

THE OHIO STATE UNIVERSITY
OFFICIAL PROCEEDINGS OF THE
TWENTY-FOURTH MEETING OF THE
WEXNER MEDICAL CENTER BOARD

Columbus, Ohio, January 31, 2018

The Wexner Medical Center Board met on Wednesday, January 31, 2018 at the Richard M. Ross Heart Hospital in Columbus, Ohio, pursuant to adjournment.

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Minutes of the last meeting were approved.

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Dr. Thompson called the meeting of the Wexner Medical Center Board to order on Wednesday, January 31, 2018 at 9:09 a.m.

Members Present: Leslie H. Wexner, Janet B. Reid, Cheryl L. Krueger, Abigail S. Wexner, Stephen D. Steinour, Robert H. Schottenstein, Alex Shumate, Michael V. Drake, Bruce A. McPheron, Geoff Chatas, K. Craig Kent, L. Arick Forrest, David P. McQuaid, Mark E. Larmore, Andrew M. Thomas, Elizabeth O. Seely, Susan D. Moffatt-Bruce, Mary A. Howard, William B. Farrar, Martha C. Taylor and Amanda N. Lucas.

W. G. Jurgensen and David B. Fischer were absent.

Dr. Drake:

I have a few preliminary announcements that I wanted to start, and so we'll do that before we actually open the meeting, which we'll do in just a minute. I know our chair will arrive in just a few minutes. So, firstly, we've had some changes. The first is to pause for a moment to recognize, actually, I don't see Geoff, where are you? Oh, there you are, you're too close. Anyway, to recognize Geoff Chatas. This is his last meeting. He's returning to his alma mater in a couple of weeks, and he's really been a great and dedicated leader for us, certainly for all of my time and for years before. He actually spent time at the medical center when I first was here, which was quite helpful in the days before Mark [Larmore] was here, that was wonderful. And then we've had several, I'll mention this to the board tomorrow as well, several quite innovative ways of looking at our assets and turning things that were not so useful to us into opportunity for the future, and Geoff's been at the center of that. So I wanted to thank Geoff and acknowledge him if we could take a moment.

I'll say this other thing that my first days as an academic, I remember getting to May/June and students who I'd met were now leaving, and I thought what an awful, it made me sad. I had gotten to know them in that year, and now they were moving on and I thought too bad. And then that happened the next year and I thought, oh too bad, you know, we work with these people and they've moved on. But what I remembered the second year was that the people who had moved on the first year, I still knew, and in fact over the years we all stayed associated and are associated in many ways to this day. So people are a part of the family and they spread and go different places, but we all stay in contact, and part of the family stays part of the family. So, we'll look forward to having you be a part of our family for all these years and in the future as well, Geoff. So, thank you and best of luck in the new endeavor.

And in my next breath, I will welcome Mike Papadakis to the interim CFO role. Mike has been with us for years and has worked very closely with us and we appreciate that. Do I see Mike? Is Mike here? Great. Yeah, everybody, maybe if I say your name you should stand up and wave to me so I know where you are. But, Mike is here and Mike has actually begun working with us in a more intense way over these last several weeks, and we're moving forward without a hitch and we appreciate Mike and welcome him. And Kris Devine also will be with us, and that's going to be great, and we'll continue with our work. Bill Farrar has assumed the role of interim CEO of the James. He did that in late November, and so we appreciate that. Bill, most of you know, has been with us for nearly, roughly four decades and actually very nicely was a protégé, well you started very young Bill, and so that's a good thing, a protégé of Dr. James Ackley. So wonderful to have you in this role, it's actually been great working with you these last several weeks and we appreciate that and look forward to it.

Gail Marsh has a new role. Gail has been the chief strategy officer for the Wexner Medical Center these last several years. We routinely are reporting on how nicely things

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are going at the medical center and the great initiatives that we've done and the great progress we've had and Gail has been at the center of many of those. And now Gail's role is expanding as we have had our strategic plan approved for the university as a whole by the trustees. Gail is expanding to a new role and she'll be the first chief

strategy officer for the university as a whole, and so we welcome you to this expanded role, Gail, and we're looking forward to that. So applause for all of our new teammates, and teammates in new roles, which we're really excited about.

And then I'll finish on a sad note that since our last meeting, we lost one of our family members and teammates and that's Pete Geier. Pete was one of the great builders of our medical center over many, many years. He was a person who really both united things that we were doing here but also reached out broadly to the community and did that in professional ways, to help the Wexner Medical Center of The Ohio State University, all of us, have the right relationships with our payers and with our providers and all of the parts of the business that help us to move forward. But he was also a real presence on campus as a friend, mentor and guide, and really helped all of our staff members, all of our team members here, know that they had a good center to their work going forward. I know that he did this really, really well for us here at our university and we appreciate him for that. And he also was that person in his community with his family, with his friends, with his neighbors. He really was one of those anchoring people who brings people together and gives us all a sense of who we are, so we were shocked really and saddened at his sudden illness and then his leaving us at such an early age, and if we could just take a moment to remember Pete and to think about him, and thank him, and know that his spirit is with us.

Thank you. I think we're ready to move forward and when, ah great, perfect, well this is actually perfect, I was going to say when Les arrives, I will pull the chair back for him and say it's time for us to do the minutes, so it's perfect timing.

Dr. Thompson:

I'll convene the meeting and note that a quorum is present of the Wexner Medical Center Board. The minutes of the November 1st meeting have been distributed to members of the board, and if there are no additions or corrections, the minutes are approved as distributed, and we are ready to move to the agenda. I believe Dr. Kent is first.

Dr. Kent:

Thank you and welcome everyone. As I think many of you know, the theme of this month's board meeting is research which turns out to be, as being in the College of Medicine, one of my favorite topics. We actually chose a bit of a subtheme which is the pipeline of new researchers in the College of Medicine and that's what we'll feature in today's presentation. We've invited to present to you today four of our recent research recruits to OSU: Doug Lewandowski has been with us for just six weeks; Lang Li, a little bit under a year; Kristin Stanford and Leah Pyter, who'll you meet, have been with us for less than two years. Our aspiration as everyone knows is to be a top 20 academic medical center. This requires a significant growth in our reputation, and I would argue that the most important determinant of reputation is the amount and quality of the research that we perform here at the medical center. Are our faculty funded through national sources? Do our faculty publish innovative research in widely read journals? Are we conducting translational research that brings patients in from around the country for the care they can receive at the Wexner Medical Center?

The college currently has hundreds of outstanding researchers, but if we're to achieve our goal of being a top 20 academic medical center, no doubt we need to grow our ranks. We're proud this past year (and many of you know) that our NIH funding actually grew 20 percent, which is pretty remarkable considering that the NIH budget has been flat. But never the less, to achieve our strategic vision, it's clear to me that we have to have a pipeline of new and talented researchers coming into OSU. So today, we'll showcase our recent success in creating that pipeline. You'll meet four investigators, all who are relatively new and they brought with them these extraordinary programs that exemplify, I'd say, both the talent and the quality that we can attract to our institution. You know, I'll pause just for a moment to give you a primer on research.

So, how do you measure research success? And I'm going to make the argument that that's focused around funding. Well, it's really about the innovation, and it's whether your research eventually will help patients, but the funding is really important for a couple of reasons. One, it's difficult to have a successful sustainable research program without funding. You have to have funding for sustainable success. The other is that the peer review process that provides funding is a really great process that is able to select the best talent in research. So for when we look at candidates for faculty positions at OSU, we want to make sure that they are extraordinarily well funded. So, just to go back to the group that's going to be presenting to you today, if you look at the average NIH funded investigator, their amount that they receive from the NIH each year is around \$250,000. So we have four people here today. So, if you do the multiplication, they should collectively have about \$1 million worth of funding, but not quite the case. Our group actually has \$5.7 million worth of funding between the four researchers, so an amazing number, and again I think exemplary of the type of talent that we can recruit for OSU. So, onto the talks. We have four individuals. The first is Leah Pyter. She was recruited from the University of Chicago in the Department of Psychiatry and also the Institute of Behavioral Medicine and her research intersects cancer and neuroscience. It's really creative research that takes two disciplines and brings them together. Dr. Lang Li was recruited from Indiana University, and he is our new chair of the Department of Medical Bioinformatics and his research focuses on mining data to inform clinical decision making. Our third talk will be from Kristin Stanford. We recruited her from Harvard from the Joslin Diabetes Research Center. She's part of the department of Physiology and Cell Biology, and her research focuses on diabetes. And then, finally, you'll hear from Doug Lewandowski who's been here six weeks and we recruited him from the Sanford Burnham Research Institute. He's part of the Department of Medicine and his research focuses on heart failure. So, Dr. Pyter.

Dr. Pyter:

My name is Leah Pyter and I am an assistant professor at the Institute for Behavioral Medicine Research in Psychiatry. And at OSU, two pillars of research are neuroscience and cancer, and my research lies at the intersection of neuroscience, cancer and immunology. And my lab is specifically interested in understanding, biologically, how cancer that is outside of the brain can influence brain function and cause things like depression, anxiety and cognitive impairments. Now thankfully, due to improved cancer treatments, we now have a large and growing population of cancer survivors. We probably all know someone in this room, but what you might not know is that these cancer survivors have persistent behavioral health issues that last long after successful cancer treatments. So in my lab, we primarily use rodent models of cancer and cancer survivorship to try to tease apart the different roles that tumor biology, the cancer treatments and stress associated with cancer may play in these behavioral issues. And we hypothesize that cancer permanently may alter the communication signals between the immune system and the brain, and cause some of these behavioral symptoms. So

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my personal vision for the Wexner Medical Center is to create a clinic for cancer survivors to provide continuing care for the aftermath of cancer, and this clinic would focus on innovative and noninvasive treatment options for both the physical and mental health issues that our former cancer patients endure. And for example, our lab actually investigates how probiotics might improve both the gut symptoms of chemotherapy, as well as the chemo brain symptoms in cancer patients. And when I'm not competing for research funding, I'm competing for goals on the soccer field. I'm so excited to be at OSU and thank you for listening to my story.

Dr. Li:

My name is Lang Li. I'm the Chair of Biomedical Informatics. Before joining OSU, I spent 16 years in Indiana University School of Medicine as the Director for Center for Computational Biology and Bioinformatics. So, I just wondered, who here is taking medications? Alright. ... my lab is actually using informatics tools to do data mining and pick data. So think about, when we initially talk about the research, looking at who would be responsible for therapy, we used to have to give the drug to the patient and see what happens. Okay. We used to find out whether the drug has toxic effect by giving it to patients and see who will respond to the drug negatively. Now, we can use patient genes and use these conditions and other information from medical records to predict the patients who will respond positively and who will respond negatively. As all these consequences, this type of particular model, we can ahead of time choose the right drug for the right patients and eliminate the treatment failure and side effects. The Department of Biomedical Informatics actually has four areas: bio stats, bioinformatics, medical informatics and health service. This is only one department and actually has such a broad research spectrum, and my first division has really transformed this department into a world class informatics program nationwide. Informatics is also a collaboration, collaboration base designs, so my second division is really leading this department in the informatics research and collaboration in OSU. Secondly to my complexity of research is navigating central Ohio as the primary driver for my fifth-grade daughter to get her volleyball tournaments, so I think I'm confident that I can do both informatics and 270 very well. Thank you very much for your support. I'm really excited to be in OSU.

Dr. Stanford:

Hi, my name is Kristin Stanford. I'm an assistant professor here in physiology and cell biology and an investigator at the Davis Heart and Lung institute. I came here from the Joslin Diabetes Center in Harvard Medical School, and we've taken some of the projects that we initiated there, and continued them on here. The focus of our research is to look at exercise as a tool to improve metabolic health. We know that diabetes effects people at all ages, so our research is looking at exercise as a tool to both prevent and to treat diabetes. To look at prevention we use a mouse model of maternal exercise, and what we've seen is that when a mom exercises both before and during pregnancy, we improve the metabolic health of their adult offspring. This means that their offspring weigh less, they have less body fat accumulation, and they have improved glucose tolerance, and this is solely the effect of the mom exercising during pregnancy. We've now identified a compound in the milk that we think is responsible for these effects. This compound is increased with exercise, and we're following up on those studies right now. We also look at fat and while we know that exercise, we think about it to reduce fat, our lab actually looks at how exercise can improve fat. We've now identified a lipid that's released from fat in response to exercise that can increase skeletal muscle fatty acid uptake. Interestingly, this lipid is reduced with age, but then restored in the presence of exercise. We think that this has some promising targets as a treatment in Type 2 Diabetes. Our goal is really to reduce the incidence of Type 2 Diabetes worldwide and

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as we do this, to make Ohio State a leading research institute in the field of diabetes. I like to keep the theme of exercise alive in my personal life as well. I'm an active marathoner, albeit a slow one, with a goal to complete a marathon in all 50 states, and I've got 17 down so far. So, thank you all very much. I'm very excited to be at Ohio State.

Dr. Lewandowski:

That's a high bar. I'm Doug Lewandowski. I'm a professor in internal medicine and investigator in the Davis Heart and Lung Institute. Thank you for giving me the chance to speak with you. You know when I was a real little kid my aunt took me to a science fiction movie, and in it they shrunk down the doctors and scientists and injected them into the patient and they explored around and fixed the problem with their lasers, ray guns. I'm still frustrated today we can't do that. Well, maybe not the ray gun part, but that may be what really motivated me in most of my adult life to try to develop novel schemes to look inside heart muscle cells, and actually watch the chemical reactions that happen – but while it's occurring in the intact, beating heart as it approaches into the diseased state. It's these chemical reactions that break during the very earliest steps of the diseased process. I've been focusing on heart failure most recently because it's the one form of cardiovascular disease that hasn't declined in the last 30 years. Patients with heart failure have no road back other than ultimately organ transplant. It also turns out that the heart is a major player in the overall chemical wellbeing of the body even without changing the way it pumps blood, and it actually can change and communicate with fat, and change the way other organs behave. What we really want to achieve is to identify heart failure patients before they get heart failure, patients at risk, by identifying these chemical signatures before they ever get a weak heart, and then use that same information to design precise, personalized treatment strategies, that can be either drugs, can be diets, or even go far upstream and manipulate the fundamental genetic code, which we're actually doing successfully in the lab right now. So this adventure has taken me from medical schools in Texas to Harvard to Illinois, and then a private nonprofit in Florida, and just six weeks ago, here, where I'm very excited to be at OSU and I really want to work towards bringing these approaches and ideas and weave them into the fabric of the Wexner Medical Center. We're still learning Columbus. My wife and I are enjoying it. We went to the symphony a week ago. That was wonderful. She's a classically trained pianist who teaches now, and I play a style of music I think best referred to as very bad guitar, and that's what we're really looking forward to advancing on all levels. Thank you very much.

Dr. Kent:

So that's a sampling of our new talent at the Wexner Medical Center, and I'll add to that by saying that Peter Mohler and I, and a number of the center directors over the last two weeks, have signed five new funded investigators into our medical center so the pipeline is alive and well, and we're doing very well I think, as evidenced by this group. We can take a few minutes, if you have questions, thoughts, comments, ideas.

Dr. Fujita:

Thank you. Dean Kent, and the four outstanding researchers. I would like to thank you very much for sharing this list of top research programs at OSU because, this gives us, you know, understanding as to what we want to focus and then where we are. And I look forward to, you know, working with you to see how we can expand these focused areas together in the coming years. Thank you very much for your leadership.

Dean Kent:

Thank you.

Dr. Drake:

My quick comment was, first thanks, nice to meet you all. And just a quick comment to the board about the, we speak quickly about peer review, it's something we say a lot and just the robustness of the peer review process is something that maybe we'd spend a moment talking about it. And so the way the national funding works, the NIH funding, is that there is a body in D.C., permanent people who are there. There are review committees that are made up of prominent scientists from around the country. You spent time on a study section rotating on and off, but it's a career honor to be respected enough by the leaders in the nation to be asked to be one of these reviewers, and so it's a badge of great honor to be a part of the study section. And the overall NIH section has a kind of, periodically publishes things that they think might be interesting for the country to focus on, that's shared and people know that, but they also review proposals that people come up with de novo, just new ideas that happen to be out there in the world that come forward. And then this group of experts, in an exhaustive process, pours through the proposals and selects a fraction of the most promising ones to be funded from their limited funds. And so we mentioned this very quickly, but it's the most robust program of its type any place, anywhere in the world, and the quality of the research having been vetted so carefully. And you know maybe in more current terms than I do, Craig, how long it generally takes for someone to be funded from the time that they first put in their first proposal until they actually are successful.

Dr. Kent:

Sure, sure, some interesting statistics there. The average age of one receiving their first NIH grant is 43, which is amazing these are individuals that have been working for many, many years before that happens. The great news, though, is the average age of the first RO1 faculty of the College of Medicine at Ohio State is 37, so we've actually beat that by six years. Precocious group.

Dr. Drake:

Yes, so just going back there, what the dean was saying is that one's training is routinely finished at 30-something. The fact that the first funded grant is 10 years later means it takes 10 years of work past that to be able to get through this process and actually to be funded. So we just say, very quickly, peer review is just one little word or little phrase that goes in a sentence, but it's years and years of work and then being reviewed by the most critical people at the highest level competing against ideas from around the country. And so, a very great measure of success and promise, and so I congratulate you and your colleagues. And having five new ones just in these last several weeks is great, and I just wanted to say a word about that so the board can remember, or think this is really a very big step. And we're really pleased and proud.

Dr. Wadsworth:

Thank you for the presentations. They're all very interesting. I could, I'm sure, have conversations that never end about each of them, but I'll restrain myself. I'm very interested in the evolution from experimental medicine into using DNA and then more sophisticated tools, and that seems to be a theme that we'll see more and more of moving from animal models maybe to in silico and other devices. I had one question about the cancer, you mentioned the cancers outside the brain that were hard tumors, what about blood cancers?

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Dr. Pyter:

Well, we have specifically focused on those outside the brain because we're interested in how anything outside of the brain could communicate to the brain, because for a long time we thought that the brain was kind of privileged and was not getting information from the outside of the body. But certainly blood cancers and solid cancers have similar signaling molecules and we're thinking their immune molecules, so that could also, and people with leukemias, also have high prevalence of behavioral vulnerabilities.

Dr. Kent:

Other questions? One more round of applause for this extraordinarily talented team.

Thank you so much.

So, I wanted to begin my [College of Medicine] report with an introduction of an individual that I really enjoyed working with over the past few weeks. Raph Pollock as many of you know is our new director of the Comprehensive Cancer Center. Just a little history about Raph, an extraordinary career, he spent his first 30 years at MD Anderson, and the last 17 of those 30 years he was chief of the Division of Surgery, which meant that he oversaw all of surgery at MD Anderson, so a very prestigious role. We were able to recruit him, fortunately, to Ohio State about six years ago and he played initially the role here of chief of the Division of Surgical Oncology and then surgeon-in-chief of the entire Wexner Medical Center. Many of you know Raph. He's an internationally known cancer surgeon, three decades of NIH funding, which continues on now, and he's world renowned for his efforts in soft tissue sarcoma, both in terms of his research and also his clinical expertise. I will say on a personal level, it's just been a delight to work with Raph in his new role. We worked together very collaboratively and have really enjoyed the larger purpose of growing research, not only in the cancer center but also the College of Medicine, and broadly across OSU. So please, a warm welcome to Raph in his new role as cancer center director.

So, onto my report. I'll break it into three sections: research, education and then our clinical enterprise. Just to carry on the research theme, our NIH funding remains strong. You know, I mentioned earlier that we had a 20 percent increase in NIH funding last year. This year, in the first half of the year, we're \$7 million ahead of budget, and that number actually is probably a little low because there have been some, you know, struggles in Washington in terms of releasing grants and so we expect that once that's released, that the number will continue to increase. Another one of the metrics on our scorecard are the number of individuals that received their first RO1 grant. Dr. Drake just spoke about the honor and privilege of receiving your first RO1 and we have a goal this year of having 20 individuals in the College of Medicine that achieve their first RO1. For the first half of the year, we're at 11, so ahead of budget, and I'm fairly certain that we'll meet that goal. We've had a number of new grants since the last board meeting, and I won't go through them, but I'll call out a couple. One is a very large neuroscience core grant that's been given to OSU. A core grant means that it comes to help a whole group of researchers that are in one discipline, so this is a very large grant, and it turns out there's only 16 of them available in the country, so we're one of those 16. Tony Brown, who is a professor of neurosciences, is the PI of the grant. And then a second large grant, it's called a UO1 and a UO1 is sort of a very large collaborative grant. You can't be the recipient of that grant unless you're working with a lot of different disciplines, and this is in the area of oncology, and it's interestingly awarded by the National Institute of Drug Abuse. But the proposal addresses the effects of e-cigarettes on lung function, a very timely topic. The PI of that grant is Peter Shields and also Mark Weber, so congratulations to both of those investigators. And Dr. Fujita commented earlier that he

has been asking at the last couple of board meetings for a list of our top research programs, and so finally I submitted and we put together a list of 12 of our really outstanding programs. You have that in front of you. Now it was a bit of a struggle to put that list together and it's sad that it's in public session, because I think we have two or three dozen other researchers that probably should have made that list, and trying to decide where the cut off would be is difficult. But these are programs that are clearly nationally recognized, collaborative team-based programs. You can see the multiple investigators for each of those programs and you can see that they cover a broad array of disciplines, all the way from cardiovascular disease, neuroscience, behavioral health, regenerative medicine and the list goes on. So thank you for asking us to do this, it was a really fun and interesting exercise, and please read through the list and learn more about our outstanding programs.

So, I'll move on to education. I'm really happy to call out that our bachelor's degree in health sciences was just ranked by *U.S. News and World Report* as No. 1 in the country for online bachelor degrees. This is a program that's about three years old, but it's subscribed to by students from all over the country. It turns out that we have a couple of other programs that are very strong, you know, outside the College of Medicine. One's in physical therapy where we're ranked 14th and another is in occupational therapy where we're ranked 10th. Deb Larsen who is the director of the School of Rehabilitation and Health Sciences is really responsible for all of this. Deb, are you in the audience? I just wanted you to stand and be recognized for this. Thank you. So, another goal that we have on our scorecard this year in the educational arena is to create an interdisciplinary educational curriculum involving all of the health sciences colleges. We actually have had a consultant that's been working with all of the health sciences deans, all seven of them, for the past several months, and I'm proud to say that we actually just completed that exercise and we have on several pieces of paper a very robust and exciting curriculum. So, you know, we're really very proud of the deans and the time that we've put into this and the investment. And of course, the real work is implementing the curriculum and, of course, that interdisciplinary health sciences learning center that we're going to have very soon is going to be an important part of that mission. But I did want to call out Dan Clinchot, who's the dean of education of the College of Medicine. Dan has been instrumental in leading this effort and putting it together. I'm not sure that Dan was able to make it today, but nevertheless, great effort and congratulations to Dan for his work.

Moving on to the clinical arena. We chatted earlier about how important research is for national prestige. Another element that's critical is having a large number of what I'll call differentiating clinical programs. And what is a differentiating clinical program? It means that patients will come from all over, maybe all over the region, all over the country, maybe even internationally, to be cared for at our medical center because of the quality and strength of that program. We have many of those programs now and I'm going to feature one of those today. But it's part of our strategic plan – we're going to grow the number of differentiating programs that we have here at the Wexner Medical Center. The one that I wanted to call out today is the department of Radiation Oncology, which far and away is best in class and one of the top programs in the country. Arnab Chakravarti, who's the chair of that program, came to Ohio State from Harvard in 2009. Very ambitious and excited about what he might be able to grow here. One of his first accomplishments, I think in his first year here with others, he was able to receive this \$100 million Health and Human Services Award that allowed building out the second floor of The James and putting eight linear accelerators, which is the tool that's used for delivering radiation to cancer, on that second floor. And what that's created is a capacity that makes us one of the strongest programs in the country in terms of our technical abilities. But in the end, it's all about treatment and patients, and if you look at our clinical

volume in a realm of radiation oncology, the growth over the past eight years has been 140 percent, doubling the volume, and then 40 percent beyond that. Really amazing growth. And it isn't just about caring for patients, it's the quality of care. This past year, the department received Press Ganey's most prestigious accolade for patient satisfaction. I mean, really top in game in terms of patient satisfaction for radiation oncology physicians. And then the question is what differentiates this program, and a lot of it is the area's specialization. We have a group of radiation oncologists that are focused on head and neck cancer and another group that are focused on prostate cancer and then GI cancer and then on and on, and having that focus means that you have expertise that's above and beyond the level of care that can be provided in other centers. If you look from the standpoint of research, when Arnab first arrived there were no NIH grants in the Department of Radiation Oncology and now it's one of the top 10 ranked and funded programs in the country, with over \$8.5 million of yearly funding. And this past year the department had publications in the New England Journal of Medicine, JAMA, these are just really great clinical journals, and you know that's just testimony to the impact that this program is having both nationally and internationally. He's a magnet for talent – five new recruits over the past year, two from the Mayo Clinic, one from MD Anderson, one from Sloan Kettering, and the other from the Cleveland Clinic, so just some all-star recruiting on Arnab's part. And then I'll finish by saying on the training side he has the only international training program in the country for radiation oncology. People come from all over the United States to learn better techniques at OSU but they also come from all over the world, you know, many from Asia, Europe, many countries. Individuals come here to improve their techniques for radiation oncology. So I'll sum by saying I'm impressed and I'm not particularly easy to impress, as people have probably learned. The good news for all of us is that Arnab has just renewed his four-year commitment for another run as chair, so we're really excited about that. And as I showcase OSU's very prestigious programs, clearly radiation oncology is at the top, so Arnab, you were kind enough to join us today, would you stand for a round of applause? So, Mr. Wexner and President Drake, that concludes my report.

Dr. Wadsworth:

Could I ask you a question?

First of all, I always like to just to congratulate you on the NIH awards because anyone who's been around that circuit knows just how difficult it is to break in, how hard they are to win, so it's a terrific achievement every time somebody wins one. I was interested, your comments on curriculum, as a layperson in medicine I don't, what I observe is a massively complex field, it's ever growing, and we heard some of that with the four speakers. How do you deal with the breadth? You know you can add time, or you can specialize earlier I guess, I was just interested how that dynamic is decided in selecting a curriculum.

Dr. Kent:

Absolutely a great question. The major focus of this interdisciplinary curriculum that we've created is team training. I think it's fairly clear to most of us – and everyone who actually saw the previous board presentation where we had the teams and the clinic out at UH East come and present to us – that the most successful care, the highest quality care, is provided by teams of individuals, not by individuals. And so I think what happens now is we all train in our silos and then we go out and then one day we're in the clinic

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and people say “we’ll work together,” and that doesn’t make a lot of sense. So the concept behind interdisciplinary training is that we’ll actually learn to work together as we’re training. And so that’s what this curriculum focuses on, and there’s two parts of it. One is more of a foundational part, where people are in classrooms and they’ll learn biochemistry together, or ethics together. And then the other is more of an experiential part, where in the clinic teams will work together, or in the hospital, or in the community, so it’s actually very detailed, it’s very robust, very exciting, very difficult. And I think you were suggesting this, to implement, and so that’s really the challenge in front of us I think over the next year or so, but all of the health sciences deans are very excited about this and I look forward to OSU being one of the national leaders in this regard.

Dr. Wadsworth:

Thank you.

Dr. Drake:

Just a comment, if I may also. To focus on both parts of what the dean was saying, and I’ll use my own training back in the last century. Usually, when I did this, we had our biochemistry and other classes, I was in a campus that had four health sciences colleges to get in – nursing, pharmacy, dentistry and medicine were all the parts and that’s all that was at the college. In things like biochemistry and physiology and some of our basic sciences, we had students from all four colleges together, because C stood for carbon no matter what your discipline was going to be. And what had been the case before was that everybody was trained in parallel. So you have four of these things going on, and the conflict was, gosh, maybe you could bring them all together and do one really good one. And then what would happen is at a certain point in the semester, there would be specializing – small sections that would break off because a pharmacist might need to understand drug compounding better than someone who was going to be a dentist, and whatever. So there were different ways you go off into your own discipline. In our second year, we had teams of people learning things together in introduction to clinical medicine. So then medical students and nursing students, primarily, would be together in small groups learning how to listen to a heart, and it was an interesting way of kind of just a toe in the water of working with the people who were then going to be on the ward together later. So in the very early part of training, so you could learn that your colleagues weren’t only people who had the same initials after their name, or had the same training. And it was meant to build a collaboration. And then on the wards we would have people from different schools, including particularly the College of Pharmacy, who’d be there to read about drug interactions and things as we walked around looking at patients. And it made perfect sense that when you’re going in to review a patient’s medications, there would be someone from pharmacy there doing that with you. That team approach seemed like a normal way of doing things. It was done in a small way, but it seemed to me it was a normal thing to do. We here have all seven health sciences colleges, it’s an amazing thing, and the concept of working together has been difficult to maintain. As you were saying, each of the fields becomes deeper and deeper and there’s more and more to do. The national movement really has been that people have gotten narrower and longer, and so this is a great opportunity to say, gosh, maybe if we really think back again about bringing it together and learning together we can be better teams in the future. So I think we have a great opportunity to be the national leader in this. Great. And now with great anticipation, David McQuaid.

Mr. McQuaid:

Thank you, Dr. Drake. So what I want to focus on this morning is to give you an update on the progress we’re making in two areas, population health and healthy populations,

and the impact that we're making on the communities that we serve. This has been a focus area for healthy communities on the scorecard if you recall. So, first let me spend a few minutes on population health and our journey. I've been in front of you before talking about our progress, how we needed to organize ourselves to prepare for payment reform. I'm happy to tell you ... through a very rigorous application process and many hours of work across multiple individuals and teams, we've been designated by the Centers for Medicare and Medicaid as a Medicare Shared Savings Program, an Accountable Care Organization, under track one, effective January of 2018.

So what does all of that mean? Let me help you to be very clear about these definitions and what we are doing. The Shared Savings Program was established by the Affordable Care Act and is a real key component of the Medicare delivery system reform initiatives. Shared savings programs, ACOs, are groups of doctors and other health care providers who voluntarily work together with Medicare to provide high quality services to Medicare fee-for-service patients and beneficiaries. And so, let me tell you the rationale, just to remind us all strategically, because everything gets back to strategy, that the rationale for creating this for Ohio State is it's a key element of our population health journey. It's really going to give us a lot of experience with new payment models, as they become the norm. It's going to create optimal understanding of our costs. That's really important so that we can create efficiencies. We have to intentionally manage clinical variation, we see that on a day-to-day basis, and we need to have the necessary structure and infrastructure to manage the health of large populations. Ohio State and the Wexner Medical Center has significant experience, since 2011, in particular in primary care dealing with the concepts such as patient-centered medical home, our comprehensive primary care plus, bundle payment program initiatives. And we're going to capitalize on that experience and bring it to this model. And then very importantly, this strategy helps us to tightly align with other community physicians as well as other network hospitals within Ohio State's health network and beyond. I would just close by giving you a couple of statistics in this space that are really important for us to understand. In 2018, there are about 560 participants in the MSSP program. I would tell you that about 30 percent of those achieve Medicare savings. The average savings is around \$5 million. The maximum award in 2016 – because we work in arrears on three-year averages – was achieved this year by the Palm Beach ACO. That was approximately \$30 million. The average number of beneficiaries in these programs is around 18,000. We will have 13,000 initially in our ACO. And finally, there are about 26 ACOs in the state of Ohio. Cleveland Clinic in 2016 was the top achiever and theirs had approximately \$20 million. So that's the update and I'm very, very proud of the team, the efforts and this is going to position us very well strategically as we look at new delivery care models.

Let me now pivot to healthy communities and tell you that the Wexner Medical Center in 2017, when we approved the strategic plan, had a priority section entitled healthy communities. And this really included initiatives to increase and improve coordination of our public health-related initiatives and programs that would meet and help us to better understand through our community health needs assessment – which comes before this board and is approved, it's also known as the Franklin Country health map – that gives us direction for the priorities in this state and for the patients that are vulnerable and we can focus on. I'll focus on two areas. I want to give you an update on the initiatives we have going on with the opioid crisis, and I want to spend a little bit of time talking about infant mortality. There will be future updates that will be given on health care disparities, a steering committee that has been put together to look at that as well as obesity reduction, and so let me start with the opioid crisis. And I'm also going to ask the provost perhaps to have some initial comments because as One University, the opioid crisis is front and center for all of us and we work closely together. So I ask the provost to comment and then I'll talk more clinically of what we are doing.

Dr. McPheron:

Thanks, David. We've taken a holistic approach across the university. The university board, the Academic Affairs Student Life Committee, heard last year from folks in our College of Pharmacy who've had a long-standing program called Generation RX with the Cardinal Health Foundation, which has provided a lot of great informational, educational sorts of work that's now being used across the country. At that point we pledged to the board that we were going to commit just about \$1.5 million centrally to seed projects to bring together expertise across the university. We're in the process of final proposals – we had 89 pre-proposals from all corners of the university, including some really innovative partnerships – selected down to about 33 of those that are now in. They have until Valentine's Day, a great present to all of us, to turn in their – they'll be doing that instead of sending flowers to their loved ones, I think – finalizing their proposal submissions. We've had external stakeholders helping with the selection of these. We actually invited folks who were not part of the finalists to partner with folks that were asked to submit a proposal. So I think we're going to see some really innovative ideas emerge from this, that will then be in play over the coming year to 18 months. We anticipate a second round of requests for funding as we see some of the ideas emerge. The next steps would be, in many cases, to actually have these groups be able to compete for national funding in these areas, and to do what we've done with issues like water quality and community health, to actually bring in other academic institutions around the state and around the region to build ever more robust partnerships. We have great people here, but we don't have a monopoly on all of the great ideas, and so finding a way to partner is a terrific notion. Many of you will recall that we announced a drug enforcement and policy center with external donor funding that brings together the College of Law, the College of Social Work and the John Glenn College of Public Affairs, and that funding will allow us to recruit national scholars in the areas that are completely relevant to this issue. And then just a reminder that Ohio State – we think about this all the time with our patient care here and how we draw patients from across the state and region for care here at the Wexner Medical Center – Ohio State also has people on the ground in every community in Ohio through OSU Extension. And we have a really great program because more and more of those extension folks are actually working in matters of community health. They have the partnerships with the local agencies and nonprofits who are dealing with this head on, and so we're connecting those people in those communities with our subject matter experts here at Ohio State to be able to ensure that each of these communities that are afflicted by this have the access to the latest information that will help them actually solve problems on the ground in those communities. Thanks for that, David.

Mr. McQuaid:

Thank you, Dr. McPheron. I don't have to remind everyone how significant a problem this is. In 2016, there were 4,149 deaths in the state of Ohio; projections to 2025 are 16,000 deaths from overdose. So we need to play our part. The committee's head at the Wexner Medical Center is led by Andy Thomas, Peter Mohler, Dan Clinchot and the dean of the School of Public Health, Bill Martin. Many, many others participate. Let me just mention a couple of things. In our STEPP clinic – substance abuse treatment, education and prenatal prevention – this is part of Maternal Fetal Medicine, McCampbell Hall. It's a clinic for pregnant moms who are addicted to opiates and heroin. Folks provide OB care, Suboxone medication, assisted treatment and weekly counseling. In the past 12 to 18 months, they've seen 150 new pregnant mothers that have been enrolled in the clinic. Another significant pilot program that's been going on at University Hospital East is a project called Project Dawn, which provides two doses of intranasal Naloxone. Naloxone is a reversal agent for opioids, and they provide two doses of this

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to patients that come to the ED with an overdose. Currently, in the past 12 months, we've distributed about 230 of these Naloxone kits to patients at UH East, and so that's a great program. And finally, let me close with a few comments about infant mortality. This committee is sponsored by Dr. Mark Landon, chair of our OBGYN department, and Dr. Cynthia Shellhaas is the committee chair. They're beginning their work. They are adding on to the great work that's been done initially, created and led by Dr. Pat Gabbe, and the Moms2B Program, where their goals are to reduce disparities amongst new moms and improve birth outcomes by providing medical and social support. This is a program that partners with several in our region, Mt. Carmel, Nationwide Children's, The Columbus Foundation, United Way, several others. They're making significant impact. They're at eight sites. I would tell you that in 2017, the impact they've made with 617 unique mothers, they've had zero infant mortality. So all of these things that we're doing, coming together, are really impacting and we're playing our part. We want to do more and we're excited about the efforts so far, and we look forward to continuing to update you on these things.

Mrs. Wexner:

Dr. Kent and I heard a presentation at the Children's Hospital board meeting last week, in which they're predicting that in the state of Ohio we are going to see 20,000 infants born who are addicted to opioids. Obviously we're making efforts, but the magnitude of this problem is so enormous, I'm wondering what greater leadership we can play in mobilizing statewide efforts. I think none of us can anticipate the burden, the trauma, that's going to create for the families. Most of those kids will enter foster care, and clearly from a medical point of view, we have no idea what the long-term effects of that type of addiction is. So whatever we're doing, we need to do more – better, faster, bigger. Happy to understand how we can all be supportive in that effort.

Dr. Drake:

Thank you, very much, I appreciate that. I appreciate the efforts. We'll now go on to the Health System Financial Summary, Mr. Larmore.

Mr. Larmore:

Good morning, everyone. Before we go to the slides, just a couple comments about the financials. We're halfway through the fiscal year, and I'd say from a financial standpoint, we've had an excellent first half. The medical center as a whole – medical center being the health system, the College of Medicine and the physician practices – are growing at a rate greater than we budgeted, and a rate greater than prior year. Year to date, our revenue has grown 9 percent and our expenses have grown 8 percent, and so that 1 percent delta shows up in our margin and profit at the end of the period. All three entities that I spoke about are positive to budget for the year, so that's good news. In addition, each one of our business units within the health system are showing improved margin year over year. The margin varies by business unit, but through the budget process and having our challenge to each of the operating officers to continue to show improvement year over year, we're achieving that. So we're tracking well financially to our strategic plan and to our long-term financial plan. And probably the question that I get asked the most is what happens to the margin from the enterprise? I answer this question every month. We invest all of that money back into the medical center, first and foremost, to quality patient care, patient satisfaction, employee satisfaction, clearly on the top of our list. And then I spend a lot of time talking about what's the cost to build for the future. Certainly we're in a big build phase now, and taking care of some building that's probably a little behind the times. And then communicating that to the staff goes a long way to explaining where the margin of the medical center goes. So the slide I have up talks

about our numbers. The color tells the story – just about everything is green, a little bit of yellow on our budget, on outpatient visits and our worked hours. So our worked hours are about three above budget and four above prior year, which is always a challenge for us. On the next slide, I spoke about the revenue growth at 9 percent, and then certainly on the bottom left you can see that our margin is tracking ahead of budget and ahead of prior year. On the bottom right, we continue to grow cash, and that's intentional, given that our major construction projects have not started yet. We're just investing the early dollars in that, you'll see some of that later, but our expectation was to grow this cash balance. The next slide is the health system operating statement, so you can see at the bottom line that we're at about \$110 million, which is about \$6 million ahead of our budget, and then we've grown about \$25 million over the prior year, which is what we anticipated. And then, if you look at the first line, all the way to the right where I spoke about our revenue growing 9 percent and then our expenses growing 8 percent, right in the middle of the page. So this is just the health system. I'll get to the other entities. These are the statistics we provide. Just focus on the, just the bottom three lines, where you can see that we do track our operating revenue per adjusted admission, and how that compares to budget. So the good news is that we're actually tracking \$183 ahead of what we had projected. Our expenses are not growing as fast as that, which is generating the margin improvement year over year. The next slide, we have the year to date for the three entities, so again the health system you can see on top, tracking about \$6 million ahead. The physician practice is tracking about \$7.5 million ahead of target, and the College of Medicine very similar numbers at \$7.5 million. So as an overall enterprise, about \$21 million ahead of our target, and actually ahead of the prior year numbers also, so great performance on all three entities. And my last slide is the balance sheet, and I spoke about the cash growth, you can see that in the top right, and then since June 30, we've actually become a \$4 billion entity from a balance unit standpoint. So the expectation is that continuing to grow. It's a good time for us and actually helps us build our case to continue to expand the medical center.

Dr. Reid:

Question, this is really tying two things together – so being approved to be an ACO is great news, and obviously all the coordinated care and other benefits will result in performance outcomes as well as shared savings. So do we have any projections on once it's up and running, and we know what we're doing and everything is working well, what the impact will be on operating revenue and on controllable costs?

Mr. McQuaid:

So, let me start, and then Mark [Larmore] can comment. So when we look at these ACOs nationally, I mentioned that there are 561, about 130 or so of the 561 are in tracks two and three, which assumes much more considerable risk. We are in track one, which is upside only, no downside risk. Medicare has created a track one plus. This is a significant journey. As you may know, Medicare started these programs in December of 2011, so there are many with significant experience, and these are a journey that people put their toe in the water – track one, one plus, move to two, move to three, take on more and more risk. And so I would tell you that right now on a net revenue basis, a risk component whether it is in any of the federal contracts or commercial contracts, is probably less than 2 percent in this marketplace. So I would tell you that for the ACO, for that component of 13,000 fee for service, we would not predict savings in that program for 18 to 36 months. We have lots of work with infrastructure, the delivery system. And my final comment would be that most of managing that clinical variation is really on the post-acute side. When we look at the evidence across these 561 ACOs, it is very clear that managing the post-acute phase, the relationships with skilled nursing

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facilities and home care facilities is paramount in the care of the patient. So it's going to be slow, but as the market and payers take on more discussion and negotiation with adding more risk, we would see a greater impact, but it's going to be a little bit of time.

Dr. Reid:

Okay, but it is going to eventually have a ...?

Mr. Larmore:

Yes, it will eventually reduce the amount of care provided and better managed care from the participants. But I look at it as we've had an unofficial ACO for a long time. We have our own health plan, which had 60,000-plus lives in it, and a lot of focus over the last couple years on how we manage that care. And we've actually had noticeable improvement in the trend on health care spends on our own health plan, and compared to what the rest of the market's done, so I think we're not starting from ground zero on the ACO, but a little different structure.

Mr. McQuaid:

So, I would just add that in the early phases of Medicare ACO we're protected, because there was no downside, and its comfortable phasing in. But eventually, if you as an organization or we can't figure out how to provide low-cost, high quality care, we're going to lose a lot of money, and so that's the challenge. I think what Mark's saying with our own ACO, our own health plan, we're actually way ahead of the curve, and we're already doing that. But efficiently run, I don't think the risk is that high.

Dr. Drake:

We're saying these things very quickly, so I just want to make sure that we pause for a second. ACO is a big concept. Having an accountable care organization is something different than the United States has used for its health care system in the past. To mimic other systems where there actually is a system of healthcare starting early and going through the acute-care and then going to the post-acute, so it takes years and years to do this. And I want to repeat again what everyone is saying about the fact that we have a sort of shadow ACO. We have our own health system of our own employees and others who we work with. And we all know very well that the health care costs in the country have been accelerating rapidly and sometimes at double digit percentage rates year over year, and we had a 1.4 percent decrease last year and projecting perhaps a 3 to 4 percent decrease as we go forward, last time I heard it was 4 percent. To be able to get ahold of our costs and have them level off and trend down is something that's unheard of nationally, and we have done this for a couple of years in a row, but that's taken years of planning and focus. So these things all take a long time to get there, but it's really the way to go and we stand down on that. So congratulations on that. I have one question also for you, Mark. The worked hours per adjusted admit has trended up slightly, what would be the reason for that?

Mr. Larmore:

Actually, probably the biggest piece of that is that we've been expanding capacity and opening up new beds, so during that expansion phase, and hiring new nursing staff on, they go through an orientation period and that actually causes sometimes a double up in the staffing costs. It's one of the costs of expansion.

Dr. Drake:

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So what you're saying is that there are extra worked hours of really not patient care, during orientation and onboarding, and so the growth is reflected there then. It's not a sign of inefficiency in the patient-provider interface.

Mr. Larmore:

Yes.

Dr. Drake:

I appreciate that.

Mr. Schottenstein:

I have a question. Mark, I thought these results were outstanding. I did have a question on the third slide, which there's a line for salaries and benefits where we're almost \$8 million over budget through the first part of the year. Is that because there's more people than were anticipated, or we're doing things from a count standpoint that we needed to do that we didn't originally budget for? What's happening there?

Mr. Larmore:

I think two pieces, one what I spoke about with the opening of beds and the orientation period, the second is our volume is ahead of budget so to the extent we have a patient in the bed, we're providing the staffing for that. You know, its 1.2 percent so it's not a huge percentage, but it looks like it's still \$7.5 million but that's nothing other than that in there. No surprises.

Dr. Drake:

Alright. You ready?

Mr. Kasey:

Thank you, Mr. Wexner, Dr. Drake. I'm here to make a fairly simple request for a large amount of money ,and before I do that, I want to make sure that I acknowledge that we're at the end of a phase of a very long process. The programming of the new replacement hospital for University Hospital here at the Wexner Medical Center anticipates the inclusion of up to 840 new private inpatient beds, ORs, parking structures, and a significant amount of side work. To get to this point, I just want to pause and recognize the leadership of both the people at this table and the people who are here in the room and elsewhere. First of all, Dr. Drake gave us direction from the very get-go on this project and reached into the project at various times over the last year to give guidance and judgment. Mrs. Wexner and Mr. Schottenstein really worked with us on a monthly basis over the last 12 months, meeting every month to give guidance and ask questions that both gave judgment and also gave vision. And I would also just add that in Bob's situation, he has become knowledgeable of this project at a level that most of us can't rival, so I want to thank him, and he'll make some comments later. And then along the way though, David McQuaid and Andy Thomas reached in and gave guidance on both the business elements of this project and the clinical elements of the project. Marti Taylor and Susan Moffat-Bruce, in the representation of University Hospital, has given us great guidance. And then finally, I want to mention that Ed Lampert, who sits behind me, really brought the project together in a way that brought a very complicated group of issues together and didn't exclude people. This is not a project built of silos. It's a project that everybody in the end, at least at this point, feels they have an ownership position in it, and that's a very difficult thing to do when you're programming what will

become a major investment for the medical center. So at this time, I wanted to make sure that I recognize that in November, you authorized us to advertise and interview and select a professional services group to take the project from programming into design. We have accomplished that and selected the HDR firm that led the programming study. They've been selected to be our architect engineering firm to go into design. The project, the fees that we're requesting today of \$70.8 million, include all A/E fees and also all the subcontractors that roll up under the A/E contract are included in that cost. We have benchmarked these fees against some major projects for academic medical center replacements across the country that are in early phase right now, including MD Anderson's new patient tower and the Penn Medical patient pavilion. We think our fees are well represented as we look at the fees that we've been able to acquire nationally, and so this work will take us through our early design phases, both schematic design and design development. We will come back to you at the end of schematic design and give you an initial idea of what we think the costs are and the progress we're making. But the entire planning through design development will take probably 14 to 16 months. At the conclusion of design development, we would be prepared to provide you a detailed estimate, at which point we would expect the board to give us more guidance prior to making a commitment toward construction.

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES CONTRACTS

Resolution No. 2018-61

WEXNER MEDICAL CENTER INPATIENT HOSPITAL

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

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

	Prof. Serv. Approval Requested	Total Project Cost	
Wexner Medical Center Inpatient Hospital	\$70.8M	TBD	auxiliary funds

NOW THEREFORE

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

BE IT FURTHER RESOLVED, that the president and/or senior vice president for Business and Finance be authorized to enter into professional services 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 XVI for background information, page 22)

Mr. Schottenstein:

Just if I could add, and I appreciate what you said Jay [Kasey], just maybe to give a little bit of context. Any project, there's three or four phases, and we have been deep into the first phase for almost two years, and that's what we've called the programming phase, which is where you sort of figure out what you're going to do, how many beds, what happens inside, thoughts about sizes of rooms, parking structures, site work, in a very high level. I always use the house analogy – are they going to be four bedrooms or five bedrooms, is there going to be a living room or just a big family room? That's a very simple way of thinking about something here that I think is very, very complex. So the very first part of any project is this so-called programming project, programming phase rather, and it's probably the most important part because everything that happens after is influenced by the answers to all these "what's." What's going to go into it? And so forth. So that's where we are, we're sort of in the first or second inning of a nine inning game, but this first or second inning is really, really important. Two innings and now we're going to move into design, and then as we move from design we'll go to construction drawings and at some point we'll actually start. The other two people that I wanted to single out because they're here and they've done great work in co-chairing the oversight committee, are Marti Taylor and Dr. Andy Thomas. They have done great work. Hundreds and hundreds and hundreds of hours have gone into this important pre-design part of the process and I think that, you know we've tried to minimize the number of unforced errors, and tried to get our arms around as much of the "what's" as we possibly can. HDR, the architectural firm that's been assisting us, and of course Ed Lampert, who has been managing it from the outside, I think have done spectacular work. HDR is one of the most respected firms in the country when it comes to new hospital towers, and they've certainly proved their worth on this, so I would just add that.

Mr. Steinour:

Question, if I could, will this estimate include, sort of, any funds for retrofit, or is that to be determined separately?

Mr. Kasey:

There are some assumptions on what happens with some of the remaining space in Rhodes Hall, so that planning is in these dollars also. And then some of the visioning of how we reorganize the traffic flow around campus is also in these dollars.

Mr. Wexner:

I think this is correct, but what we're looking at and had been looking at in terms of capital needed, whether it's new facilities or retrofitting facilities, is to make sure that we've got an all-in cost and always looking out about 10 years. So it isn't just this end to that end to that end, but constantly updating, and I think the time horizon for the physical planning of these facilities is probably looking at 30 or 40 neighborhoods, secondary uses, you know. If there are autonomous vehicles, what do you do with parking lots? All kind of things that are not done. It's always interesting to me, when I come up to the medical center, is that so many well-intended people planned buildings and they put almost all of them in the wrong place. So even next to this building, one would've thought that somebody might have thought that this building would need to be expanded rather than building a parking lot directly next to the building. So we're trying to benefit from these mistakes. I want to take a couple of minutes, you know, there's a lot of challenge and reputation and conversations in the community broadly about what goes on in the medical center, what doesn't go on in the medical center, who came, who left, why, and I'm sensitive to those feelings. As I look at it, and probably I'm prejudiced, but I want to tell you what I think.

This medical center board has been functioning for about three years and probably the first year, for me and I think for most of the other civilian members, was trying to figure out what the hell is going on, and what does a medical center board do? What are our responsibilities? Clearly none of us civilians are doctors, but yet we care. We're responsible to patients, to students, to faculty, to staff, to The Ohio State University Board, to central Ohio, to the state, and in some ways, to the nation and the world for what goes on in a complex medical center. So it began by a learning process, if you would. The civilian members of the medical center board, it took us a while to figure it out. Look around the room today, and this table, this room, is very different than it was three years ago. Virtually everybody sitting around the table wasn't at the table three years ago, and I think that's important to recognize – the enormous change in leadership that was undertaken. I think in cooperating with the administration, clearly Dr. Drake and the medical center staff and the university board, what we recognized was that we had the opportunity to change a lot of things, to make a lot of things better, and in embarking on this – probably inspired by the Hippocratic Oath – clearly we wanted to do no harm. But the changes that we've undertaken, clearly have been transformational. And when you undertake transformational change, clearly you're going to have disruption. You can't change in a dramatic way and have everything smooth, it's just impossible.

So as I look back at these last several years, and looking forward to the work the year ahead and the years beyond, what strikes me is by virtually every metric we've made progress. Whether it's in NIH grants; whether it's the expansion or the retention of the professional staff; the acquisition of talent, people coming to the medical center; progress in teaching and research; whether it's the quality of the med students and nurses who are coming in or the quality of our research and how its valued independently by the NIH. By every measure, more patients and our share of market if you would, clearly reputationally people want to come here. We are, I think, beyond full capacity and adding 72 beds as soon as possible. If you look at the financial metrics in terms of our economic efficiencies and performance to budget, year after year the financial results have simply been better across the entire medical center. If you measure patient care, patient satisfaction, every metric that one could have, we say we've done better. And clearly reputation to a medical center is important because it attracts doctors, it attracts patients, it attracts referrals, it attracts students, it attracts funding from the state and from donors, because they just simply know that we're running the place better and better and better.

So as we look forward, not just to the balance of the year but out a year or more, in my judgment all the arrows are pointing up, and clearly we take responsibility, the total board with the staff, for making sure that the human factors and the capabilities that we have are on pace with the physical plans that we're making. The promotion of Dr. Pollock and Dr. Farrar taking over the leadership of the cancer hospital, those are significant promotions from within and it speaks to the ability for us to have successful succession within the institution. And as we've been making this tactical progress, looking out decades in the physical planning for the facility and the academic and structural planning to make sure that we're in sync with each other, making sure that we've got the proper processes, procedures, practice doctors, professions, as we're building these new facilities that will serve the community and the state and hopefully the nation. So, I think it's very important to recognize the significance of the progress of the last several years and the foundational progress that we've made to be successful in the years forward. So I think that the medical center board, with leadership of the medical center, together we've been a supportive force to the medical center and have made significant changes which have produced significant positive results. And I think the outlook clearly is very, very, very bright. We should all celebrate how well we've done and recognize how lucky

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we are to have such an opportunity for the future. With that I'd like to adjourn this meeting and move into executive session.

Dr. Thompson:

Mr. Chairman, I have one resolution on the consent agenda that needs to be approved by the full board. May I have a motion? May I have a second? This is a voice vote.

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

Dr. Thompson:

The motion carries.

Mr. Chairman, I will attempt a motion to move us into recess for executive session to consider business-sensitive trade secrets required to be kept confidential by the federal and state statutes, to discuss quality matters which are required to be kept confidential under Ohio law, and to consult with legal counsel regarding pending or imminent litigation. May I have a motion? May I have a second? I need to call the role on this.

Upon motion of Mr. Shumate, seconded by Mr. Wexner, the Wexner Medical Board members adopted the foregoing motion by unanimous roll call vote, cast by board members Dr. McPheron, Mr. Chatas, Dr. Drake, Mr. Schottenstein, Mr. Steinour, Mrs. Wexner, Ms. Krueger, Dr. Reid, Mr. Shumate and Mr. Wexner.

The motion carries.

Attest:

Leslie H. Wexner
Chairman

Blake Thompson
Secretary

(ATTACHMENT XVI)

Project Data Sheet for Board of Trustees Approval

Wexner Medical Center Inpatient Hospital

OSU-180391 (CNI# 17000099)

Project Location: 12th Avenue & Cannon Drive



- **approval requested and amount**
professional services \$70.8M

- **project funding**
 - university debt
 - development funds
 - university funds
 - auxiliary funds (health system)
 - state funds
- **project schedule**

BoT professional services approval	2/18
Design (thru design development)	3/18 – 10/19
- **project delivery method**
 - general contracting
 - design/build
 - construction manager at risk

project team

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

Project Data Sheet for Board of Trustees Approval

Wexner Medical Center Inpatient Hospital

OSU-180391 (CNI# 17000099)

Project Location: 12th Avenue & Cannon Drive

- **planning framework**
 - project programming completed January 2018
 - the FY 2018 Capital Investment Plan will be amended to include professional services

- **project scope**
 - advance the next phase of design of a new inpatient hospital tower including complete design of two parking garages
 - up to 840 private-room beds, replacing and expanding on the 440 beds in Rhodes Hall and Doan Hall
 - state-of-the-art diagnostic, treatment and inpatient service areas (emergency department, imaging, operating rooms, critical care and medical/surgical beds)
 - leading-edge digital technologies to advance care and teaching
 - design to include elements to achieve LEED Silver rating and enhance patient care services

- **approval requested**
 - approval is requested to enter into professional services contracts

project team

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