Maryland
Hospital Association

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August 4, 2010

The Honorable Martin J. O'Malley
Governor of the State of Maryland
State House, 2nd Floor
Annapolis, Maryland 21401-1991

Dear Governor O'Malley:

I am writing to formally submit the recommendations of the Maryland Hospital Association (MHA) Hospital Bond Project Review Committee for consideration in the State's FY 2012 Capital Improvement Program (CIP). This year, a total of $5 million is being requested for four worthy projects. We have also submitted electronically the detailed data required by the Department of Budget and Management's Office of Capital Budgeting through the Capital Budget Information System (CBIS).

Process

Applications for this year's process were due on June 18. Four hospitals submitted applications for projects that have a total cost of more than $25 million; $5.3 million was requested under the Hospital Bond Project Review Program.

During June and July, the applications were reviewed by the program staff. Subsequently, the Committee met in late July to hear presentations from applicant hospitals. The Committee then used the criteria, weighting and scoring system, and subjective review to evaluate the projects carefully and thoughtfully to ensure compliance with the program criteria.

Why did only four hospitals apply this year? Unfortunately, many hospitals have put their capital programs on hold as they cope with general economic uncertainties, the recent Health Services Cost Review Commission update factor decision, and the unknown impact of national health care reform in Maryland.

Recommendations

Two of the four projects recommended for funding this year are located in Baltimore City; the other two are in Anne Arundel and Dorchester counties. These projects will provide their communities with a broad array of expanded and enhanced services in the areas of substance abuse, behavioral health, care for mothers and newborns and emergency services--each with a focus on improving patient safety.

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Below are the committee's specific recommendations (in descending order of scoring/ranking):

Mercy Medical Center
Recommended Allocation: $2,700,000

The purpose of this project is to enhance patient safety and clinical outcomes, advance medical education, and better serve poor and underserved women by creating a state-of-the-art maternal child health facility. This will be accomplished by expanding and relocating the labor and delivery suites, C-section procedure rooms, post-partum rooms, neonatal intensive care rooms, and pediatric rooms.

Shore Health System (Dorchester General Hospital)
Recommended Allocation: $1,000,000

The purpose of this project is to renovate existing space within the Behavioral Health Unit of the Dorchester General Hospital campus. This renovation will allow the creation of a dual diagnosis treatment program to address the mental health and substance abuse needs of a growing population. The need for these programs has been intensified by the closure of the Upper Shore Community Mental Health Center.

Maryland General Hospital
Recommended Allocation: $1,000,000

This project will allow the hospital to expand its Emergency Department to better meet the complex needs of its patient population and treat its community for emergent care more efficiently. A renovation of the space will allow an expansion of the number of rooms available so patients can be seen faster and receive quality medical care in a timelier manner. The project also includes the establishment of new units dedicated to chest pain, observation and psychiatric crisis evaluation.

Anne Arundel Medical Center
Recommended Allocation: $ 300,000

This project will support the final two phases of renovation and upgrade for the Pathways Alcohol and Drug Abuse Treatment Center. The second phase and first priority will address patient safety issues. The third phase will improve care delivery by increasing efficiencies in workflow.

I also would like to point out that, as suggested in our program application, hospitals recommended for funding have been reminded and encouraged to utilize women and minority-owned businesses for their projects.

Attachments

Attached for your review are the program criteria and guidelines, the weighting criteria used to evaluate the projects, and the project scoring summary. Also attached is the Hospital Bond Project Review Committee membership list. As in previous years, the members of the Review Committee were committed to providing a fair and thorough review of all the applications submitted by hospitals.

I also want to commend Angela Clark of the Department of Budget and Management staff for her assistance and counsel in this effort.

If you have any questions regarding our Committee's recommendations, please call me or Denise Matricciani at MHA.

Sincerely,

Joanne Goldsmith
Chair, Hospital Bond Project Review Committee

Attachments
cc: The Honorable Ulysses Currie
The Honorable Ed DeGrange
The Honorable Norman H. Conway
The Honorable Adrienne Jones
The Honorable T. Eloise Foster
Chadfield B. Clapsaddle, Department of Budget and Management
Angela Clark, Department of Budget and Management
Members, Hospital Bond Project Review Committee
Denise Matricciani, MHA

HOSPITAL BOND PROJECT REVIEW PROGRAM
SUMMARY

INTRODUCTION

In the 1993 Joint Chairman's Report, the General Assembly requested that a work group be formed to recommend a process for the allocation of state funds to private hospital capital projects that was similar to the process used by the private colleges and universities. The work group was chaired by a representative from the Department of Budget and Fiscal Planning (DBFP) and included members from the Department of Health and Mental Hygiene, Health Resources Planning Commission, Health Services Cost Review Commission, and the Maryland Hospital Association. The work group's recommendations, as accepted by the Governor and the legislature, included a delineation of "criteria for projects." Further, it was recommended that each project undergo an application and screening process and then a scoring and ranking process. Finally, the work group recommended that the MHA establish an 11-member project review committee to implement the review process.

HOSPITAL BOND PROJECT REVIEW COMMITTEE

The Hospital Bond Project Review Committee is appointed by the MHA Executive Committee and chaired by a hospital trustee. Of the 11 members, 7 are hospital trustees, 4 are hospital executives, and a representative of the Department of Budget and Management serves in a non-voting, ex-officio capacity. In addition, each of the following regions must be represented by at least one member: Baltimore Metro; Eastern Shore; Southern Maryland; Western Maryland; and, the Washington suburbs.

GENERAL POLICY/HEALTH PROMOTION CRITERIA

According to these criteria, a requested project should:

a. Improve patient care by enhancing access to primary and preventive services; focus on unmet community health and related social needs; and, improve the patient safety environment.
b. Encourage collaboration with other community partners, where appropriate.

In addition, serious consideration should be given to the unique needs of hospitals which are:

a. Sole community providers;
b. Proposing projects located in underserved areas;
c. Proposing projects of special regional or statewide significance; or
d. Proposing projects not requiring multi-year state bond funding.

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Application and Screening Process

Applicants must submit a formal application to the committee. In addition to any other requirements established by the Hospital Bond Project Review Committee, applicants must:

- Submit audited financial statements;
- Provide assurances that the project provides access to all citizens regardless of insurance status;
- Obtain any necessary approvals/exemptions for the proposed project from the MHCC and HSCRC (i.e., CON, rate orders, etc.);
- Provide matching funds, including demonstrated community financial support (in most cases matching funds should be at least equal to the proposed grant and should not include real property or in-kind contributions);
- Submit proposals for projects which have at least a 15-year life, including information that the subject property is owned by the grantee or is to be held by them under a lease extending at least 15 years; and
- Submit proposals for projects that are well-developed and ready to be initiated during the ensuing fiscal year. Projects should be distinct and should be completed within the two-year period for certifying matching funds, but construction cannot begin prior to the start of the grant cycle.

Once the application submittal is judged complete and the requesting hospital has passed the screening checklist and has made a presentation to the Hospital Bond Project Review Committee, the proposal is then scored and ranked.

Scoring and Ranking Process

In order to make the scoring and ranking process as objective and quantitative as possible, the criteria has been divided into several categories. For each category, the Hospital Bond Project Review Committee has approved a guideline narrative, a weight, and a maximum score.

In terms of the scoring, each project is scored individually using the project scoring sheet. All projects are then ranked against each other by category with special attention being given to the patient care, community needs and improving patient safety categories which account for a significant portion of the category weights.

Eligibility

All private, non-governmental hospitals located in Maryland are eligible to apply for funds.

FINANCIAL CAPACITY CRITERIA

When considering the merits of a project, the committee may examine the overall financial capacity and need of the hospital requesting bond funds. In conducting this review, the committee shall, among other relevant factors, consider:

- Whether reimbursement/payments for the service rendered by the project will cover expected expenses and the hospital is committed to subsidizing the operating costs of the project;
- The hospital's level of uncompensated care;
- The hospital's debt to equity ratio;
- The hospital's debt service coverage ratio; and
- The hospital's Medicaid disproportionate share.

EXCLUSIONS

Hospital projects that will not be considered for funding under any circumstances include those for:

- Construction of new hospitals;
- Projects for which the result is a net increase in inpatient beds, not approved by the MHCC;
- Purchase of major medical equipment;
- Construction or renovation of parking facilities or other non-patient care-related facilities; or
- Retroactive grants.

In addition, any projects that the Governor determines to fund directly in the capital budget are separate and distinct from this program.

MATCHING FUNDS

As indicated above, most grants should be supported by cash-matching funds in an amount at least equal to the amount of the grant. In some circumstances, this requirement may prevent a project from moving forward. If a project meets a critical and urgent need to serve a low-income population and the requesting hospital is financially unable to provide an equal cash match, then the committee may recommend a more liberal matching fund requirement.

SANCTIONS

- If a hospital does not apply for funds via the MHA program, then has a bond bill introduced outside of the program, MHA will oppose the bill and the hospital is prohibited from submitting an application for two years.
- If a hospital applies for funding via the MHA program, is not recommended for funding, then has a bond bill introduced outside of the program, MHA will oppose the bill and the hospital is prohibited from submitting an application for two years.
- If an applicant is recommended for funding under this program and subsequently withdraws its project, the hospital is prohibited from submitting an application for two years.
- If an applicant is recommended for funding and funding is approved by the Governor and the General Assembly, but the applicant subsequently does not move forward with the project, the hospital is prohibited from submitting an application for two years.

HOSPITAL BOND PROJECT REVIEW PROGRAM
PROJECT SELECTION AND SCORING GUIDELINES

Guideline Narratives

1. **Improve patient care by enhancing access to primary and preventive services.**

   This criterion will be viewed as improving direct patient care, particularly access to primary and preventive services.

   Scores in this category will **relate to the breath and depth of services provided**. For example, a high score could be obtained for an in-depth program in the patient care area or for a program that was less in-depth, but focused on primary and preventive services.

   Improve patient care means **establishing new services which provide direct, hands-on care** as opposed to indirect care, such as patient education. These **services would relate to a meaningful patient contact**, such as a scheduled visit as compared to a screening fair where there is patient contact for a blood sample.

   While maximum points in this category are attained for a project where new, hands-on services are broad-based, across several departments, or across multiple medical disciplines, some points can also be attained if a project for existing services improves direct, hands-on care.

   Primary care includes the following services: OB, pediatrics, family medicine, internal medicine, and mental health.

   Preventive services include programs such as: wellness programs, pre- and postnatal care, screening, and early-detection programs.

   Uninsured--Scores in this category will relate to how the **specific project** significantly enhances access to services for the uninsured/underinsured, such as creative new strategies and action plans (e.g., expanding service times/staff/specialties; increasing special counseling and coordination for those needing assistance, etc.). New strategies are defined as ones which will be put in place during the grant cycle, not those which are presently being conducted.

   Social Services are defined as complementary, unmet health needs specific to the project, not social services solely offered. These may include social services related to:

   - Particular community health problems;
   - Self-assessment and management of health needs;
   - Patient education programs;

- Family counseling;
- Family abuse; or
- Substance abuse.

Training means programs specific to the project that improve the supply of primary care physicians and other allied health professionals.

2. **Focus on unmet community health needs (*Distinct from underserved as defined in #6 below*).**

   Unmet implies that new services **will be provided** or that **these services are not readily available from other community sources**. Services which are not readily available and which will be provided by the project should be specified and demonstrated. **A wide-range of services will be viewed favorably.**

   Consideration also will be given to projects that require staff and/or equipment to be added (services not able to be provided with existing resources), and a volume increase of 20 percent is projected. Volume increases of less than 20 percent will be given limited consideration.

   Scoring in this category will relate to evidence of defined and needed services and to the lack of availability of these services from other sources in the community.

   Evidence of service requests or endorsements of the project from the community, community agencies, business, and insurers will be favorably considered.

3. **Improve the patient safety environment.**

   Improve the patient safety environment means to enhance the efficiency and effectiveness of the delivery of patient care; i.e., redesign of nurses' station(s) to streamline workflow and access to patients; redesign of patient rooms, operating rooms and treatment areas (consistent with the most recent industry guidelines), to accommodate new technology and enhance traffic flow, etc.

   Concurrent with a renovation there may be improvements in the patient environment, which are not presently in place. Some may be substantial, while others may be more restricted/limited in scope.

   Substantive enhancements are those which are **multifaceted.** In such cases, the benefits should be enumerated, described, and demonstrated.

   Examples of substantive enhancements include multiple benefits to patients through improved technology, security, observation; increased access to patients through improved visibility and consolidation of services; reduced patient movements among services and

medical professionals; lessened wait times; safety code issues; decreased number of patients leaving the emergency department without being seen; and/or improved workflow issues.

Examples of limited enhancements include those for a single service; those where technology improvements are secondary to the main project; those where the project focus is on renovations, with little emphasis on improving access to patients, minimizing patient movements, etc.

4. **Last renovations.**

Points in this category are attained if the project is for a unit(s) that has not been upgraded/renovated in the last five years or more. ***Please note, however, that if the upgrade/renovation is for a project that received state funding within the last 15 years, it is not eligible for funding.***

Points in this category will be allocated as follows:

- 5 – 9 years;
- 10 – 30 years; and
- 30+ years.

5. **Sole community provider and sole provider of a service.**

The intent of this category is to give extra credit to a hospital that is a **sole provider**. A sole provider is defined as being the only hospital in the county.

It is not intended that a sole provider hospital also be given additional credit for providing sole services.

For hospitals that are not the sole provider in a county, the committee also will consider subjectively whether a project meets **sole provider of a service** criteria, given the committee's limited ability to identify whether the service is available from other providers in the county.

6. **Serious consideration should be given to underserved areas (*Distinct from unmet needs as defined in #2 above)*.**

An ***underserved area*** means that a **federal, state or local agency has deemed the area as underserved. Dated documentation must be provided** on federal, state, or city evidence of areas which are deemed to be medically underserved. Explain how the project falls within the MHCC definition of the area being regionally underserved. Consideration will be given to "**moderately served**" areas if information is supplied to support this description. This information may relate **to inadequate capacity, withdrawn services**, or **patient travel** to such services.

7. **Serious consideration should be given to projects of statewide or regional significance.**

   Statewide means a unique/specialized service(s) to be provided by the project which will draw patients from around the State of Maryland and from out-of-state. This does not include general services provided by a hospital to out-of-state patients by virtue of the fact the hospital is a border-state hospital.

   Regional designation means beyond the primary and secondary service areas.

8. **Encourage collaboration with other community partners.**

   Collaboration would include, but is not limited to, a shared patient service, an avoidance of patient service duplication, a consolidation, or a merger. Activities should be those which will be put in place during the grant cycle, and specifically not activities which are presently underway. Consideration also will be given to downsizing and other cost efficiencies. Scoring will be based on the scope of activities undertaken with outside partners, as well as how the dollars are applied. Projects of the nature described here that specifically demonstrate collaboration with other existing providers or entities in the community **for this project** will be evaluated favorably.

9. **Demonstrate community financial support for the project.**

   The intent of this category is to give weight to demonstrated financial support from the community. An amount of support equal to or greater than five percent of the requested project funds would be classified as support. It is recommended that the financial support actually be in hand. Special consideration will be given to mitigating circumstances presented by a hospital when an active fund raising effort did not raise the five percent amount.

Project Scoring Sheet

Hospital:

Criteria	Maximum Points	Weight	Score			Weighted Points
Improve Patient Care:			New/Innovative	Not New But Significant	Limited	
› hands-on care	20	5	4	2	1	
› access to primary/preventive	10	5	Significant 2		Limited 1	
› project enhances access to services for the uninsured/under insured	20	10	Significant 2		Limited 1	
› social services	5	5	Integral to Project 1		Not Integral 0	
› training	5	5	Included 1		Not Included 0	
	60	30				
Unmet Community Needs:						
› new services or not readily available from other community resources	20	10	Wide Range of Services 2		Limited Range of Services 1	
› additional volume/services	10	5	Vol. Increase Significant 2		Vol. Increase Not Significant 1	
	30	15				
Improve Patient Safety Environment:: › multi-faceted enhancements	25	12.5	Significant 2		Limited 1	
Last Renovation	20	5	30 yrs. + 4	10-30 yrs. 2	5-9 yrs. 1	
Sole Provider: › only hospital in county OR	10	5	Yes 2			
Sole Service: › unique service provided by a hospital that is not the only hospital in a county.	5	5	Yes 1			
Underserved Areas	20	10	Underserved 2	Moderately Served 1	Well Served 0	
Statewide/Regional	10	5	Statewide 2	Regional 1	No 0	
Project Encourages Collaboration with Other Community Partners	10	5	Yes 2	Limited 1	No 0	
Community Support	10	10	Yes 1		No 0	
Total	200/195	102.5				

Comments: ____

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Project Scoring Summary
2010

Total Project Cost	Requested Funds	Percent Requested (%)	Hospital	Patient Care Access Preventive	Unmet Community Need	Improve Patient Safty	Last Renova-tion	Sole Provider	Sole Service	Under-served	State/ Regional	Collaborative Networks Cost Contain.	Comm. Support	Total
16,033,920	3,000,000	18.7%	Mercy Medical Center	30	15	25	20	0	0	20	5	10	10	135.0
2,516,443	1,000,000	39.7%	Shore Health Sys./Dorchester	20	20	12.5	10	10	0	20	5	10	10	117.5
6,000,000	1,000,000	16.7%	Mearyland General Hospital	20	15	25	10	0	0	20	0	0	10	100.0
600,000	300,000	50.0%	Anne Arundel Medical Center	20	10	25	5	0	0	10	10	10	10	100.0
25,150,363	5,300,000	21.1%	TOTAL	90	60	87.5	45	10	0	70	20	30	40	452.5
				19.9%	13.3%	19.3%	9.9%	2.2%	0.0%	15.5%	4.4%	6.6%	8.8%	100.0%

Comments:

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Hospital Bond Project Review Committee

2010

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