WEXNER MEDICAL CENTER BOARD

Leslie H. Wexner
Janet B. Reid
W. G. Jurgensen
Cheryl L. Krueger
Abigail S. Wexner
David B. Fischer
Stephen D. Steinour
Robert H. Schottenstein
Alex Shumate (ex officio, voting)
Michael V. Drake (ex officio, voting)
Bruce A. McPheron (ex officio, voting)
Michael Papadakis (ex officio, voting)
K. Craig Kent (ex officio, non-voting)
L. Arick Forrest (ex officio, non-voting)
David P. McQuaid (ex officio, non-voting)
Mark E. Larmore (ex officio, non-voting)
Andrew M. Thomas (ex officio, non-voting)
Elizabeth O. Seely (ex officio, non-voting)
Susan D. Moffatt-Bruce (ex officio, non-voting)
Mary A. Howard (ex officio, non-voting)
William B. Farrar (ex officio, non-voting)
Martha C. Taylor (ex officio, non-voting)
Amanda N. Lucas (ex officio, non-voting)

Location: Richard M. Ross Heart Hospital
Ross Heart Hospital Auditorium

Time: 9:00am-2:00pm

Public Session

1.	Approval of January 31, 2018, Wexner Medical Center Board Meeting Minutes	9:00-9:05am
2.	Teaching and Learning: Medical Education and Service - Dr. Kent	9:05-9:30am
3.	Philanthropy Update - Ms. Hill-Callahan	9:30-9:45am
4.	The James/OSUCCC Update (verbal) - Dr. Farrar, Dr. Pollock	9:45-9:55am
5.	College of Medicine Report - Dr. Kent	9:55-10:05am
6.	Health System Operations Report (verbal) - Mr. McQuaid, Dr. Holliday	10:05-10:15am
7.	Health System Financial Summary - Mr. Larmore	10:15-10:25am
8.	Authorization to Purchase Real Property - Mr. Kasey	10:25-10:30am
9.	Authorization to Enter into Professional Services Contracts - Mr. Kasey	10:30-10:35am
10.	Amendments to the *Bylaws and Rules and Regulations of the Medical Staff:* University Hospitals and Arthur G. James Cancer Hospital - Ms. Krueger, Dr. Thomas	10:35-10:40am
11.	Approval for Verification of University Hospitals' Trauma Programs - Ms. Krueger, Dr. Thomas	10:40-10:45am

Executive Session 11:00am-2:00pm

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.

** ** **

Minutes of the last meeting were approved.

** ** **

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 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 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 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?

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 form 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.

(See Attachment XX for background information, page XX)

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 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 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-terms 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 then 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.

(See Attachment XX for background information, page XX)

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 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:

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 though 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.

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 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

Health Sciences Academy at East High School

THE OHIO STATE UNIVERSITY
COLLEGE OF MEDICINE

Anthony Vargas, David Allen, Jaron Hansen, Khaled Himed, Stephanie Choo

Needs Assessment

The objective of the Health Science Academies program is to facilitate improved outcomes in high school students in Columbus' Near East Side community by encouraging a healthier lifestyle and assisting in health care career development.

Columbus' Near East Side - Community Study, 2013

- 60% of adults had no post-high school education
- 25% of adults did not have a high school diploma or GED

Development Initiative, 2015

- Planning organization: Partners Achieving Community Transformation, PACT
- Objective: revitalize one of Columbus' most historic neighborhoods
  - Aim 1: Emphasis on health and wellness of all residents
  - Aim 2: 100% percent high school graduation rate by 2025

Community Revitalization

- Holistic Approach
  - Link between lack of education and increased crime, poverty, drug use and unemployment [1]
- Cradle to College
  - Program developed by charter school in Georgia
  - Focus on strong early childhood involvement coupled with preparation for college
  - Math competency increased from 5% to 98% after implementation

The Health Science Academies program hopes to continue implementing educational programs that encourage educational achievement and enable students to pursue health science occupations and post-secondary education.

[1] [Zimmerman et. Al., 2015]

Program Implementation

Program Logistics:

- Health Science Academy is a program designed to increase the number of students seeking advanced study in health sciences academic fields and increase student interest and achievement in career fields that require health sciences skills or other occupations within health industries (office/clerical, food service, maintenance).
- Our group was assigned to work with the students at East High School, and provide these students with exposure to various different healthcare fields through speakers, engaging presentations, and hands on activities.
- We also helped to work with the faculty and board members at East High School responsible with improving HSA, and we all brainstormed ways to make HSA more amenable for the students.
- We spoke to classes in the Columbus Public Schools district during career day to better understand students' knowledge of health science careers.
- Through these meetings we hoped to create a foundation of communication to facilitate future medical student efforts and expedite programing in the future.

Program Challenges:

- Communication and coordination between our team and the East High School faculty was unorganized and led to difficulties in scheduling.
- Medical student availability was prohibitive in recruiting sustainable volunteers to implement lessons.
- Differences in program expectations between our team and East High School organizers impeded longitudinal collaboration.
- The students seemed to be not interested during presentations.

Program Development/Planning

Purpose: To provide East High School students, grades 9 - 12, with exposure to a variety of healthcare fields and topics with the goal to increase student interest and achievement in career fields that require health sciences skills or other occupations within health industries.

Program Objectives:

Education: Create relationships with the core faculty and students of East High school and to create a framework for an Health-Professional Educational Series program

Measurability: Assess the knowledge and effectiveness of presentation material through pre- and post- surveys

Timeframe: Presentations were designed for implementation throughout the school year. The Application workshop framework was created with the intent to recruit volunteers to begin the program at the beginning of application cycle for summer opportunities, January 2018.

Program Development:

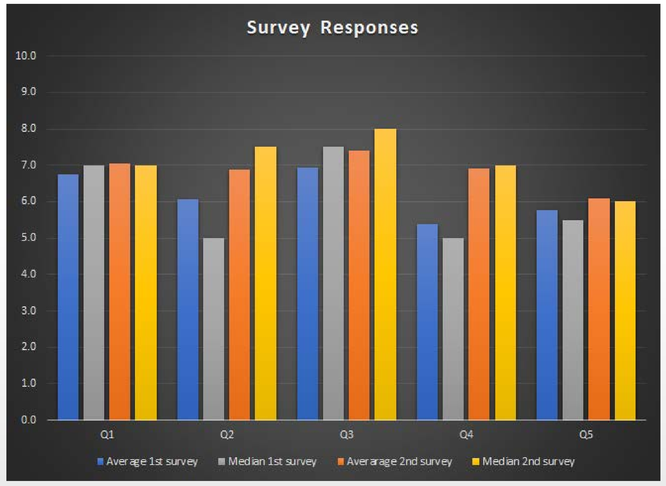
1. Presentations were developed to teach students about health career fields and to discuss resources for engaging in summer opportunities related to these professions.
2. Presentations focused on topics including "High School and beyond", "Health career professions- is there one right for me?", "Medical School - a students perspective", "Veterinary School- a students perspective", and "Dentistry School- a students perspective".
3. Meetings with East High School Board allowed discussion of scheduling Application workshops to assist the students in their applications for summer programs, internships, and college.
4. After creating the core curriculum, a larger body of health-professional students were recruited to assist in implementing the lessons and hands on activities.
5. Students in the program are evaluated for understanding about health-field careers, their interest in pursuing a health profession, and their willingness to utilize the resources and apply for educational programs in the health-field of interest.

Program Evaluation

Pre- and post-program surveys were administered to students in the East High School Health Science class with eighteen (18) and seventeen (17) students responding respectively. The pre-survey consisted of five (5) rating questions and the post-survey, six (6).

1. On a scale of 1 to 10, how familiar do you feel you are with careers in the health sciences?
2. On a scale of 1 to 10, how confident are you that you want to pursue a career in the health sciences?
3. On a scale of 1 to 10, how confident are you that you can obtain a career in the health sciences if that is what you choose to do?
4. On a scale of 1 to 10, how familiar are you with programs that can help you learn more about health science careers?
5. On a scale of 1 to 10, how likely are you to participate in a summer Health Science program such as OSU MD camp?
6. On a scale of 1 to 10, how likely are you to begin/continue attending the HSA club at East High School? The following table and corresponding graph summarize the numerical responses obtained by administering the survey to the same group of Health Science students at East High School.

The results of the surveys, visualized in the accompanying table and graph, indicate that our program had the greatest effect on increasing student confidence and desire to pursue a Health Professional career and interest in participating in the HSA school club. All responses showed an absolute increase demonstrating that our project had an overall positive effect on the students and their prospects in Health Professions.



Survey Responses						
	Question 1	Question 2	Question 3	Question 4	Question 5	Question 6
Pre-Program Survey Responses (n=18)						
Average	6.8	6.1	6.9	5.4	5.8	N/A
Median	7.0	5.0	7.5	5.0	5.5	N/A
stdev	1.2	2.4	2.3	2.5	3.2	N/A
Post-Program Survey Responses (n=17)						
Average	7.1	6.9	7.4	6.9	6.1	7.9
Median	7.0	7.5	8.0	7.0	6.0	10.0
stdev	1.4	2.7	2.5	2.4	3.5	2.7

Future Directions

Potential plans to continue and improve OSUCOM student involvement in Health Science Academies at East High School include, but are not limited to:

- Further implementation of a more structured lecture series, included guest lecturers for the following areas of medical careers
  - Nursing
  - Dentistry
  - Medicine
  - Veterinary
  - Physical Therapy
- Provide a more active role in the leadership of Health Science Academies, in particular in focusing how we can further find potential mentors for these students.
- Update the summer internship/opportunities list available to the students that was provided to the faculty leadership of the Health Science Academies
- Follow up by coordinating "Application Workshops", where we will provide these students an opportunity to work on applications/create resumes/college essays etc., in an environment where we can provide support and guidance
- Implement a structured Big sibling/little sibling opportunity for the students to have mentors from graduate students in a field in which they are potentially interested.

Implementing Health Education Workshops Improves Health Literacy among Low-income, Minority Children in Central Ohio

THE OHIO STATE UNIVERSITY
COLLEGE OF MEDICINE

Lauren Chen, YingYu Gao, Mayuran Ravindran, Melissa LeRoux, Charles Zhang, Francesca Brown[2]
The Ohio State University College of Medicine[1], Asian American Community Services[2]

Needs Assessment Summary

Healthy Asian Youth (HAY) is a combined after-school and summer program that offers a safe, educational environment for socioeconomically and academically disadvantaged K-12 youths from the Columbus metropolitan area. These children are predominantly Asian-American and African-American students who come from low-income schools and families, and lack access to quality education and healthy lifestyles.

Our CHE project aimed to integrate health education and wellness programs into the 8-week summer program curriculum by incorporating weekly nutrition, tobacco prevention, physical wellness, and mental wellness programs throughout the summer of 2017. Ultimately, we hoped to promote lifelong healthy behaviors and build rapport within the underserved community in Columbus.

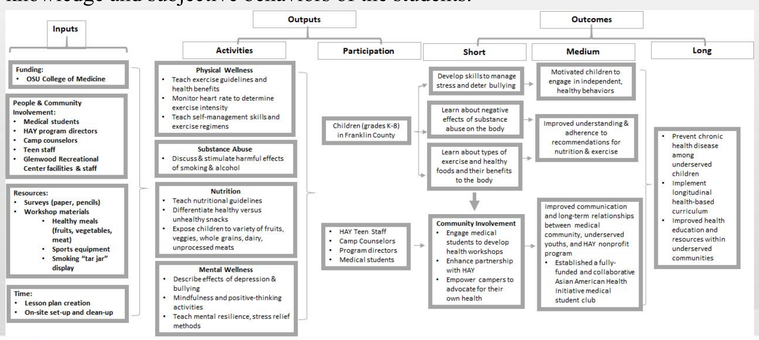
We chose these workshop topics based on the advice of the program directors and research regarding our specific population of underserved Asian American youth. The program director, Francesca Brown, suggested a tobacco prevention workshop as many of the older youth within the program smoke. We chose to do a nutrition workshop because South-East Asian Americans are three times as likely to be obese compared to Caucasian Americans (Kwon, SC) and diet and obesity is a contributor to disparities in a wide variety of chronic diseases and conditions (Satia , JA). Promotion of exercise and participation in physical activities were incorporated into our program because Asian Americans are among the least physically active major ethnic groups (Maxwell AE). Finally, we chose to incorporate a mental wellness workshop because youth populations (ages 10-24) are at a particularly high risk for psychiatric issues including depression and suicide (Campo JV).

Program Development/Planning

Based on the needs assessment, we designed a program to improve health literacy and form long-lasting healthy habits in minority, low-income children living in Columbus, OH. Specifically, we focused on areas of physical wellness, substance abuse, nutrition, and mental wellness.

To address these needs, we drafted a series of 4 workshops for the summer of 2017 to focus on educating the students on these points. Each workshop had an assigned team member as the leader of the activity. We then reviewed and revised these drafts with Francesca and the HAY staff to tailor our plans to the specific HAY site.

To measure the impact of these workshops, we developed a series of surveys administered both before and after each workshop as well as at the beginning and end of the 8-week summer program. These surveys measured both objective knowledge and subjective behaviors of the students.



Program Implementation

Four health education and wellness workshops were incorporated into HAY's 8-week summer program curriculum. Teaching points were emphasized at the start of each session and reviewed at the conclusion of group activities. Multiple choice pre- and post-session surveys were distributed to participating students before and after each session. An overall health behavior assessment survey was administered before the start of and after the program's completion.

Project Timeline
Mid-June - Mid-August

Week 1: Introduction and Nutrition Workshop

Sugar content of common drinks
Food groups and build-your-own healthy snack time

Week 3: Physical Wellness Workshop

Target heart rate and heart rate measurement
Playing outside vs electronic/TV time

Week 5: Mental Wellness and Cyber-Bullying Workshop

Good apple vs bruised apple
Stress ball assembly

Week 7: Tobacco and Alcohol Workshop

Anti-smoking - straw breathing race
Anti-alcohol - dizzy ball toss

Program challenges: The primary challenges encountered were inconsistent survey participation and completion due to intermittent summer camp attendance and low literacy levels, respectively. Thus, surveys were given immediately before and after workshops to maximize survey responses. In addition, questionnaires were verbalized to aid survey completion among younger children.

Program Evaluation

We administered surveys to gauge the effectiveness of each workshop. Selected results are shown.

Nutrition

	Importance of Eating Healthy	Rather Eat Healthy vs. Unhealthy	% Knew all food groups	% Answered that Sugary Drinks Rot Teeth
Pre-activity	4.4 (0.86)	3.4 (1.1)	56.9%	92.9%
Post-activity	4.5 (0.82)	3.5 (1.1)	77.1%	98.0%

Physical Wellness

	Importance of Exercise	Rather Play outside or inside
Pre activity	3.5 (1.2)	3.4 (1.4)
Post activity	3.8 (1.0)	3.8 (1.2)

	Hrs exercise/wk	Light exercise BPM	Heavy exercise BPM
Pre Activity	27%	11%	0%
Post Activity	53%	22%	6%

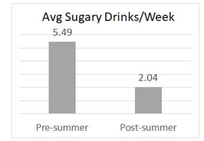
Mental Wellness

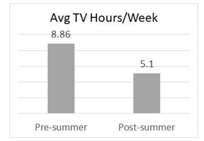
	Smoking	StdDev	Alcohol	StdDev
Pre-Test Avg	4.53	0.78	4.30	0.84
Post-Test Avg	4.65	0.67	4.45	0.79
Difference	0.12		0.15	

Substances

	Mood and Physical Health Connection	Stress Relief Strategies	% Children who have bullied someone	Forms of Bullying	Dealing with bullying	Total knowledge
Pre-activity knowledge	73.70%	71%	57.90%	68.40%	71%	68.4
Post- activity knowledge	100%	94%	66.70%	88.90%	88.90%	87.7

Behavior Change





Summary/Future Directions

Summary:
Implementing interactive workshops to teach health literacy and healthy habits to minority children from low-income families led to improved dietary, physical, and mental health knowledge and behaviors

Recommendations for Revisions:
Plan different activities for different age groups or ensure that activities are appropriate for all ages.

Opportunities for Future Use:
Establish a medical student organization in collaboration with HAY to enhance our ability to promote health-based education and preventative medicine

References

Campo JV. Youth suicide prevention: Does access to care matter? Curr Opin Pediatr 2009; 21(5):628-34

Kwon SC, Rideout C, Patel S, et al. Improving Access to Healthy Foods for Asian Americans, Native Hawaiians, and Pacific Islanders: Lessons Learned from the STRIVE Program. Journal of health care for the poor and underserved. 2015;26(2 0):116-136. doi:10.1353/hpu.2015.0063

Satia JA. DIET-RELATED DISPARITIES: UNDERSTANDING THE PROBLEM AND ACCELERATING SOLUTIONS. Journal of the American Dietetic Association. 2009;109(4):610-615. doi:10.1016/j.jada.2008.12.019.

Maxwell AE, Crespi CM, Alano RE, Sudan M, Bastani R. Health Risk Behaviors among Five Asian American Subgroups in California: Identifying Intervention Priorities. Journal of immigrant and minority health / Center for Minority Public Health. 2012;14(5):890-894. doi:10.1007/s10903-011-9552-8.

Metabolic Syndrome in the Ghanaian Community of Columbus

THE OHIO STATE UNIVERSITY
COLLEGE OF MEDICINE

Adejare, Aderinola; Lartey, Grace; Montfort, Janel; Ngombu, Stephany; Tolliver, Starling; Vu, Yalan; Sisters Across Borders.

Needs Assessment Summary

Sisters Across Borders (SAB) is an organization formed by healthcare providers dedicated to serving the African community. To date, SAB has provided health outreach, primarily to the Ghanaian community, through health screening at community events. Their goals to reduce morbidity and mortality through screening and self-directed programs, prompted our assessment of the health needs of the Ghanaian community in Columbus and how to meet these needs.

Components of Needs Assessment:

- Discussion with SAB members regarding health literacy and needs of the Ghanaian community
- Discussion with leaders in the Ghanaian community regarding customs for sharing information and social gatherings
- Review of literature regarding mortality of African Americans in Franklin County

Results:

- Although many members of the Ghanaian community have some level of education, health literacy can be improved.
- The Ghanaian community is concentrated in North Columbus, where most of their churches, businesses and ethnic organizations are located. Members rely on community events and other members to help them navigate the healthcare system.
- Metabolic syndrome encompasses many predisposing factors for conditions like CKD, HTN, and heart disease, which cause disproportionately higher mortality in Non-Hispanic African Americans in Franklin County[2, 3, 4]

Implications for Implementing Intervention:

- Intervention should include screening, along with lifestyle education to raise awareness and help reverse or prevent progression of metabolic syndrome.
- Utilization of resources from affiliated organizations (Ghanaian food pantry) that are more accessible to the community will encourage future use.
- Planning our events to coincide with other community events will allow us to meet our target population in their communal spaces, helping maximize event turnout.

Program Evaluation

Aim of Evaluation:

- To collect baseline data on the metabolic syndrome status of members of the Ghanaian community
- To assess knowledge of metabolic syndrome of members of the community pre-education and post-education.

Methods used:

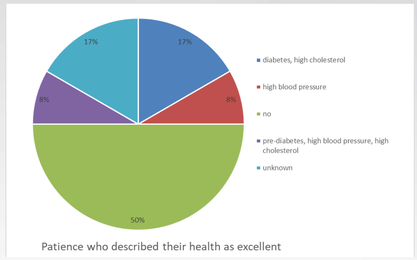
- Survey

Limitations:

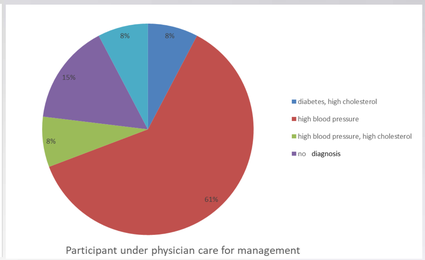
- The survey method relied on the participant's comprehension and interpretation of questionnaire and presumed honesty.
- Participants in the survey had other commitments and therefore came in at different times during the educational event. This made it difficult to track and assess.

Results

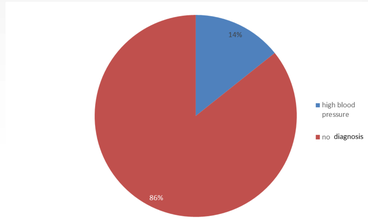
Presurvey



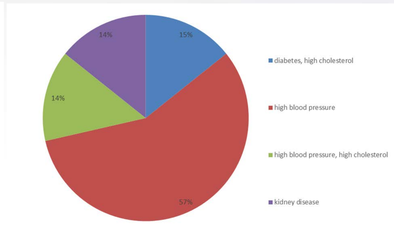
Patience who described their health as excellent



Participant under physician care for management

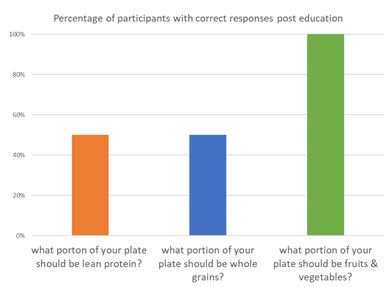


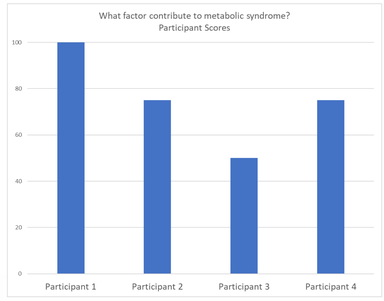
Participants with at least 20 mins of exercise 3x/week



Participants with at least 20 mins of exercise 3x/week

Postsurvey





Program Development/Planning

Purpose:

- Promote regular screening of metabolic syndrome
- Educate community on importance of reversing metabolic syndrome through diet changes

Objectives - SMART Criteria:

S - Specific	• Education on Metabolic Syndrome • Promote healthier alternatives within the African diet
M - Measurability	• Increased screening rates for metabolic syndrome and survey sampling
A - Attainability	• Events conducted at annual picnic and a local church
R - Realistic	• Partnering with SAB and local church facilitated programming
T - Time	• Timeline was determined at start of project, facilitating completion

Methods:

- Involved parties: OSUCOM students, SAB, audience at Annual Ghana Picnic, audience at Ebenezer Methodist Church
- Designed survey gathering baseline data on health of Ghanaian population in Columbus
- Surveys administered at Annual Ghana Picnic and final event at church in Columbus
  - Sample size: 31 people
- Conducted health screenings, an AfroBeats workout, a food demonstration on healthier alternatives, and a presentation on metabolic syndrome
- Survey results analyzed using excel to view trends in dietary habits and perceptions of health

Program Implementation

Students coordinated with SAB to develop strategies to best reach the Ghanaian community and facilitate implementation of the CHE project. Students also met with Central Ohio Diabetes Association (CODA) representatives to receive training and supplies for diabetes screenings.

Program Logistics:

- Students created an action plan focused on assessing metabolic syndrome risk factors and improving health literacy. To effectively reach the target audience, students coordinated with community members to partner in Ghanaian focused events including the Annual Ghana Picnic and Ebenezer Methodist Church Fair. Such partnerships provided increased access to the target community and increased the resources available for program implementation. During the planned events, students conducted blood pressure and diabetes screenings, an AfroBeats workout session, and administered pre-surveys assessing participants' health knowledge and health status. Three students conducted a presentation on the metabolic syndrome and cooking demonstration focused on healthy eating practices. Participants completed a post-survey assessing the impact of the presentations on their health knowledge.

Program Challenges:

- The challenges encountered were low attendance at the church fair and difficulty getting participants to complete both pre-and post surveys since some participants presented for screening during or after the presentations. We attempted to mitigate the effects of these challenges by adjusting our presentation timeline to ensure it fell within the time frame where event attendance was highest and focusing on ensuring participants who completed a pre-survey prior to the presentation also completed a post-survey. Additionally, some participants had difficulty completing the surveys due to language barriers. To address this issue, we enlisted the help of SAB and other community members to serve as translators.

Future Directions

<u>Suggestions for Health Fair at Annual Ghana Picnic</u>

- Hold AfroBeats workout later in afternoon to increase attendance
- Limit research survey to 2 pages and help participants fill out thoroughly
- Be mindful of language barrier and have designated translators available

<u>Suggestions for CHE Community Project:</u>

- Ensure proper advertisement for community event
- Manage event time frame so that participants are able to complete pre & post survey at the appropriate times to better gauge impact of implementation
- Provide additional follow-up for health screening participants with high metabolic disease risk factors
- Use other styles of educating such as teach back method using food models to ensure that participants grasp the information shared.

References

1. The Columbus Council on World Affairs. The Global Report 2012. [Ghanaians in Columbus]. 2012:44.
2. Agbemabiase P. The changing 'face' of African immigrants and refugees; the case of Ghanaian immigrants in Columbus, Ohio: 03/26/2017.
3. Moore JX, Chaudhary N, Akinyemiju T. Metabolic Syndrome Prevalence by Race/Ethnicity and Sex in the United States, National Health and Nutrition Examination Survey, 1988–2012. Prev Chronic Dis 2017;14:160287. DOI: http://dx.doi.org/10.5888/pcd14.160287
4. Bennett, Suellen. Unequal Health: The Black/White Gap in Franklin County. Columbus Public Health, Office of Assessment & Surveillance. https://www.columbus.gov/WorkArea/DownloadAsset.aspx?id=43162
5. Gaillard T, Schuster D, Osei K. Metabolic syndrome in black people of the African diaspora the paradox of current classification, definition and criteria. Ethn Dis. 2009;19(Supp 2):S2-1–7.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

CLINICAL PROGRAMS OF DISTINCTION

Head and Neck Cancer

Sports Medicine

Electrophysiology

Neuro-Oncology

Transplantation

Hematology

Robotic Surgery

Gynecologic Oncology

Pulmonary

Renal

Radiation Oncology

Stroke

Sarcoma

Skull Base Surgery

These criteria were used to identify Wexner Medical Center's clinical programs of distinction:

- Clinical volume
- National reputation
- Innovation
- Program differentiation
- Clinical trials

Head and Neck Cancer

Our team of head and neck cancer subspecialists spans a broad range of disciplines—from medical and radiation oncologists to head and neck surgeons, dentists, voice and swallowing specialists, molecular and biological pathologists, genetic scientists and more—all specializing in a specific type of head and neck cancer research, prevention, detection, treatment and cure.

Highlights:

- 6th highest volume in the country
- Otolaryngology – Head and Neck Cancer is ranked #6 by *U.S. News & World Report*

Sports Medicine

Our Sports Medicine program is a unique multidisciplinary center consisting of athletic trainers, physical therapists, physicians and researchers.

Highlights:

- National leader in clinical volume, training and reputation
- Developed innovative clinical procedures that have been adopted nationally
- Believed to be in top 10 percent nationally for research and clinical trials

Electrophysiology

The Electrophysiology program at the Ohio State Ross Heart Hospital comprises the largest group of electrophysiologists in Ohio, as well as more than 100 nursing staff dedicated to the care of patients with heart rhythm problems.

Highlights:

- One of the top five academic medical centers for volume
- A top enroller nationally in most electrophysiology clinical trials
- First in the nation to implant several arrhythmia devices
- Home to one of the only dedicated electrophysiology hybrid operating suites in the nation

Neuro-Oncology

Our brain cancer treatment team includes world-renowned subspecialists in the prevention, diagnosis, genetic sequencing and treatment of brain cancer.

Highlights:

- Highest volume in the state
- Multiple innovative clinical trials

Transplantation

Our Comprehensive Transplant Center has one of the largest organ transplant programs in the nation, performing more than 350 kidney, liver, pancreas, combined kidney-pancreas, heart and lung transplants each year.

Highlights:

- National leader in solid organ transplant at #16 for overall volume
- Kidney #11, lung anticipated to be in top 10
- Outcomes are significantly better than national averages and best in Ohio for several organs
- Multiple innovative clinical trials

Hematology

Our world-renowned hematology experts are transforming the way blood diseases are detected, prevented and treated.

Highlights:

- Site of innovative therapies that draw patients from throughout the world
- One of only a few centers nationally funded by the NCI to conduct both phase I and phase II clinical trials

Robotic Surgery

The Robotic Surgery program is multidisciplinary and led by more than 40 robotically skilled surgeons working in more than 11 different specialties. More than 200 residents and fellows are trained at OSU annually.

Highlights:

- Ranked #8 in the country among all health systems for volume and in top five for academic health systems
- First in the country to perform surgery with the da Vinci® robot
- Most experienced and comprehensive program in Ohio

Gynecologic Oncology

Our team of gynecologic cancer subspecialists spans a broad range of disciplines—from gynecologic oncology and radiation oncology to molecular and biological pathology, genetics and more—all specializing in a specific kind of gynecologic cancer research, prevention, detection, treatment and cure.

Highlight:

- One of the top five programs nationally based upon volume and resident training reputation

Pulmonary

Our Pulmonary Division is a national leader in acute respiratory distress syndrome, critical care, sarcoidosis and fundamental pulmonary biology.

Highlights:

- Ranked #25 by *U.S. News & World Report*
- Lung Volume Reduction Surgery Program was first in the nation to receive a two-year certificate of distinction from The Joint Commission

Renal

We are a national leader in treating glomerulonephritis, lupus and in interventional nephrology.

Highlights:

- Ranked #17 by *U.S. News & World Report*
- #11 nationally for kidney transplant

Radiation Oncology

Our Department of Radiation Oncology provides patients with cancer leading-edge radiation therapy in a caring, supportive environment with internationally recognized medical expertise, education and research.

Highlights:

- One of the top five in the country for patient volume
- Ranked #7 in the country for volume of cancer therapy clinical trials
- Received the Press Ganey Award in 2017 for highest patient satisfaction scores in the country
- Developed the first international training center for radiation oncology in the U.S.

Stroke

Largest stroke network in Ohio and in the top 10 nationally

Highlights:

- One of seven sites nationally participating in cutting-edge stroke clinical trials
- Our Stroke Rehabilitation Program provides comprehensive rehabilitative services for people who have experienced a stroke

Sarcoma

Our orthopedic and oncologic surgeons have created one of the most comprehensive sarcoma programs not only in the state of Ohio but in the United States.

Highlights:

- Highest volume in the state and one of the top 20 in the country
- Faculty have leadership roles in nearly every major sarcoma national academic society

Skull Base Surgery

We have a world-renowned, multidisciplinary team of skull base experts who are transforming the way skull base tumors are diagnosed and treated, optimizing outcomes for patients and improving their quality of life.

Highlights:

- Our surgeons pioneered and are internationally recognized leaders for several minimally invasive surgical approaches
- In fiscal year 2017 we welcomed 216 unique patients from 91 countries
- Since 2012 we have received over 200 international physician visits from 51 countries
- We host an international course on skull base surgery each year

Improving People's Lives Through Innovations in Personalized Health Care

Wexner Medical Center Board
Public Session
Health System Financial Summary

April 4, 2018

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

The Ohio State University Health System

Financial Highlights

For the YTD ended: February 28, 2018

Admissions	
Budget	0.5%
Prior Yr	4.4%
Actual	42,589
Budget	42,397
Prior Yr	40,795

Surgeries	
Budget	0.6%
Prior Yr	2.1%
Actual	29,547
Budget	29,371
Prior Yr	28,931

O/P Visits	
Budget	-0.2%
Prior Yr	3.0%
Actual	1,188,046
Budget	1,190,692
Prior Yr	1,153,385

Worked Hrs / Adjusted Admit	
Budget	-0.5%
Prior Yr	-1.4%
Actual	202
Budget	201
Prior Yr	199

The Ohio State University Health System

Financial Highlights

For the YTD ended: February 28, 2018

Operating Revenue	
Budget	2.8%
Prior Yr	10.0%
Actual	$1,965,283
Budget	$1,911,273
Prior Yr	$1,785,825

Controllable Costs	
Budget	-2.6%
Prior Yr	-8.5%
Actual	$1,520,097
Budget	$1,482,159
Prior Yr	$1,400,457

Excess Revenue over Expense	
Budget	12.8%
Prior Yr	43.2%
Actual	$154,734
Budget	$137,234
Prior Yr	$108,043

Days Cash on Hand		
Jun FY17	13.0%	
PY MTD	19.6%	
Actual	144.2	$984M
Jun FY17	127.6	$826M
PY MTD	120.6	$760M

The Ohio State University Health System

Consolidated Statement of Operations

For the YTD ended: February 28, 2018
(in thousands)

OSUHS	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
OPERATING STATEMENT						
Total Operating Revenue	$ 1,965,283	$ 1,911,273	$ 54,010	2.8%	$ 1,785,825	10.0%
Operating Expenses						
Salaries and Benefits	860,790	844,808	(15,982)	-1.9%	802,201	-7.3%
Resident/Purchased Physician Services	72,806	72,474	(332)	-0.5%	68,573	-6.2%
Supplies	209,140	204,300	(4,840)	-2.4%	196,123	-6.6%
Drugs and Pharmaceuticals	204,211	188,148	(16,063)	-8.5%	177,274	-15.2%
Services	205,937	204,811	(1,126)	-0.5%	187,778	-9.7%
Depreciation	103,582	105,197	1,615	1.5%	93,985	-10.2%
Interest	25,522	25,696	174	0.7%	26,676	4.3%
Shared/University Overhead	35,627	35,627	-	0.0%	32,696	-9.0%
Total Expense	1,717,615	1,681,061	(36,554)	-2.2%	1,585,306	-8.3%
Gain (Loss) from Operations (pre MCI)	247,670	230,210	17,460	7.6%	200,520	23.5%
Medical Center Investments	(100,593)	(99,926)	(667)	-0.7%	(98,430)	-2.2%
Income from Investments	7,409	6,949	460	6.6%	6,250	18.5%
Other Gains (Losses)	248	-	248	---	(297)	---
Excess of Revenue over Expense	$ 154,734	$ 137,234	$ 17,500	12.8%	$ 108,043	43.2%

The Ohio State University Health System

Consolidated Activity Summary

For the YTD ended: February 28, 2018

OSUHS	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
CONSOLIDATED ACTIVITY SUMMARY						
Activity						
Admissions	42,589	42,397	192	0.5%	40,795	4.4%
Surgeries	29,547	29,371	176	0.6%	28,931	2.1%
Outpatient Visits	1,188,046	1,190,692	(2,646)	-0.2%	1,153,385	3.0%
Average Length of Stay	6.39	6.22	(0.17)	-2.7%	6.28	-1.9%
Case Mix Index (CMI)	1.85	1.85	(0.00)	-0.2%	1.83	1.0%
Adjusted Admissions	80,129	79,128	1,002	1.3%	76,906	4.2%
Operating Revenue per AA	$ 24,526	$ 24,154	372	1.5%	$ 23,221	5.6%
Operating Expense per AA	$ 21,436	$ 21,245	(191)	-0.9%	$ 20,613	-4.0%

OSU Wexner Medical Center

Combined Statement of Operations

For the YTD ended: February 28, 2018
(in thousands)

	ACTUAL	BUDGET	ACT-BUD VARIANCE	BUDGET % VAR	PRIOR YEAR	PY % Var
Health System						
Revenues	$1,965,283	$1,911,273	$ 54,010	2.8%	$1,785,825	10.0%
Expenses	1,810,551	1,774,038	(36,513)	-2.1%	1,677,783	-7.9%
Net	154,734	137,234	17,500	12.8%	108,043	43.2%
OSUP						
Revenues	$ 283,252	$ 284,381	$ (1,129)	-0.4%	$ 267,597	5.9%
Expenses	276,781	286,241	9,460	3.3%	253,672	-9.1%
Net	6,471	(1,859)	8,330	448.1%	13,925	-53.5%
COM/OHS						
Revenues	$ 151,300	$ 153,683	$ (2,383)	-1.6%	$ 143,754	5.2%
Expenses	136,844	143,855	7,011	4.9%	128,331	-6.6%
Net	14,456	9,830	4,626	47.1%	15,423	-6.3%
Total Medical Center						
Revenues	$2,399,835	$2,349,337	$ 50,498	2.1%	$2,197,176	9.2%
Expenses	2,224,176	2,204,134	(20,042)	-0.9%	2,059,786	-8.0%
Net	175,661	145,205	30,456	21.0%	137,391	27.9%

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: February 28, 2018
(in thousands)

	February 2018	June 2017	Change
Cash	$ 904,546	$ 734,302	$ 170,244
Net Patient Receivables	429,670	410,404	19,266
Other Current Assets	425,083	395,833	29,250
Assets Limited as to Use	403,206	403,052	154
Property, Plant & Equipment - Net	1,493,757	1,503,002	(9,245)
Other Assets	449,649	428,241	21,408
Total Assets	$ 4,105,911	$ 3,874,834	$ 231,077
Current Liabilities	$ 382,637	$ 323,892	$ 58,745
Other Liabilities	120,542	93,741	26,801
Long-Term Debt	813,174	852,129	(38,955)
Net Assets - Unrestricted	2,195,926	2,026,145	169,781
Net Assets - Restricted	593,632	578,927	14,705
Liabilities and Net Assets	$ 4,105,911	$ 3,874,834	$ 231,077

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

April 4, 2018

APPROVAL FOR ACQUISITION OF UNIMPROVED REAL PROPERTY

LOCATED AT STATE ROUTE 161 AND HAMILTON ROAD
IN FRANKLIN COUNTY, OHIO

Synopsis: Authorization to purchase approximately 31.59 acres of unimproved real property located at the southeast corner of State Route 161 and Hamilton Road in Columbus, Franklin County, Ohio, is proposed.

WHEREAS the property is located at the southeast corner of State Route 161 and Hamilton Road in Columbus, Ohio; and

WHEREAS the property will be utilized for the construction of an ambulatory care facility, which is a key component of the Wexner Medical Center's strategic plan; and

WHEREAS the acquisition will be contingent upon the university obtaining entitlements allowing construction of medical facilities; and

WHEREAS it has been recommended by the Office of Planning and Real Estate, in coordination with the Wexner Medical Center, that the university purchase the land; and

WHEREAS funds for the acquisition will be provided by the Wexner Medical Center:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center hereby approves and proposes that the purchase of said property 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 take any action required to effect the sale of the property and to negotiate a purchase contract containing terms and conditions deemed to be in the best interest of the university.

APPROVAL FOR PURCHASE OF UNIMPROVED REAL PROPERTY
STATE ROUTE 161 AND HAMILTON ROAD
COLUMBUS, FRANKLIN COUNTY, OHIO

Background

The Ohio State University's Wexner Medical Center (WMC) seeks to acquire vacant land for development of additional ambulatory care facilities in Franklin County, Ohio. Acquisition of this land is important in meeting the objectives of the WMC's ambulatory care strategy, which is in turn a key component of the WMC strategic plan and its mission to improve health in Ohio and across the world through innovation in research, education and patient care.

Location and Description

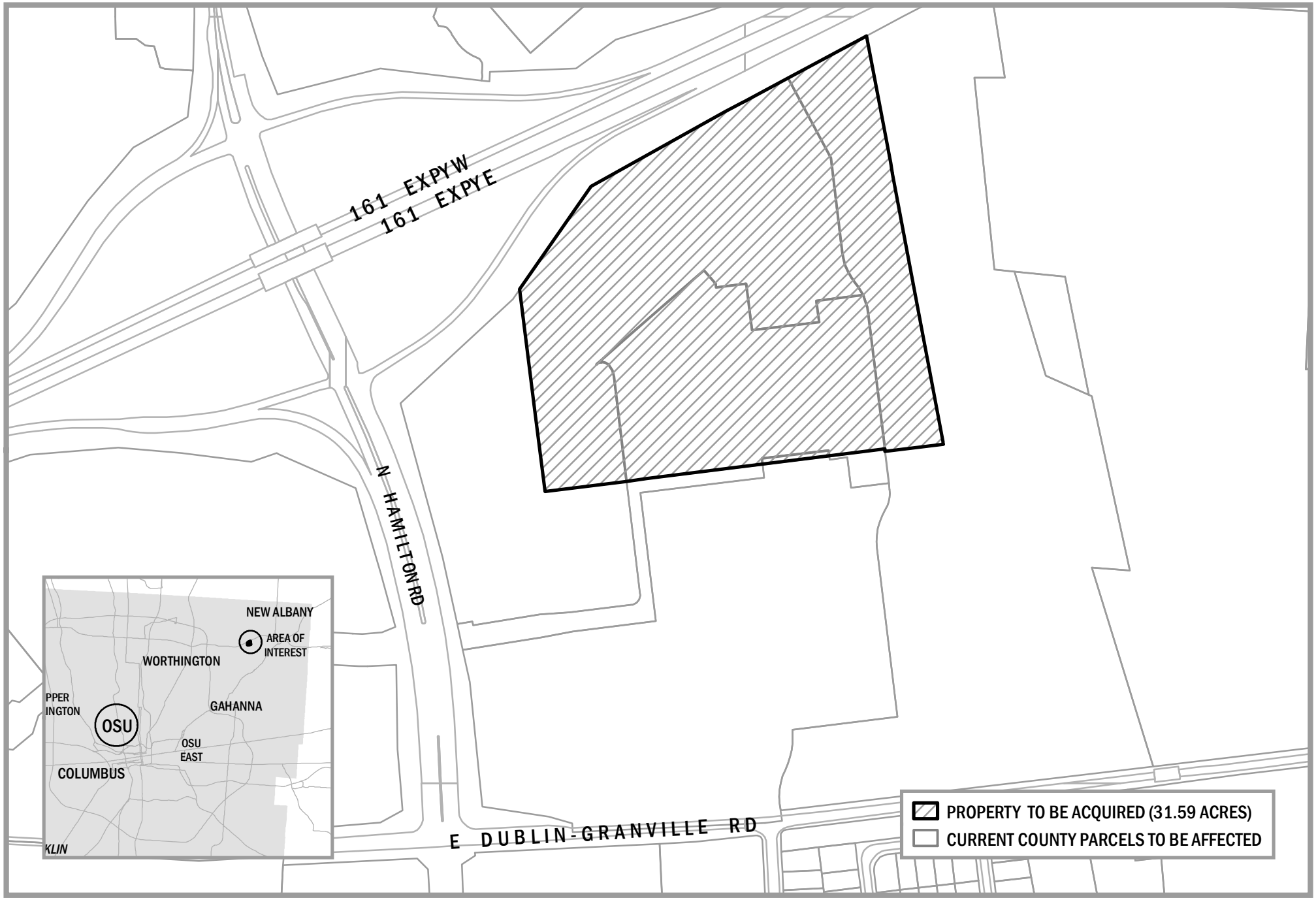
The property is located at the southeast corner of State Route 161 and Hamilton Road. The total land area being acquired is approximately 31.59 acres. The site is zoned CPD (Commercial Planned Development) and a rezoning application has been filed by The Ohio State University to obtain entitlements allowing construction of medical facilities. The purchase contract shall contain a contingency permitting the university to terminate the contract if it does not obtain the desired entitlements and shall also obligate the seller to perform certain site balancing work to elevate portions of the site out of the floodplain and additional infrastructure work.

Property History

The +/- 31.59 acres is currently comprised of portions of four legal parcels, and title to the properties is vested in HC Office Sub 6 LLC, Stephen L. Harper, Trustee, and Target Corporation. Prior to WMC's acquisition of the property, title will be consolidated to HC Office Sub 6 LLC, which will be the seller.

Purchase of Property

WMC recommends that the +/- 31.59 acres of unimproved real property described above be acquired on terms and conditions that are in the best interest of the university. The source of funding for the acquisition and subsequent development of the property will be the Wexner Medical Center. The acquisition price is $11,000,000, subject to appropriate adjustments and pro-rations at closing.



THE OHIO STATE UNIVERSITY

PURCHASE OF 31.59 ACRES OF REAL PROPERTY
SR-161 & HAMILTON RD
COLUMBUS, FRANKLIN COUNTY, OHIO 43054

Prepared By: The Ohio State University
Office of Planning and Real Estate
Issue Date: February 22, 2018
The Ohio State University Board of Trustees

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES CONTRACTS

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES CONTRACTS
Wexner Medical Center Regional Ambulatory Facilities

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; and

	Prof. Serv. Approval Requested	Total Project Cost	
WMC Regional Ambulatory Facilities	$4.0M	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.

WMC Regional Ambulatory Facilities

OSU-180636

Project Location: TBD

- **approval requested and amount**

professional services	$4.0M

- **project budget**

professional services	$4.0M
construction w/contingency	TBD
total project budget	TBD

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

- **project schedule**

BoT professional services approval	4/18
design	4/18
construction	TBD

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

- **planning framework**
  - o consistent with the strategic plans of the university and Wexner Medical Center to provide medical services within community-based ambulatory facilities
  - o conceptual site plan completed March 2018
  - o the FY 2018 Capital Investment Plan will be amended to include the professional services amount

- **project scope**
  - o design approximately 200,000 square foot ambulatory building that will include ambulatory surgery, endoscopy, primary care, specialty medical and surgical clinics, and related support
  - o site planning for a potential phase II is included in the scope
  - o the design is intended to provide a branded identity which could be deployed to additional future sites

- **approval requested**
  - o approval is requested to amend the FY2018 Capital Investment Plan
  - o approval is requested to enter into professional services contracts

---

- **project team**

University project manager:	Paul Lenz
AE/design architect:	TBD

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

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 October 9, 2017; 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 December 13, 2017; 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 January 5, 2018; 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 March 27, 2018:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Board hereby approves and proposes that the attached amendments to the *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.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

UH Bylaws Committee: 10.09.2017
MSAC: 12.13.2017
Medical Staff Vote: 01.05.2018
Quality & Professional Affairs: 3.27.2018
MC Board: 4.04.2018
UBOT: 4.06.2018

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

3335-43-01 Medical staff name.

No change.

3335-43-02 Purpose.

The purpose of the self-governing, democratically organized medical staff, which is accountable to the Ohio state university Wexner medical center board for the quality of care provided to the patients of the Ohio state university hospitals, shall be:

(A) - (D) No change.

(E) To govern medical staff and credentialed practitioners these bylaws are not intended to and shall not create any contractual rights between the Ohio state university Wexner medical center and any practitioner. Any and all contracts of affiliation, association or employment shall control contractual and financial relationships between the Ohio state university Wexner medical center and such practitioners.

(Board approval dates: 6/7/2002, 2/2/2007, 9/19/2008, 4/8/2011, 11/7/2014)

3335-43-03 Patients.

No change.

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,~~ All members, except for physician scholar medical staff, 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 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.

UH Bylaws Committee: 10.09.2017
MSAC: 12.13.2017
Medical Staff Vote: 01.05.2018
Quality & Professional Affairs: 3.27.2018
MC Board: 4.04.2018
UBOT: 4.06.2018

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) All members of the medical staff and credentialed providers must maintain continuous uninterrupted enrollment with all governmental health care programs.

(a) It shall be the duty of all medical staff members and credentialed providers to promptly inform the chief medical officer and the corporate credentialing office of any investigation, action taken, or the initiation of any process which could lead to an action taken by any governmental programs.

(b) Exclusion of any medical staff member or ~~licensed health care professional~~credentialed provider from participation in any federal or state government program or suspension from participation, in whole or part, in any federal or state government reimbursement program, shall result in immediate lapse of membership on the medical staff of the Ohio state university hospitals and the immediate lapse of clinical privileges at the Ohio state university hospitals as of the effective date of the exclusion or suspension. Medical staff members may submit a request to resign their medical staff membership to the Chief Medical Officer in lieu of automatic termination. The resignation in lieu of automatic termination shall be discussed at the next credentialing committee and medical staff administrative committee in order to provide recommendations to the Quality and Professional Affairs Committee of the Wexner Medical Center Board. A final determination should be decided by the Quality and Professional Affairs Committee at its next regular meeting.

(c) If the medical staff member's or credentialed provider's ~~licensed health care professional's~~ participation in ~~these~~ all governmental programs is fully reinstated, the affected medical staff member or ~~licensed health care professional~~credentialed provider shall be eligible to apply for

membership and clinical privileges at that time. ~~It shall be the duty of all medical staff members and licensed health care professionals to promptly inform the chief medical officer of any action taken, or the initiation of any process which could lead to such action taken by any of these programs.~~

(4) – (7) No change.

(B) – (F) No change.

(G) Resumption of clinical privileges following leave of absence.

(1) A member of the medical staff or credentialed provider shall request a leave of absence in writing for good cause shown such as medical reasons, educational and research reasons or military service to the chief of clinical service and the chief medical officer. Such leave of absence shall be granted at the discretion of the chief of the clinical service and the chief medical officer provided, however, such leave shall not extend beyond the term of the member's or credentialed provider's current appointment. A member of the medical staff or credentialed provider who is experiencing health problems that may impair his or her ability to care for patients has the duty to disclose such impairment to his or her chief of clinical department and the chief medical officer and the member or credentialed provider shall be placed on immediate medical leave of absence until such time the member or credentialed provider can demonstrate to the satisfaction of the chief medical officer that the impairment has been sufficiently resolved and can request for reinstatement of clinical activities. During any leave of absence, the member or credentialed provider shall not exercise his or her clinical privileges, and medical staff responsibilities and prerogatives shall be inactive.

(2) The member or credentialed provider must submit a written request for the reinstatement of clinical privileges to the chief of the clinical service. The chief of the clinical service shall forward his recommendation to the credentialing committee which, after review and consideration of all relevant information, shall forward its recommendation to the medical staff administrative committee and quality and professional affairs committee of the Wexner medical center board. The credentials committee, the chief medical officer, the chief of the clinical service or the medical staff administrative committee shall have the authority to require any documentation, including advice and consultation from the member's or credentialed provider's treating physician or the committee for practitioner health that might have a bearing on the medical staff member's or credentialed provider's ability to carry out the clinical and educational responsibilities for which the medical staff is seeking privileges. Upon return from a leave of absence for medical reasons the medical staff member or credentialed provider must demonstrate his or her ability to exercise his or her clinical privileges upon return to clinical activity.

(3) All members of the medical staff or credentialed providers who take a leave of absence for medical or non-medical reasons must be in good standing upon resumption of clinical activities. No member shall be granted leave of absence in excess or his or her current appointment and the usual procedures for appointment and reappointment, including deadlines for submission of application as set forth in this rule, will apply irrespective of the nature of the leave. Absence extending beyond his or her current term or failure to request reinstatement of clinical privileges shall be deemed a voluntary resignation from the medical staff and of clinical privileges, and in such event, the member or credentialed provider shall not be entitled to a hearing or appeal.

UH Bylaws Committee: 10.09.2017
MSAC: 12.13.2017
Medical Staff Vote: 01.05.2018
Quality & Professional Affairs: 3.27.2018
MC Board: 4.04.2018
UBOT: 4.06.2018

3335-43-05 Peer review and corrective action.

(A) Informal peer review.

(1) All medical staff members agree to cooperate in informal peer review activities that are solely intended to improve the quality of medical care provided to patients at the Ohio state university hospitals.

(2) Information indicating a need for informal review, including patient complaints, disagreements, questions of clinical competence, inappropriate conduct and variations in clinical practice identified by the clinical departments or divisions and medical staff committees shall be referred to the chair of the practitioner evaluation committee.

~~The practitioner evaluation committee chair or his or her designee will consult with the affected medical staff member and obtain information or opinions from knowledgeable persons within the medical center as well as external peer review consultants pursuant to criteria outlined in these bylaws.~~

(3) The practitioner evaluation committee chair or his or her designee may obtain information or opinions from medical staff members or credentialed providers as well as external peer review consultants pursuant to criteria outlined in these bylaws. The information or opinions from the informal peer review may be presented to the practitioner evaluation committee or another designated peer review committee.

~~(2)~~(4) Following the assessment by the practitioner evaluation committee chair or his or her designee, the practitioner evaluation committee may make recommendations for educational actions of additional training, sharing of comparative data or monitoring or provide other forms of guidance to the medical staff member to assist him or her in improving the quality of patient care. Such actions are not regarded as adverse, do not require reporting to any governmental or other agency, and do not invoke a right to any hearing.

~~(3)~~(5) At the conclusion of the evaluation, the practitioner evaluation committee chair or his or her designee submits a report to the applicable clinical department chief and the chief medical officer. The chief of the clinical department and the chief medical officer shall evaluate the matter to determine the appropriate course of action. They shall make an initial written determination on whether:

~~(1)~~ (a) The matter warrants no further action;

~~(2)~~ (b) Informal resolution under this paragraph is appropriate. The chief of the clinical department and the chief medical officer shall determine whether to include documentation of the informal resolution in the medical staff member's file. If documentation is included in the member's file, the affected member shall have an opportunity to review it and may make a written response which shall also be placed in the file. Informal review under this paragraph is not a procedural prerequisite to the initiation of formal peer review under paragraph (B) of this rule; or

~~(3)~~ (c) Formal peer review under paragraph (B) of this rule is warranted.

(6) In cases where the chief of the clinical department and chief medical officer cannot agree on the need for formal peer review, the matter shall be submitted for formal peer review and determined as set forth in paragraph (B) of this rule.

UH Bylaws Committee: 10.09.2017
MSAC: 12.13.2017
Medical Staff Vote: 01.05.2018
Quality & Professional Affairs: 3.27.2018
MC Board: 4.04.2018
UBOT: 4.06.2018

(B) Formal peer review.

(1) – (4) No change.

(5) The formal peer review committee shall investigate every request and shall deliver written findings and recommendations for action to the chief of the clinical department. ~~within 30 days.~~ The formal peer review committee may recommend a reduction, suspension or revocation of the medical staff member's clinical privileges or other action as it deems appropriate. In making its recommendation the formal peer review committee may consider, relevant literature and clinical practice guidelines, the opinions and views expressed throughout the review process, information or explanations provided by the member under review, and other relevant information. Prior to making its report, the committee shall afford the medical staff member against whom the action has been requested an opportunity for an interview. At such interview, the medical staff member shall be informed of the specific actions or omissions alleged to constitute grounds for formal peer review and shall be given copies of any statements, reports, opinions or other information compiled at prior stages of the proceedings. The medical staff member may furnish written or oral information to the formal peer review committee at this time and shall be given an opportunity to discuss, explain, or refute the allegations and to respond to any statements, reports or opinions previously compiled in the proceedings. However, such interview shall not constitute a hearing, but shall be investigative in nature. The medical staff member shall not be represented by an attorney at this interview. The written findings and recommendations for action are expected to be submitted within 90 days, unless an extension is deemed necessary by the committee.

(6) Upon receipt of the written report and recommendation from the formal peer review committee, the chief of the clinical department shall ~~within seven days~~ make his or her own written recommendation for corrective action and forward that recommendation along with the findings and recommendations of the formal peer review committee to the chief medical officer.

(7) The chief medical officer shall ~~have ten days to~~ decide whether to accept, reject or modify the recommendation of the chief of the clinical department. If the chief medical officer decides the grounds are not substantiated, the chief medical officer will notify the formal peer review committee, the chief of the clinical department, the person(s) who filed the complaint and the affected medical staff member, in writing, that no further action will be taken.

If the chief medical officer finds the grounds for the requested corrective action are substantiated, the chief medical officer shall promptly notify the affected medical staff member of that decision and the corrective action that will be taken. This notice shall advise the affected medical staff member of his or her right to request a hearing before the medical staff administrative committee pursuant to rule 3335-43-06 of the Administrative Code and shall also include a statement that failure to request a hearing in the timeframe prescribed in this rule shall constitute a waiver of rights to a hearing and to an appeal on the matter and the affected medical staff member shall also be given a copy of the rule 3335-43-06 of the Administrative Code. This notification and an opportunity to exhaust the administrative hearing and appeal process shall occur prior to the imposition of the proposed corrective action unless the emergency provisions outlined in paragraph (D) of this rule apply. This written notice by the chief medical officer shall be sent certified return receipt mail to the affected medical staff member's last known address as determined by university records.

UH Bylaws Committee: 10.09.2017
MSAC: 12.13.2017
Medical Staff Vote: 01.05.2018
Quality & Professional Affairs: 3.27.2018
MC Board: 4.04.2018
UBOT: 4.06.2018

(8) – (9) No change.

(C) – (D) No change.

(E) Automatic suspension and termination.

(1) – (2) No change.

(3) Failure to maintain the minimum required type and amount of professional liability insurance with an approved insurer, shall result in immediate and automatic suspension of a medical staff member's appointment and privileges until such time as proof of appropriate insurance coverage is furnished. In the event such proof is not provided within ten days of notice of such suspension, the medical staff member or credentialed provider shall be deemed to no longer comply with medical staff requirements under 3335-43-04 and automatically relinquish ~~voluntarily terminated~~ his or her appointment and privileges.

(4) Upon exclusion, debarment, or other prohibition from participation in any state or federal health care reimbursement program, or a federal procurement or non-procurement program, the medical staff member's appointment and privileges shall ~~be~~ immediately and automatically terminate, unless resignation in lieu of automatic terminations is permitted to rule 3335-43-04(A)(3). ~~suspended until such time as the exclusion, debarment, or prohibition is lifted.~~

(5) – (9) No change.

(F) No change.

3335-43-06 Hearing and appeal process.

(A) Right to hearing and to an appeal.

(1) When a member of the medical staff who has exhausted all remedies under paragraphs (E) and (F) of rule 3335-43-04 of the Administrative Code on appointment or reappointments; or under rule 3335-43-05 of the Administrative Code for corrective action; or who has been summarily suspended under paragraph (D) of rule 3335-43-05 of the Administrative Code, ~~or who receives notice of proposed action that will adversely affect membership on the medical staff or the exercise of clinical privileges (see paragraph (A)(6) of rule 3335-73-04 of the Administrative Code),~~ the staff member shall be entitled to an adjudicatory hearing.

(2) A medical staff member shall not be entitled to a hearing under the following circumstances:

(a) Denial by the Wexner medical center board to grant a waiver of board certification for a medical staff member.

(b) Termination of a medical staff member because of exclusion from participation in any government reimbursement program.

(c) Voluntary withdrawal of a medical staff application.

(d) Failure to submit a reappointment application.

UH Bylaws Committee: 10.09.2017
MSAC: 12.13.2017
Medical Staff Vote: 01.05.2018
Quality & Professional Affairs: 3.27.2018
MC Board: 4.04.2018
UBOT: 4.06.2018

(e) A leave of absence extending beyond current appointment or failure to request reinstatement of clinical privileges following a leave of absence.

(f) Actions or recommendations resulting from an informal peer review.

(g) Termination of courtesy B medical staff appointments upon approval by the Wexner medical center board.

(3) No change.

(B) - (E) No change.

3335-43-07 Categories of the medical staff.

The medical staff of the Ohio state university hospitals shall be divided into seven categories: physician scholar medical staff; attending medical staff; courtesy A medical staff; courtesy B medical staff; community affiliate medical staff; consulting medical staff; and limited staff. Medical staff members who do not wish to obtain any clinical privileges shall be exempt from the requirements of medical malpractice liability insurance, DEA registration, demonstration of recent active clinical practice during the last two years and specific annual education requirements as outlined in the list maintained in the chief medical officer's office, but are otherwise subject to the provisions of these bylaws.

(A) Physician scholar medical staff.

(1) Qualifications: The physician scholar medical staff shall be composed of those faculty members of the colleges of medicine and dentistry who are recognized for outstanding reputation, notable scientific and professional contributions, and high professional stature. This medical staff category includes but is not limited to emeritus faculty members. Nominations may be made to the chair of the credentialing committee who shall present the candidate to the medical staff administrative committee for approval.

(2) Prerogatives: Members of the physician scholar medical staff have access to the Ohio state university hospitals and shall be given notice of all medical staff activities and meetings. Members of the physician scholar medical staff shall enjoy all rights of an attending medical staff member except physician scholar members shall not possess clinical privileges.

(3) Physician scholar medical staff must have either a full license or an emeritus registration by the state medical board of Ohio.

(B) – (D) No change.

(E) Limited staff.

Limited staff are not considered full members of the medical staff, do not have delineated clinical privileges and do not have the right to vote in general medical staff elections. Except where expressly stated, members of the limited staff are bound by the terms of these bylaws, the rules and regulations of the medical staff, and the limited staff agreement.

(1) Qualifications

No change.

UH Bylaws Committee: 10.09.2017
MSAC: 12.13.2017
Medical Staff Vote: 01.05.2018
Quality & Professional Affairs: 3.27.2018
MC Board: 4.04.2018
UBOT: 4.06.2018

(2) Responsibilities:

(a) - (d) No change.

(f) Appeal by a member of the limited staff of probation, lack of ~~reappointment~~ promotion, suspension or termination for failure to meet expectations for professional growth or failure to display appropriate humanistic qualities or failure to successfully complete any other competency as required by the accreditation standards of an approved training program will be conducted and limited in accordance with written guidelines established by the respective department or training program and approved by the ~~medical~~program director and the Ohio state university hospitals graduate medical education committee as delineated in the limited staff agreement and by the graduate medical education policies.

Alleged misconduct by a member of the limited staff, for reasons other than failure to meet expectations of professional growth as outlined above, shall be handled in accordance with rules 3335-43-05 and 3335-43-06 of the Administrative Code.

(3) Failure to meet reasonable expectations.

~~Failure to meet reasonable expectations may result in sanctions including but not limited to probation, lack of reappointment, suspension or termination.~~ Termination of employment from the limited staff member's residency or fellowship training program ~~limited staff member status~~ shall result in automatic termination of the limited staff member's ~~residency or fellowship~~ appointment pursuant to these bylaws.

(4) Temporary appointments. No change.

(5) Supervision.
Limited staff members shall be under the supervision of an attending or courtesy A medical staff member. Limited staff members shall have no privileges as such but shall be able to care for patients under the supervision and responsibility of their attending or courtesy A medical staff member. The care they extend will be governed by these bylaws and the general rules and regulations of each clinical department. The practice of care shall be limited by the scope of privileges of their attending or courtesy A medical staff member. Any concerns or problems that arise in the limited staff member's performance should be directed to the attending or courtesy A medical staff member or the director of the training program.

(a) Limited staff members may ~~admit and~~ write admission, discharge and other orders for the care of patients under the supervision of the attending or courtesy A medical staff member.

(b) All records of limited staff member cases must document involvement of the attending or courtesy A medical staff member in the supervision of the patient's care to include co-signature of the admission order, history and physical, operative report, and discharge summary.

(F) - (H) No change.

(I) Clinical privileges.

(1) Delineation of clinical privileges. No change.

UH Bylaws Committee: 10.09.2017
MSAC: 12.13.2017
Medical Staff Vote: 01.05.2018
Quality & Professional Affairs: 3.27.2018
MC Board: 4.04.2018
UBOT: 4.06.2018

(2) Temporary privileges:

(a) Temporary privileges may be extended to a doctor of medicine, osteopathic medicine, dental surgery, psychologist, podiatry or to a licensed health care professional upon completion of an application prescribed by the medical staff administrative committee, upon recommendation of the chief of the clinical department, and approval by the chief medical officer. The chief medical officer ~~acting as a member and on behalf of the Wexner Medical Center board,~~ has been delegated responsibility by the Wexner medical center board to grant approval of temporary privileges. The temporary privileges granted shall be consistent with the applicant's training and experience and with clinical department guidelines. Prior to granting temporary privileges, primary source verification of licensure and current competence shall be required. Temporary privileges shall be limited to situations which fulfill an important patient-care need, and shall be granted for a period not to exceed one hundred twenty days.

(3) – (11) No change.

3335-43-08 Organization of the medical staff.

No change.

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

(A) – (D) No change.

(E) Election of officers.

(1) – (3) No change.

(4) The committee's nominees shall be submitted to all voting members of the attending staff no later than ~~March~~ May first of the election year.

(5) – (6) No change.

(F) – (G) No change.

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

(A) Chief medical officer.

The chief clinical officer functions as the chief medical officer as referred to herein these bylaws. The chief medical officer is the senior medical officer for the medical center with the responsibility and authority for all health and medical care delivered at the medical center. The chief medical officer is responsible for overall quality improvement and clinical leadership throughout the medical center, physician alignment, patient safety and medical staff development. The appointment, scope of authority, and responsibilities of the chief medical officer shall be as outlined in the Ohio state university Wexner medical center board bylaws.

(B) Chief quality and patient safety officer.

UH Bylaws Committee: 10.09.2017
MSAC: 12.13.2017
Medical Staff Vote: 01.05.2018
Quality & Professional Affairs: 3.27.2018
MC Board: 4.04.2018
UBOT: 4.06.2018

The chief quality and patient safety officer of the Ohio state university Wexner medical center is referred to herein these bylaws as the chief quality officer. The chief quality officer reports to the chief medical officer~~. for administrative and operational issues and has an independent reporting relationship to the executive vice president for health sciences regarding quality data and patient safety events~~. The chief quality officer works collaboratively with clinical leadership of the medical center, including the director of medical affairs for the James cancer hospital, nursing leadership and hospital administration. The chief quality officer provides leadership in the development and measurement of the medical center's approach to quality, patient safety and reduction of adverse events. The chief quality officer communicates and implements strategic, operational and programmatic plans and policies to promote a culture where patient safety is an important priority for medical and hospital staff.

(C) – (E) No change.

(F) Credentialing committee of the hospitals of the Ohio state university:

(1) Composition:

The credentialing responsibilities of medical staff are delegated to the credentialing committee of the hospitals of the Ohio state university, the composition of which shall include representation from the medical staff of each health system hospital.

The credentialing committee of the hospitals of the Ohio state university shall be appointed by the chief medical officer. The chief of staff, director of medical affairs ~~or~~ and medical directors of each ~~health system~~ hospital shall make recommendations to the chief medical officer for representation on the credentialing committee of the hospitals of the Ohio state university.

The credentialing committee of the hospitals of the Ohio state university shall meet at the call of its chair, who shall be appointed by the chief medical officer of the health system.

(2) Duties:

(a) – (d) No change.

(e) To make recommendations to the medical staff administrative committee through the ~~chief medical officer~~ chairperson of the credentialing committee regarding appointment applications and initial requests for clinical privileges. Such recommendations shall include the name, status, department (division), medical school and year of graduation, residency and fellowships, medical-related employment since graduation, board certification and recertification, licensure status as well as all other relevant information concerning the applicant's current competence, experience, qualifications, and ability to perform the clinical privileges requested;

(f) – (m) No change.

(3) No change.

(G) – (M) No change.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

UH Bylaws Committee: 10.09.2017
MSAC: 12.13.2017
Medical Staff Vote: 01.05.2018
Quality & Professional Affairs: 3.27.2018
MC Board: 4.04.2018
UBOT: 4.06.2018

3335-43-11 History and physical.

No change.

3335-43-12 Meetings and dues.

(A) Meetings.

The medical staff of the Ohio state university hospitals shall conduct scheduled meetings twice yearly. Notice of the meeting shall be sent to all medical staff at least two weeks prior to the meeting. Attendance is encouraged, but shall not be a requirement for continued medical staff membership and clinical privileges. Special and/or electronic meetings of the medical staff may be called at the option of the medical staff administrative committee.

3335-43-13 Amendments and adoption.

No change.

3335-43-14 Rules of construction.

No change.

APPENDIX I

No change.

APPENDIX II

No change.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Quality and Professional Affairs: 3.28.18
MC Board: 4.4.18
UBOT: 4.6.18

MEDICAL STAFF RULES AND REGULATIONS
The Ohio State University Hospitals

Updated September 2, 2016

84-01 Ethical pledge.

No change.

84-02 Admission procedures.

No change.

84-03 Attending assignment.

No change.

84-04 Consultations.

No change.

84-05 Privileges for giving orders.

No change.

84-06 Death and autopsy procedures.

No change.

84-07 Disaster plan.

No change.

84-08 Emergency care.

No change.

84-09 Surgical case review.

No change.

84-10 Tissue disposition.

No change.

84-11 Committees and policy groups.

No change.

Quality and Professional Affairs: 3.28.18
MC Board: 4.4.18
UBOT: 4.6.18

MEDICAL STAFF RULES AND REGULATIONS
The Ohio State University Hospitals

Updated September 2, 2016

84-12 Medical records.

(A)(1) – (5) No change.

(6) Records storage and security.

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

(7) – (10) No change.

84-13 Operating room committee.

No change.

84-14 Pharmacy and therapeutics committee.

No change.

84-15 Transfusion and isoimmunization committee.

No change.

84-16 Standards of practice.

No change.

84-17 Mechanism for changing rules and regulations.

No change.

84-18 Adoption of the rules and regulations.

No change.

84-19 Sanctions.

No change.

April 4, 2018

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

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 October 9, 2017, and the James Bylaws Committee on December 1, 2017; 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 December 8, 2017; 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 December 22, 2017; 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 March 27, 2018:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves and proposes that the attached 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 be recommended to the University Board of Trustees for approval.

The James

THE OHIO STATE UNIVERSITY
COMPREHENSIVE CANCER CENTER

UH and James Bylaws Committee: 10.09.17
James Bylaws Committee: 12.01.17
MSAC: 12.08.17
Medical Staff Vote: 12.22.17
Quality and Professional Affairs: 03.27.18
MC Board: 04.04.18
UBOT: 04.06.18

Bylaws of the Medical Staff of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute Chapter 3335-111

3335-111-01 Medical staff name.

No changes.

3335-111-02 Purpose.

(E) To govern medical staff credentialed practitioners and these Bylaws are not intended to and shall not create any contractual rights between the Ohio state university Wexner medical center and any practitioner. Any and all contracts of affiliation, association or employment shall control contractual and financial relationships between the Ohio state university Wexner medical center and such practitioners.

3335-111-03 Patients.

No changes.

3335-111-04 Membership.

(A) Qualifications.

(1) Membership on the medical staff of the CHRI is a privilege extended to doctors of medicine, osteopathic medicine, dentistry, and to practitioners of psychology and podiatry who consistently meet the qualifications, standards, and requirements set forth in the bylaws, rules and regulations of the medical staff, and the board of trustees of the Ohio state university. Membership on the medical staff is available on an equal opportunity basis without regard to race, color, creed, religion, sexual orientation, national origin, gender, age, handicap, genetic information or veteran/military status. Doctors of medicine, osteopathic medicine, dentistry, and practitioners of psychology and podiatry in faculty and administrative positions who desire medical staff membership shall be subject to the same policies and procedures as all other applicants for the medical staff.

(2) All members of the medical staff of the CHRI, except ~~community associate attending staff~~physician scholar medical 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 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.

(4) All members of the medical staff and credentialed providers must maintain continuous uninterrupted enrollment with all governmental healthcare programs. This includes any federal and state government programs.

(a) It shall be the duty of all medical staff members and credentialed providers to promptly inform the chief medical officer and the corporate credentialing office of any investigation, action taken, or the initiation of any process which could lead to an action taken by any governmental program.

(b) Exclusion of any medical staff member or ~~allied health professional~~ credentialed provider from participation in any federal or state government program or suspension from participation, in whole or in part, in any federal or state government reimbursement program, shall result in immediate lapse of membership on the medical staff of the CHRI and the immediate lapse of clinical privileges at the CHRI as of the effective date of the exclusion or suspension. Medical staff members may submit a request to resign their medical

staff membership to the Chief Medical Officer in lieu of automatic termination. The resignation in lieu of automatic termination shall be discussed at the next credentialing committee and medical staff administrative committee in order to provide recommendations to the Quality and Professional Affairs Committee of the Wexner Medical Center Board. A final determination should be decided by the Quality and Professional Affairs Committee at its next regular meeting.

~~(a)~~(c) If the medical staff member's or ~~allied health professional's~~ credentialed provider's participation in ~~these~~ all governmental programs is fully reinstated, the affected medical staff member or ~~allied health professional~~ credentialed provider shall be eligible to apply for membership and clinical privileges at that time. ~~It shall be the duty of all medical staff members and allied health professionals to promptly inform the director of medical affairs or medical director of credentialing of any action taken, or the initiation of any process, which could lead to such action taken by any of these programs.~~

(5) - (6) No Changes.

~~(7) Applicants for community associate attending medical staff category, practicing in a CHRI unit at another hospital, must have and maintain clinical privileges and active medical staff membership at that hospital~~.

(8) - (10) No Changes.

(B) Application for membership.

No Changes.

(C) Terms of appointment.

Initial appointment to the medical staff, except for the honorary category, shall be for a period not to exceed twenty-four months. An appointment or grant of privileges for a period of less than twenty-four months shall not be deemed an adverse action. During the first six months of the initial appointment, except medical staff appointments without clinical privileges, appointees shall be subject to focused professional practice evaluation (FPPE) in order to evaluate the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization pursuant to these bylaws. FPPE requires the evaluation by the clinical department chief with oversight by the credentials committee and the medical staff administrative committee. ~~In the case of community associate attendings, receipt of the positive evaluation provided by the clinical department chief in the primary hospital in which they hold privileges is required.~~

The provisional appointee identifies the primary hospital. Following the six month FPPE period, the clinical department chief may: (1) recommend the initial appointee to transition to ongoing professional practice evaluation (OPPE), which is described later in these bylaws to the medical staff administrative committee; (2) extend the FPPE period, which is not considered an adverse action, for an additional six months not to exceed a

total of twelve months for purposes of further monitoring and evaluation; or (3) terminate the initial appointee's medical staff membership and clinical privileges. In the event that the medical staff administrative committee recommends that an adverse action be taken against an initial appointee, the initial appointee shall be entitled to the provisions of due process as outlined in these bylaws.

(D) Professional ethics.

No Changes.

(E) Procedure for appointment.

(1) - (3) No Changes.

(4) The clinical department chief shall be responsible for investigating and verifying the character, qualifications and professional standing of the applicants by making inquiry of the primary source of such information and shall within thirty days of receipt of the completed application, submit a report of those findings along with a recommendation on medical staff membership and clinical privileges to the applicant's respective CHRI department chairperson and/or division director~~section chief~~. Licensed allied health professional applicants will have their clinical department chief's report submitted to the subcommittee of the credentials committee charged with review of applications for associates to the medical staff.

(5) The department chairperson and/or division director ~~section chiefs~~ shall receive all initial signed and verified applications from the appropriate clinical department chief and shall make a recommendation to the medical director of credentialing on each application. The medical director of credentialing shall make an initial determination as to whether the application is complete. The credentials committee, the medical staff administrative committee, the quality and professional affairs committee, and the Wexner medical center board have the right to render an application incomplete, and therefore not able to be processed, if the need arises for additional or clarifying information. The medical director of credentialing shall forward all completed applications to the credentials committee.

(6) - (11) No Changes.

(12) The recommendation of the medical staff administrative committee regarding an appointment decision shall be made within thirty days of receipt of the credentials committee recommendation and shall be communicated by the medical director of credentialing, along with the recommendation of the director of medical affairs, to the quality and professional affairs committee of the Wexner medical center board, and thereafter to the Wexner medical center board. When the Wexner medical center board has acted, the chair of the Wexner medical center board shall instruct the director of medical affairs to transmit the final decision to the clinical department chief, the applicant, and the respective department chairperson and/or division director~~section chief~~.

(13) No Changes.

UH and James Bylaws Committee: 10.09.17
James Bylaws Committee: 12.01.17
MSAC: 12.08.17
Medical Staff Vote: 12.22.17
Quality and Professional Affairs: 03.27.18
MC Board: 04.04.18
UBOT: 04.06.18

(14) The director of medical affairs, who may make a separate recommendation to the Wexner medical center board, shall directly communicate the final recommendation of the medical staff administrative committee to the Wexner medical center board. When the Wexner medical center board has acted, the director of medical affairs will transmit the final decision to the clinical department chief, the applicant, the respective department chairperson and/or division director~~section chief~~, and the Ohio state university board of trustees.

(F) Procedure for reappointment.

(1) No Changes.

(2) The reappointment application shall include all information necessary to update and evaluate the qualification of the applicant. The clinical department chief shall review the information available on each applicant for reappointment and shall make recommendations regarding reappointment to the medical staff and for granting of privileges for the ensuing appointment period. The clinical department chief's recommendation shall be transmitted in writing along with the signed and completed reappointment forms to the appropriate department chairperson and/or division director ~~section chief~~ at least forty-five days prior to the end of the individual's appointment. The terms of paragraphs (A), (B), (C), (D), (E)(1), and (E)(2) of this rule shall apply to all applicants for reappointment. Only completed applications for reappointment shall be considered by the credentials committee.

(3) - (4) No Changes.

(5) The clinical department chief shall submit a report of those findings along with a recommendation on reappointment to the applicant's respective CHRI department chairperson and/or division director~~section chief~~. Licensed allied health professional applicants will have their clinical department chief's report submitted to the subcommittee of the credentials committee charged with review of application for associates to the medical staff. The department chairperson and/or division director ~~section chief~~ shall review the reappointment application and forward to the medical director of credentialing with a recommendation for reappointment. The medical director of credentialing shall forward the reappointment forms and the recommendations of the clinical department chief and department chairperson and/or division director ~~section chief~~ to the credentials committee. The credentials committee shall review the request for reappointment in the same manner, and with the same authority, as an original application for medical staff membership. The credentials committee shall review all aspects of the reappointment application including source verification of the member's quality assurance record for continuing membership qualifications and for continuing clinical privileges. The credentials committee shall review each member's performance-based profile to ensure that all medical staff members deliver the same level of quality of care with similar delineated clinical privileges across all clinical departments and across all categories of medical staff membership.

(6) - (8) No Changes.

(9) The medical staff administrative committee shall review each request for reappointment in the same manner and with the same authority as an original application for appointment to the medical staff and shall accept, reject, or modify the request for reappointment in the same manner and with the same

authority as an original application. The recommendation of the medical staff administrative committee regarding reappointment shall be communicated by the medical director of credentialing, along with the recommendation of the director of medical affairs, to the quality and professional affairs committee of the Wexner medical center board, and thereafter to the Wexner medical center board. When the Wexner medical center board has acted, the chair of the Wexner medical center board shall instruct the director of medical affairs to transmit the final decision to the clinical department chief, the applicant, and the department chairperson and/or division director~~section chief~~.

(10) - (11) No Changes.

(G) Resumption of clinical activities following a leave of absence:

(1) A member of the medical staff or credentialed provider shall request a leave of absence in writing for good cause shown such as medical reasons, educational and research reasons or military service to the chief of clinical service and the director of medical affairs. Such leave of absence shall be granted at the discretion of the chief of the clinical service and the director of medical affairs provided, however, such leave shall not extend beyond the term of the member's or credentialed provider's current appointment. A member of the medical staff or credentialed provider who is experiencing health problems that may impair his or her ability to care for patients has the duty to disclose such impairment to his or her chief of clinical department and the director of medical affairs and the member or credentialed provider shall be placed on immediate medical leave of absence until such time the member or credentialed provider can demonstrate to the satisfaction of the director of medical affairs that the impairment has been sufficiently resolved and can request for reinstatement of clinical activities. During any leave of absence, the member or credentialed provider shall not exercise his or her clinical privileges, and medical staff responsibilities and prerogatives shall be inactive.

(2) The member or credentialed provider must submit a written request for the reinstatement of clinical privileges to the chief of the clinical service. The chief of the clinical service shall forward his recommendation to the credentialing committee which, after review and consideration of all relevant information, shall forward its recommendation to the medical staff administrative committee and the quality and professional affairs committee of the Wexner medical center board. The credentials committee, the director of medical affairs, the medical director of credentialing, the chief of the clinical service or the medical staff administrative committee shall have the authority to require any documentation, including advice and consultation from the member's or credentialed provider's treating physician or the committee for practitioner health that might have a bearing on the medical staff member's or credentialed provider's ability to carry out the clinical and educational responsibilities for which the medical staff is seeking privileges. Upon return from a leave of absence for medical reasons the medical staff member or credentialed provider must demonstrate his or her ability to exercise his or her clinical privileges upon return to clinical activity.

(3) All members or credentialed providers of the medical staff who take a leave of absence for medical or non-medical reasons must be in good standing on the medical staff upon resumption of clinical activities. No member shall be granted leave of absence in excess of his or her current appointment and the usual procedure for appointment and reappointment, including deadlines for submission of application as set forth in this rule will apply irrespective of the nature of the leave. Absence extending beyond his or her current term of failure to request reinstatement of clinical privileges shall be deemed a voluntary

resignation from the medical staff and of clinical privileges, and in such event, the member or credentialed provider shall not be entitled to a hearing or appeal.

(Board approval dates: 9/1/1993, 3/3/1995, 4/3/1996, 12/6/1996, 9/1/1999, 12/3/1999, 6/2/2000, 4/5/2002, 2/6/2004, 11/4/2005, 8/6/2007, 2/6/2009, 9/18/2009, 5/14/2010, 10/29/2011, 4/8/2011, 8/31/2012, 2/1/2013, 6/6/2014, 11/7/2014, 11/6/2015, 9/2/2016)

3335-111-05 Peer review and corrective action.

(A) Informal peer review.

(1) All medical staff members agree to cooperate in informal peer review activities that are solely intended to improve the quality of medical care provided to patients at the CHRI.

(2) Information indicating a need for informal review, including patient complaints, disagreements, questions of clinical competence, inappropriate conduct and variations in clinical practice identified by the clinical ~~sections~~ departments or divisions and medical staff committees shall be referred to the chair of the practitioner evaluation committee.

(3) The practitioner evaluation committee chair or his or her designee may obtain information or opinions from medical staff members or credentialed providers as well as external peer review consultants pursuant to criteria outlined in these bylaws. The information or opinions from the informal peer review may be presented to the practitioner evaluation committee or another designated peer review committee.

~~The practitioner evaluation committee chair, or his or her designee, will consult with the affected medical staff member and obtain information or opinions from knowledgeable persons within the medical center as well as external peer review consultants, pursuant to criteria outlined in these bylaws.~~

(4) Following the assessment by the practitioner evaluation committee chair or his or her designee, the practitioner evaluation committee may make recommendations for educational actions of additional training, sharing of comparative data or monitoring or provide other forms of guidance to the medical staff member to assist him or her in improving the quality of patient care. Such actions are not regarded as adverse, do not require reporting to any governmental or other agency, and do not invoke a right to any hearing.

(5) At the conclusion of the evaluation, the practitioner evaluation committee chair or his or her designee submits a report to the applicable clinical department chief and the director of medical affairs. The clinical department chief and the director of medical affairs shall evaluate the matter to determine the appropriate course of action. They shall make an initial written determination on whether:

~~(1)~~ (a) The matter warrants no further action;

~~(2)~~ (b) Informal resolution under this paragraph is appropriate. The clinical department chief and the director of medical affairs shall determine whether to include documentation of the informal resolution in the medical staff member's file. If documentation is included in the member's file, the affected member shall have an opportunity to review it and may make a written response which shall also be placed in the

file. Informal review under this paragraph is not a procedural prerequisite to the initiation of formal peer review under paragraph (B) of this rule; or

~~(3)~~ (c) ~~-~~Formal peer review under paragraph (B) of this rule is warranted. In cases where the clinical department chief and director of medical affairs cannot agree, the matter shall be submitted and determined as set forth in paragraph (B) of this rule.

(B) Formal peer review.

(1) No Changes.

(2) Formal peer review may be initiated by the clinical department chief, the department chairperson and/or division director~~section chief~~, the director of medical affairs, any member of the medical staff, the chief executive officer of the CHRI, the dean of the college of medicine, any member of the Wexber medical center board, or the vice president for health services. All requests for formal peer review shall be in writing, shall be submitted to the director of medical affairs, and shall be supported by reference to the specific activities or conduct which constitute grounds for the requested action.

(3) - (4) No Changes.

(5) The formal peer review committee shall investigate every request and shall report in writing ~~within thirty days~~ its findings and recommendations for action to the appropriate clinical department chief and notice given to the ~~section chief~~division director. In making its recommendation the formal peer review committee may consider as appropriate, relevant literature and clinical practice guidelines, all the opinions and views expressed throughout the review process, and any information or explanations provided by the member under review. Prior to making its report, the medical staff member against whom the action has been requested shall be afforded an opportunity for an interview with the formal peer review committee. At such interview, the medical staff member shall be informed of the specific activities alleged to constitute grounds for formal peer review, and shall be afforded the opportunity to discuss, explain or refute the allegations against the medical staff member. The medical staff member may furnish written or oral information to the formal peer review committee at this time. However, such interview shall not constitute a hearing, but shall be investigative in nature. The medical staff member shall not be represented by an attorney at this interview. The written findings and recommendations for action is expected to be submitted within 90 days, unless an extension is deemed necessary by the committee.

(6) Upon receipt of the written report from the formal peer review committee, the appropriate clinical department chief shall~~, within seven days,~~ make his or her own written determination and forward that determination along with the findings and recommendations of the formal peer review committee to the director of medical affairs, or if required by paragraph (B)(3) of this rule, to the executive vice president for health sciences or designee.

(7) Following receipt of the recommendation from the clinical department chief and the report from the formal peer review committee, the director of medical affairs, or the executive vice president for health sciences or designee, shall ~~have ten days to~~ approve or to modify the determination of the clinical department chief. Following receipt of the report of the clinical department chief, the director of medical

affairs or executive vice president for health sciences or designee shall decide whether the grounds for the requested corrective action are such as should result in a reduction, suspension or revocation of clinical privileges. If the director of medical affairs, or executive vice president for health sciences or designee, decides the grounds are not substantiated, the director of medical affairs will notify the formal peer review committee; clinical department chief and if applicable, the academic department chairperson; division director~~section chief~~; person(s) who filed the complaint and the affected medical staff member, in writing, that no further action will be taken.

In the event the director of medical affairs or executive vice president for health sciences or designee finds the grounds for the requested corrective action are substantiated, the director of medical affairs shall promptly notify the affected medical staff member of that decision and of the affected medical staff member's right to request a hearing before the medical staff administrative committee pursuant to rule 3335-111-06 of the Administrative Code. The written notice shall also include a statement that the medical staff member's failure to request a hearing in the timeframe prescribed in rule 3335-111-06 of the Administrative Code shall constitute a waiver of rights to a hearing and to an appeal on the matter; a statement that the affected medical staff member shall have the procedural rights found in rule 3335-111-06 of the Administrative Code; and a copy of the rule 3335-111-06 of the Administrative Code. This notification and an opportunity to exhaust the administrative hearing and appeal process shall occur prior to the imposition of the proposed corrective action unless the emergency provisions outlined in paragraph (D) of this rule apply. This written notice by the director of medical affairs shall be sent certified return receipt mail to the affected medical staff member's last known address as determined by university records.

(8) - (9) No Changes.

(C) Composition of the formal peer review committee.

No Changes.

(D) Summary suspension.

(1) Notwithstanding the provisions of this rule, a member of the medical staff shall have all or any portion of clinical privileges immediately suspended or appointment terminated by the chief executive officer or ~~section chief~~ department chairperson and/or division director, whenever such action must be taken when there is imminent danger to patients or to the patient care operations. Such summary suspension shall become effective immediately upon imposition and the chief executive officer will subsequently notify the medical staff member in writing of the suspension. Such notice shall be by certified return receipt mail to the affected medical staff member's last known address as determined by university records.

(2) No Changes.

(3) Immediately upon the imposition of a summary suspension, the chief executive officer in consultation with the appropriate ~~section chief~~ department chairperson and/or division director, shall have the authority to provide for alternative medical coverage for the patients of the suspended medical staff member who remain in the hospital at the time of suspension. The wishes of the patient shall be considered in the selection of such alternative medical coverage. While a summary suspension is in effect,

the member of the medical staff is ineligible for reappointment to the medical staff. Medical staff and hospital administrative duties and prerogatives are suspended during the summary suspension.

(E) Automatic suspension and termination~~.~~

(1) - (2) No Changes.

(3) Failure to maintain the minimum required type and amount of professional liability insurance with an approved insurer, shall result in immediate and automatic suspension of a medical staff member's appointment and privileges until such time as proof of appropriate insurance coverage is furnished. In the event such proof is not provided within ten days of notice of such suspension, the medical staff member or credentialed provider shall be deemed to no longer comply with medical staff requirements under 3335-111-04 and automatically relinquish ~~have voluntarily terminated~~ his or her appointment and privileges.

(4) Upon exclusion, debarment, or other prohibition from participation in any state or federal health care reimbursement program, or a federal procurement or non-procurement program, the medical staff member's appointment and privileges shall ~~be~~ immediately and automatically terminate, unless resignation in lieu of automatic terminations is permitted pursuant to rule 3335-43-04(A)(4). ~~suspended until such time as the exclusion, debarment, or prohibition is lifted.~~

(5) - (8) No Changes.

(Board approval dates: 9/1/1993, 5/2/1997, 9/1/1999, 10/1/1999, 12/3/1999, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 2/6/2009, 9/18/2009, 10/29/2011, 4/8/2011, 11/7/2014, 11/6/2015)

3335-111-06 Hearing and appellate review procedure

(A) Right to hearing before the medical staff administrative committee and to appellate review.

(1) When a member of the medical staff has exhausted remedies under paragraph (F) of rule 3335-111-04 of the Administrative Code on reappointments; or under rule 3335-111-05 of the Administrative Code for corrective action; or who has been summarily suspended under paragraph (D) of rule 3335-111-05 of the Administrative Code ~~receives notice of a proposed action by the chief executive officer or the director of medical affairs that will adversely affect reappointment as a member of the medical staff or the exercise of clinical privileges,~~ the staff member shall be entitled to an adjudicatory hearing.

(2) A medical staff member shall not be entitled to a hearing under the following circumstances:

(a) Denial of the Wexner medical center board to grant a waiver of board certification for a medical staff member.

(b) Termination of a medical staff member because of exclusion from participation in any government reimbursement program.

(c) Voluntary withdrawal of a medical staff application.

(d) Failure to submit a reappointment application.

(e) A leave of absences extending beyond current appointment or failure to request reinstatement of clinical privileges following a leave of absence.

(f) Actions or recommendations resulting from an informal peer review.

(g) Termination of courtesy B medical staff appointments upon approval by the Wexner medical center board.

(32) All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this rule to assure that the affected medical staff member is accorded all rights to which the member is entitled.

(B) Request for hearing.

No Changes.

(D) Conduct of hearing.

No Changes.

(E) Appeal process.

(1) - (6) No Changes.

(7) Any final decision by the Wexner medical center board shall be communicated by the chief executive officer by certified return receipt mail to the affected medical staff member at the member's last known address as determined by university records. The chief executive officer shall also notify in writing the executive vice president for health sciences, the dean of the college of medicine, the chief medical officer of OSU medical center, the vice president for health services, the director of medical affairs, chief of staff, the ~~section chief~~department chairperson and/or division director, clinical department chief and the academic department chairperson and the person(s) who initiated the request for formal peer review. The chief executive officer shall take immediate steps to implement the final decision.

(Board approval dates: 9/1/1993, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 2/6/2009, 9/18/2009, 10/29/2010, 4/8/2011, 11/7/2014, 11/6/2015)

3335-111-07 Categories of the medical staff.

The medical staff of the CHRI shall be divided into honorary, physician scholar, attending, associate attending, clinical attending, ~~community associate attending,~~ consulting medical staff and limited designations. All medical staff members with admitting privileges may admit patients in accordance with state law and criteria for standards

UH and James Bylaws Committee: 10.09.17
James Bylaws Committee: 12.01.17
MSAC: 12.08.17
Medical Staff Vote: 12.22.17
Quality and Professional Affairs: 03.27.18
MC Board: 04.04.18
UBOT: 04.06.18

of care established by the medical staff. Medical staff members who do not wish to obtain any clinical privileges shall be exempt from the requirements of medical malpractice liability insurance, DEA registration, demonstration of recent active clinical practice during the last two years and specific annual education requirements as outlined in the list maintained in the chief medical officer's office, but are otherwise subject to the provisions of these bylaws.

(A) Honorary staff.

The honorary staff will be composed of those individuals who are recognized for outstanding reputation, notable scientific and professional contributions, and high professional stature in an oncology field of interest. The honorary staff designation is awarded by the Wexner medical center board on the recommendation of the chief executive officer of the CHRI, executive vice president for health sciences, ~~section chief~~department chairperson and/or division director, or the credentials committee after approval by the medical staff administrative committee. This is a lifetime appointment. Honorary staff are not entitled to patient care privileges.

(B) Physician scholar medical staff.

(1) Qualifications: The physician scholar medical staff shall be composed of those faculty members of the colleges of medicine and dentistry who are recognized for outstanding reputation, notable scientific and professional contributions, and high professional stature. This medical staff category includes but is not limited to emeritus faculty members. Nominations may be made to the chair of the credentialing committee who shall present the candidate to the medical staff administrative committee for approval.

(2) Prerogatives: Members of the physician scholar medical staff shall have access to the CHRI and shall be given notice of all medical staff activities and meetings. Members of the physician scholar medical staff shall enjoy all rights of an attending medical staff member except physician scholar members shall not possess clinical privileges.

(3) Physician scholar medical staff must have either a full license or an emeritus registration by the State Medical Board of Ohio.

(C) Attending medical staff.

(1) Qualifications:

The attending staff shall consist of those regular faculty members of the colleges of medicine and dentistry who are licensed or certified in the state of Ohio, whose practice is at least seventy-five percent oncology and with a proven career commitment to oncology as demonstrated by the majority of the following:

Training, current board certification (as specified in paragraph (A)(5) of rule 3335-111-04 of the Administrative Code), publications, grant funding, other funding and experience (as deemed appropriate by the chief executive officer and the ~~section chief~~department chairperson and/or division director); and who satisfy the requirements and qualifications for membership set forth in rule 3335-111-04 of the Administrative Code.

(2) Prerogatives:

No Changes.

UH and James Bylaws Committee: 10.09.17
James Bylaws Committee: 12.01.17
MSAC: 12.08.17
Medical Staff Vote: 12.22.17
Quality and Professional Affairs: 03.27.18
MC Board: 04.04.18
UBOT: 04.06.18

(3) Responsibilities:

No Changes.

(D) Associate attending staff.

No Changes.

(E) Clinical attending staff.

(1) Qualifications:

The clinical attending staff shall consist of those clinical faculty members of the colleges of medicine and dentistry who have training, expertise, and experience in oncology, as determined by the chief executive officer in consultation with the ~~section chief~~ department chairperson or division director and who satisfy the requirements and qualifications for membership set forth in rule 3335-111-04 of the Administrative Code.

(2) Prerogatives:

No Changes.

(3) Responsibilities:

No Changes.

~~(F) Community associate attending staff.~~

~~(1) Qualifications:~~

~~The community associate attending staff shall consist of those applicants who do not have faculty appointments in any of the academic units of the Ohio state university and who are licensed in the state of Ohio and who satisfy the requirements and qualifications for membership set forth in rule 3335-111-04 of the Administrative Code. All applications for appointment and reappointment to the community associate attending staff shall be made to the chief executive officer for initial evaluation. The chief executive officer shall consult with the clinical department chief and the chairperson of the appropriate academic department and when appropriate may refer each application for completion of the appointment procedure in accordance with pertinent requirements of paragraph (E) or (F) of rule 3335-111-04 of the Administrative Code. The approval of the clinical department chief and the academic department chairperson or section chief shall not be required.~~

~~(2) Prerogatives:~~

~~The community associate attending staff members may:~~

~~(a) Provide consulting services to James patients.~~

~~(b) Admit patients when the primary diagnosis is cancer or cancer-related.~~

~~(c) Be free to exercise such clinical privileges as are granted pursuant to these bylaws.~~

~~(d) Attend all meetings of the medical staff as non-voting members and attend any and all medical staff or hospital education programs. The community associate attending staff member may not hold elected office in the medical~~

~~staff organization except to serve as a non-voting, ex-officio member of medical staff committees if appointed pursuant to these rules.~~

~~(3) Responsibilities:~~

~~The community associate attending staff members shall:~~

~~(a) Meet the basic responsibilities set forth in rules 3335-111-02 and 3335-111-03 of the Administrative Code.~~

~~(b) Retain responsibility within their care area of professional competence for the continuous care and supervision of each patient for whom the member is providing care, or arrange a suitable alternative for such care and supervision.~~

~~(c) Actively participate in such quality evaluation and monitoring activities as required by the staff and discharge such staff functions as may be required from time to time.~~

~~(d) Satisfy the requirements set forth in rule 3335-111-13 of the Administrative Code for attendance at staff meetings and meetings of those committees of which they are a member.~~

~~(e) Supervise members of the limited staff in the provision of patient care in accordance with accreditation standards and policies and procedures of approved clinical training programs.~~

(~~G~~F) Consulting medical staff.

No Other Changes.

(~~G~~H) Limited staff.

Limited staff are not considered members of the medical staff, do not have delineated clinical privileges, and do not have the right to vote in general medical staff elections. Except where expressly stated, limited staff are bound by the terms of these bylaws, rules and regulations of the medical staff and the limited staff agreement.

(1) Qualifications:

No Changes.

(2) Responsibilities:

The limited staff shall:

(a) No Changes.

(b) No Changes.

(c) Participate in the care of all patients assigned to the limited staff member under the appropriate supervision of a designated member of the attending medical staff in accordance with accreditation standards and policies and procedures of the clinical training programs. The clinical activities of the limited staff shall be determined by the program director appropriate for the level of education and training. Limited staff shall be permitted to perform only those services that they are authorized to perform by the member of the attending medical staff based

on the competence of the limited staff to perform such services. The limited staff may admit or discharge patients only when acting on behalf of the attending, associate attending or~~,~~ clinical attending ~~or community associate attending~~ medical staff. The limited staff member shall follow all rules and regulations of the service to which he or she is assigned, as well as the general rules of the CHRI pertaining to limited staff.

(d) No Changes.

(e) No Changes.

(f) Appeal by a member of the limited staff of probation, lack of ~~reappointment~~promotion, suspension or termination for failure to meet expectations for professional growth or failure to display appropriate humanistic qualities or failure to successfully complete any other competency as required by the accreditation standards of an approved training program will be conducted and limited in accordance with written guidelines established by the respective academic department or training program and approved by the program director ~~of medical affairs~~ and the Ohio state university's graduate medical education committee as delineated in the limited staff agreement and by the graduate medical education policies..

Alleged misconduct by a member of the limited staff, for reasons other than failure to meet expectations of professional growth as outlined above, shall be handled in accordance with rules 3335-111-05 and 3335-111-06 of the Administrative Code.

(3) Failure to meet reasonable expectations:

~~Failure to meet reasonable expectations may result in sanctions including but not limited to probation, lack of reappointment, suspension or termination.~~ Termination of employment from the limited staff member's residency or fellowship training program ~~limited staff member status~~ shall result in automatic termination of the limited staff member's ~~residency or fellowship~~ appointment pursuant to these bylaws.

(4) Temporary appointments:

(a) No Changes.

(b) No Changes.

(5) Supervision:

Limited staff members shall be under the supervision of an attending, associate attending~~,~~ or clinical attending ~~or community associate attending~~ medical staff member. Limited staff members shall have no privileges as such but shall be able to care for patients under the supervision and responsibility of their attending, associate attending or~~,~~ clinical attending ~~or community associate attending~~ medical staff member. The care they extend will be governed by these bylaws and the general rules and regulations of each clinical department. The practice of care shall be limited by the scope of privileges of their attending, associate attending~~,~~ or clinical attending ~~or community associate attending~~ medical staff member. Any

concerns or problems that arise in the limited staff member's performance should be directed to the attending, associate attending~~,~~ or ~~-~~clinical attending ~~or community associate attending~~ medical staff member or the director of the training program.

(a) Limited staff members may write admission, discharge and other orders for the care of patients under the supervision of the attending, associate attending or~~,~~ clinical attending ~~or community associate attending~~ medical staff member.

(b) All records of limited staff member cases must document involvement of the attending, associate attending~~,~~ or clinical attending ~~or community associate attending~~ medical staff member in the supervision of the patient's care to include co-signature of the admission order history and physical, operative report, and discharge summary.

(H~~I~~) Associates to the medical staff.

No Other Changes.

(I~~J~~) Temporary medical staff appointment.

No Other Changes.

(J~~K~~) Clinical privileges.

(1) Delineation of clinical privileges:

(a) No Changes.

(b) Each clinical department and CHRI ~~section~~ department and/or division shall develop specific clinical criteria and standards for the evaluation of privileges with emphasis on invasive or therapeutic procedures or treatment which represent significant risk to the patient or for which specific professional training or experience is required. Such criteria and standards are subject to the approval of the medical staff administrative committee and the Wexner medical center board.

(c) - (i) No Changes.

(2) Temporary and special privileges:

(a) Temporary privileges may be extended to a doctor of medicine, osteopathic medicine, dental surgery, psychologist, podiatry or to a licensed allied health professional upon completion of an application prescribed by the medical staff administrative committee, upon recommendation of

the chief of the clinical department, and approval by the director of medical affairs. The director of medical affairs~~, acting as a member and on behalf of the Wexner medical center board,~~ has been delegated responsibility by the Wexner medical center board to grant approval of temporary privileges. The temporary privileges granted shall be consistent with the applicant's training and experience and with clinical department guidelines. Prior to granting temporary privileges, primary source verification of licensure and current competence shall be required. Temporary privileges shall be limited to situations which fulfill an important patient care need and shall not be granted for a period not to exceed one hundred twenty days.

(b) - (g) No Changes.

(3) Expedited privileges:

No Changes.

(4) Podiatric privileges:

No Changes.

(5) Psychology privileges:

No Changes.

(6) Dental privileges:

No Changes.

(7) Oral and maxillofacial surgical privileges:

No Changes.

(8) Licensed allied health professionals:

No Changes.

(9) Emergency privileges:

No Changes.

UH and James Bylaws Committee: 10.09.17
James Bylaws Committee: 12.01.17
MSAC: 12.08.17
Medical Staff Vote: 12.22.17
Quality and Professional Affairs: 03.27.18
MC Board: 04.04.18
UBOT: 04.06.18

(10) Disaster privileges:

No Changes.

(11) Telemedicine:

No Changes.

(Board approval dates: 9/1/1993, 3/3/1995, 4/3/1996, 12/6/1996, 9/1/1999, 12/3/1999, 6/2/2000, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 7/7/2006, 8/6/2006, 2/6/2009, 9/18/2009, 5/14/2010, 10/29/2011, 4/8/2011, 8/31/2012, 2/1/2013, 11/7/2014, 11/6/2015)

3335-111-08 Organization of the CHRI medical staff.

(A) The chief executive officer.

No Changes.

(B) The director of medical affairs (physician-in-chief/chief medical officer of the James cancer hospital).

(1) Method of appointment:

The director of medical affairs shall be appointed by the executive vice president for health sciences upon recommendation by the chief executive officer of the James Cancer Hospital. The director of medical affairs is the physician-in-chief and shall be the chief medical officer of the CHRI and must be a member of the attending medical staff of the CHRI.

(2) Responsibilities:

The director of medical affairs shall report to the chief executive officer~~, the executive vice president for health sciences, the CHRI hospital board,~~ and the Wexner medical center board for the quality of patient care provided in the CHRI. The director of medical affairs shall assist the chief executive officer in the administration of medical affairs including quality assurance and credentialing. In addition, the director of medical affairs ~~will decide~~ determines~~the~~ initial ~~attending status~~ medical staff category appointments, ~~and~~ reappointments and any changes in categories of the medical staff. ~~ongoing categorization of CHRI faculty~~.

(C) The chief medical officer of the Ohio state university medical center.

The chief medical officer of the Ohio state university medical center is the senior medical officer for the medical center with the responsibility and authority for all health and medical care delivered at the medical center. The chief medical officer is responsible for overall quality improvement and clinical leadership throughout the medical center, physician alignment, patient safety and medical staff development. The appointment, scope of authority,

UH and James Bylaws Committee: 10.09.17
James Bylaws Committee: 12.01.17
MSAC: 12.08.17
Medical Staff Vote: 12.22.17
Quality and Professional Affairs: 03.27.18
MC Board: 04.04.18
UBOT: 04.06.18

and responsibilities of the chief medical officer shall be as outlined in the Ohio state medical center board bylaws. The director of medical affairs will work collaboratively with the chief medical officer and medical directors of each hospital of the medical center for the: coordination and supervision of patient care and clinical activities, responsibility for the clinical organization of his or her respective hospital, and to establish priorities, jointly with the chief executive officer or executive director of his or her respective hospital, for capital medical equipment, clinical space, and the establishment of new clinical programs, or the revision of existing clinical programs.

(D) The chief quality officer of the Ohio state university medical center.

The chief quality and patient safety officer of the Ohio state university medical center is referred to herein these bylaws as the chief quality officer. The chief quality officer reports to the chief medical officer ~~for administrative and operational issues and has an independent reporting relationship to the executive vice president for health sciences regarding quality data and patient safety events~~. The chief quality officer works collaboratively with clinical leadership of the medical center, including medical director of quality for the CHRI, director of medical affairs for the CHRI, nursing leadership and hospital administration. The chief quality officer provides leadership in the development and measurement of the medical center's approach to quality, patient safety and reduction of adverse events. The chief quality officer communicates and implements strategic, operational and programmatic plans and policies to promote a culture where patient safety is an important priority for medical and hospital staff.

(E) Medical director of credentialing.

No Changes.

~~(F) Associate physician-in-chief.~~

~~The associate to the physician-in-chief oversees the alignment of clinical service lines within the cancer program. The associate serves at the direction of the physician-in-chief to further the global cancer mission at OSU. The role functions as a key strategic liaison between the physician-in-chief, chief of staff and the medical staff to strategically grow the footprint of the cancer program. The associate physician-in-chief reports to the physician-in-chief of the James.~~

(~~G~~F) Medical director ~~of surgical services~~, James surgical services.

The ~~chief of surgical services~~medical director, James surgical services has oversight of all James designated perioperative services and procedural suites. Working collaboratively with the administrator of perioperative services, the ~~chief of surgical services~~medical director, James surgical services facilitates the timely sharing of OR resources (including personnel and equipment) across the medical center in order to maximize the efficiency of OR services. The ~~chief of surgical services~~medical director, James surgical services works with clinical service lines and clinical leadership to coordinate OR services in a manner that enhances the quality of care and safety of services for patients. The ~~chief of surgical services~~medical director, James surgical services reports to the ~~physician-in-chief~~Director of medical affairs of the James.

UH and James Bylaws Committee: 10.09.17
James Bylaws Committee: 12.01.17
MSAC: 12.08.17
Medical Staff Vote: 12.22.17
Quality and Professional Affairs: 03.27.18
MC Board: 04.04.18
UBOT: 04.06.18

~~-~~(H) ~~The sections.~~Professional assignments

Each member of the attending, associate attending, clinical, limited, physician scholar and honorary staff shall be assigned to a ~~CHRI section~~ division and/or department by the chief executive officer upon the recommendation of the appropriate academic department chairperson and the credentials committee.

~~There are four clinical sections: medical oncology, surgical oncology, radiation oncology and pathology.~~ Appointment to a specific ~~section~~ department and/or division ~~-~~is based on the clinical specialty of the applicant for medical staff membership. Each ~~section~~ department and/or division ~~-~~is headed by a ~~section chief~~ department chairperson or division director who has the responsibility to oversee all research and clinical activities conducted by members of the ~~section~~ department and/or division. Specifically, the ~~section chief~~ department chairperson or division director shall be responsible for the following: the development and implementation of policies and procedures that guide and support the provision of service; recommendations re: staffing needs and clinical privileges for all members appointed to the ~~section~~ department and/or division; the orientation and continuing surveillance of the professional performance of all ~~section~~ department and/or division members; recommendation for space and other resources needed. ~~The section chiefis appointed by the chief executive officer.~~

(I) Clinical department chief.

No Changes.

(Board approval dates: 9/1/1993, 3/3/1995, 12/6/1996, 12/3/1999, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 7/7/2006, 2/6/2009, 9/18/2009, 5/14/2010, 2/11/2011, 4/8/2011, 8/31/2012, 2/01/2013, 6/6/2014, 11/6/2015)

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 ~~physician-in-chief~~director of medical affairs and chief of staff-elect for approval by the CHRI medical staff administrative committee.

(5) - (6) No Changes.

UH and James Bylaws Committee: 10.09.17
James Bylaws Committee: 12.01.17
MSAC: 12.08.17
Medical Staff Vote: 12.22.17
Quality and Professional Affairs: 03.27.18
MC Board: 04.04.18
UBOT: 04.06.18

(B) Chief of staff-elect.

No Changes.

(C) Delegates at-large.

Up to two additional at-large member(s) may be appointed to the ~~-~~medical staff administrative committee at the recommendation of the chief executive officer of the CHRI, subject to the approval of the medical staff administrative committee and subject to review and renewal ~~on a yearly basis~~ every two years. ~~There shall be two delegates at-large that are members of the medical staff. Each delegate at large shall be a member of the medical staff administrative committee and shall serve on those committees of the medical center board as appointed by the chairperson of the medical center board.~~

(D) Qualifications of officers.

(1) Officers must be members of the attending or associate attending staff at the time of their nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

(2) The chief executive officer and director of medical affairs, chiefs of the clinical departments, ~~department chairperson~~ or division director~~section chiefs~~, medical directors, associate and/or assistant medical directors are not eligible to serve as chief of staff or chief of staff-elect unless they are replaced in their CHRI administrative role during the period of their term of office.

(E) Election of officers.

(1) - (3) No Changes.

(4) The committee's nominees will be submitted by electronic or written ballot to all voting members of the medical staff no later than ~~April~~May.

(5) Candidates for the office of chief of staff-elect will be listed and each attending ~~or associate attending~~ staff member may vote for one. ~~Candidates for the at-large positions will be voted upon as a group. Each voting member of the medical staff may vote for two at-large candidates. The two candidates with the highest number of votes will be elected. A majority of the votes is not necessary.~~

(6) No Changes.

(F) Term of office.

The James

THE OHIO STATE UNIVERSITY
COMPREHENSIVE CANCER CENTER

UH and James Bylaws Committee: 10.09.17
James Bylaws Committee: 12.01.17
MSAC: 12.08.17
Medical Staff Vote: 12.22.17
Quality and Professional Affairs: 03.27.18
MC Board: 04.04.18
UBOT: 04.06.18

No Changes.

(G) Vacancies in office.

(1) - (2) No Changes.

(3) Vacancies in the at-large representatives' positions will be filled by appointment by the ~~chief of staff~~ chief executive officer.

(Board approval dates: 9/1/1993, 3/3/1995, 12/6/1996, 9/1/1999, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 2/6/2009, 9/18/2009, 2/11/2011, 4/8/2011, 6/6/2014, 9/2/2016)

3335-11-10 Administration of the medical staff of the CHRI

Medical staff committees.

(A) - (B) No Changes.

(C) Medical staff administrative committee:

(1) Composition:

(a) Voting membership includes: chief of staff, chief of staff-elect, immediate past chief of staff, ~~section chiefs~~ clinical department chief ~~chairperson~~ or division director of medical oncology, radiation oncology, ~~surgical oncology, and~~ anatomic pathology and molecular pathology;~~;~~ ~~division chiefs of~~ department chairperson or division director of hematology, gynecologic oncology, otolaryngology/head and neck, hospital medicine, human genetics, infectious diseases, surgical oncology, thoracic surgery, neurological oncology, orthopaedic oncology/sarcoma, pulmonary, critical care and sleep medicine and urology; medical director of James emergency services; clinical department chiefs of anesthesia, physical medicine and rehabilitation, plastic surgery, psychiatry, and radiology; CHRI medical director of quality, CHRI medical director of credentialing, CHRI chief executive officer, CHRI director of medical affairs, director of the division of palliative medicine, chairperson of the cancer subcommittee, CCC director for clinical research, ~~and~~ CCC director for cancer control, and medical director of the James surgical services ~~and associate director of James surgical services~~. Up to two additional at-large member(s) may be appointed to the MSAC at the recommendation of the chief executive officer of the CHRI, subject to the approval of the medical staff administrative committee and subject to review and renewal on a yearly basis. If a division ~~or section head~~chairperson ~~or~~ director is a member by

leadership position, he or she will also fulfill the role of division ~~or section~~ ~~department~~ ~~chief~~ director appointment. The director of medical affairs shall be the chairperson and the chief of staff shall be the vice-chairperson.

(b) Ex-officio non-voting membership includes: the CHRI executive director, ~~the CHRI associate director for professional education,~~ the CHRI chief nursing officer, CHRI executive director of patient services, the medical director of university hospital and/or the chief medical officer of the medical center, the dean of the Ohio state university college of medicine and~~,~~ the executive vice president for health sciences. ~~and the associate director for medical staff affairs.~~

(c) - (e) No Changes.

(2) - (4) No Changes.

(D) Credentialing committee of the hospitals of the Ohio state university:

(1) Composition:

The credentialing responsibilities of the medical staff are delegated to the credentialing committee of the hospitals of the Ohio state university, the composition of which shall include representation from the medical staff of each hospital.

The chief medical officer of the medical center shall appoint the credentialing committee of the hospitals of the Ohio state university. The ~~chief of staff,~~ director of medical affairs and medical director of credentialing shall make recommendation to the chief medical officer for representation on the credentialing committee of the hospitals of the Ohio state university.

The credentialing committee of the hospitals of the Ohio state university shall meet at the call of its chair, whom shall be appointed by the chief medical officer of the medical center.

(2) Duties:

(a) - (d) No Changes.

(e) To make recommendations to the medical staff administrative committee through the medical director of credentialing regarding appointment applications and initial requests for clinical privileges. Such recommendations shall include the name, status, department (division and/or department~~division/section~~), medical school and year of graduation, residency and fellowships, medical-related employment since graduation, board certification and recertification, licensure status as well as all other relevant information concerning the applicant's current competence, experience, qualifications, and ability to perform the clinical privileges requested;

UH and James Bylaws Committee: 10.09.17
James Bylaws Committee: 12.01.17
MSAC: 12.08.17
Medical Staff Vote: 12.22.17
Quality and Professional Affairs: 03.27.18
MC Board: 04.04.18
UBOT: 04.06.18

(f) - (l) No Changes.

(3) Licensed health care professionals subcommittee:

No Changes.

(E) Medical staff bylaws committee:

(1) Composition.

(F) Committee for practitioner health.

No Changes.

(G) Cancer subcommittee:

(1) Composition:

Required to be included as members of the cancer subcommittee are physician representatives from surgery, medical oncology, ~~diagnostic~~ radiology, radiation oncology, anesthesia, plastic surgery, urology, otolaryngology/head and neck, hematology, gynecologic oncology, thoracic surgery, orthopaedic oncology, neurological oncology, emergency medicine, palliative medicine and pathology, the cancer liaison physician and nonphysician representatives from the cancer registry, administration, nursing, social services, and quality assurance. Other disciplines should be included as appropriate for the institution. The chairperson is appointed at the recommendation of the chief executive officer of the CHRI and the director of medical affairs, subject to the approval of the medical staff administrative committee and subject to review and renewal on a yearly basis.

(2) - (3) No Changes.

(H) Ethics committee.

No Changes.

(I) Practitioner evaluation committee.

No Changes.

UH and James Bylaws Committee: 10.09.17
James Bylaws Committee: 12.01.17
MSAC: 12.08.17
Medical Staff Vote: 12.22.17
Quality and Professional Affairs: 03.27.18
MC Board: 04.04.18
UBOT: 04.06.18

(J) Professionalism consultation committee.

No Changes.

3335-111-11 History and physical.

No changes.

3335-111-12 Amendments and Adoption

No changes.

3335-111-13 Meetings and dues.

(A) Meetings.

The medical staff of the CHRI shall conduct scheduled meetings semi-annually. Notice of the meetings will be sent to all medical staff at least two weeks prior to the meeting. Attendance is encouraged, but shall not be a requirement for continued medical staff membership and clinical privileges. ~~A s~~Special or electronic meetings may be called at the option of the medical staff administrative committee.

(B) No Changes.

3335-11-14 Rules of construction.

No Changes.

The James

THE OHIO STATE UNIVERSITY
COMPREHENSIVE CANCER CENTER

Quality and Professional Affairs: 3.28.18
MC Board: 4.4.18
UBOT: 4.6.18

Medical Staff Rules and Regulations – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute

Updated September 2, 2016

01 Ethical pledge.

No Change

02 Admission procedures.

No Change

03 Attending assignment.

No Change

04 Consultations.

No Change

05 Order writing privileges.

No Change

06 Death procedures.

No Change

07 Emergency preparedness.

No Change

08 Surgical case review (tissue committees).

No Change

09 Tissue disposition.

No Change

The James

THE OHIO STATE UNIVERSITY
COMPREHENSIVE CANCER CENTER

Quality and Professional Affairs: 3.28.18
MC Board: 4.4.18
UBOT: 4.6.18

Medical Staff Rules and Regulations –
Arthur G. James Cancer Hospital and Richard J. Solove Research Institute

10 Medical records.

(A) (1)-(5) No Change

(6) Records storage, security, and accessibility.

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

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

(7) – (11) No Change

11 Committees.

No Change

12 Standards of practice.

No Change

13 Mechanism for changing rules and regulations.

No Change

Quality and Professional Affairs: 3.28.18
MC Board: 4.4.18
UBOT: 4.6.18

Medical Staff Rules and Regulations –
Arthur G. James Cancer Hospital and Richard J. Solove Research Institute

14 Adoption of the rules and regulations.

No Change

15 Sanctions.

No Change

UNIVERSITY HOSPITALS TRAUMA CERTIFICATION

Synopsis: Applications for a Level 1 trauma verification for University Hospitals and a Level 3 trauma verification for University Hospitals East by the American College of Surgeons-Committee on Trauma, are proposed.

WHEREAS the Ohio State University Wexner Medical Center's mission includes teaching, research and patient care; and

WHEREAS the Wexner Medical Center is committed to maintaining the high standards required to provide optimal care for all trauma patients at University Hospitals emergency departments; and

WHEREAS the Wexner Medical Center is cognizant of the resources needed to support a Level 1 Trauma Program at University Hospitals and a Level 3 Trauma Program at University Hospitals East, and the contributions of these programs to its tripartite mission; and

WHEREAS on February 12, 2018, the University Hospitals Medical Staff Administrative Committee approved the proposed applications for a Level 1 trauma verification for University Hospitals and a Level 3 trauma verification for University Hospitals East by the American College of Surgeons-Committee on Trauma; and

WHEREAS on March 27, 2018, the Quality and Professional Affairs Committee of the Wexner Medical Center Board approved the proposed applications for a Level 1 trauma verification for University Hospitals and a Level 3 trauma verification for University Hospitals East by the American College of Surgeons-Committee on Trauma:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the applications for a Level 1 trauma verification for University Hospitals and a Level 3 trauma verification for University Hospitals East by the American College of Surgeons-Committee on Trauma.