added language requiring immediate disclosure for and licensure action in any state, any malpractice claims filed by any state, and any arrest by law enforcement. The amendments are in the sections related to privileges for giving orders and we have added some updates under the medical records section to provide greater clarity and guidance around discharge documentation and orders. Andy Thomas is here. Andy, do you want to make any comments?

Dr. Thomas:

No, you hit on the exact points that I had circled.

Dr. Retchin:

I believe a voice vote is required by the Board to include on the University's Board consent agenda so I guess I need to get a motion to approve.

AMENDMENTS TO THE *BYLAWS AND RULES AND REGULATIONS OF THE MEDICAL STAFF* OF UNIVERSITY HOSPITALS

Resolution No. 2017-02

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

WHEREAS the proposed amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were approved by a joint University Hospitals and James Bylaws Committee on April 19, 2016; and

WHEREAS the proposed amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were approved by the University Hospitals Medical Staff Administrative Committee on May 11, 2016; and

WHEREAS the proposed amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were approved by the University Hospitals Medical Staff on June 3, 2016; and

WHEREAS the proposed amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board on June 28, 2016:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves and proposes that the attached *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals be recommended to the University Board of Trustees for approval.

(See Attachment I for background information, page 33)

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AMENDMENTS TO THE *BYLAWS AND RULES AND REGULATIONS OF THE MEDICAL STAFF* OF THE ARTHUR G. JAMES CANCER HOSPITAL AND RICHARD J. SOLOVE RESEARCH INSTITUTE

Resolution No. 2017-03

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

WHEREAS the proposed amendments to the *Bylaws and the Rules and Regulations of the Medical Staff* of The James Cancer Hospital were approved by a joint University Hospitals and James Bylaws Committee on April 19, 2016; and

WHEREAS the proposed amendments to the *Bylaws and the Rules and Regulations of the Medical Staff* of The James Cancer Hospital were approved by the James Medical Staff Administrative Committee on June 8, 2016; and

WHEREAS the proposed amendments to the *Bylaws and the Rules and Regulations of the Medical Staff* of The James Cancer Hospital were approved by the James Medical Staff on June 22, 2016; and

WHEREAS the proposed amendments to the *Bylaws and the Rules and Regulations of the Medical Staff* of The James Cancer Hospital were approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board on June 28, 2016:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves and proposes that the attached *Bylaws and Rules and Regulations of the Medical Staff* of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute be recommended to the University Board of Trustees for approval.

(See Attachment II for background information, page 39)

Upon the motion of Mr. Shumate, seconded by Mr. Wexner, The Wexner Medical Center Board members adopted the foregoing motion by unanimous voice vote.

Dr. Retchin:

> The next item is the Plans for Patient Care Services for University Hospitals and The James. These must be approved annually. The plans describe the medical centers mission, values, and vision of its philosophy for patient care services. They have been reviewed and approved at the respective medical staff administrative committees for both University Hospitals and The James as well as reviewed and approved by the Quality and Professional Affairs Committee. There are no substantial changes to the documents from last year. And with that, I believe we also need a motion.

PLAN FOR PATIENT CARE SERVICES

Resolution No. 2017-04

University Hospitals

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

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

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

WHEREAS the University Hospitals Plan for Patient Care Services was approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board on June 28, 2016:

NOW THEREFORE

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

(See Attachment III for background information, page 45)

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PLAN FOR PATIENT CARE SERVICES

Resolution No. 2017-05

Arthur G. James Cancer Hospital

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

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

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

WHEREAS the Arthur G. James Cancer Hospital Plan for Patient Care Services was approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board on August 23, 2016:

NOW THEREFORE

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

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

(See Attachment IV for background information, page 56)

Dr. Retchin:

> With that, I will move on to my report, Mr. Chair. I am going to go over a few things under my report and first I want to make some introductions. Second, I am going to talk and call on Dan Like to talk about new construction and how we are doing in our current facilities and then I would like to give an overview for the year so let me begin by introductions.
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> Cheryl Lee joined the Wexner Medical Center on July 1 and serves as the Chair of the Department of Urology. She comes to us from the University of Michigan where she was the Robert H. and Eva M. Moyad Research Professor of Urology and only one of a handful of women in the U.S. to Chair a Department of Urology. She is a prominent expert in bladder cancer and has served as principal investigator, co-principal investigator, and site principal investigator for 50 clinical research trials supported by a broad range of funding. She also holds the Dorothy M. Davis Chair in Cancer Research.

Second, let me introduce to you, Tim Pawlik. I am going to hold applause and have them stand in a second. Tim joined our team on August 1 and serves as the Chair of the Department of Surgery. He joins us from Johns Hopkins where he was the John Cameron Professor in Alimentary Tract Diseases, chief of the Division of Surgical Oncology, program director of the Surgical Oncology Fellowship and director of the Hopkins Liver Tumor Center. He is the author of more than 600 published articles. Tim and I had a little discussion about that and it is amazing that he could do that by age 17. He has had more than 50 book chapters and has edited 5 surgical textbooks. Dr. Pawlik also holds the Urban Meyer and Shelley Meyer Chair for Cancer Research. This is just a reflection of being able to recruit people from top institutions with a background and fresh look about health care, health care delivery, and research. I think is all part of the transformation of The Ohio State University Wexner Medical Center. I would love for Tim and Cheryl to stand and be recognized. Cheryl, would you like to say anything.

Dr. Lee:

My family and I are really enjoying our time here in Columbus. We have had a fantastic welcome. I would like to publically thank Dr. Ellison, Dr. Caliguiri, Mr. Larmore, Dr. Retchin, and Dr. Drake and of course the board for the real commitment and energy towards our department. It is fantastic and great priveiledge to be a part of this medical center. Thank you.

Dr. Pawlik:

I would just like to echo Cheryl's comments. I would like to thank Chris, Mike, Sheldon and President Drake and really the entire medical center which I think put trust in me to continue on the legacy of outstanding medical care that will not only live here and at the university, but the rich legacy in the department of surgery with Dr. Zollinger and Dr. Ellison. I am incredibly excited to be here. My family is incredibly excited to be here. We have got some of those cakes that were mentioned earlier. It is a really wonderful and rich community here in Columbus and also here at the medical center so I am really excited. Thank you.

Dr. Retchin:

Thanks Tim and Cheryl. With that, I am going to move on to facilities updates. We are continuing to build and I always say that you know a great medical center when there is a crane on the property and of course with the openings of the Crane Sports Medicine Institute, it is even more poignant. Dan, will you update us?

Mr. Like:

Good morning, everybody. Going on what Mr. Wexner said, here are two facilities that Mr. John Wolfe had left a mark on. Personally, I got to meet him through this process and would not be here giving these great updates if it was not for his involvement. In fact, at the ribbon cutting, certainly we reflected on his legacy and his impact on the Upper Arlington facility. Mr. Wolfe was at the groundbreaking, 367 days before our ribbon cutting. He went to the beam topping off ceremony, signed the beam, had pictures, and we know he was with us in spirit on June 25. It was a sad day in the sense of reflecting on Mr. Wolfe and what he meant and that he is not with us anymore but certainly he left a legacy and this was a facility, one of many, that he left an impact on.

We had our ribbon cutting on the June 25. Cheryl Krueger joined us, government dignitaries, OSU leaders, and City of Upper Arlington officials. It was followed by a great community open house with over 500 people. A couple weeks later, we started opening the facility and as you can see, each week we essentially opened up a floor at a time, starting with the first floor and registration and lab and moving up to the heart floor, the third floor with internal medicine, and then the last group that moved in the first week of August was primary care and behavioral health. Just this week, general OB/GYN

opened up and then in the first quarter of next calendar year, we are going to open optometry, dentistry, and then The James mammography. This facility is unique in that this is our first ambulatory facility. It is the first of many things but one of them is to bring the health sciences into our ambulatory facilities which is unique for us at The Ohio State University and definitely a competitive advantage. It is a differentiation for us and it is great to have the Colleges of Optometry and Dentistry that will join us at the beginning of the calendar year.

I will speak briefly about the patient visits. As I discussed, we have moved in on a staggered fashion so that is part of the reason for the growth each week in patient visits. The total bar represents the weekly visits and the grey part of the bar represents existing patients that were being seen by our medical center. That is defined as if they have had a billed patient appointment within the last three years for a specialty. The red part of the bar is the one that we really want to pay attention to. Why we invest in ambulatory services is really to expand access to our community and this is an area that we want to continue to see grow. You can see at the bottom the percent of new patient visits. We expect this to be more in the mid-20's or even higher in some services. We have new physicians that are going to be starting in some services who are going to make a difference specifically in primary care and obstetrics and gynecology. It is a great start. With almost 500 visits per day in week six, we are well over 500 which is what we expected in the business plan and this is not even with optometry and dentistry numbers which of course will come in in the beginning of the calendar year.

Lastly, before I move on to the Jameson Crane facility, the capital budget of this facility is in a great position where we have a good contingency left, plenty that we will have available to build out optometry and dentistry and still even return money to the capital projects. It is definitely a great team effort with facilities and information technology, Mr. Lampert's involvement, and Mr. John Wolfe. It turned out fantastic. Early results for patient satisfaction, will be out in the next couple of weeks and I expect them to be very high. Any questions?

Mr. Wexner:

How do you define new patients?

Mr. Like:

A new patient is a patient that has not had an appointment with that particular specialty or a billed visit within the last three years, that is the CMS (Centers for Medicare and Medicaid Services) definition of a new patient, or has never even been to the medical center before so we are creating a brand new, unique patient number. Those are the areas that we really want to pay attention to. Are we able to attract new patients from the community into our medical center and one of the main objectives of why we invest in ambulatory and why it is really important to keep access available to our community.

Mr. Wexner:

Thinking in terms of market share and growing the practice, if you could average 400 times 50 weeks, just child's math, and we pick up 20,000 new customers/patients, that are in the medical center.

Mr. Like:

Yes, this is on patient visit, so this is not unique medical record numbers. I think later on Mr. McQuaid will go over the new scorecard. We are actually going to look at unique, new medical record numbers, for example, the 427 in week six, this could be a unique medical record numbers that could have gone to primary care but then also referred to and seen a cardiologist in the same week and they both would have been a new provider visit to those respective specialties.

Mr. Wexner:

I would be curious in terms of ambition when you open a patient care center like this, is it new patients to the system, what the target would be. Would it be 5,000? 10,000? There has to be some number that you would apply.

Dr. Retchin:

It was in the proforma wasn't it, Dan?

Mr. Like:

It was, yes.

Dr. Retchin:

It is not only driving market share, but new patients bring a trickle effect, as they become a part of the system, loyalty, and the families they bring.

Mr. McQuaid:

I was simply going to add that it is very intentional, right? It is a focus and that is why we call it out now on the scorecard and really look at those unique identifier numbers. As we look across service lines, how are we making sure that in all of these various locations that we are growing new patient volume.

Mr. Wexner:

Any speculation though on a facility of this size? What you would expect in a population as large as Central Ohio?

Mr. McQuaid:

I think we could see 5%. I think we could see a range between 5% and 10%.

Mr. Wexner:

What would that be in numbers?

Mr. Larmore:

What is the annual business projected?

Mr. Like:

We are talking about approximately 600 visits per week times roughly 50; and then you have to back out and divide into that an average person may have three visits per year to get the number. I would say for a setting like this, for the size of the facility, we are adding new physicians and a full time primary care physician can actually add anywhere from 1800 to 2000 new patients to their panel if they are a brand new physician. I would say in the 5000 range is potential for this facility.

Mr. Larmore:

Remember this is not all in new capacity. Some of it is consolidating some of the smaller office locations into this.

Mr. Wexner:

The idea of consolidating and having a new facility would be that you could attract patients across multiple disciplines and build loyal patients. If normally we are saying it is a population to attract new to our system of 5000, and then there is a follow or a shadow network relationship that falls out of that, how do we communicate to those new patients about the services and make them true loyals to the medical center.

Mr. Like:

You are exactly right and that is exactly why the services that are in this facility are the services that are community based that create that foundation and that loyalty; primary care, dentistry, optometry, women's care. That is why our investment in space and people in this facility is around those service lines.

President Drake:

It would also be interesting, as time goes on, to look at the referral patterns from those patients who come into our system through this particular facility.

Mr. Like:

We have a new tool that will track just that. It has historically been very difficult for any health care system to really look at outpatient market share. Inpatient market share is publically reported and available with the state department of health. Outpatient is just hospital based, but it does not take into account all of the free standing physician practices. Now we have a tool that will be able to look at our outpatient market share and then also look at our referral patterns in and outside to see what impact we are going to make.

Dr. Wadsworth:

I had a question on that topic also. I reviewed a program this week called the HUMAN Project from New York University. I learned about the databases and the fact that they do not connect very well in order to do large scale studies. I am wondering if it might be useful for us to hear about because it is a bigger topic than just this but how are we going to deal with the data generation and the use of that data and do we have the right systems in place to take advantage and ask the various questions in a very systematic way. It is a rapidly evolving field and there are lots of competing methods and I am intrigued by how we are going to bring all of that together.

Dr. Retchin:

Jeff, are you talking about for research or system market analysis?

Dr. Wadsworth:

System market analysis which allows you to predict health outcomes which allows you to understand how different strata get treated and all of those things. The disparate databases are causing new ventures to start collecting their own data because they cannot trust the existing data or they cannot intersect it. I was wondering from a university perspective.

Dr. Retchin:

The Ohio State University Wexner Medical Center has a single platform. It is an electronic health record, which is EPIC, and EPIC is in both the hospital and in the outpatient arena and captures a wide variety of data, both text and closed coding that can be queried in an enterprise data warehouse. More importantly, the medical center

is part of a network of institutions that have similar capabilities and a grant to actually study that and collaborate and that is the CTSA, the Clinical and Translational Science Award. There are about 62 of them in the United States and we are one of those, we are one of the successful ones. Some have actually received those awards and then lost them because it is so competitive. Duke was one of those, not calling them out, but we are a leader and it would be useful at a future board meeting to have the principal investigator come and talk about those queries and how we are all connected. That is Becky Jackson so we may do that, I think it would be a great dialogue.

Dr. Gabbe:

I was going to add that when the building was planned it was recognized that Upper Arlington had a large number of university employees who were members of the university health plan and bringing those services to that community was especially important. I think it would be important to describe as well how much more business we are getting from our own health plan members.

Mr. Like:

Great point, Dr. Gabbe, and we actually are tracking that. I should have added that on there but our tracker does include the percent of new patient visits of our own health plan members because as you stated that was also one of the main objectives of this facility.

The Jameson Crane Sports Medicine Institute, not yet open but getting closer by the day. A couple of important dates coming up, September 22 will be a private event with the sports medicine philanthropic advisory council and other dignitaries that are invited and on the 24th there will be the faculty, staff, and family member appreciation in the morning followed by the ribbon cutting and community open house later that afternoon. That was purposefully set-up on the 24th because that is a bye-weekend for the Ohio State football team so we will not have traffic in and around the area. In October, similar to Upper Arlington, we will have a phased opening which we found works very well. On October 10, physical therapy will open and the 17 the clinics will open. By mid-November we will start performing outpatient surgical operations at the facility.

Mrs. Wexner:

Can you remind us what happens with the other facilities? What is the percentage of migration in Morehouse and others?

Mr. Like:

With Upper Arlington and the Jameson Crane there were actually services that moved out of Martha Morehouse into Upper Arlington - high risk obstetrics, cardiac rehab, and cardiology, in order to better position those ambulatory services together. In combination of maternal/fetal medicine, cardiology, cardiac rehab, and sports medicine, we are talking about 35000 square feet or so that was vacated in Martha Morehouse. The long-term plan for the tower at Martha Morehouse is really to continue to add growth and capacity to the cancer ambulatory program. The cancer program has taken over the space that was vacated by high-risk obstetrics which is in the tower and then the sole remaining non-cancer service that is in the tower is neurology. We would love to bring neurology and really expand neurosciences in the pavilion where we already have a lot of neuro-related ambulatory services, neuro-rehab, physical medicine and rehabilitation, our assisted device clinic, and our comprehensive imaging center. It is really better setting up that complex around the patient and signature services. Great question. Any other questions or comments about the Jameson Crane?

Mr. McQuaid:

I wanted to address the issue of big data and perhaps Beth NeCamp can make a comment on this. We are going to be working really hard with CRM (Customer Relationship Management) technology and I think that really gets to the core of how we can get after market share and patient preferences and tracking that information in these sites. Beth, did you want to offer anything else on that.

Ms. NeCamp:

We implemented a CRM for the customers in March and we have great feedback from those who are in the target group right now. We chose a firm called Evariant, which is the vendor and one of the reasons is they fit very nicely with EPIC. We can have all of the data, both our own data as well as Experian data, which is a large consumer database inside of that so we really can transform from a mass approach for marketing to a more individual and targeted approach. They also have a PRM (Physician Relationship Management) system that we are working very closely with strategic planning, so that we have the claims data and what referring physicians' patterns are more clearly versus just what they tell us. Those are all relatively new this fiscal year for us and I would be happy to come back and talk more about that.

Dr. Wadsworth:

Does that intersect with Kaiser Permanente, as an example, their databases?

Dr. Retchin:

Is it different?

Dr. Wadsworth:

Yes. What are the market forces? How much interoperability is there amongst these big databases?

Dr. Retchin:

Kaiser actually was homegrown in terms of its platform but obviously, size matters. I do not know if they have converted to EPIC but they are able to do that because of their size. Even then, it actually is an interesting segway to the ORIEN (Oncology Research Information Exchange Network) project. Many of the questions that we have require much bigger data than Kaiser. It requires a network to be able to get though the volume that you need to ask the appropriate questions. The ORIEN project that Mike's led is an example where you can get into some of the biomarkers and genomic information.

Dr. Caligiuri:

In cancer we have realized that no one center will have enough data so we have combined 13 cancer centers across the country. We co-founded an organization with Moffitt Cancer Center, an organization called ORIEN. The U.S. military has joined now and the VA (Veterans Affairs) has just joined and we currently have about 150,000 patients who consented to have all of their tissue and all their records to be electronic. We have a system to capture from different electronic medical records so that we can start to put the subsets of patients together. We have gotten two subscriptions from pharma, Celgene and Takeda who both bought five year subscriptions to the service to use it for, as Sheldon said, validation, biomarkers, discovery, and ultimately, clinical trial matching.

Dr. Wadsworth:

I was also made aware of the difficulties of inherent bias in the data sets so it is big, complicated, and very sophisticated. I do not want to go down a rabbit trail. I think it is the future and it would be very valuable for the board to learn a little bit about how were dealing with it, what the options are, and what the new pieces are because those are very interesting.

Dr. Retchin:

It is one of the opportunities for the medical center to be a national leader and in fact it has one of few Departments of Biomedical Informatics, getting back to the CTSA as one of the leaders in this developing and emerging field.

Dr. Wadsworth:

Great. Thank you.

Dr. Retchin:

I will continue on my report. This is the scorecard for Fiscal Year 2016. I will maybe brag about the red bars a little bit which is maybe a little contrarian but, in part, some of the red bars reflect the fact that the team has selected ambitious goals of continued improvement. Not looking to continue where we are, this is a time of health reform and expanding and augmenting expectations. To comment on one of those, inpatient mortality, a few basis points in change but in large part, continuing to lead the nation in inpatient mortality, which is rather blunt but is an important aspect of patient care. Readmissions continues to be a challenge. We will talk about that some a little later and then patient satisfaction, continued improvement, and our ambitious goals to become one of the nations' leaders.

Skipping down to the good thing, and despite the continued competitiveness of the NIH (National Institutes of Health), we are continuing to grow our NIH portfolio which is where many medical schools are compared with their peers. I will talk about the *U.S. News and World Report* ratings and then the finances will be discussed by Mr. Larmore in a few minutes.

I thought I would segway from the scorecard and take a little poetic license and look at the year in review. It has been an important year, my rookie year if you will, getting to know some of the players with a very big staff and employment base.

We view patient satisfaction as a really important marker, not in terms of the business necessarily but in terms of the patient care we deliver. If you look and break down inpatient satisfaction and outpatient satisfaction, the important thing here is that directionally we continue to improve. We spend a lot of effort on patient satisfaction and recognize moving this requires a unified team approach with 20,000 employees. Every person counts from the bedside nurse and physician, to the front desk, and to those who keep the environment hygienic and clean. Everyone has a role. That is the only way we can continue to improve our satisfaction scores and most importantly the loyalty and confidence that our patients have for the system and you will continue to see this focus here.

If you were to ask me, when I started, where I thought the biggest opportunity and biggest challenge would be, it would be to recruit a very talented team. It is always the way I looked at a medical center. It is always the way I have looked at building and transforming a place where there was a division, a department, a school, or an institution. You can see I have spent the last year recruiting a team from great places I might add, from Wisconsin, Michigan, Hopkins, Texas, Jefferson, New York Presbyterian, St. Louis, and San Diego. I would stand behind every one of these

individuals. They come with a host of experience and expertise and a fresh look from the outside. Every one of these individuals is characterized by a quest to make this place better and we continue to blend with the existing individuals who also have a sense of what is possible for the medical center. I am very proud of this team. I am very proud of those who are already here and blending together and I look for great things in the future. The word of the day, if you were to ask me, is transformation. Mr. Wexner said when I was recruited here, that was what was needed - transformation and with health reform, changes in the marketplace, and changes in health care.

When I first got here, I met with George Barrett and was talking to him about what there is to see in the healthcare environment. It is always useful to pick the brains of someone who is in another segment and he said, what shocked him the most was the velocity of change. Healthcare is moving really fast and that is why bringing a team together of new and old is of paramount importance. I mentioned satisfaction and the need to move the organization and in my view, the most important component of that is the people and human resources. This year we updated our engagement scores, this is a Press Ganey instrument that we used. You can see we have improved ten basis points which is not easy. Again, you have 20,000 employees that you are reaching out to to gauge how they feel about where they work. As I said to an external group this past week, if you ask me about the medical center and compare with our peers in the marketplace. I only wish, given the recent Olympics, that we were able to judge this with a degree of difficulty, like a drive. Our people who come here, dive past a lot easier places to work. Every academic health center is like that and yet the loyalty that I have found, the teamwork, the comradery, and the esprit de corps is remarkable but something that we work at every day.

Dr. Wadsworth:

Sheldon, do you mind an observation? Employee engagement is really interesting, comparing to other institutions. It is also interesting internally. If you build a risk assessment map of the highest risk enterprises and plot that against employee engagement, because you really do not want disengaged people working on nuclear weapons, in my world, or nuclear reactors. This is an interesting internal exercise to try and ensure that the highest risk areas are the highest engaged employees.

Dr. Retchin:

I think that is a great point. I wish you had not brought up nuclear weapons but it is still a great point. When you look at becoming a high reliability organization, we looked at the nuclear power industry where no mistakes can be made. If you look at that in terms of the tedium of prevention of a single incident, you have to have engagement to be able to do that and a single purpose.

President Drake:

To point at something that came to us more broadly was the Gallup organization who was looking at a survey of alumni across the country over many years. They have a very large database and one of the things that they looked at most was engagement and they found a couple of things that were interesting.

First, they were sharing this with us because we had an extraordinarily engaged alumni group. It was really something that stood out as being wonderful for the university broadly, but they made a tie between engaged employees and employees who performed at a very high level saying that there was a high correlation between engaged employees and good things or disengaged employees and bad things like absenteeism, mistakes, and injuries on the job. Engagement was extremely important and just as a note to the group, they found that one of the things that was the strongest predictor of an engaged employee was someone who was engaged in college. In their description, one of the things that they found would be very useful for you to know when hiring

someone is whether or not that person had been engaged when they were a collegiate student because engaged people in college became engaged employees and engaged employees perform better. It was an interesting thing for us to think about broadly from the time that freshmen come in all the way through, being engaged makes you a better citizen, better employee, et cetera.

Dr. Reid:

The importance of engagement is there. Dr. Retchin, on this, this is all people, everywhere, total faculty and cafeteria workers, everybody all together?

Dr. Retchin:

The only group that was missing was the faculty on this one. We are going to build toward that for this year.

Dr. Reid:

Okay, and this is 4.15 on a 1 to 5 scale?

Dr. Retchin:

Yes.

Dr. Reid:

I am making sure it is not 1 to 10. The other piece is, I assume this has been broken down so you see different divisions or different departments where there are great things going on and then the lessons learned and the best practices are being applied to the areas where maybe the scores are not as high.

Dr. Retchin:

We broke it down into some tiers so we can really focus some of our efforts in the coming year for continued improvement. I will say, to that point as we talk about engagement, there is a remarkable literature that is growing now on patient engagement. Judith Hibbard has spent her career exploring that to show one of the most powerful tools that we have in healthcare and improving outcomes is patient engagement and the whole science that is developing.

Mr. Jurgensen:

I do not know what tool we use to do employee engagement, but beyond numerical responses to set questions a lot of the tools have the ability for people to put in free form commentary. The challenge becomes how do you get into that, because if you have 50,000 people you create a rather large database of just comments. We always found a lot more fruitful things to explore in the commentary than we found in the numerical answers to set responses. Also, the next point would be that the numbers can get skewed in areas or departments or groups that are extremely small because people think they can find out who I am and what I said. If they have the law of large numbers to hide behind, they answer questions one way and if you do not have the law of large numbers, you answer questions a different way.

Dr. Retchin:

Points well made. The comments are a rich source, not to attempt to codify but in terms of insights. I read them and I do find them very insightful. Thank you.

Continuing on, research in a very competitive environment. We grew overall and also grew at the NIH level. Highlighting a few here with Joanne Turner's program project. Program projects are projects that are very large with components of smaller that fit thematically into a single program and program projects. The number you have is really the marker of the caliber of the institution and we are growing that as a portfolio. Of course, to point out Mike and the renewal of the cancer core grant with the Bo Derek award of a perfect 10 and just a remarkable success at the cancer center. We congratulate Mike once again.

Dr. Hammer and his $2.6 million dollar grant from the National Institute of Allergy and Infectious Diseases and then Susan Moffatt-Bruce's award. It is one thing to look at quality as a factor in terms of delivering care, it is yet another to make it a part of your grant portfolio in terms of exploring and contributing to the literature. We congratulate Susan for that effort as well.

In other areas we are continuing to push capacity. Our problem here is not demand, it is capacity. Every day we are full at the end and we continue to look for more capacity to grow because the market place looks to us as a great medical center. You will see further efforts of this to expand our capacity both in terms of people becoming more efficient and also in terms of becoming more effective.

In financial performance, which you will hear more from Mr. Larmore in a second, we grew both the operations at a prestigious rate with the most successful year in the medical center's history and we also continue to improve the balance sheet now at 114 days in cash which is a remarkable growth on both.

In facilities, you have heard about Jameson Crane and Upper Arlington and the Brain and Spine Hospital, we are opening in the Fall.

I will get back to national rankings in a second. I wanted to acknowledge and shout out to the other colleges at the medical center. I see Henry Mann here from pharmacy who has got a top six College of Pharmacy in the nation, but also you can see the other colleges here all ranked. Veterinary medicine is now one of the top veterinary colleges in the country, dentistry in terms of NIH funding, and then the College of Optometry as well so a very successful health science enterprise. National rankings in terms of hospitals, we now have eight specialties ranked. We have jumped, so we are now one of the top 25 hospitals and health systems in the country and we have gone from, I believe, in the top 50 in one year. The methodology changed but also focus as well, and you can see the top specialties ranked. If you follow the lines across in this ranking, ENT/Otolaryngology is now number 7 and getting to the mantra, top five in five which was Ted Teknos' challenge to his faculty. We had an event recently celebrating that and reaching the top seven in the country. It is a noteworthy accomplishment Ted and I wonder if you would stand and be recognized. Ted, do you have any comments?

Dr. Teknos:

Of course, I always have comments. I also would like to echo what Tim and Cheryl said and we could not do this without resources from the hospital and the board. It has allowed us to really recruit the best talent in the country. We have great people and we are not going to quit until we are the best.

President Drake:

I appreciate your modesty and say that the key resources are really important but how those resources are employed is really where the rubber meets the road. I really want to congratulate you and the great focus you have brought to your department.

Dr. Teknos:

Thank you.

Dr. Retchin:

Well done.

For national awards, just a few in terms of the most wired, you were talking, Jeff, about the electronic health record and the database and the platform. We continue to be recognized nationally, not only for our connectivity which is transactional but also our ability to create a data warehouse and be able to query the system. Of course, the recognition as a comprehensive cancer center, one of 45, and then some of the other recognitions on health grades and the UHC Birnbaum award for quality leadership.

For outreach and engagement, this is an area of partnership efforts by the medical center to reach out to other smaller hospitals, in large part, but also even hospitals that are similar size. We continue to explore partnerships but I would like to give a shout out here to Gail Marsh and her team for continuing to build on a virtual network as well as a real network using creative effort in terms of telestroke and in terms of using our GPO (Group Purchasing Organization) to bring value to our member and partners. You can see at the bottom as well, the influence of the PACT (Partners Achieving Community Transformation) to create a healthy community in the near east side of the region.

For strategic planning, we have embarked on an effort to establish direction and lay out a roadmap for our future after the first year now and bringing in this outstanding team to meld with those who are already here. Aligning this, most importantly, with the university's strategic planning effort that has also now commenced that I will be a part of, with a five-year time horizon in terms of the medical center and then a ten-year plan in terms of the facility development and long range financial plan. This also contains a very timely and proactive communications plan so that both in terms of development of the plan as well as getting input from all of our staff and faculty.

I will turn to our FY17 priorities and continuing to enhance quality, safety, and service. We believe that faculty recruitment is of paramount importance as well as retaining the talented individuals that we already have. We will continue to open new facilities, both at the medical center and in the community to spread our influence on the health of our community. We believe that our future involves growth but also as I mentioned, the demand is there, we need to build capacity so that we can ensure access to all of the remarkable services that we offer. We will continue to forge partnerships, both as a strategy and as a destiny for the medical center and above all, research is a major priority, not just to differentiate ourselves but to fulfill our destiny in terms of contributing to the literature and to the science of healthcare. All of this will be a part of our strategic plan and I will answer questions.

Dr. Wadsworth:

I would like to just do a shout out to the people who won research dollars and just to make the point. It is a world I live in and I know it is so competitive. It is so hard to do. It is a flat budget and to show increases is more impressive than maybe the numbers just up here because it is a real fight out there to win new money. Thank you.

Dr. Retchin:

Thanks Jeff. One of the reasons we attracted somebody of Craig Kent's caliber, who is a clinician scientist himself, a dean who will come here and bring two R01s, an active lab, which I think is a great marker. Our faculty are incredibly productive and if you look at it in terms of dollars per square foot it is amazing what they squeeze out to be ranked and continue to grow. Mike, I don't know if you have a comment on that.

Dr. Caligiuri:

Absolutely. To Sheldon's earlier point, what is really exciting is that while R01 grants, which is a type of NIH award that is very difficult to get, only about 7% are funded. Our programmatic grants through team collaborative work, without changing the number of investigators but getting those investigators to work collaboratively, 20 years ago we did not have any. In the last five years, we have put in over 80 such grants and 47% of them were funded. This is way above the funding metric which is about 14%. It is really what has developed here is not only intellectual rigor but collaborative culture.

President Drake:

Just a comment that was on one of the slides earlier that I think is a great reflection of all of the things that we are doing. That the hospital ranking was at 25 and I believe that is out of about 4700 hospitals that the organization used, so it is really at the tip top half of one percent of hospitals and moving up close to a magical line in the tiered world of 20, which is the honor roll of the most outstanding hospitals in the world. They have made a line arbitrarily at 20, but this is very close to that level and it reflects something else that Sheldon was saying, that it really is everyone, from the people who are cleaning the halls to the people that are working in the back rooms on data, to the operating rooms. Every one doing every little bit is what allows us to provide that better quality of care and it links to our founding mission as a university to do things that try to elevate the quality of life in our community. We have a great capacity to do good and we are doing really wonderfully in that and we have a great opportunity to do even more. It is wonderful to see this moving forward. Congratulations to everyone. Our doctors and nurses and the people on the frontlines are really working incredibly hard on the clinical side to improve outcomes and patient satisfaction and then in our laboratories to produce that new knowledge to help us elevate the quality of care broadly beyond our borders. We had a great year.

Dr. McPheron:

Sheldon, if I could just lean in on Jeff's comment about research. You saw Sheldon highlight the other health sciences colleges but last fiscal year, 14 of Ohio State's 15 colleges had NIH funding and it was in fact largely collaborative across college lines. It is an all of the university commitment to medical and biomedical advances.

President Drake:

It must be my turn again and one last comment is that we have had a very impressive year of recruiting outstanding people from across the country from New York to California and from Texas to Baltimore. We really brought in wonderful people to help lead us forward and what that says is that we had opportunities where we needed to have new leaders to come in and help us to move things forward. I want to say that a few months before that all started, Sheldon came on board and was able to grab the reigns and try to pull together a team to help things move forward. We have seen the incredible progress that we have made. We will talk a little bit more about the financial success, but all of the speaking we have been doing now has really been about the outcomes that we are most interested in but even the financial goals that we talk about later have been really remarkable. I want to take a pause and congratulate Sheldon on a great first year.

(See Attachment V for background information, page 68)

Dr. Retchin:

Thank you. I think we ought to end there. Next item, Mr. Chair, is a financial report. Mark?

Mr. Larmore:

I have set the record for the most number of slides. I will not spend a lot of time on each one but we have in the book the final results, some of which the numbers Sheldon spoke about. We also have the first month into fiscal year 2017, and then, since we did not have the board meeting last time, I have included the budget presentation. It was reviewed through the finance group before the prior board meeting and it went through at the university board meeting, but I thought it was important the board members here saw our forecast for 2017.

I have focused, given the end of year, more on how we grew year over year. On this slide, everything is positive growth, with the exception of worked hours because we had growth higher than we had budgeted so it is something we are currently working on. Operating revenue grew 8.6%. Our controllable expenses grew 8% and remember, we were in an expansion mode at this point because this includes a full year of the larger James facility being open and the prior year only had six months of that. Excess revenue over expenses grew 8.6% and Sheldon already spoke about the days cash on hand. A little larger than normal growth on cash and the capital budget went out a little late, so there is probably six of seven days and a day is just under $8 million. There is a lag on capital so that is contributing to part of that growth but absent that almost a 20-day growth.

Focusing on the column all the way to the right, year-over-year growth, so all volumes positive and a slight increase in length of stay. If I had shown these slides in the first half of the year, you would have seen the length of stay had grown quite a bit and during the year we were able to take that down, so that is good.

There is a pretty noticeable increase in case mix. This is a small number but has a big impact on our financial numbers. You can see that our adjusted admissions, which we went through at the last meeting, have been normalized and it grew 3.7%, revenue grew 4.7%, and operating expenses grew 5.3%. This is more of a detailed presentation on the ambulatory growth. On the year-to-date you can see total growth of 3.6%. I will not read down through the various categories but just about every category grew. A couple of the smaller categories had slight decreases but we had volume growth across the board.

This is the P and L (Profit and Loss) at the end of fiscal year 2016. Across the bottom, you can see $199 million bottom line. The budget was $208 million and that is about $9 million behind budget, but it was $183 million last year, so it was an 8.6% bottom line growth year-over-year. With that bottom line growth, you can look at the capital cost, both depreciation and interest, grew by $40 million. That is a full year of bringing the new building online. That 9.1% growth in total expenses if you strip the capital piece of it out is about 7.2% and as you can see from a budget standpoint, we expected that growth.

On the next page is the balance sheet. Other than with the net asset growth and the cash growth, nothing dramatic. Patient accounts receivable is always a challenge and so we have got rate growth, we have got volume growth, and we have a number of payers that are a challenge to collect from. It is a constant effort on that front. The next slide is the medical center and now we have rolled in the College of Medicine and the practice plan so that brings the bottom line to $244 million with a budget of $228 million. This is $16 million positive to budget and a 12% growth over the $218 million over from the prior year. Percentages don't change dramatically. The practice plan is about a $425 million entity and the College of Medicine is $215 million roughly. Both of those actually performed quite a bit better than budget and that is why this combined shows us ahead of budget.

Mrs. Wexner:

Can you explain that positive performance and the repeatability?

Mr. Larmore:

The next slide breaks it out. I spoke of the health system and the health system number includes the medical center investments. This was a year where, as Sheldon stated, we recruited a dean and we recruited two new chairs and with each of those, there is an expense that comes with that. The McI (Medical Center Investments) number had grown year over year and that is reflecting on the health system side.

On the practice plan, a number of pluses and minuses. On the year-over-year base, that is $9 to $30 million. If you look, in the $30 million there was a big deficit in the Department of Neurology in part of onboarding the new dean and that actually comes into the practice plan as a positive transfer so when you look from $9 million to $30 million, it's a pretty big growth. I would say volume had grown considerably on the practice plan side and then we actually qualified for a program called, Upper Payment Limit subsidy in the practice plan this year. That was actually a part of their positive variance. The college is a little unusual in that the college still operates on a cash basis, so the positive variance here was we received a number of payments on pledges that came in during June. From the college standpoint, that flows through, it is the spendable funds, not endowment funds. Endowment funds we would not count through the P and L here. These are good numbers and you will see when I get to the budget how we forecasted it so the practice plan will be similar. The college will not be similar to this because we do not expect those payments in the next year. That is how, as Sheldon said, how we ended fiscal year 2016 and from my view, a successful year. I could remember many years where just having a positive bottom line in a health system was success so it sets us up well for going forward, entering the strategic planning process that we are doing.

Mr. Steinour:

Mark, I think that is a really good year on top of a record year. I want to make sure we noted that.

Mr. Larmore:

I will move on to July, which I used to say red was my least favorite color but I cannot say that here, or scarlet. There is too much red on the slide. I think July started out soft on a volume standpoint, not on admissions. You can see surgical volume and outpatient volume are behind our targets. It was an odd month, a 31-day month which is usually a stronger revenue month. There was a three day weekend in the month. We look at many different variables as we spread volume during the year from where the clinical meetings are, what month they are in, holidays, and such like that. Next year we will have to watch the weekends. That may have tripped us up a little bit there.

On the surgical side, I will mention that we had two of our most active surgeons that were out on injury. One with a leg injury and one with a hand injury so they were out of the OR (Operating Room) for the month and one that had a preplanned long vacation. They are back and the good news is I looked yesterday and the surgical volume for August is about 300 cases ahead of target. I think they are not only back operating but making up some of the ground that we were short last month, so that is good news.

On the bottom right, you can see worked hours per adjusted admission grew slightly at 3%, but the budget anticipated a higher growth. Operating revenue was 1.1% off budget. Quite frankly, from the statistics I would guess that would have been a little bit worse so I was happy to see that. As I said, costs were contained so we were 0.8% under budget, but we did miss our bottom line by roughly, a little less than $1 million and cash continued to grow slightly in the month. July is a weak first month of the year. Admissions, we were

16 ahead but on the surgical side soft. We definitely get paid better on surgical business than medical business. Outpatient visits were 6000 behind, but I will show you where that is on one of the next slides. You can see that length of stay is very good. I would love to hang on to 6.02 all year if we could. For case mix, with the surgical volume being down you would expect the case mix to be softer than we had budgeted. The adjusted admissions are pretty close to budget with the revenue trailing and then expense is positive.

The outpatient chart, again, we probably could have trimmed it since the month and the year-to-date are the same this month, but you can see the 6000 visits. Rehab was about 5000 off and the physicians visits which are non-OSUP, these are the physician visits within the specialty care network and primary care network are slightly off by 4000 visits. Here is the P and L for the month of July. You can see the revenue, $215 million, $2.5 million short of target and actually a little short of last year and then on the expense side, savings on the expenses of $1.8 million offsetting the revenue shortfall and about a 3% growth year-over-year. The bottom line is $11.4 million profit, $12.2 budgeted, so about $800,000 behind budget.

I know that a few have asked the question on the prior year. In the prior year there was some judgmental accruals put in the first couple of months and until we get through the first quarter, I am a little suspect on the bottom line numbers but certainly, I am confident that we are pretty close to budget. From a balance sheet standpoint, there has not been a lot of change from June, just a one-month change, but cash continues to grow. It is a challenging receivable month but we can see some growth in the Adjusted Admission side.

The medical center includes the college so you can see actually both the college and the practice plan did better than budget. Most of it was on the practice plan side and you can see that swings the negative bottom line variance to $2.7 million positive variance. With the practice plan, which you will see on the next slide, a little short on revenue given the volume but they had even larger savings on the expense side so that is where we picked up the positive variance on the budget. This is the slide that splits it so the top, which is what I spoke about, the medical center, you can see the practice plan had a $2.2 million bottom line which was budgeted to actually have a loss in July. The College of Medicine was about $700,000 better than the forecast. This is just the combined balance sheet which does not change from the one I spoke about. That is June and July. Any questions on the year-end or the month?

Ms. Vilagi:

I want to ask a question about the case mix index number. What does that number indicate and what are the consequences of it?

Mr. Larmore:

It is a measure of severity of the cases that are discharged. You can have an obstetrics case that may have a weight of 1 and you can have a cardiac surgery case or transplant that can have a weight of 35. It not only drives the severity but the rates that we are paid. Given my simple example, you would get paid 35 times the amount for the heart transplant than you would get paid for the delivery.

I am going to run through our forecast for fiscal year 2017. Interestingly enough, just a quick flashback, Anne Garcia, came up with during the cleaning out one of the desks in her office, the 1944 budget for the medical center. I was actually going to present that and see if anyone noticed but the total operating revenue for the medical center was $500,000 and ironically the total number of patient rooms were 110 with 300 beds so they were triple rooms and the total number of discharges was 7700, of which 2500 of that was free care so a whole different time. I think Anne was most upset that within the dietary budget, the amount of money that the health system spent on relishes was more

than they spent on legal so she was a litter perturbed on that. That is all the history that I have from 1944.

President Drake:

I am glad it did not sound like an aspirational goal for us.

Mr. Larmore:

Here is the fiscal year 2017 budget for the health system. I think from a payer standpoint, here are the assumptions. Certainly as the population continues to age, our payer mix skirts more to the Medicare payer. Our challenge is to keep attracting more commercial to balance that. Just for an example, 1% shift to Medicare from a commercial payer is about $7.5 million difference in the bottom line and Medicaid has decided to rebase the Medicaid program across the state. It is a work in progress. It should have already gone into place. They delayed it and they delayed it again. It is the challenge of getting everyone's data and the variety of interests, whether it is big academic hospitals, rural hospitals, safety net hospitals, the childrens' hospitals, trying not to leave anyone with a big gain or put a hurt on any is a challenge for them. They were almost there and then they found a huge error in the program and we just get periodic updates through the Ohio Health Association. They still have not come to conclusion on that. Our exposure in the last version that they sent out was about $13 million, which we are pushing back on, so that is a pending issue during this year. We continue to negotiate rate increases with our managed care payers. For our volume, we are expecting a 3% growth on the inpatient side which is 1% more than we grew this year and we do have the Brain and Spine Hospital opening and that is 100 plus beds coming online. We have the capacity to grow faster than we grew last year. For the outpatient, Dan spoke about the two new ambulatory site openings and there is the capacity to grow there. Surgical volume is forecasted 1.6% growth, case mix fairly similar to 2016, length of stay at 6.2, which drives our capacity and it drives our staffing too because for every day, especially on the nursing side, we have variable staffing and as I said, brain and spine will open. From an expense standpoint 2% merit increase.

Dr. Reid:

I have a question for you. On the slide before, this is regarding the in- and out- patient growth and the surgical growth and how you put the projections together. We are opening the Brain and Spine Hospital, therefore we have x many more beds and therefore we should have x much more inpatient volume, or is it based on a stretch goal of increased referrals. How do we know if these are really super safe estimates or if these are stretch goals?

Mr. Larmore:

The baseline where we start are the physician complement who is here, where are they in their career here, are they established, do they have the similar book of business each year, who have we recruited over the last three years, where are they in their ramp up, and who do we know that has been recruited and is coming on board. We will count that but if they are not signed and in the moving van moving from where they are coming, we do not count that volume growth and that is how we establish the baseline. Of course, we do that initially and as we move through the budget process, a few more people will get signed. We will move that up but if not, you open 100 beds, you can bring 6000 cases through the place so we do not do it that way, saying well we expect 50% of that to fill up and target the growth that way. It is all based on the physicians that are here.

Dr. Reid:

These are based on very calculated assumptions based on the physicians we have and so forth, so there is no stretching here?

Mr. Larmore:

No, but you will see when I get back it to their risks and opportunities. Volume is good and plus and minuses because we lose a couple of high volume physicians in one direction but the more we attract that is an opportunity on the upside.

Dr. Retchin:

It requires a lot of collaborative team work to make it happen. Those are still ambitious numbers. Forget how we got to them, there are many health systems, as you know, who are experiencing softening.

Mr. Larmore:

I think it is also an access issue. We talked a little bit earlier about how we are tracking new patients coming into the system. You will see when I speak about the fiscal year 2017 scorecard, specifically putting transfers into the institution. How is that intentional, how are we growing across service lines, how are we pulling those patients into the system, how are we opening up access? We have significant challenges on the practice side of the equation. While we want to track new patient visits, some of them will not be able to do those visits unless we change the operating model and/or the physical part of the capacity for them to get in. While there is some conservatism built in, there are also aggressive tactics that we are working on so that we can open up the lid and grow more of that volume. In terms of length of stay, although 6.02 does not seem like a big number, we have roughly 60,000 discharges. Half of a day is 30,000 days which is 5000 discharges of capacity and it is why there is constant focus on keeping the length of stay as low as we can.

Mr. Wexner:

Janet, I think there is a further piece of this that reflects itself in the planning. Getting the days of cash, getting the leadership team in place, opening up the new James, and understanding where we are. The question is, what is the ambition? If you look at market share on a local basis, regional basis, how is the market growing, how has the market grown, and is our share of market high enough so you could do better than you have done and your relative position could fall back. I think that at a preliminary level it appears to me, that we have enormous opportunity for growth but that is the work of the work. If you just said you were going to compound growth, 15% you double, now maybe you cannot do that or maybe you can. I think there is some blue sky thinking about how the market has grown in the last 20 years and how I do not believe we have our fair share of the market, however it is defined, whether it is this county or six adjacent ones or within a 200 or 500-mile radius. I think that the point that Mark is making about the budget is looking at it line-by-line, function-by-function, person-by-person, rather than just saying well, 100 beds is x, I think is appropriate. The next big leap is to start looking at futures and ambitions.

Mr. Larmore:

On the expense side assumptions, you can see salaries at 2% and the fringe benefit rate is 35%, which is actually a small decrease from the prior year. Drug inflation is faster than medical supplies and a lot of that is driven by the new cancer drugs that continue to come out.

Mr. Steinour:

Mark, would you be able to comment on fringe. That is a very high number I think, comparatively, certainly for us not in health care?

Mr. Larmore:

All of the employees of the health system are in the university benefit package and I look at a couple components. One is the state pension component. The contributions to the state pension program is 14% and I think if you looked at your own businesses, the pension costs is probably half of that or less in most companies. That makes that number seem larger. The health component, I am not going to say it does not have work to do on it but it is not really disproportionate to normal health costs. We benchmark ourselves about national per member per year costs there. The tuition benefit is a couple percentage points of that number, there is a much better tuition benefit here than there is at most companies.

Mr. Jurgensen:

Mark, I'm curious about that pharma drug line. If you have been watching our income statement and I assume ours is not really materially different than anybody else's, that line has been a double digit grower for some time. I know we probably do not buy a lot of EpiPens but listening to that interview, which I thought was appalling, I wonder about price controls in pharma. If we price control utilities, is there going to be a cry to start reigning in people's ability to raise price just because they can when they cannot justify orphan drug pricing policy? I know that some of the stuff in Mike's world is extremely expensive and has a high research and development component but I am not sure that is really what is driving this aggregate number.

Mr. Caligiuri:

Excellent points, Jerry and there is a movement underway now certainly in the areas where combination chemotherapy that is prohibitively expensive from generic drugs and actually offers no increase in survival. It might be one dose versus three or a pill instead of IV. We are really getting push back, appropriately so, from the medical community about the pricing. There have been a number of drugs released where based on the merits of R&D, this needs to be 3, 4, 5 times a generic drug that gives you the same result. There is finally, both in the literature and in the late press, pushback from us as a community because we are not doing this. You see people backing down in the pricing, so this is a big problem.

President Drake:

In a macro sense, that is an issue with health care broadly and fee for service health care models that the value of the product is infinite and so that is a hard price magnet. It is hard to control prices in those circumstances if an incredible, miracle drug comes out. The one that got a lot of national attention was a cure for hepatitis C. The concept that you could cure a disease that someone might have had for 20, 30, 40 years, and you could make it go away in 8 weeks versus having liver cancer or a liver transplant, that is incredibly valuable. How much you charge for that and the charge was a fraction of the liver transplant surgery and a fraction of the cost of having liver cancer but was still $100,000. That is a real debate that is going on in a variety of places. There is progress on one side and then a debate about value and pricing on the other.

Mr. Larmore:

There is a program that allows you to buy formulary drugs at a greatly discounted price called the 340B program and the medical center had come off of that a couple of years ago for compliance reasons. In the last year we fixed the compliance issues and we have been recertified to go back onto that program. It takes a while for them to activate it so there is probably $5 million in savings this year but then the year after that it will be north of $10 million.

For capital costs there is no planned debt increase and this year depreciation comes in slightly above. I guess we could say the James building is getting older by one year which is the big increase I spoke about prior. Capital is $241 million and then the medical center investment is budgeted at $150 million. It was $140 million last year. Our vision is to continue to grow the physician base and most physicians today struggle in the first couple years as they ramp up their volume and the health system provides support towards that.

These are the volume projections at 3% on the inpatient side and so when we put this together we forecasted 2016 to come in at 59, 391 and it actually ended in 59,358. We were pretty close on that and you can see the biggest growth percentage wise is Harding. It is only 173 cases but then University Hospitals has 4.6%, but that includes the brain and spine so about 1,200 case growth there.

On the ambulatory side, you can see the outpatient visits broken out by hospital and then with Dan's presentation you can see the ambulatory volume of 13% and that is with those two new facilities coming on.

The budget that we established was, at forecast, $207 million. We actually came in at $198 million. I did not change this because this was the budget that was incorporated in the university, overall. The biggest change in that was some of the year-end accruals. I would say that June was a little soft, just like we saw July. The budget is $204 million and 5.2% growth in revenue and 5.7% growth on total expenses and 2.4% growth in bottom line or after the medical center investments stepping up $10 million, it is just slightly below what our forecasts were at this time. The $204 million is actually $6 million higher than we actually ended the year.

The balance sheet is our best guess as to how the year will play out. We expect, since we are controlling capital growth, the capital spending cash should grow again in 2017. Here you can see that cash growth on the bottom $156 million. This is the capital budget that I spoke of. We made some decisions last year along the way and they had not been packaged into an annual budget. Our normal capital budget is equivalent to our depreciation number of $136 million and on the bottom I broke out those projects that we approved along the way last year, which was building out the 72 shell beds, a floor and a half in the James, one parking garage at $25 million, and then the 700 Ackerman facility. The funds have been set aside in prior years but went through the capital process last year. They started out as a big buildout of a warehouse space that is there and we took a building that we were renting about 60,000 or 70,000 square feet in total and actually ended up buying it instead of continuing on a lease. It includes a lot of the back office for the physician practice and the health plan and it is right on the corner of Ackerman and 315.

We are going through the process right now. You can see on the right where the "must-dos" are listed and then the other projects are about $52 million. The internal team is prioritizing what the capital ask is and of course the ask is always five times what is available and looking at the economics of it and the need to spend some of this money.

The Medicaid rebasing is still up in the air. We expect we will get more into bundled payments as we go through the year and certainly the value based purchasing. More and more of our increases from managed care companies are coming with a contingency attached to meet certain quality benchmarks. It is not just a straight increase anymore, therefore, the amount that we are seeing at risk in those contracts continues to grow. They have passed a new regulation on hospital based clinics. You get paid more if it is a hospital based clinic than if it is a physician clinic. We have a fix but there is a one year hold in it with Jameson Crane and Upper Arlington. They fixed it, at least for those two facilities but they fixed it with a year gap which makes no sense. Certainly as we are onboarding new medical leadership, I look at that as an opportunity. 340B I spoke about and then we continue with many revenue cycle projects to bring more dollars out of the same volume that we have.

Dr. Reid:

Can you give me just your hunch about the impact of bundled payments? That seems like it would continue to increase, but what does that mean for us?

Mr. Larmore:

It definitely does not mean we are getting paid more. I think as we package together not only the physician and the hospital piece of business, but then, looking at packaging the front end and the back end of the stay. That will be a challenge for us because we do not own that whole continuum right now. It is something that, as we go through the strategic plan, we have to be ready to do.

Mr. Reid:

Yeah, I would like to know more about that as we get more information because that is a trend.

Mr. McQuaid:

That is a really good point and one of the things that we will talk about for 2017 is that we are actually going to have a line item for this. How are we going to track this episode of care and today? If we were to look at where we are, about 1% of our total system growth's revenues are related to this. We have 250 patients and the CABG (Coronary Artery Bypass Grafting) and valve bundle. We have Medicaid waive one episode and COPD and asthma. The state program reconciles our payments annually. We have a small percentage of that but trending over time, to your really important point is, now that the director of Medicare has insisted by 2018 they want 50% of these to be bundled and that is the cautionary tale to the risks to the plan. You can get that same admission in but because of a new payment methodology, the qualities of those earnings goes down significantly.

Dr. Reid:

I know it is going to have an impact on us and I want to get a sense of how large the impact will be because the 1% today will not be the 1% soon.

Mr. McQuaid:

That is exactly right and Dr. Susan Moffatt-Bruce and teams of so many people are really working on this piece to prepare, to understand our cost accounting systems. How are we able to competitively price these types of things? It is a critically important strategic question.

Dr. Reid:

Alright, so more later. Just know, I care.

Mr. McQuaid:

We are going to track it so you will see it on the scorecard every month starting this fiscal year.

Mr. Jurgensen:

Mark, I have a question on salary and benefits. You have a 2% merit but a 6% plan increase in salary and benefits. What is happening with planned FTE (Full-time Equivalent) count and then the second would be how much of our salary and benefit line is variable or tied to productivity of one kind of another. How do we plan that?

Mr. Larmore:

The difference between the two is the volume growth. I would say almost half of our employee base is on a direct care side so that is totally variable to volume. An extra day in the bed is an extra 8 to 24 hours of nursing care that goes along with that so when we look at our volume growth, we actually look at what type of volume growth it is and if it is going to be short stay volume or long stay volume. In some of the ancillary areas, lab, radiology, and such like that, there is less of a direct correlation to volume growth but we do ramp that up and on the administrative side we have tried to hold that flat.

Mr. Wexner:

Going back to the Upper Arlington facility, we should do it offline, but look at that as a detailed business in and of itself. I think how patients come into this system, how we retain them, the volume of the facility, the dynamics of it, because we have never really done this. We would do more of this if it is a way to influence the market, offense, defense, all the aspects of it, but even just look at the budget of it because we are looking at numbers of patients and visits. I think there is an enormous amount of learning from this that can impact the medical center in a very dramatic way.

Mr. McQuaid:

Jerry, I would like to take a minute if I could, to address your question, an important piece of labor. On a biweekly basis, we have a team of folks that pay careful attention to biweekly paid FTEs, if you will, versus budgeted FTEs. We look at fixed and variable, we can adjust based upon acuity, we can adjust based upon a number of different variables to track on that. There is always opportunity to make sure we are keeping that in check but I wanted to let you know that internally, there is an entire team of folks that look at that and generally they are only looking at new incremental positions that are necessary and trying to keep all of that labor just right, if you will.

Mr. Larmore:

I will run quickly through the practice plan and the college, very similar assumptions. The benefits are a little different in the practice plan. They are in the university health program but priced differently so we did a budget increase there. Patient encounters is $2.7 million. This is every encounter with a patient, whether it is in an ambulatory or inpatient, so it is the total encounters. We have changed the DEE (departmental efficiency and effectiveness) to college management system and this focuses more on controlling expense growth and making sure revenue growth is faster than the expense growth. Changing the messaging to be a growth mode not a cut mode but not saying we totally disregard managing the expense growth side on the practice plan and the same thing with the college. As you can see, there is pretty sizable growth from $400 million to $430 million and the bottom line, when I presented the bottom line from last year it was that $30 million we finished and that included the $10 million for neurology. If you took that out, $19 million, we are projecting about a $2 million increase in the bottom line for the practice plan.

I do not see the medical center investments are committed in there and established so there is not much sensitivity on that. We did resolve the issues with neurology. We have the new chairs on board and then the new facilities. We are implementing a new financial system across the entire university. Across the medical center and we are implementing a new decision support system called Strata. Both of those are IT initiatives that will take a lot of work this year.

The College of Medicine, again, similar assumptions going in is done on a cash basis. If you look on the bottom, more renovations during the year that come through the P and L, especially on smaller renovations is actually expensed so you can see a difference here. The forecast for 2016 was a loss. I showed you, again, this is what we submitted

to the university. It was a positive number because of those pledge payments that came in June. We are actually forecasting a $12 million decrease in cash and some of this is money that is within the college that departments are utilizing during the year. It is a little different format because it is not on an accrual basis. When we put this together, there is only a number of these things we have actually done so it is a good start to the year. We are at the final forecast and $213 million will be our budget for 2017.

Mrs. Wexner:

Mark, I am having trouble reconciling that 222 to 244, right?

Mr. Larmore:

The $10 million, actually, the pledge payments that came in June for the College of Medicine is in the $244 million, that was $19 million. That came in after we put the budget together so that is reflected as an increase to the 2016 forecast.

Mrs. Wexner:

If that was ultimately the case of $244 million, forget the timing, then we are talking of a variance of much greater than 4.1%.

Mr. Larmore:

The pledge payments were a one-time thing. We are not expecting that so they are not built into the 2017 budget. There are challenges that we have built into the budget. I spoke about the Medicaid rebasing as the extra $10 million on the medical center investments which is a reduction in that bottom line. I would not use $244 million, I would use $224 million, compared to the $213 million. Yes, the budget is slightly lower than where we ended last year. That is the last slide.

(See Attachment VI for background information, page 69)

Dr. Retchin:

Any other questions for Mr. Larmore? Excellent presentation, great summary of 2016 and looking forward to 2017. I am going to move quickly, Jay, on contracts, we have one item.

Mr. Kasey:

This is a renewal project on the infrastructure for the Martha Morehouse complex. The complex was built in 1983. It was built as a residential and free-for-service for the state of Ohio and the tower was residential but the building was a treatment area. It was given to the university in 2000. At that time, there were three chillers in the unit and they were on the side that the state would cool the residents during the evening when the patients were there. When the residents were there, they would cool the building during the day when they were receiving treatment. When the university accepted ownership, the building was deemed as a hub for the medical center and the building backed towards 315 was the Wright Center for Imaging, very high tech equipment. At that time, we accepted the building, we added a chiller which enabled us to chill the entire facility at one time. However, there has been a steady increase in occupancy for ambulatory care at Martha Morehouse over the last 16 years.

Three cooling seasons ago, in some level of redundancy, we added a chiller on a flatbed tractor-trailer which we plugged into the back of the unit. We now are coming forward and asking for a replacement of the three old chillers and, of course, the truck gets removed. We will add three new chillers. Two of those chillers will be sufficient to carry the load on an average day at Martha Morehouse, with one back-up for redundancy. In

addition, there are two emergency generators on site to carry the load if we lose power. One is a 350 kilowatt generator and the other is a 750 kilowatt generator. We are asking to replace the 350 kilowatt generator with another 750 kilowatt generator to carry the additional load that has developed at Martha Morehouse over the years. The generator is being removed and will be taken elsewhere in the university. I can answer questions.

Dr. Retchin:

We need a motion to approve. Is there any discussion?

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES AND CONSTRUCTION CONTRACTS

Resolution No. 2017-06

Approval to Enter Into Professional Services and Construction Contracts

Morehouse - Chiller and Electrical Distribution

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

WHEREAS in accordance with the attached materials, the university desires to enter into professional services and construction contracts for the following project:

	Prof. Serv. Approval Requested	Construction Approval Requested	Total Project Cost	
Morehouse - Chiller and Electrical Distribution	$1.8M	$6.2M	$8M	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 project listed above be recommended to the University Board of Trustees for approval; and

BE IT FURTHER RESOLVED, That the president and/or senior vice president for business and finance be authorized to enter into professional services contracts and construction contracts for the project listed above in accordance with established university and state of Ohio procedures, with all actions to be reported to the board at the appropriate time.

(See Attachment VII for background information, page 92)

Upon the motion of Mr. Shumate, seconded by Mrs. Wexner, The Wexner Medical Center Board members adopted the foregoing motion by unanimous voice vote.

Dr. Retchin:

I am going to skip the *U.S. News and World Report* Item, even though it still deserves to be underscored. It was a great year. We are now number 25. Which is 5 behind honor roll and we have overtaken and passed University Hospital in Cleveland as the number two system in the state just behind the Cleveland Clinic. With that, Mr. Chair, I believe we need to move into executive session.

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

August 31, 2016 meeting, Wexner Medical Center Board

Attest:

Leslie H. Wexner Chairman	Heather Link Associate Secretary

ATTACHMENT I

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

Updated ~~November 6, 2015~~

3335-43-04 Membership.

(A) Qualifications.

(1) No change

(2) All members of the medical staff of the Ohio state university hospitals shall, except as specifically provided in these bylaws, be members of the faculty of the Ohio state university college of medicine, or in the case of dentists, of the Ohio state university college of dentistry, and shall, except for members of the limited staff, be duly licensed or certified to practice in the state of Ohio. Members of the limited staff shall possess a valid training certificate, or an unrestricted license from the applicable state board based on the eligibility criteria defined by that board. All members of the medical staff and limited staff and licensed health care professionals with clinical privileges shall comply with provisions of state law and the regulations of the state medical board or other state licensing board if applicable. Only those physicians, dentists, and practitioners of psychology and podiatry who can document their education, training, experience, competence, adherence to the ethics of their profession, dedication to educational and research-goals, and ability to work with others with sufficient adequacy to assure the Wexner medical center board and the board of trustees of the Ohio state university that any patient treated by them at university hospitals will be given the high quality of medical care provided at university hospitals, shall be qualified for membership on the medical staff of the Ohio state university hospitals.

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

interest, HIPAA compliance, and access and communication guidelines. Medical staff members and licensed health care professionals with clinical privileges must also comply with the university integrity program requirements including but not limited to billing, self-referral, ethical conduct and annual education. Medical staff members and licensed health care professionals with clinical privileges must immediately disclose to the chief medical officer and the department chairperson the occurrence of any of the following events: a licensure action in any state, any malpractice claims filed in any state or an arrest by law enforcement.

(3) - (7) No change

(B) - (G) No change

3335-43-09 Elected officers of the medical staff of the Ohio state university hospitals.

(A) Chief of staff.

The chief of staff shall:

(1) - (7) No change

~~(8) Be representative to the council of the academy of medicine of the city of Columbus and Franklin county, or select a representative to serve on the council.~~

(~~9~~)(8) No change

(~~10~~)(9) Hold ~~regular~~ meetings of the elected medical staff officers, representatives from medical staff committees, the chief executive officer, the chief nursing officer and medical directors.

(B) - (G) No change

3335-43-10 Administration of the medical staff of the Ohio state university hospitals

(A) - (C) No change

(D) Medical staff committees.

(1) Appointments:

Appointments to all medical staff committees except the medical staff administrative committee, nominating committee and all health system committees, shall be made jointly by the chief of staff, chief of staff-elect, and the medical directors with medical staff administrative committee ratification. Representatives from the Ohio state university hospitals to health system committees shall be appointed jointly by the chief medical officer of the health system and the medical director. Unless otherwise provided by these bylaws, all appointments to medical staff committees shall be for ~~one year~~ two years and may be renewed. The chief of staff, chief medical officer, medical director, and the chief executive officer of the Ohio state university hospitals may serve on any medical staff committee as an ex-officio member without vote.

(2) - (3) No change

(E) Medical staff administrative committee.

(1) Composition.

(a) This committee shall consist of the following voting members: chief of staff, chief of staff-elect, chiefs of the clinical departments, three medical staff representatives elected at large, the chief medical officer, and the chief executive officer of the Ohio state university hospitals. Additional members may be appointed to the medical staff administrative committee at the recommendation of the dean or the chief medical officer of the medical center subject to the approval of the medical staff administrative committee and subject to review/renewal on a ~~yearly~~ biennial basis. Any members may be removed from the medical staff administrative committee at the recommendation of the dean, the executive vice president for health sciences or the chief medical officer of the medical center and subject to the review and approval of the medical staff administrative committee. A replacement will be appointed as outlined above to maintain the medical staff administrative committee's constituency. The chief medical officer shall be the chairperson and the chief of staff shall be vice-chairperson.

(b) - (c) No change

(2) - (4) No change

(F) - (M) No change

MEDICAL STAFF RULES AND REGULATIONS (as of ~~April 6, 2016~~)
The Ohio State University Hospitals

84-05 Privileges for giving orders.

(A) - (M) No change

(N) Hospital admission/observation orders.

Hospital admission/observation requires an appropriate level of care (ALOC)~~admission/observation orders~~ designating the patient as an inpatient or an outpatient (observation). The appropriate level of care (ALOC) order may be written and signed by the attending physician. If the ALOC order for inpatient admission is written by a member of the limited staff or other licensed healthcare practitioner with appropriate clinical privileges, it must be co-signed by the attending physician prior to the patient being discharged from the hospital. Admission to any inpatient unit or placing a patient in observation status requires new, rewritten/reentered or renewed orders by the responsible physician, limited staff member or other licensed healthcare practitioner with appropriate clinical privileges and under the supervision of the collaborating physician.

84-12 Medical records.

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

(1) - (2) No change

(3) Discharges

(a) Patients may not be discharged without a ~~shall be discharged only on~~ written or electronically entered discharge order from the appropriately credentialed, ~~of the~~ responsible medical staff member, limited staff member, or other licensed healthcare professional ~~with appropriate clinical privileges~~.

~~(b)~~ At the time of ~~ordering the patient's~~ discharge, the appropriately credentialed ~~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, limited staff member, or other licensed healthcare professional ~~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, the principal procedure, if any, and any other significant invasive procedures that were performed during the hospitalization~~in the medical record by the time of discharge~~. If a principal diagnosis has not yet been determined, ~~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~~ then a "provisional" principal diagnosis should be used instead~~by the time of discharge~~.

~~(b)~~(c) The discharge summary ~~for each patient~~ must be available to any facility receiving the patient before the patient arrives at

~~the facility~~~~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.~~ Similarly, the discharge summary must be available to the care provider before the patient arrives at any outpatient care visit subsequent to discharge. The discharge summary should be available within forty-eight hours of discharge for all patients. The discharge summary should be signed by the responsible medical staff member within forty-eight hours of availability.

(d) The discharge summary must contain the following elements:

i. hospital course including reason for hospitalization and significant findings upon admission;
ii. principal and secondary diagnoses or provisional diagnoses;
iii. relevant diagnostic test results;
iiii. procedures performed and care, treatment and services provided;
ivi. condition at discharge;
vi. medication list and medication instructions;
vii. plan for follow up of tests and studies for which results are pending at discharge;
viii. coordination and planning for follow-up testing and appointments;
viiii. plans for follow up care and communication, and the instructions provided to the patient.

(~~c~~)(e) 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~~)(f) All medical records must be completed by the attending medical staff member or, when applicable, the limited staff member or other licensed healthcare professional~~by the attending medical staff member's designee, who is appropriately credentialed by the hospital,~~ within twenty-one days of discharge of the patient.

(g) 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~~ Attending medical staff members shall receive electronic notification of delinquent records~~, 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, electronically for completion, the record shall not be counted against the attending medical staff member. Medical staff members who are suspended for a period of longer than one hundred twenty consecutive days are required to appear before the practitioner evaluation committee.

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

(4) - (10) No change

ATTACHMENT II

Chapter 3335-111 - *Bylaws of the Medical Staff* of the
Arthur G. James Cancer Hospital and Richard J. Solove Research Institute
Updated ~~November 6, 2015~~

3335-111-04 Membership.

(A) Qualifications.

(1) No change

(2) All members of the medical staff of the CHRI, except community associate attending staff, shall be members of the faculty of the Ohio state university college of medicine, or in the case of dentists, of the Ohio state university college of dentistry, and shall be duly licensed or certified to practice in the state of Ohio. Members of the limited staff shall possess a valid training certificate, or an unrestricted license from the applicable state board based on the eligibility criteria defined by that board. All members of the medical staff and limited staff and licensed health care professionals with clinical privileges shall comply with provisions of state law and the regulations of the respective state ~~licensing board~~medical board or other state licensing board if applicable. Only those physicians, dentists, and practitioners of psychology and podiatry who can document their education, training, experience, competence, adherence to the ethics of their profession, dedication to educational and research goals and ability to work with others with sufficient adequacy to assure the Wexner medical center board and the board of trustees of the Ohio state university that any patient treated by them at the CHRI will be given high quality medical care provided at CHRI, shall be qualified for eligibility for membership on the medical staff of the CHRI. Except for community associate staff, CHRI medical staff members shall also hold appointments to the medical staff of the Ohio state university hospitals for consulting purposes. Loss of such appointment shall result in immediate termination of membership on the CHRI medical staff and immediate termination of clinical privileges as of the effective date of the Ohio state university hospitals appointment termination. This consequence does not apply to an individual's suspension for completion of medical records. If the medical staff member regains an appointment to the Ohio state university hospitals medical staff, the affected medical staff member shall be eligible to apply for CHRI medical staff membership at that time. All applicants for membership, clinical privileges, and members of the medical staff must provide basic health information to fully demonstrate that the applicant or member has, and maintains, the ability to perform requested clinical privileges. The director of medical affairs of the CHRI, the medical director of credentialing, the department chairperson, the credentialing committee, the medical staff administrative committee, the quality and professional affairs committee of the Ohio state university Wexner medical center board, or the Ohio state university Wexner medical center board may initiate and request a physical or mental health evaluation of an applicant or member. Such request shall be in writing to the applicant.

(3) All members of the medical staff and licensed health care professionals will comply with medical staff and the CHRI policies regarding employee and medical staff health and safety, provision of uncompensated care, and will comply with appropriate administrative directives and policies which, if not followed, could adversely impact overall patient care or may adversely impact the ability of the CHRI employees or staff to effectively

and efficiently fulfill their responsibilities. All members of the medical staff and licensed health care professionals shall agree to comply with bylaws, rules and regulations, and policies and procedures adopted by the medical staff administrative committee and the Wexner medical center board, including but not limited to policies on professionalism, behaviors that undermine a culture of safety, annual education and training (list approved by the medical staff administrative committee and maintained in the chief medical officer's office), conflict of interest, HIPAA compliance and access and communication guidelines. Medical staff members and licensed health care professionals with clinical privileges must also comply with the university integrity program requirements including but not limited to billing, self-referral, ethical conduct and annual education. Medical staff members and licensed health care professionals with clinical privileges must immediately disclose to the chief medical officer and the department chairperson the occurrence of any of the following events: a licensure action in any state, any malpractice claims filed in any state or an arrest by law enforcement.

(4) - (10) No changes

(B) - (G)

3335-111-09 Elected officers of the medical staff of the CHRI.

(A) Chief of staff.

The chief of staff shall:

(1) - (3) No changes

(4) Make medical staff committee appointments jointly with the ~~director of medical affairs~~ physician-in-chief and chief of staff-elect for approval by the CHRI medical staff administrative committee.

(5) No changes

~~(6) Be representative to the council of the academy of medicine of Columbus and Franklin county, or select a representative to serve on the council.~~

~~(7)~~(6) Serve as chairperson of the nominating committee of the medical staff.

(B) - (G) No changes

3335-111-10 Administration of the medical staff of the CHRI.

Medical staff committees.

(A) Appointments: Appointments to all medical staff committees except the medical staff administrative committee (MSAC) and the nominating committee will be made jointly by the chief of staff, chief of staff-elect, and the director of medical affairs with medical staff administrative committee ratification. Unless otherwise provided by the bylaws, all appointments to medical staff committees are for ~~one year~~two years and may be renewed. The chairperson shall control the committee agenda, attendance of staff and guests and conduct the proceedings. A simple majority of appointed voting members shall constitute a quorum. All committee members appointed or elected to serve on a medical staff committee are expected to participate fully in the activities of those committees. The chief of staff, director of

medical affairs and the chief executive officer of the CHRI may serve on any medical staff committee as an ex-officio member without vote.

(B) - (J) No changes

MEDICAL STAFF RULES AND REGULATIONS
Arthur G. James Cancer Hospital and Richard J. Solove Research Institute
as of ~~April 6, 2016~~

05 Order writing privileges.

(A) - (K) No changes

(L) Hospital admission/observation orders.

Hospital admission/observation requires an appropriate level of care (ALOC) ~~admission/observation orders~~order designating the patient as inpatient or outpatient (observation). The appropriate level of care (ALOC) order may be written a signed by the attending physician. If the ALOC order for inpatient admission is written by a member of the limited staff or other licensed healthcare practitioner with appropriate clinical privilege, it must be co-signed by the attending physician prior to the patient being discharged from the hospital. Admission to any inpatient unit or placing a patient in observation status requires new, rewritten/reentered or renewed orders by the responsible medical practitioner or limited staff member or other licensed healthcare professional with appropriate privileges and under the supervision of the responsible medical staff member.

10 Medical records.

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

(1) - (2) No changes

(3) Discharges.

~~(~~a) Patients ~~shall~~may not be discharged ~~only on~~ without a written or electronically entered discharge order from the appropriately credentialed, ~~of the~~ responsible medical staff member, a limited staff member or other licensed healthcare professional ~~with appropriate clinical privileges~~.

~~(b)~~ At the time of discharge, the appropriately credentialed~~ordering the patient's discharge or at the time of next visit to the hospital, if the~~ attending medical staff member, limited staff member, or other licensed healthcare professional ~~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, the principal procedure, if any, and any other significant invasive procedures that were performed during the hospitalization~~in the medical record by the time of discharge~~. If a principal diagnosis ~~cannot be~~ has not yet been determined, ~~in the absence of outstanding test results, the attending medical staff member must record~~then a "provisional" principal diagnosis ~~by the time of discharge~~should be used instead.

~~(b)~~(c) 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~~ available to any facility receiving the patient before the patient arrives at the facility. Similarly, the discharge summary must be available to the care provider before the patient arrives at any outpatient care visit subsequent to discharge. The discharge summary should be available within forty-eight hours of discharge for all patients. The discharge summary should be signed by the responsible attending medical staff member within forty-eight hours of availability.

(d) The discharge summaries must contain the following elements:

i. ~~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;
ii. principal and secondary diagnoses or provisional diagnosis;
iii. relevant diagnostic test results;
iv. procedures performed and care, treatment and services provided ~~to the patient~~;
v. condition on discharge;
vi. medication list and medication ~~instruction~~instructions;
vii. ~~the~~ plan for follow-up of tests and studies ~~where~~ for which results are ~~still~~ pending at discharge;
viii. coordination and planning for follow-up testing and physician appointments;
~~ix.~~ plans for follow-up care and communication, and the instructions provided to the patient. ~~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)~~(e) All medical records must be completed by the attending medical staff member or, when applicable, the limited staff member or other licensed healthcare professional who is appropriately credentialed by the hospital, within twenty-one days of discharge of the patient.

(f) Attending medical staff members shall be notified prior to suspension for all incomplete records. After notification, attending medial staff members shall have their admitting and operative scheduling privileges suspended until all records are completed. Attending medical staff members shall receive electronic notification of delinquent records. If an attempt is made by the attending medical staff member, or the attending medical staff member's designee, who is appropriately credentialed by the hospital, when applicable, to complete the record, and the record is not available electronically for completion, the record shall not be counted against the attending medical staff member.~~by his/her appropriately credentialed designee within twenty-one 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 consecutive days are required to appear before the practitioner evaluation committee.

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

(4) - (11) No changes

ATTACHMENT III

Approvals:
MSAC- 3/12/2014; 6/10/2015, 6/8/2016
QPAC-7/16/2014; 7/22/2015; 6/28/2016
Wexner Medical Center Board - 8/29/2014; 8/25/2015

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

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

OSU WEXNER MEDICAL CENTER MISSION, VISION AND VALUES

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

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

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

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

PHILOSOPHY OF PATIENT CARE SERVICES

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

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

team meetings, administrative staff meetings, special forums, and leadership and employee education/development;

h) Maintaining competent patient care leadership and staff by providing education designed to meet identified needs;

i) Respect for each patient's rights and decisions as an essential component in the planning and provision of care; and,

j) Staff member behaviors reflect a philosophical foundation based on the values of Ohio State's Wexner Medical Center.

THE HOSPITAL LEADERSHIP

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

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

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

Other leadership responsibilities include:

a) Communication of the organization's mission, goals, objectives and strategic plans across the organization;

b) Ensuring appropriate and competent direction, management and leadership of all services and/or departments;

c) Collaborating with community leaders and organizations to ensure services are designed to be appropriate for the scope and level of care required by the patients and communities served;

d) Supporting the patient's continuum of care by integrating systems and services to improve efficiencies and care from the patient's viewpoint;

e) Ensuring staffing resources are available to appropriately and effectively meet the needs of the patients served and to provide a comparable level of care to patients in all areas where patient care is provided;

f) Ensuring the provision of a uniform standard of patient care throughout the organization;

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

ROLE OF THE CHIEF NURSING OFFICER

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

The Chief Nursing Officer ensures the following functions are addressed:

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

DEFINITION OF PATIENT SERVICES, PATIENT CARE AND PATIENT SUPPORT

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

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

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

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

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

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

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

SCOPE OF SERVICES / STAFFING PLANS

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

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

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

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

Staffing plans for patient care service departments are developed based on the level and scope of care provided, the frequency of the care to be provided, and a determination of the level of staff that can most appropriately (competently and confidently) provide the type of care needed. Nursing units are staffed to accommodate a projected average daily patient census. Unit management (including nurse manager and/or charge nurse) reviews patient demands to plan for adequate staffing. Staffing can be increased or decreased to meet patient needs. When the number of patients is high or the need is great, float staff assist in providing care. When staff availability is projected to be low due to leaves of absence, the unit manager and director may request temporary agency nurses. Ohio State's Wexner Medical Center follows the Staffing Guidelines set by the American Nurses Association. In addition, we utilize staffing recommendations from various specialty nursing organizations, including: ENA, ANCC, AACN, AORN, ASPN, and others.
The Administrator, in conjunction with the budget and performance measurement process, reviews all patient care areas staffing and monitors ongoing regulatory requirements. Each department staffing plan is formally reviewed during the budget cycle and takes into consideration workload measures, utilization review, employee turnover, performance assessment, improvement activities, and changes in customer needs/expectations. A variety of workload measurement tools may be utilized to help assess the effectiveness of staffing plans.

STANDARDS OF CARE

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

Patients of the Hospitals can expect that:

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

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

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

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

CARE DELIVERY MODEL
The care delivery model is guided by the following goals:

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

PATIENT RIGHTS AND ORGANIZATIONAL ETHICS

Patient Rights

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

Organizational Ethics

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

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

Biomedical Ethics

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

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

INTEGRATION OF PATIENT CARE AND SUPPORT SERVICES

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

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

To facilitate effective interdepartmental relationships, problem solving is encouraged at the level closest to the problem at hand. Staff is receptive to addressing one another's issues and concerns and work to achieve mutually acceptable solutions. Supervisors and managers have the responsibility and authority to mutually solve problems and seek solutions within their spans of control; positive interdepartmental communications are strongly encouraged. Employees from departments providing patient care services

maintain open communication channels and forums with one another, as well as with service support departments to ensure continuity of patient care, maintenance of a safe patient environment and positive outcomes.

CONSULTATIONS AND REFERRALS FOR PATIENT SERVICES

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

INFORMATION MANAGEMENT PLAN

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

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

PATIENT CARE ORGANIZATIONAL IMPROVEMENT ACTIVITIES
All departments are responsible for following the Hospitals' plan for improving organizational performance.

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

Appendix A: Scope of Services: Patient Support Services

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

DEPARTMENT	SERVICE
CASE MANAGEMENT	As part of the health care team, provides ~~world class~~ personalized care coordination and resource management with patients and families.
CHAPLAINCY AND CLINICAL PASTORAL EDUCATION	Assists patients, their families and hospital personnel in meeting spiritual needs through professional pastoral and spiritual care and education.
CLINICAL ENGINEERING	Routine equipment evaluation, maintenance, and repair of electronic equipment, evaluation of patient owned equipment.
COMMUNICATIONS AND MARKETING	Responsible for developing strategies and programs to promote the organization's overall image and specific products and services to targeted internal and external audiences. Handles all media relations, advertising, internal communications, special events and publications.
DIAGNOSTIC TESTING AREAS	Provides tests based on verbal, electronic or written order. Preliminary report via phone or electronic patient record. Permanent reports are included in the patient record.
DIAGNOSTIC TRANSPORTATION	Provision of transportation services for patients requiring diagnostic, operative or other ancillary services.
EARLY RESPONSE TEAM (ERT)	Provides timely diagnostic and therapeutic intervention before there is a cardiac or respiratory arrest or an unplanned transfer to the Intensive Care Unit. Consists of a Critical Care RN and Respiratory Therapist who are trained to help patient care staff when there are signs that a patient's health is declining.
EDUCATIONAL DEVELOPMENT & RESOURCES	Provides and promotes ongoing development and training experiences to all member of the OSU Wexner Medical Center community; provides staff enrichment programs, organizational development, leadership development, orientation and training, skills training, continuing education, competency assessment and development, literacy programs and student affiliations.
ENDOSCOPY	Provides services to patients requiring a nonsurgical review of their digestive tract.
ENVIRONMENTAL SERVICES	Provides quality monitoring for routine housekeeping in patient rooms. Routine housekeeping of nursing unit environment. Additional services upon request: extermination, wall cleaning, etc.
EPIDEMIOLOGY	Enhance the quality of patient care and the work environment by minimizing the risk of acquiring infection within the hospital setting.
FACILITIES OPERATIONS	Provide oversight, maintenance and repair of the building's life safety, fire safety, and utility systems. Provide preventative, repair and routine maintenance in all areas of all buildings serving patients, guests, and staff. This would include items such as electrical, heating and ventilation, plumbing, and other such items. Also providing maintenance and repair to basic building components such as walls, floors, roofs, and building envelope. Additional services available upon request.
FISCAL SERVICES	Works with departments/units to prepare capital and operational budgets. Monitors and reports on financial performance monthly.

DEPARTMENT	SERVICE
HUMAN RESOURCES	Serves as a liaison for managers regarding all Human Resources information and services; assists departments with restructuring efforts; provides proactive strategies for managing planned change within the Health System; assists with Employee/Labor Relations issues; assists with performance management process; develops compensation strategies; develops hiring strategies and coordinates process for placements; provides strategies to facilitate sensitivity to issues of cultural diversity; provides HR information to employees, and establishes equity for payroll.
INFORMATION SYSTEMS	Work as a team assisting departments to explore, deploy and integrate reliable, state of the art Information Systems technology solutions to manage change.
MATERIALS MANAGEMENT	Routinely stocks supplies in patient care areas, distributes linen. Sterile Central Supply, Storeroom - upon request, distributes supplies/equipment not stocked on units.
MEDICAL INFORMATION MANAGEMENT	Maintains patient records serving the needs of the patient, provider, institution, and various third parties to health care.
NUTRITION SERVICES	Provides nutrition care and food service for Medical Center patients, staff, students, and visitors. Clinical nutrition assessment, care plan development, and consultation are available in both inpatient and outpatient settings. The Department provides food service to inpatients and selected outpatient settings in addition to operating a variety of retail café locations and acts as a liaison for vending and sub-contracted food services providers ~~a full-service cafeteria and acts as a liaison for vending and sub-contracted food services providers~~. Serve as dietetic education preceptors.
PATIENT ACCESS SERVICES	Coordinates registration/admissions with nursing management.
PATIENT EXPERIENCE	Develops programs for support of patient relations and customer service, and includes front-line services such as information desks.
PATIENT FINANCIAL SERVICES	Provides financial assistance upon request from patient/family. Also responsible for posting payments from patients and insurance companies among others to a patient's bill for services.
PHARMACY	Provides comprehensive pharmaceutical care through operational and clinical services. Responsible for medication distribution via central and satellite pharmacies, as well as 797 compliant IV compounding room and automated dispensing cabinets. Some of the many clinical services include pharmacokinetic monitoring, renal and hepatic dose adjustments, and patient educational Specialist pharmacists also round with patient care teams to optimize medication regimens and serve as the team's primary medication information resource.
PULMONARY DIAGNOSTICS LAB	Provides service to patients requiring an evaluation of the respiratory system. Performs Pulmonary Function Testing to assess the functional status of the respiratory system. Bronchoscopy and other diagnostic/interventional pulmonology procedures are performed to diagnose and/or treat abnormalities that exist in the airways, lung parenchyma or pleural space.
QUALITY AND OPERATIONS IMPROVEMENT	Provides an integrated quality management program and facilitates continuous quality improvement efforts throughout the medical center.
RESPIRATORY THERAPY	Provide all types of respiratory therapeutic interventions and diagnostic testing, by physician order, mainly to critically ill adults and neonates, requiring some type of ventilator support, bronchodilator therapy, or pulmonary hygiene, due to chronic lung disease, multiple trauma, pneumonia, surgical intervention, or prematurity.

DEPARTMENT	SERVICE
REHABILITATION SERVICES	Physical therapists, occupational therapists, speech and language pathologists, and recreational therapists evaluate and develop a plan of care and provide treatment based on the physician's referral. The professional works with each patient/family/caregiver, along with the interdisciplinary medical team, to identify and provide the appropriate therapy/treatment and education needed for the established discharge plan and facilitates safe and timely movement through the continuum of care.
RISK MANAGEMENT	Protect resources of the hospital by performing the duties of loss prevention and claims management. Programs include: Risk Identification, Risk Analysis, Risk Control, Risk Financing, Claims Management and Medical-Legal Consultation.
SAFETY	Handles issues associated with licensing and regulations, such as EPA and fire regulations.
SECURITY	Provides a safe and secure environment for patients, visitors, and staff members by responding to all emergencies such as workplace violence, fires, bomb threats, visitor/staff/patient falls, Code ~~b~~B lues (cardiac arrests) in public places, internal and external disasters, armed aggressors, or any other incident that needs an emergency response.
SOCIAL WORK SERVICES	Social Work services are provided to patients/families to meet their medically related social and emotional needs as they impact on their medical condition, treatment, recovery and safe transition from one care environment to another. Social workers provide psychosocial assessment and intervention, crisis intervention, financial counseling, discharge planning, health education, provision of material resources and linkage with community agencies. Consults can be requested by members of the treatment team, patients or family members.
VOLUNTEER SERVICES	Volunteer Services credential and place volunteers to fill departmental requests. Volunteers serve in wayfinding, host visitors in waiting areas, serve as patient / family advisors, and assist staff. Volunteer Services manage the patient mail & flower room, cultural support volunteer program, and the pet visitation program. Volunteer Services serve as a liaison for the Service Board auxiliary which annually grants money to department-initiated projects than enhance the patient and family experience.

(ATTACHMENT IV)

The James

The Ohio State University
Wexner Medical Center

Revised: May 2016
MSAC Approval: July 8, 2016
QPAC Approval: August 23, 2016
Board Approval:

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

PLAN FOR PROVIDING PATIENT CARE SERVICES

Prepared by: **ADMINISTRATION**

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

THE HOSPITAL'S MISSION, VISION, AND VALUES

Mission: To eradicate cancer from individuals' lives by creating knowledge and integrating
groundbreaking research with excellence in education and patient centered-care
Vision: Creating a cancer-free world. One person, one discovery at a time.

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

Each of the three elements of The James Cancer Hospital's Mission contributes to the strength of the other two elements. The James' patient centered care is enhanced by the teaching and research programs, while patient service both directly and indirectly provides the foundation for teaching and research programs. At The James, no cancer is routine. Our researchers and oncologists study the unique genetic makeup of each patient's cancer, understand what drives it to develop and deliver the most advanced targeted treatment for the individual patient. This three-part mission and a staff dedicated to its fulfillment distinguish The Arthur G. James Cancer Hospital and Richard J. Solove Research Institute as one of the nation's premier cancer treatment centers.

Philosophy of Patient Care Services

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

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

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

Hospital Leadership

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

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

The hospital leadership works collaboratively with all operational and clinical leaders to ensure integration in the planning, evaluation and communication processes both within and between departments to enhance patient care services and support. This occurs informally on a daily basis and formally via multi-disciplinary leadership meetings. The leadership team works with each department manager to evaluate, plan and recommend annual budget expenses and capital objectives, based on the expected resource needs of their department. Department leaders are accountable for managing and justifying their budgets and resource utilization. This includes, but is not limited to identifying, investigating and budgeting for new technologies and resources that are expected to improve the delivery of patient care and services.
Other leadership responsibilities include:

- Communicate the organization's mission, goals, objectives and strategic plans across the organization;
- Ensure appropriate and competent management and leadership of all services and/or departments;
- Collaborate with community leaders and organizations to ensure services are designed to be appropriate for the scope and level of care required by the patients and communities served;
- Support the continuum of care by integrating systems and services to improve efficiencies and care from the patient's viewpoint;

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

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

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

- Evaluate patient care programs, policies, and procedures that describe how patients' care needs are assessed, evaluated, and met throughout the organization;
- Develop and implement the Plan for the Provision of Patient Care;
- Participate with leaders from the governing body, medical staff and clinical areas in organizational decision-making, strategic planning and in planning and conducting performance improvement activities through the organization;
- Implement an effective, ongoing program to assess, measure and improve the quality and safety of care provided to patients;
- Develop, approve, and implement standards of nursing practice, standards of patient care, and patient care policies and procedures that include current research and evidence based practice;
- Participate with organizational leaders to ensure that resources are allocated to provide sufficient number of qualified staff to provide patient care;
- Ensure that services are available to patients on a continuous, timely basis; and
- Review and/or revise the Plan for the Providing Patient Care Services on an annual basis.

Definition of Patient Services, Patient Care and Patient Support

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

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

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

Patient Care encompasses the recognition of disease and health, patient education allowing the patient to participate in their care, patient advocacy, and spirituality. The full scope of patient care is provided by professionals who perform the functions of assessing and planning patient care based on information gathered from the assessment as well as past medical history, social history and other pertinent findings. Patient care and services are planned, coordinated, provided, delegated and supervised by professional health care providers who recognize the unique physical, emotional and spiritual (body, mind and spirit) needs of each person. Under the auspices of the hospital, medical staff, registered nurses and allied health care professionals function collaboratively as part of a multi-disciplinary, patient-focused care team in order to achieve positive patient outcomes and personalized care.

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

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

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

Scope of Services/Staffing Plans

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

- The types and age ranges of patients served;
- Methods used to assess and meet patient care needs (including services most frequently provided such as procedures, medication administration, surgery, etc.);
- The scope and complexity of patient care needs
- The appropriateness, clinical necessity and timeliness of support services provided directly or through referral contact;
- The extent to which the level of care or service meets patient needs, hours of operation if other than 24 hours a day/7days a week and a method used to ensure hours of operation meet the needs of the patients to be served with regard to availability and timeliness;
- The availability of necessary staff (staffing plans); and
- Recognized standards or practice guidelines,

Staffing plans for patient care service departments are developed based on the level and scope of care provided, the frequency of the care to be provided, and a determination of the level of staff that can most appropriately competently and confidently provide the type of care needed. Nursing units are staffed to accommodate a projected average daily patient census. Unit management (including nurse manager and/or charge nurse) review patient demands to plan for adequate staffing. Staffing can be increased or decreased to meet patient needs or changes in volume. When the census is high or the need is great, float/resource staff are available to assist in providing care. When staff availability is projected to be low due to leaves of absence, the unit manager and director may request temporary agency nurses. The James follows the staffing guidelines set by the American Nurses Association. In addition, recommendations from various specialty nursing organizations, including ANCC, AACN, AORN, OCN, and others are used to develop staffing plans.

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

Standards of Care

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

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

- Hospital staff provide the correct procedures, treatments, interventions and care. Their efficacy and appropriateness will be demonstrated based on patient assessment and reassessments, state-of-the-art practice and achievement of desired outcomes
- Hospital staff design, implement and evaluate care delivery systems and services which are consistent with a patient- centered care focus delivered with compassion, respect and dignity for each individual without bias in a manner that best meets the individual needs of the patients and families.
- Staff will provide a uniform standard of care and services throughout the organization
- Care will be coordinated through interdisciplinary collaboration to ensure continuity and seamless delivery of care to the greatest extent possible
- Efficient use of financial and human resources, streamlined processes, decentralized services, enhanced communication, supportive technological advancements while maintaining patient safety

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

James **Coordination of Care:**
Staff identify patients who require discharge planning to facilitate continuity of medical care and/or other care to meet identified needs. Discharge planning is timely, addressed

during initial assessment and/or upon admission as well as during discharge planning process (rounds, etc.) and can be initiated by any member of the multidisciplinary team. Patient Care Resource Managers, Advanced Practice Nurses, and Social Workers coordinate and maintain close contact with the health care team members to finalize a discharge plan best suited for each individual patient.

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

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

Care Delivery Model

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

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

Patient Rights and Organizational Ethics

Patient Rights

In order to promote effective and compassionate care, The James systems, processes, policies, and programs are designed to reflect an overall concern and commitment to

each person's dignity and privacy. All hospital employees, physicians and staff have an ethical obligation to respect and support the rights of every patient in all interactions. It is the responsibility of all employees, physicians and staff to support the efforts of the health care team, and for seeing that the patient's rights are respected. Each patient (and/or family member as appropriate) is given a list of patient rights and responsibilities upon admission and copies of this list are posted in conspicuous places throughout the hospital.

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

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

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

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

Integration of Patient Care and Support Services

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

An open line of communication exists between all departments providing patient care, patient services and support services within the hospital, and, as appropriate with community agencies to ensure efficient, effective and continuous patient care. Functional relationships between departments are evidenced by cross-departmental performance improvement initiatives as well as the development of policies, procedures, protocols, and clinical pathways and algorithms

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

Consultations and Referrals For Patient Services

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

Information Management Plan

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

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

Patient Organization Improvement Activities

All departments participate in the hospital's plan for improving organizational performance.

Plan Review

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

Appendix A: Scope of Services: Patient Support Services

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

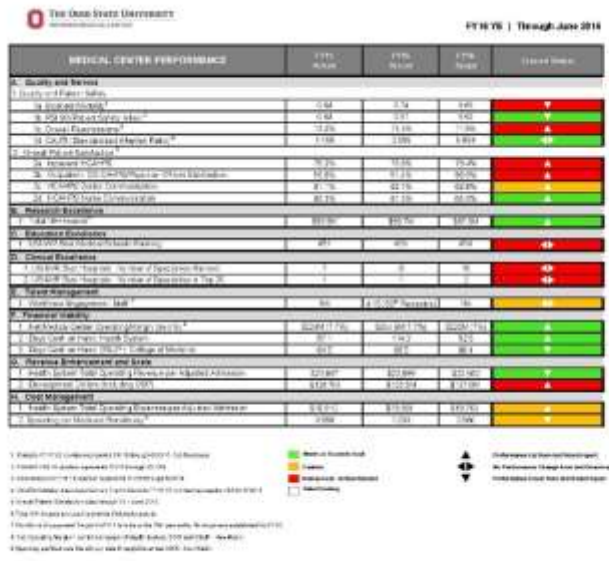
DEPARTMENT	SERVICE
Chaplaincy and Clinical Pastoral Education	Assists patients, their families and hospital personnel in meeting spiritual needs through professional pastoral and spiritual care and education.
Clinical Engineering	Routine equipment evaluation, maintenance, and repair of electronic equipment,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

DEPARTMENT	SERVICE
Human Resources	Serves as a liaison for managers regarding all human resources information and services; assists departments with restructuring efforts; provides proactive strategies for managing planned change within the health system; assists with Employee/Labor Relations issues; assists with performance management process; develops compensation strategies; develops hiring strategies and coordinates process for placements; provides strategies to facilitate sensitivity to issues of cultural diversity; provides human resources information to employees, and established equity for payroll
Information Systems	Assists departments to explore, deploy and integrate reliable, state of the art information systems technology solutions to manage change.
Laboratory	Provides laboratory testing of ambulatory patients with a diagnosis of malignant disease and those that require urgent medical treatment given by the emergency department. Lab Reports are included in the patient record.
Materials Management	Supplies stock in patient care areas
Medical Information Management	Maintains patient records serving the needs of the patient, provider, institution and various third parties to health care in the inpatient and ambulatory setting
Nutrition Services	Provides nutrition care and food service to The James and ambulatory site patients, staff and visitors. Clinical nutrition assessment and consultation are available in both inpatient and outpatient settings. The department provides food service to inpatients and selected ambulatory settings.
Oncology Laboratories	Provides clinical laboratory support services for medical, surgical, bone marrow transplantation and radiation oncology units
Pathology	The Molecular Pathology Laboratory provides testing of inpatient and ambulatory patients with a diagnosis of malignant disease and/or genetic disease. Final Reports are included in the patient record.
Patient Access Services (PAS)	Coordinates registration/admissions with nursing management
Patient Care Resource Management and Social Services	Provides personalized care coordination and resource management with patients and families. Provides discharge planning, coordination of external agency contacts for patient care needs and crisis intervention and support for patients and their families. Provides services upon phone/consult request of physician, nurse or the patient or family
Patient Financial Services	Provides financial assistance upon request from the patient/family
Perioperative Services	Provides personalized care of the patient requiring surgical services from pre anesthesia through recovery for the ambulatory and in patient surgical patient.

DEPARTMENT	SERVICE
Pharmacy	Patient care services are delivered via specialty practice pharmacists and clinical generalists. Each practitioner promotes optimal medication use and assists in achieving the therapeutic goals of the patients. Areas of service include, but are not limited to: Oncology, Breast Oncology, Hematology, Bone Marrow Transplant, Gynecologic Oncology, Pain and Palliative Care, Anticoagulation Management, Infectious Disease, and Intensive Care.
Process Engineers	Process engineering utilizes industrial engineering knowledge and skills, as well as LEAN and Six Sigma methods to provide internal consulting, coaching and training services for all departments across all parts of The James Hospital in order to develop, implement, and monitor more efficient, cost-effective business processes and strategies.
Quality and Patient Safety	Provides integrated quality management and facilitates continuous quality improvement efforts throughout the Hospital.
Pulmonary Diagnostics Lab	Provides service to patients requiring an evaluation of the respiratory system including pulmonary function testing, bronchoscopy and other diagnostic/interventional pulmonary procedures.
Radiation Safety	Oversees the safe use of all forms of ionization radiation used in conjunction with humans for diagnostic, therapeutic, or research purposes at all OSUMC James locations.
Radiation Oncology	Responsible for clinical care related to the application of radiation treatments
Radiology Services	Provide state-of-the-art radiological diagnostic and therapeutic testing and treatment, Services offered by the Radiology Imaging Department range from general radiography and fluoroscopy to new and advanced interventional procedures, contrast imaging, which include, but not limited to CT, MRI, IVP, etc., in which contrast agents are administered by IV certified radiology technologists.
Rehabilitation Services	Physical therapists, occupational therapists, speech and language pathologist and recreational therapists, evaluate, formulate a plan of care, and provide treatment based on physician referral and along with the interdisciplinary medical team for appropriate treatment and education needed for the established discharge plan.
Respiratory Therapy	Provides respiratory therapeutic interventions and diagnostic testing, by physician order including ventilator support, bronchodilator therapy, and pulmonary hygiene.
Security	Provides a safe and secure environment for patients, visitors, and staff members by responding to emergencies such as workplace violence, fires, bomb threats, internal and external disasters, armed aggressors, or any other incident that needs and emergency response.
Staff Development and Education	Provides and promotes ongoing employee development and training related to oncology care, provides clinical orientation, and continuing education of staff

DEPARTMENT	SERVICE
Transfer Center	Responsible for greater patient flow efficiency and improved accessibility for patients who seek our high-quality care with improved throughput and patient flow management. Our patient flow management system, Tele Tracking, provides a real-time global view of OSUWMC's bed capacity and throughput. This helps us improve processes while increasing accessibility and maintaining quality and safety.

(ATTACHMENT V)



Medical Center Performance Scorecard - 1 of 2

Medical Center Performance Scorecard - 2 of 2

(ATTACHMENT VI)

Wexner Medical Center Board Meeting
Health System Financial Summary

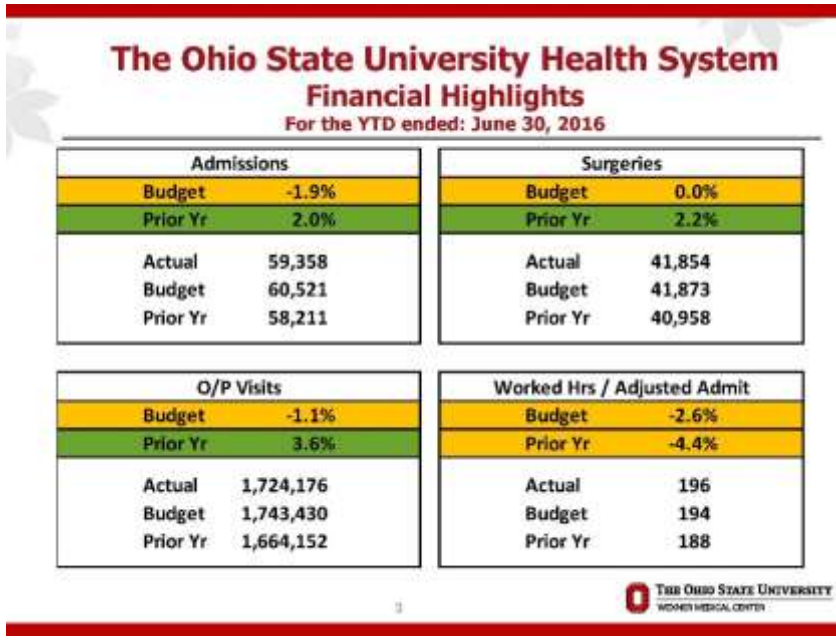
August 31, 2016

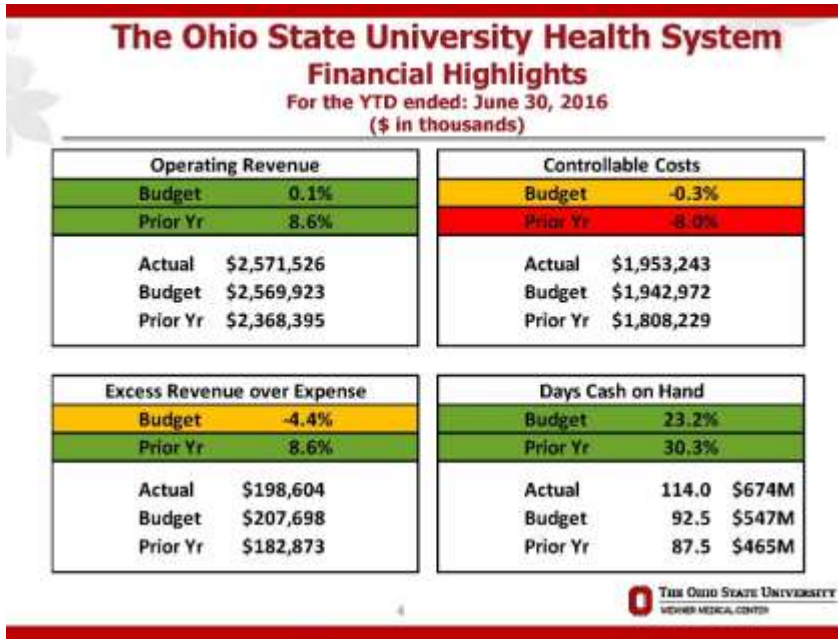
The Ohio State University
Wexner Medical Center

Health System Financial Summary

June 2016

The Ohio State University
Wexner Medical Center


The Ohio State University Health System
Financial Highlights
For the YTD ended: June 30, 2016
Admissions
Budget -1.9%
Prior Yr 2.0%
Actual 59,358
Budget 60,521
Prior Yr 58,211
Surgeries
Budget 0.0%
Prior Yr 2.2%
Actual 41,854
Budget 41,873
Prior Yr 40,958
O/P Visits
Budget -1.1%
Prior Yr 3.6%
Actual 1,724,176
Budget 1,743,430
Prior Yr 1,664,152
Worked Hrs / Adjusted Admit
Budget -2.6%
Prior Yr -4.4%
Actual 196
Budget 194
Prior Yr 188
The Ohio State University
Wexner Medical Center


The Ohio State University Health System
Financial Highlights
For the YTD ended: June 30, 2016
($ in thousands)
Operating Revenue
Budget 0.1%
Prior Yr 8.6%
Actual $2,571,526
Budget $2,569,923
Prior Yr $2,368,395
Controllable Costs
Budget -0.3%
Prior Yr -8.0%
Actual $1,953,243
Budget $1,942,972
Prior Yr $1,808,229
Excess Revenue over Expense
Budget -4.4%
Prior Yr 8.6%
Actual $198,604
Budget $207,698
Prior Yr $182,873
Days Cash on Hand
Budget 23.2%
Prior Yr 30.3%
Actual 114.0 $674M
Budget 92.5 $547M
Prior Yr 87.5 $465M
The Ohio State University
Wexner Medical Center

The Ohio State University Health System
Consolidated Activity Summary
For the YTD ended: June 30, 2016

OSUHS

CONSOLIDATED ACTIVITY SUMMARY	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
Activity						
Admissions	59,358	60,521	(1,163)	-1.9%	58,211	2.0%
Surgeries	41,852	41,873	(21)	-0.1%	40,951	2.2%
Outpatient Visits	1,724,176	1,743,430	(19,254)	-1.1%	1,664,152	3.6%
Average Length of Stay	6.29	6.10	(0.18)	-3.0%	6.12	-2.7%
Case Mix Index (CMI)	1.86	1.78	0.08	4.3%	1.78	4.2%
Adjusted Admissions	112,348	112,508	(161)	-0.1%	108,361	3.7%
Operating Revenue per AA	$ 22,889	$ 22,842	47	0.2%	$ 21,857	4.7%
Operating Expense per AA	$ 19,908	$ 19,764	(144)	-0.7%	$ 18,910	-5.3%

The Ohio State University
Wexner Medical Center

The Ohio State University Health System
Consolidated Outpatient Visit Summary
For the MTD & YTD ended: June 30, 2016

MONTH ACTUAL	MONTH BUDGET	MONTH ACT-BUD VAR	MONTH BUDGET % VAR	MONTH PRIOR YEAR	MONTH PY % VAR	CATEGORY	YTD ACTUAL	YTD BUDGET	YTD ACT-BUD VAR	YTD BUDGET % VAR	YTD PRIOR YEAR	YTD PY % VAR
2,298	2,236	62	2.8%	2,390	-3.9%	**Surgeries**	26,085	25,699	386	1.5%	25,000	4.3%
9,385	10,250	(865)	-8.4%	9,800	-4.2%	**ED Visits**	113,810	117,000	(3,190)	-2.7%	112,870	0.8%
10,917	10,909	34	0.3%	10,658	2.0%	**Procedures**	125,972	124,454	1,518	1.2%	118,360	6.5%
[illegible]	328	[illegible]	[illegible]	[illegible]	[illegible]	Cath Lab	4,0[illegible]	3,7[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	EP Lab	7,6[illegible]	7,6[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	887	(68)	-7.7%	[illegible]	[illegible]	Interventional Radiology	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Radiation Oncology	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	All Other	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
36,572	37,444	(872)	-2.3%	36,208	1.0%	**Clinic Visits**	423,948	427,416	(3,467)	-0.8%	420,478	0.8%
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Clinic/Office Visits	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
2,417	2,598	(181)	-7.0%	2,487	-2.8%	Chemo Visits	36,437	36,617	[illegible]	[illegible]	[illegible]	[illegible]
11,908	11,639	269	2.3%	10,716	11.1%	**Rehab Services**	133,178	132,858	320	0.2%	119,526	11.4%
14,304	14,525	(221)	-1.5%	14,225	0.6%	**Radiology**	163,013	163,515	(502)	-0.3%	152,141	7.1%
21,873	23,468	(1,687)	-7.2%	22,318	-2.0%	**Lab**	268,327	270,173	(1,846)	-0.7%	266,082	0.8%
2,188	2,050	138	6.7%	2,061	6.2%	**Pharmacy**	25,768	25,402	366	0.7%	25,996	-1.6%
5,244	5,348	(104)	-1.9%	5,259	-1.3%	**Other OP Visits**	82,928	81,049	1,879	3.1%	81,[illegible]	2.7%
31,958	34,561	(2,603)	-7.5%	32,253	-0.9%	**Physician Visits**	383,347	397,866	(14,519)	-3.6%	374,855	2.3%
146,425	152,424	(5,999)	-3.9%	144,414	1.4%	**TOTAL OUTPATIENT VISITS**	1,724,176	1,743,430	(19,254)	-1.1%	1,664,152	3.6%

The Ohio State University
Wexner Medical Center

The Ohio State University Health System
Consolidated Statement of Operations
For the YTD ended: June 30, 2016
(in thousands)

OSUHS

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	$ 2,571,526	$ 2,569,923	$ 1,603	0.1%	$ 2,368,395	8.6%
Operating Expenses						
Salaries and Benefits	1,139,902	1,147,302	7,400	0.6%	1,052,083	-8.3%
Supplies	280,954	287,972	7,018	2.4%	266,767	-5.3%
Drugs and Pharmaceuticals	231,115	215,317	(15,798)	-7.3%	207,338	-11.5%
Services	284,433	276,571	(7,862)	-2.8%	270,346	-5.2%
Depreciation	140,279	136,920	(3,359)	-2.5%	112,982	-24.2%
Interest	41,578	42,511	933	2.2%	28,856	-44.1%
Other	118,099	117,047	(1,052)	-0.9%	110,677	-6.7%
Total Expense	2,236,360	2,223,640	(12,720)	-0.6%	2,049,049	-9.1%
Gain (Loss) from Operations (pre MCI)	335,166	346,283	(11,117)	-3.2%	319,346	5.0%
Medical Center Investments	(140,191)	(140,000)	(191)	0.1%	(136,888)	-2.4%
Income from Investments	2,578	1,280	1,298	101.4%	1,869	37.9%
Other Gains (Losses)	1,051	135	916	678.8%	(1,454)	172.3%
Excess of Revenue over Expense	$ 198,604	$ 207,698	$ (9,094)	-4.4%	$ 182,873	8.6%

The Ohio State University Health System
Consolidated Balance Sheet
As of: June 30, 2016
(in thousands)

	June 2016	June 2015	Change
Assets			
Cash	$ 538,576	$ 330,141	$ 208,435
Net Patient Receivables	334,231	299,338	34,893
Other Current Assets	53,668	69,180	(15,512)
Assets Limited as to Use	255,498	255,029	469
Property, Plant & Equipment - Net	1,397,414	1,420,127	(22,713)
Other Assets	13,016	21,019	(8,003)
Total Assets	$2,592,403	$2,394,834	$ 197,569
Liabilities & Net Assets			
Current Liabilities	$ 306,652	$ 268,237	$ 38,415
Other Liabilities	46,298	47,338	(1,040)
Long-Term Debt	793,762	839,232	(45,470)
Net Assets - Unrestricted	1,445,691	1,240,027	205,664
Net Assets - Restricted	-	-	-
Total Liabilities & Net Assets	$2,592,403	$2,394,834	$ 197,569

OSU Wexner Medical Center
Combined Statement of Operations
For the YTD ended: June 30, 2016
(in thousands)

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	$3,208,723	$3,148,147	$ 60,576	1.9%	$2,940,252	9.1%
Operating Expenses						
Salaries and Benefits	1,672,057	1,643,109	(28,948)	-1.8%	1,553,459	-7.6%
Supplies	306,799	313,237	6,439	2.1%	291,993	-5.1%
Drugs and Pharmaceuticals	257,874	239,565	(18,309)	-7.6%	232,213	-11.1%
Services	360,995	345,940	(15,056)	-4.4%	347,095	-4.0%
Depreciation	153,444	149,209	(4,235)	-2.8%	124,854	-22.9%
Interest/Debt	53,043	54,675	1,632	2.8%	40,599	-30.7%
Other Operating Expense	139,963	138,371	(1,592)	-1.2%	131,615	-6.3%
Medical Center Investments	20,068	35,953	15,885	44%	239	—
Total Expense	2,964,242	2,919,958	(44,284)	-1.5%	2,722,056	-8.9%
Excess of Revenue over Expense	$ 244,481	$ 228,189	$ 16,292	7.1%	$ 218,196	12.0%
Financial Metrics						
Adjusted Admissions	112,348	112,509	(161)	-0.1%	108,381	3.7%
OSUP Physician Encounters	2,436,363	2,389,448	46,915	1.9%	2,248,295	8.3%
Operating Revenue per AA	$ 22,889	$ 22,042	$ 47	0.2%	$ 21,857	4.7%
Total Expense per AA	$ 19,908	$ 19,764	$ (144)	-0.7%	$ 18,910	-5.3%

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.

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

OSU Wexner Medical Center
Combined Statement of Operations
For the YTD ended: June 30, 2016
(in thousands)

	ACTUAL	BUDGET	ACT-BUD VARIANCE	BUDGET % VAR	PRIOR YEAR	PY % Var
Health System						
Revenues	$2,571,526	$2,569,923	$ 1,603	0.1%	$2,368,396	8.6%
Expenses	2,372,922	2,362,225	(10,697)	-0.5%	2,185,522	-8.6%
Net	198,604	207,698	(9,094)	-4.4%	182,873	8.6%
OSUP						
Revenues	$ 424,816	$ 394,943	$ 29,872	7.6%	$ 369,899	14.8%
Expenses	394,283	367,066	(27,217)	-7.4%	360,721	-9.3%
Net	30,332	27,876	2,454	8.8%	9,138	231.9%
COMIOHS						
Revenues	$ 212,582	$ 183,281	$ 29,301	16.0%	$ 201,998	5.2%
Expenses	197,036	190,667	(6,371)	-3.3%	175,810	-12.1%
Net	15,545	(7,386)	22,931	310.5%	26,188	-40.6%
Total Medical Center						
Revenues	$3,208,723	$3,148,147	$ 60,576	1.9%	$2,940,252	9.1%
Expenses	2,964,242	2,919,958	(44,284)	-1.5%	2,722,056	-8.9%
Net	244,481	228,189	16,292	7.1%	218,196	12.0%

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: June 30, 2016
(in thousands)

	June 2016	June 2015	Change
Cash	$ 683,576	$ 460,071	$ 223,505
Net Patient Receivables	371,910	334,746	37,164
Other Current Assets	304,016	281,887	22,129
Assets Limited as to Use	255,498	255,029	469
Property, Plant & Equipment - Net	1,517,227	1,548,833	(31,605)
Other Assets	409,731	391,514	18,217
Total Assets	$ 3,541,958	$ 3,272,080	$ 269,878
Current Liabilities	$ 351,480	$ 311,474	$ 40,007
Other Liabilities	46,298	47,338	(1,040)
Long-Term Debt	904,418	962,032	(57,614)
Net Assets - Unrestricted	1,722,444	1,469,419	253,026
Net Assets - Restricted	517,318	481,818	35,500
Liabilities and Net Assets	$ 3,541,958	$ 3,272,080	$ 269,878

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

The Ohio State University Wexner Medical Center

Health System Financial Summary

July 2016

The Ohio State University
Wexner Medical Center

The Ohio State University Health System

Financial Highlights

For the YTD ended: July 31, 2016

Admissions	
Budget	0.3%
Prior Yr	-0.8%
Actual	5,083
Budget	5,067
Prior Yr	5,126

Surgeries	
Budget	-6.7%
Prior Yr	-6.8%
Actual	3,230
Budget	3,462
Prior Yr	3,464

O/P Visits	
Budget	-4.4%
Prior Yr	-5.7%
Actual	134,712
Budget	140,930
Prior Yr	142,880

Worked Hrs / Adjusted Admit	
Budget	12.1%
Prior Yr	-3.1%
Actual	195
Budget	207
Prior Yr	189

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The Ohio State University
Wexner Medical Center

The Ohio State University Health System

Financial Highlights

For the YTD ended: July 31, 2016

($ in thousands)

Operating Revenue	
Budget	-1.1%
Prior Yr	-0.5%
Actual	$214,862
Budget	$217,350
Prior Yr	$216,038

Controllable Costs	
Budget	0.8%
Prior Yr	-4.0%
Actual	$168,108
Budget	$169,489
Prior Yr	$161,598

Excess Revenue over Expense	
Budget	-6.3%
Prior Yr	-40.4%
Actual	$11,434
Budget	$12,209
Prior Yr	$19,177

Days Cash on Hand		
PY FY16	1.1%	
PY MTD	27.5%	
Actual	115.6	$688M
PY FY16	114.3	$674M
PY MTD	90.7	$487M

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

The Ohio State University Health System

Consolidated Activity Summary

For the MTD ended: July 31, 2016

OSUHS

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
CONSOLIDATED ACTIVITY SUMMARY						
Activity						
Admissions	5,083	5,067	16	0.3%	5,126	-0.8%
Surgeries	3,230	3,462	(232)	-6.7%	3,464	-6.8%
Outpatient Visits	134,712	140,930	(6,218)	-4.4%	142,880	-5.7%
Average Length of Stay	6.02	6.17	0.15	2.4%	6.15	2.1%
Case Mix Index (CMI)	1.74	1.86	(0.12)	-6.4%	1.74	0.1%
Adjusted Admissions	9,611	9,431	180	1.9%	9,601	0.1%
Operating Revenue per AA	$ 22,357	$ 23,047	(690)	-3.0%	$ 22,502	-0.6%
Operating Expense per AA	$ 19,884	$ 20,460	576	2.8%	$ 19,304	-3.0%

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

The Ohio State University Health System
Consolidated Outpatient Visit Summary
For the MTD & YTD ended: July 31, 2016

MONTH							YTD					
ACTUAL	BUDGET	ACT-BUD VAR	BUDGET % VAR	PRIOR YEAR	PY % VAR	CATEGORY	ACTUAL	BUDGET	ACT-BUD VAR	BUDGET % VAR	PRIOR YEAR	PY % VAR
2,043	2,250	(207)	-9.2%	2,176	-6.1%	**Surgeries**	2,043	2,250	(207)	-9.2%	2,176	-6.1%
9,656	10,529	(873)	-8.3%	9,838	-1.9%	**ED Visits**	9,656	10,529	(873)	-8.3%	9,838	-1.9%
9,765	9,887	(122)	-1.2%	10,183	-4.1%	**Procedures**	9,765	9,887	(122)	-1.2%	10,183	-4.1%
279	308	(29)	-9.4%	317	-12.0%	Cath Lab	279	308	(29)	-9.4%	317	-12.0%
233	208	25	12.1%	214	8.9%	EP Lab	233	208	25	12.1%	214	8.9%
302	355	(53)	-14.9%	368	-17.9%	Interventional Radiology	302	355	(53)	-14.9%	368	-17.9%
3,607	3,441	166	4.8%	3,568	1.1%	Radiation Oncology	3,607	3,441	166	4.8%	3,568	1.1%
5,344	5,576	(232)	[illegible]	[illegible]	[illegible]	All Other	5,344	5,576	(232)	[illegible]	[illegible]	[illegible]
33,293	31,919	1,374	4.3%	35,216	-5.5%	**Clinic Visits**	33,293	31,919	1,374	4.3%	35,216	-5.5%
30,861	28,803	2,058	7.1%	32,765	-5.8%	Clinic/Office Visits	30,861	28,803	2,058	7.1%	32,765	-5.8%
2,337	2,260	77	3.4%	2,446	-4.5%	Home Visits	2,337	2,260	77	3.4%	2,446	-4.5%
10,786	15,849	(5,063)	-31.9%	11,346	-4.9%	**Rehab Services**	10,786	15,849	(5,063)	-31.9%	11,346	-4.9%
12,768	13,075	(307)	-2.3%	13,012	-1.9%	**Radiology**	12,768	13,075	(307)	-2.3%	13,012	-1.9%
21,177	22,002	(825)	-3.7%	22,174	-4.5%	**Lab**	21,177	22,002	(825)	-3.7%	22,174	-4.5%
1,809	1,905	(96)	-5.0%	2,046	-11.6%	**Pharmacy**	1,809	1,905	(96)	-5.0%	2,046	-11.6%
4,729	503	4,226	840.2%	5,109	-7.4%	**Other OP Visits**	4,729	503	4,226	840.2%	5,109	-7.4%
28,686	33,011	(4,325)	-13.1%	31,732	-9.6%	Physician Visits	28,686	33,011	(4,325)	-13.1%	31,732	-9.6%
134,712	**140,930**	**(6,218)**	**-4.4%**	**142,880**	**-5.7%**	TOTAL OUTPATIENT VISITS	**134,712**	**140,930**	**(6,218)**	**-4.4%**	**142,880**	**-5.7%**

The Ohio State University Health System
Consolidated Statement of Operations
For the YTD ended: July 31, 2016
(in thousands)

OSUHS

OPERATING STATEMENT	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
Total Operating Revenue	$ 214,862	$ 217,350	$ (2,488)	-1.1%	$ 216,038	-0.5%
Operating Expenses						
Salaries and Benefits	96,141	98,434	2,293	2.3%	91,373	-5.2%
Supplies	22,517	23,228	711	3.1%	24,421	7.8%
Drugs and Pharmaceuticals	20,508	21,000	492	2.3%	22,281	8.0%
Services	25,359	25,377	18	0.1%	22,797	-11.2%
Depreciation	11,568	11,441	(127)	-1.1%	11,827	2.2%
Interest	3,349	3,340	(9)	-0.3%	3,517	4.8%
Other	11,658	10,127	(1,531)	-15.1%	9,120	-27.8%
Total Expense	191,100	192,947	1,847	1.0%	185,336	-3.1%
Gain (Loss) from Operations (pre MCI)	23,762	24,403	(641)	-2.6%	30,702	-22.6%
Medical Center Investments	(12,548)	(12,414)	(134)	1.1%	(11,683)	-7.4%
Income from Investments	220	220	-	0.0%	158	39.2%
Other Gains (Losses)	-	-	-	---	-	---
Excess of Revenue over Expense	$ 11,434	$ 12,209	$ (775)	-6.3%	$ 19,177	-40.4%

The Ohio State University Health System
Consolidated Balance Sheet
As of: July 31, 2016
(in thousands)

	July 2016	June 2016	Change
Assets			
Cash	$ 552,181	$ 538,576	$ 13,606
Net Patient Receivables	351,187	334,231	16,956
Other Current Assets	57,450	53,668	3,782
Assets Limited as to Use	256,537	255,498	39
Property, Plant & Equipment - Net	1,391,091	1,397,281	(6,190)
Other Assets	13,701	13,016	685
Total Assets	$ 2,621,147	$ 2,592,270	$ 28,877
Liabilities & Net Assets			
Current Liabilities	$ 322,459	$ 301,235	$ 21,224
Other Liabilities	46,438	46,298	140
Long-Term Debt	789,842	793,762	(3,920)
Net Assets - Unrestricted	1,462,408	1,450,975	11,433
Net Assets - Restricted	-	-	-
Total Liabilities & Net Assets	$ 2,621,147	$ 2,592,270	$ 28,877

OSU Wexner Medical Center
Combined Statement of Operations
For the YTD ended: July 31, 2016
(in thousands)

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	$ 259,322	$ 266,193	$ (6,871)	-2.2%	$ 257,548	0.7%
Operating Expenses						
Salaries and Benefits	138,275	145,977	7,702	5.3%	130,404	-6.0%
Supplies	24,249	24,975	725	2.9%	26,503	8.5%
Drugs and Pharmaceuticals	22,342	23,369	1,027	4.4%	24,874	10.2%
Services	32,501	33,006	505	1.5%	30,467	-6.7%
Depreciation	12,361	12,064	(297)	-2.5%	12,690	2.6%
Interest/Debt	4,301	4,286	(16)	-0.3%	4,520	4.9%
Other Operating Expense	13,322	12,409	(913)	-7.4%	10,810	-23.2%
Medical Center Investments	640	448	(192)	-43%	3,576	--
Total Expense	247,990	256,532	8,542	3.3%	243,845	-1.7%
Excess of Revenue over Expense	$ 11,332	$ 8,661	$ 2,671	30.8%	$ 13,703	-17.3%
Financial Metrics						
Adjusted Admissions	9,611	9,431	180	1.9%	9,601	0.1%
Operating Revenue per AA	$ 22,357	$ 23,047	$ (690)	-3.0%	$ 22,502	-0.6%
Total Expense per AA	$ 19,884	$ 20,460	$ 576	2.8%	$ 19,304	-3.0%

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.

OSU Wexner Medical Center
Combined Statement of Operations
For the YTD ended: July 31, 2016
(in thousands)

	ACTUAL	BUDGET	ACT-BUD VARIANCE	BUDGET % VAR	PRIOR YEAR	PY % Var
Health System						
Revenues	$ 214,862	$ 217,350	$ (2,488)	-1.1%	$ 216,038	-0.5%
Expenses	203,428	205,141	1,713	0.8%	196,861	-3.3%
Net	11,434	12,209	(775)	-6.3%	19,177	-40.4%
OSUP						
Revenues	$ 30,521	$ 33,652	$ (3,132)	-9.3%	$ 28,670	6.5%
Expenses	28,317	34,159	5,841	17.1%	29,836	5.1%
Net	2,203	(507)	2,710	535.0%	(1,167)	288.8%
COM/OHS						
Revenues	$ 13,940	$ 14,191	$ (252)	-1.8%	$ 12,841	8.6%
Expenses	16,245	17,231	987	5.7%	17,145	5.3%
Net	(2,305)	(3,040)	735	24.2%	(4,304)	-46.4%
Total Medical Center						
Revenues	$ 259,322	$ 265,193	$ (5,871)	-2.2%	$ 257,548	0.7%
Expenses	247,990	256,532	8,542	3.3%	243,845	-1.7%
Net	11,332	8,661	2,671	30.8%	13,703	-17.3%

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 Balance Sheet
As of: July 31, 2016
(in thousands)

	July 2016	June 2016	Change
Cash	$ 703,526	$ 680,218	$ 23,308
Net Patient Receivables	387,954	371,794	16,160
Other Current Assets	307,467	282,526	24,941
Assets Limited as to Use	255,537	255,498	39
Property, Plant & Equipment - Net	1,510,456	1,524,145	(13,689)
Other Assets	410,448	394,973	15,475
Total Assets	$ 3,575,389	$ 3,509,155	$ 66,234
Current Liabilities	$ 368,206	$ 337,828	$ 30,378
Other Liabilities	46,438	46,298	140
Long-Term Debt	899,805	911,469	(11,664)
Net Assets - Unrestricted	1,751,188	1,724,254	26,934
Net Assets - Restricted	509,751	489,306	20,445
Liabilities and Net Assets	$ 3,575,389	$ 3,509,155	$ 66,234

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

The Ohio State University
Wexner Medical Center
FY17 Budget

August 31, 2016

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

The Ohio State University Health System

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

Assumptions
FY17 Budget

Factor	Assumptions & Explanation
Payors	Increasing Medicare with aging population, Medicaid rebasing; Managed care at current contract rates 4%-6%
Admissions/outpatient visits	3.0% inpatient growth and 5.1% in outpatient growth
Surgeries	1.6% growth
Case mix index	1.85 equal to FY16
Length of stay	6.2 days
Total beds	Total average beds available of 1,304 with the addition of 87 Brain & Spine beds in FY2017

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

Assumptions
FY17 Budget

Factor	Assumptions & Explanation
Salary/wages	2% merit increase
Benefits	35% of salaries
Pharma/drugs	Drug cost inflation of 5% (James 7%)
Interest	Decreasing with no debt increase
Depreciation	Decrease 3.6% from FY16
Capital Projects to be approved	$241M
Medical Center Investments (cash transfers to the College of Medicine and Faculty Group Practice)	Increased level of reinvestment to $150M in FY17

The OSU Wexner Health System
FY2017 Budget - Admissions

ADMISSIONS	Actual 2015	Forecast 2016	Budget 2017	Inc(Dec) FY16 to FY17
University Hospital *	25,413	25,820	27,000	4.6%
Ross Heart Hospital	6,927	6,620	6,700	1.2%
James Cancer Hospital	12,653	13,504	13,860	2.6%
University Hospital East	10,178	10,537	10,550	0.1%
OSU Harding Hospital	3,042	2,910	3,083	5.9%
Consolidated	58,213	59,391	61,193	3.0%

*Includes Brain & Spine

The OSU Wexner Health System

FY2017 Budget – Outpatient Visits

OUTPATIENT VISITS	Actual 2015	Forecast 2016	Budget 2017	Inc(Dec) FY16 to FY17
University Hospital	504,573	513,500	522,000	1.7%
Ross Heart Hospital	52,164	50,300	51,500	2.4%
James Cancer Hospital	359,253	397,354	417,222	5.0%
University Hospital East	235,800	229,624	232,317	1.2%
OSU Harding Hospital	25,776	25,683	25,683	0.0%
Ambulatory Services	329,717	406,680	458,190	12.7%
Speciality Care Network	161,436	112,610	116,895	3.8%
Consolidated	1,668,719	1,735,751	1,823,807	5.1%

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

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FY17 Health System Budget

	Forecast 2016	Budget 2017	% Change
OPERATING STATEMENT			
Total Operating Revenue	$ 2,547,574	$ 2,680,777	5.2%
Operating Expenses			
Salaries and Benefits	1,151,941	1,219,655	5.9%
Supplies	276,198	281,831	2.0%
Drugs and Pharmaceuticals	224,208	254,683	13.6%
Services	271,057	295,986	9.2%
Depreciation	138,787	133,605	-3.7%
Interest	41,865	39,385	-5.9%
Other	100,422	104,131	3.7%
Total Expenses	$ 2,204,477	$ 2,329,286	5.7%
Gain/Loss from Operations	$ 343,097	$ 351,491	2.4%
Medical Center Investments	(140,000)	(150,000)	7.1%
Investment Income	3,736	2,943	-21.2%
Excess of Revenue over Expenses	$ 206,833	$ 204,434	-1.2%
Financial Metrics			
Total Revenue per AA	$ 22,870	$ 23,237	1.6%
Total Expense per AA	$ 19,790	$ 20,191	2.0%
Total Expense per AA (excl Depr & Int)	$ 18,168	$ 18,691	2.9%
Operating EBIDA Margin	20.6%	19.6%	
Days Cash on Hand	116.7	137.1	
Debt Service Coverage	5.9	6.0	

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

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Balance Sheet
(in thousands)

Balance Sheet	Preliminary 2016	Budget 2017
Assets		
Cash	$ 660,174	$ 816,424
Accounts Receivable & Other Current Assets	419,075	437,534
Property, Plant, Equipment - net of Depreciation	1,362,516	1,406,410
Other	143,520	91,020
Total Assets	$ 2,585,285	$2,751,388
Liabilities & Fund Balance		
Current Liabilities	$ 302,331	$ 304,701
Debt	843,554	797,063
Fund Balance	1,439,400	1,649,624
Total Liabilities and Fund Balance	$ 2,585,285	$2,751,388

Statement of Cash Flow from Operations

	Preliminary 2016	Budget 2017
Sources of Cash:		
Excess of Revenues over Expenses	$ 206,833	$ 204,434
Depreciation	138,797	133,606
Interest, Other and Non Operating, net	3,417	2,797
Total Sources of Cash	$ 349,047	$ 340,837
Uses of Cash:		
Change in Working Capital	$ 17,778	$ 13,096
Long Term Debt Payments	50,166	46,491
Cash Growth (Days Cash)	205,707	156,250
Routine Capital Expenditures	75,396	125,000
Total Uses of Cash	$ 349,047	$ 340,837

FY17 Health System Capital Budget

Sources of Capital Funds		
Cash Reserves	$	105,000
Cash from Operations		136,000
Funds Available	$	241,000
Uses of Capital Funds		
Bed Expansion (72 Beds)	$	60,000
Parking Garage Replacement		25,000
700 Ackerman Acquisition/Renovation		20,000
Select projects and equipment replacement		136,000
Funds Used	$	241,000

Selected Projects and Equipment (Detail not finalized)	
Bed Replacement	$ 3,000
Lab Equipment	8,200
Infrastructure, Renovation	32,000
Unit directed funds	20,000
IT and analytics	11,000
Contingency/Opportunities	10,000
Other projects > $00K	51,800
	$ 136,000

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THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

The OSU Wexner Health System
FY2017 Risks & Opportunities

- Volume
- Greater shift to Medicare with aging population
- Medicaid base rate changes, impact not finalized
- No allowance for bundled payments and alternative payment models
- Hospital based clinic impact on Jameson Crane & UA – FY17 ($6M)
- Managed Care - Value Based Purchasing goals
- New College of Medicine Dean / Chair of Surgery / Chair of Urology
- 340B Drug Program
- Revenue Cycle projects

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THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

The Ohio State University Physicians, Inc. (OSUP)

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Assumptions
FY17 Budget

Factor	Assumptions & Explanation
Salaries/Wages Benefits	2% merit increases 5% increase over FY'16 rates
Dean's Tax	4% with no exclusions
Payors	High deductible plans continue to impact bad debt; Medicaid Diagnosis Groups Wave 1 impacts
Medicaid Upper Payment Limit	Budgeted $6.5M at Corporate level
Patient Encounters (any billed patient)	2,700,000
DEE Guidelines	5% Revenue growth; operating expense growth half of revenue growth; provider expense growth equal to or less than revenue growth; unfunded admin time reduced by 10%.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

FY17 OSU Physicians Budget

	Forecast 2016	Budget 2017	% Change
OPERATING STATEMENT			
Revenues			
Total Revenue	$ 400,894	$ 430,964	7.5%
Expenses			
Faculty Salaries and Benefits	$ 273,463	$ 289,760	6.0%
Non Faculty Salaries and Benefits	85,512	93,327	9.1%
Supplies and Pharmaceuticals	33,357	37,027	11.0%
Purchased Services	25,520	25,861	1.3%
Depreciation	4,399	4,243	-3.5%
Interest	385	365	-5.4%
Other Operating Expense	33,177	36,803	10.9%
Medical Center Investments	(73,940)	(77,364)	4.6%
Total Expenses	381,873	410,022	7.4%
Gain/(Loss)	$ 19,021	$ 20,943	10.1%

Budget Sensitivities

- MCI support and funding commitments.
- Resolution of specific Departmental deficits – progress in groups such as Neuroscience and Physical Medicine & Rehab reduction in operating loss.
- Potential impact of new Chairs of Surgery and Urology.
- Opening of new Ambulatory Facility (Upper Arlington) – net new practice site – new provider revenue not covering expense in first year of operation.
- Two system implementations: Workday for financials, Strata for decision support. Timing and resource constraints.

The Ohio State University
College of Medicine
Office of Health Sciences
FGP

The Ohio State University
Wexner Medical Center

Assumptions
FY17 Budget

Factor	Assumptions & Explanation
Salary/Wages Benefits	2% merit increase 2% increase over FY16 rates
Dean's Tax	4% with no exclusions
DEE	Monitoring progress toward established guidelines for revenue growth, operating leverage and management of administrative and unfunded research activity
General Funds Allocation	Flat with current year
Capital	Includes renovations for Atwell Hall $1.3M, Institute for Behavioral Medicine $1.0M, and Hamilton Hall & Lincoln Tower $0.5M each

The Ohio State University
Wexner Medical Center

FY17 College of Medicine Budget

	Forecast 2016	Budget 2017	% Change
OPERATING STATEMENT			
Sources			
General Funds and Appropriations	$ 88,824	$ 88,518	-0.3%
Support from related entities	42,271	28,676	-32.2%
Other	54,948	54,269	-1.2%
Total Sources	$ 186,043	$ 171,463	-7.8%
Uses			
Faculty Salaries	$ 58,046	$ 61,871	6.6%
Non Faculty Salaries	61,106	61,965	1.4%
Benefits	40,820	44,267	8.4%
Supplies	16,951	12,829	-24.3%
Services	43,273	44,163	2.1%
Debt	12,174	12,134	-0.3%
Capital	9,643	7,923	-17.8%
Medical Center Investments	(52,583)	(61,572)	17.1%
Total Uses	189,430	183,580	-3.1%
Gain/(Loss)	$ (3,387)	$ (12,117)	-257.7%

Budget Sensitivities

- DEE analysis expanded into Basic Sciences (SBS) and the School of Health and Rehabilitation Sciences (HRS) for FY17. Budgeted ratios improve for only 2 of 6 SBS departments vs. FY16 forecast. The FY17 ratio for HRS is flat vs. FY16.
- Continued sensitivity regarding MCI support and other funding commitments for proposed strategic initiatives
- Continued progress on Neurology workout plan

Combined Medical Center

The Ohio State University
Wexner Medical Center

OSUWMC Combined Income Statement
For the years ended June 30,

	Forecast 2016	Budget 2017	% Change
OPERATING STATEMENT			
Total Operating Revenue	$3,134,512	$3,283,204	4.7%
Operating Expenses			
Salaries and Benefits	1,670,888	1,770,846	6.0%
Supplies and Pharmaceuticals	550,715	586,369	6.5%
Services	339,850	366,020	7.7%
Depreciation	152,829	145,771	-4.6%
Interest/Debt	54,424	51,884	-4.7%
Other Operating Expense	129,863	137,992	6.3%
Medical Center Investments	13,477	11,064	-17.9%
Total Expense	2,912,045	3,069,945	5.4%
Excess of Revenue over Expense	$ 222,467	$ 213,259	-4.1%
Financial Metrics			
Adjusted Admissions	111,393	115,318	3.5%
Net Revenue per AA	$ 22,082	$ 22,345	1.2%
Total Expense per AA	$ 19,790	$ 20,199	2.1%

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

OSUWMC Combined Income Statement For the years ended June 30,

	Forecast 2016	Budget 2017	% Change
Health System			
Revenues	$2,547,574	$2,680,777	5.2%
Expenses	2,340,741	2,476,344	5.8%
Net	206,833	204,434	-1.2%
OSUP			
Revenues	$ 400,894	$ 430,964	7.5%
Expenses	381,873	410,022	7.4%
Net	19,021	20,943	10.1%
COM/OHS			
Revenues	$ 186,043	$ 171,463	-7.8%
Expenses	189,430	183,580	-3.1%
Net	(3,387)	(12,117)	-257.7%
Total Medical Center			
Revenues	$3,134,512	$3,283,204	4.7%
Expenses	2,912,045	3,069,945	5.4%
Net	222,467	213,259	-4.1%

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

(ATTACHMENT VII)

Project Data Sheet for Board of Trustees Approval

Morehouse - Chiller and Electrical Distribution

OSU-160589 (CNI# 15000068)

Project Location: Morehouse Medical Plaza

- **approval requested and amount**
  professional services/construction $8.0M

- **project budget**

construction w/contingency	$6.2M
professional services	$1.8M
total project budget	$8.0M

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

- **project schedule**

BoT prof services /construction approval	09/16
design/bidding	10/16 - 11/17
construction	07/17 - 11/18

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

- **planning framework**
  - this project is included in the FY 2016 Capital Improvement Plan

- **project scope**
  - this project will install a new chilled water plant to serve the Martha M. Morehouse Medical Plaza
  - the project will also address code compliance concerns and update the primary electrical systems

- **approval requested**
  - approval is requested to enter professional services and construction contracts

- **project team**

University project manager:	Kevin Koesters
AE/design architect:	TBD
CM at Risk:	TBD

Office of Administration and Planning — September 2016