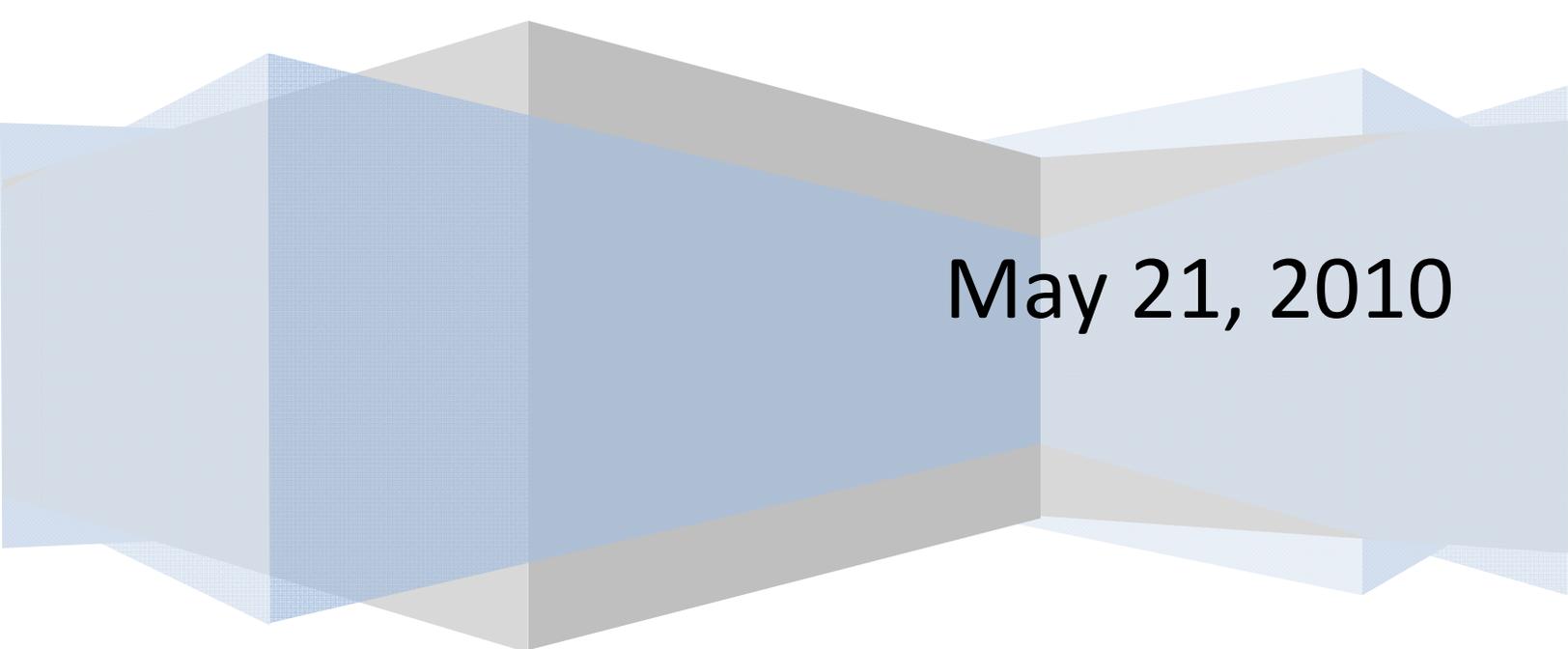


PRINCE GEORGE'S COUNTY HOSPITAL AUTHORITY

FINAL REPORT AND RECOMMENDATIONS

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May 21, 2010

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EXECUTIVE SUMMARY

In May 2008, Governor Martin O'Malley signed into law Chapter 680 of the 2008 Laws of Maryland which created the Prince George's County Hospital Authority (the "Authority") to implement a process for the purpose of transferring the Prince George's County healthcare system (the "system") from County ownership. The Authority's mandate was to attempt to find one or more new owners which would deliver enhanced community-oriented health and hospital services to the residents of Prince George's County (the "County") and would be capable of operating independently. Upon identifying potential owner(s), the Authority was required to report its findings and recommendations to the County and the State of Maryland (the "State"), to be referred to hereafter as "the Primary Stakeholders." This report represents the fulfillment of those two mandates.

In pursuit of these goals, the Prince George's County Hospital Authority, with the assistance of the nationally-recognized advisory and consulting firm, Alvarez & Marsal, marketed the system's assets nationwide to over 80 nonprofit and for-profit healthcare entities. It should be noted that the Authority's efforts were challenged by extreme turmoil in the country's financial and credit markets. This challenge notwithstanding, nine entities responded and participated in the Authority's process over the ensuing months.

During the 2009 legislative session, the Authority sought greater flexibility in the way it set about accomplishing its goal of finalizing a proposal to the Primary Stakeholders which would facilitate the transfer of the System and ensure high quality healthcare for the County. In April 2009, new legislation was enacted that accomplished the following:

1. Extended to May 2010 the time the Authority had to complete its recommendations on the transfer of the healthcare system in its entirety;¹
2. Confirmed that all other provisions of Chapter 680 remained in effect through the duration of the Authority's existence; and
3. Added two provisions, one of which afforded the Maryland Health Care Commission the flexibility to waive certain Certificate of Need requirements if necessary and appropriate to help facilitate the transfer of the system.

Further, the 2009 legislation directed certain State and County agencies to serve as consultants to the Authority's process, if requested by the Authority. The bill also provided that while separate entities may acquire individual components of the system as part of the overall transaction, any agreement should effectuate the transfer of the system in its entirety.

After working with the interested parties to refine their proposals, the Authority determined that in their then-current form, no submission or combination of submissions fulfilled the statutory mandate to develop a plan to transfer the County's assets in their entirety and to improve the overall quality of healthcare in Prince George's County. At the same time, however, the market's response to the Authority's process revealed that major healthcare entities would, in fact, be interested in taking over the system and

¹ The extension of time for the Authority to fulfill its mandate did not extend the term of the Authority which is scheduled to sunset on May 22, 2010.

developing an enhanced healthcare delivery system in the County if the system's assets were streamlined and reconfigured in such a way as to stem current operating losses and satisfy ongoing bond debt and pension liabilities. This reconfiguration could set the stage for both a new replacement hospital and a more decentralized, primary care and community-oriented delivery system consistent with the recommendations of the RAND report commissioned and adopted by the County Council, and with the critical services identified by Authority members, Drs. Donald E. Wilson and Joseph L. Wright. This reconfiguration would also be consistent with the 2002 Prince George's Hospital System Improvement Task Force and the 2005 Dimensions Oversight Working Group Report, both of which proposed a series of operational and management steps to move the County's healthcare model to a new level. Further, Dimensions Healthcare System (the current operator) supported this general shift in its 2007 strategic plan which specifically identified:

- 1) The need for a stable source of external funding to support indigent care;
- 2) The need for an affiliation with an academic medical center or larger healthcare system;
- 3) The need for significant re-capitalization including a replacement facility for Prince George's Hospital Center; and
- 4) The need for continued operational improvements.

Thus, while a series of interim steps would be required before transferring the system to new ownership, this multi-staged approach would fulfill the Authority's mandate and the Primary Stakeholders' goal of achieving a stable, modern, high-quality healthcare delivery system for the citizens and residents of Prince George's County.

To this end, the Authority makes the following recommendations to all stakeholders:

1. **Stakeholder Agreement on Reconfiguration of Healthcare System's Assets:** The Primary Stakeholders should **immediately** execute a Memorandum of Understanding (MOU) outlining the transition process. The MOU should include: a) continued commitment of \$174 Million to satisfy the system's debts and liabilities and to make necessary interim investments in the restructuring of the system to set the stage for a new hospital and healthcare delivery system; and b) confirmation of the transition strategy for Dimensions Healthcare System or the then-current operator ("Current Operator");
2. **Development of Strategic Restructuring and Cost Containment Plan:** The Primary Stakeholders, in conjunction with the current operator, should develop a strategic plan to right-size the services provided throughout the system and otherwise institute cost containment and revenue enhancement strategies necessary to reduce and finally eliminate operating losses. The plan must also include a roadmap and viable options for ensuring continuity of critical services during the transition period pending construction of a new hospital;
3. **Interim Transfer of System Assets:** The Primary Stakeholders, in conjunction with the bond trustee and the current operator, should develop a plan to effectuate the **interim transfer** of the system's assets from the County to the current operator. The purpose of this interim transfer will be to secure

- the availability of the public funding commitment to help make the assets “market-ready” and to continue facilitating the interim restructuring and continuation of all critical services throughout the healthcare system to set the stage for the permanent transfer of all assets;
4. **“Cleaning up” the System’s Balance Sheet:** The Primary Stakeholders should leverage the State and County’s \$174 Million to begin the process of implementing the above-referenced Cost Containment Plan;
 5. **Preliminary Approval of Permanent Owner of System’s Assets and Developer of New Hospital:** Entities seeking approval to proceed with development of a new hospital and takeover of the restructured system assets should present Primary Stakeholders with firm financing and operational proposals; and
 6. **Final Stakeholder and Regulatory Approval of New Inpatient Facility:** The entity receiving preliminary development plan approval should submit its comprehensive hospital development proposal to the appropriate regulatory bodies and stakeholders.

In order to implement these recommendations, the Authority has enclosed, in the body of this report, an implementation timeline with specific dates for action. Consistent with that timeline, the Authority offers the following key actions and related target dates:

1. **Repositioning the County’s Hospital Operations.** (Implementation Period: June 15, 2010 through September 15, 2010). Overall Goal: Develop and implement a cost containment plan to reduce operating losses across all facilities managed by the current operator and begin to develop a strategic modernization plan supporting the development of new state-of-the-art healthcare facilities;
2. **Interim Transfer of Assets to New Ownership.** (Implementation Period: June 1, 2010 through October 1, 2010). Overall Goal: Consistent with the legislative mandate, transfer ownership and control of the County’s healthcare system assets to the current operator so that: (i) there is access to a broader range of financing options; (ii) there is an ability to restructure and expand critical services throughout the healthcare system; and (iii) there is a structure for a future sale on a permanent basis of all or part of the remaining system assets, if deemed appropriate by the Primary Stakeholders; and
3. **Long-Term Implementation of the Strategic Plan for New Community-Based and Inpatient Capacity.** (Implementation Period: June 15, 2010 through August 1, 2013). Overall Goal: In conjunction with the permanent transfer of assets, new healthcare facility operators will leverage public and private-sector financing to develop a range of inpatient and outpatient services to serve the Prince George’s County region.

INTRODUCTION

Dimensions has been challenged for over a decade by its financial losses and its inability to adequately capitalize the healthcare system it manages, surviving only through repeated infusions of public subsidies. Despite longstanding efforts to reverse this course, Dimensions' delivery of healthcare services has continued to fall short of meeting the needs of the residents of Prince George's County and the surrounding region.

In 2008, under the leadership of Maryland State Governor Martin O'Malley, Prince George's County Executive Jack Johnson, the Prince George's County Council and many legislators, the State and County (the "Primary Stakeholders") took action to find a solution. Through Chapter 680 of the 2008 Laws of Maryland, the Maryland General Assembly established the Prince George's County Hospital Authority (the "Authority") to assist in the transfer of County-owned, Dimensions-managed, healthcare facilities to private sector ownership. This legislation did four things:

1. Created the seven-member Prince George's County Hospital Authority;
2. Required the State of Maryland and Prince George's County to reach agreement on long-term public funding for the County's hospital system;
3. Provided \$24 million in State/County interim support funding for FY'09 and '10 if agreement was reached on long-term funding; and
4. Directed the Authority to conduct a review process to transfer the healthcare system in its entirety to one or more respondents capable of transforming system into self-sustaining entity, able to deliver high-quality healthcare to the region.

Over the last two years, the Authority has conducted a far-reaching process to attempt to fulfill its statutory mandate to facilitate the transfer of these troubled assets. The Authority's process confirmed that, because of market conditions and the financial and operational challenges of the assets, the system cannot - at this juncture - be transferred as a whole in its current condition and configuration. Despite these challenges, however, including the unfortunate timing of conducting its work during the worst economic downturn of a generation, the Authority has nonetheless identified a set of recommendations which can result in the ultimate stabilization and transfer of the healthcare system to new owners. Should the Primary Stakeholders accept these recommendations and take the steps necessary to implement them, they can set the stage - not only for the transfer of the assets to new ownership - but also for the creation of a new hospital and an enhanced healthcare delivery system for the residents of Prince George's County and the Southern Maryland region.

The Authority recognizes the complexity of this proposal. It will require collaboration and consensus among Primary Stakeholders, difficult decisions affecting healthcare and hospital resources, and the renewed commitment of ongoing financial support. Yet these recommendations can lead to resolution of intractable challenges that are twenty years in the making and continue to worsen every day. Thus, the Authority respectfully presents this report and requests that all stakeholders give it the fullest possible consideration

THE AUTHORITY'S STATUTORY MANDATE

The Authority was established by the Maryland General Assembly to achieve certain long-term goals.² A major element of this effort was to recommend a means of transferring the Prince George's County healthcare system, including the system's healthcare facilities, assets, leasehold rights and operations to new owners through an open and competitive process. This was not, however, the full extent of the legislative mandate. Notably, the Authority was to consider how a new owner might:

1. Establish a financially self-sustaining healthcare system capable of providing high quality, community-oriented health and hospital services;
2. Implement the proposal without additional public funding;
3. Supplement the plan with private sector resources;
4. Satisfy Dimensions' existing obligations and liabilities;
5. Attract and retain qualified medical personnel; and
6. Operate and/or develop a plan for use of all real property, assets and existing facilities in the current healthcare system.³

During the 2009 legislative session, the Authority sought greater flexibility in the way it set about accomplishing its goal of finalizing a proposal to the Primary Stakeholders which would facilitate the transfer of the System and ensure high quality healthcare for the County. In April 2009, new legislation was enacted that accomplished the following:

- 1) Extended to May 2010 the time the Authority had to complete its recommendations on the transfer of the healthcare system in its entirety;⁴
- 2) Confirmed that all other provisions of Chapter 680 remained in effect through the duration of the Authority's existence; and
- 3) Added two provisions, one of which afforded the Maryland Health Care Commission the flexibility to waive certain Certificate of Need requirements if necessary and appropriate to help facilitate the transfer of the system.

Further, this legislation directed certain State and County agencies to serve as consultants to the Authority's process, if requested by the Authority. The bill also provided that while separate entities may acquire individual components of the system as part of the overall transaction, any agreement would effectuate the transfer of the system in its entirety.

HISTORICAL ANALYSES AND THE EMERGING STRATEGIC VISION

The work of the Authority has been informed by three reports examining the Prince George's County healthcare system and assessing the healthcare needs of the

² See, Health-General Article, Section 24-1602.

³ See, Health-General Article, Section 24-1605(c)

⁴ The extension of time for the Authority to fulfill its mandate did not extend the term of the Authority which is scheduled to sunset on May 22, 2010.

County's population: the 2002 report of the Prince George's Hospital System Improvement Task Force, the 2005 report of the Dimensions Oversight Committee, and the 2009 report prepared for the Prince George's County Council by the RAND Corporation. The recommendations and findings of these three reports are outlined in Attachments B, C, and D.

The Authority has paid close attention to these well-reasoned and largely-consistent reports. To the greatest extent feasible, the Authority has attempted to incorporate these analyses in its evaluation process and in these final recommendations. Set forth below is a brief summary of these prior findings.

Key Lessons from Prior Reports

1. Review and Modernize the Existing Dimensions Healthcare System/County Relationship. As noted in the 2005 report, the existing Dimensions structure has been unable to modernize facilities or to stem operating deficits. The current configuration is not a long-term solution to the existing situation. At best, a reconfigured Dimensions is the transitional vehicle for movement to a new healthcare system based on an alliance with a major healthcare organization
2. Take necessary financial actions. These reports also recommend two critical actions: a) Identify public funding resources to support system operations and capital improvements; and b) transfer ownership of assets to facilitate long-term bond financing.
3. Actively pursue a partnership that will allow the system to strengthen its clinical services and achieve its mission of providing quality healthcare.
4. Determine the best strategy for rate-setting in collaboration with the Maryland Health Services Cost Review Commission. This strategy should take a long-term view of system recovery, not simply institute stop-gap measures.

OVERVIEW OF THE AUTHORITY'S MARKETING EFFORTS

In August 2008, the Authority hired Alvarez & Marsal, a nationally-recognized healthcare consultant firm with extensive experience facilitating all aspects of hospital system sales, to assist the Authority in the valuation and marketing of the system and the issuance of a Request for Proposals for the purchase of the system's assets.

On September 19, 2008, the Authority began the first phase of the process. An Opportunity Description Memorandum (a marketing document) was sent to eighty-four entities across the country. Recipients included local healthcare entities, leading national healthcare organizations and related persons having a known or potential interest in acquiring the Prince George's County healthcare system. Additionally, a Confidentiality Agreement was signed by potentially-qualified buyers interested in receiving additional information about the healthcare system.

The Authority anticipated a challenging process, given the system's long-standing financial and management difficulties, but the economic crisis and the resulting paralysis in credit markets made the situation far worse. Recognizing the unexpected additional challenges, the Authority explored means through which respondents might

secure additional financing support. Specifically, Authority representatives had preliminary discussions with the staffs of the Maryland Health and Higher Education Facilities Administration (MHHEFA) and the State Department of Business and Economic Development.

Notwithstanding the challenges, nine entities expressed interest in some or all components of system by signing non-disclosure agreements and the Authority's primary marketing document known as the "Confidential Information Memorandum". This document detailed information about the assets and operations of the system, its market and service area, State and County expectations and commitments, and the State's regulatory environment. The entities expressing interest in all or part of the system were: the Anne Arundel Medical Center, Children's National Medical Center, Dimensions Healthcare System, HealthSouth Corp., Physicians Group of Laurel LLC, Rockledge Realty Partners LLC, Solomon Eye Associates, Southern Maryland (Michael Chiaramonte), and Washington Adventist Hospital.

The Authority informed all interested parties that the objective of the marketing effort was to transfer all County-owned assets to new ownership. Different assets could be transferred to different owners but, in the end, none of the facilities would remain under County control. The Authority's consultants began an intense, yearlong effort to evaluate and support an array of partnerships to achieve the goal of full asset transfer. Parties could establish relationships with other participants or entertain new relationships with other entities having special financing, management, or programmatic capabilities. While the Authority could not mandate that each ~~responseaddressresponse address~~ every asset, each interested party was reminded that it is the Authority's mandate to transfer the system in its entirety.

To aid in the formation of viable proposals, Authority members were divided into small workgroups to address (a) Financial and Business Matters; (b) Legal and Regulatory Issues; and (c) Delivery of Healthcare Services. A&M used this information to inform discussions they had with potential purchasers regarding the minimal levels of acceptable healthcare provision. This was, of course, a dynamic process. Interested parties needed to respond to this guidance and the Authority had to continually recalibrate how various partnerships might best meet the overall statutory objectives.

In March 2009, the Authority issued an RFP seeking responses from firms interested in assisting the Authority with the assessing the value of the assets and negotiating the transfer of the system. Alvarez & Marsal was also successful in securing this phase of the work, and they have worked with each of the interested parties as they conduct their due diligence and explored additional partnering opportunities.

Interested parties conducted due diligence, including receiving documents from the current system's management, touring the medical and nursing home facilities, and asking questions of the Authority's consultants. On September 18, 2009, eight of the nine parties that expressed interest submitted responses to the Authority. Some components of the healthcare system received considerable interest from respondents, while others received minimal interest. The Authority and its consultants continued to review submissions and to ask questions of each respondent in an attempt to confirm that they remained committed to performing, as indicated in its submission.

On September 30, 2009 ~ after responses were received, but before they were reviewed by Authority members ~ the Authority conducted a hearing at which the public

was encouraged to express opinions about any aspect of the Authority's work. There were a few comments urging the Authority to give favorable consideration to a particular respondent, but most of the comments emphasized maintaining – or exceeding – the current level of healthcare in Prince George's County, ensuring continued access to HIV/AIDS, family planning and high-risk infant healthcare services, and protecting the jobs of current healthcare system employees. The Authority paid careful attention to the comments and determined it had an opportunity not only to conduct a process but to change the model for healthcare delivery in Prince George's County.

THE OUTCOME OF THE AUTHORITY'S MARKETING AND NEGOTIATION EFFORTS

Initially, the Authority identified the following objectives for the process:

1. To maintain each of the respective acute care facilities as general acute care hospitals and maintain identified core services/programs in each of the respective communities, including the provision of emergency/trauma medical services, consistent with meeting all regulatory requirements and providing the highest quality, most effective care in a changing healthcare environment;
2. To maintain service levels for uncompensated care at each of the facilities, consistent with community needs and the financial viability of the institutions;
3. To maintain participation in both the Medicaid and Medicare programs;
4. To select a respondent (or multiple respondents if necessary) that is able to demonstrate access to, and identify, experienced healthcare management personnel;
5. To identify a respondent capable of demonstrating sufficient financial resources to operate healthcare facilities commensurate with the size and complexity of Dimension Healthcare System;
6. To maintain a strong medical staff and an appropriate medical staff structure while committing to recruit additional high quality physicians to the medical staff;
7. To select a respondent that agrees to assume the existing collective bargaining agreements or propose an alternative approach that recognizes the employees' decision to have collective representation;
8. To select a respondent that agrees to make a significant capital commitment supporting the facilities in each of the communities being served, and
9. To select a respondent willing to acquire or otherwise assume operational and financial responsibility for all or substantially all of the assets and liabilities that currently comprise Dimensions Healthcare ("Dimensions"),

Upon review, the Authority found the following: **no proposal was sufficiently detailed and comprehensive enough to warrant immediate positive recommendation by the Authority to stakeholders. However, many positive attributes in the proposals could be combined in a way that could lead to creation of a better healthcare system for County residents.** An overview of the proposals is presented in Attachment G. Two of the partial-system submissions were "complete" in that they

'stand alone' and call for the transfer of specific facilities to new ownership. However, the Authority could not recommend these submissions for immediate acceptance since other assets, including Laurel Regional Hospital and the Prince George's Hospital Center ("Cheverly"), would remain under County ownership. See, Health-General Article, Section 24-1606.

The Authority has found synergy in the proposals from all nine respondents, but recommends that special consideration be given to the three proposals – each of which has special attributes - from (in alphabetical order):

1. Anne Arundel
2. Dimensions Healthcare System/~~Newco~~[New co](#)
3. Southern Maryland (Michael Chiamonte)

From the Authority's perspective, the County and State could and should continue to evaluate which array of options will ultimately be most advantageous to citizens in Prince George's County.

KEY MARKET FINDINGS

Thus, the Authority presents six primary recommendations for consideration by the Primary Stakeholders. These recommendations are premised on certain assumptions and market findings. The assumptions are not novel; they are grounded in existing stakeholder commitments and the prior oversight committee proposals. The market findings are similarly unsurprising; they reflect direct feedback from potential purchasers that existing fiscal barriers must be addressed before assets can be transferred.

The Authority's recommendations are based on the following assumptions:

1. The Primary Stakeholders' funding in the amount of \$174 million remains available to facilitate the final asset transfer plans and to support ongoing system operations during the transitional period.
2. Key clinical and fiscal issues must be addressed in order to maintain a viable "glide path" during the transition process. To this end, State and County funds may be used to resolve existing pension, tax, and bond obligations, thereby stabilizing the current operations and allowing critical inpatient services to continue during the transition.
3. The Primary Stakeholders will seek the best means of implementing the RAND Report and County Council Resolution 12-2010. This effort will be tied to similar efforts to implement the Dimensions Healthcare System's 2007 Strategic Vision insofar as it is consistent with the RAND Report and prior oversight committee recommendations.
4. As described in Attachment F, critical public health services will continue to be made available in conjunction with these facilities and other local resources. However, the precise mix of ambulatory and inpatient services might need to evolve over the next several years. At the conclusion of the transition period, the system's new owner must make a strong and continuing commitment to preserve access to essential public health services at the replacement hospital. Community access to a full range of inpatient services must also continue.

5. The stakeholders should identify a reliable revenue source to support the modernization effort and the capital improvements needed to effect the “market readiness” of all facilities. In turn, this fiscal commitment will increase opportunities to access long term bond financing for both the new hospital and the community programs Contemplated by the RAND Report.

The Authority has learned a great deal from the marketing of the County assets and the subsequent negotiations with potential purchasers. These findings may be summarized as follows:

1. No “whole system” sale is feasible at this time; no interested party is presently willing and able to assume existing long-term obligations in addition to current operating deficits.
2. “Individual asset sales” alone would not improve healthcare services. Although certain facilities could be sold quickly, there are insufficient assurances that this will improve overall care capabilities
3. A transitional period is needed during which the assets can be made market-ready to set the stage for the Primary Stakeholders To select the major healthcare entity which will build a replacement hospital and take over the restructured assets of the new healthcare delivery system.
4. Critical health services must continue during the transition in order to provide a continuity of healthcare to the citizens of Prince George’s County.

The Authority’s marketing effort has produced an opportunity to transition assets from local Government sector ownership. Interested parties are willing to incorporate these assets into their long term service delivery plans. However, this can only be accomplished if current fiscal obligations are squarely addressed. If this occurs, stakeholders will be able to transfer current facilities to an interested party capable of establishing a comprehensive healthcare delivery system with modern capabilities and stable financing.

RECOMMENDATIONS

While a series of interim steps would be required before transferring the system to new ownership, this multi-staged approach would fulfill the Authority’s mandate and the Primary Stakeholders’ goal of achieving a stable, modern, high-quality healthcare delivery system for the citizens and residents of Prince George’s County.

To this end, the Authority makes the following recommendations to all stakeholders:

1. **Stakeholder Agreement on Reconfiguration of Healthcare System’s Assets:** The Primary Stakeholders should **immediately** execute a Memorandum of Understanding (MOU) outlining the transition process. The MOU should include: a) continued commitment of \$174 Million to satisfy the system’s debts and liabilities and to make necessary interim investments in the restructuring of the system to set the stage for a new hospital and healthcare delivery system; and b) confirmation of the transition strategy for the current operator;
2. **Development of Strategic Restructuring and Cost Containment Plan:** The Primary Stakeholders, in conjunction with the current operator, should

develop a strategic plan to right-size the services provided throughout the system and otherwise institute cost containment and revenue enhancement strategies necessary to reduce and finally eliminate operating losses. The plan must also include a roadmap and viable options for ensuring continuity of critical services during the transition period pending construction of a new hospital;

3. **Interim Transfer of System Assets:** The Primary Stakeholders, in conjunction with the current operator, should develop a plan to effectuate in the **interim transfer** of the system's assets from the County to the current operator. The purpose of this interim transfer will be to secure the availability of the public funding commitment to help make the assets "market-ready" and to continue facilitating the interim restructuring and continuation of all critical services throughout the healthcare system to set the stage for the permanent transfer of all assets;
4. **"Cleaning up" the System's Balance Sheet:** The Primary Stakeholders should leverage the State and County's \$174 Million to begin the process of implementing the above-referenced Cost Containment Plan;
5. **Preliminary Approval of Permanent Owner of System's Assets and Developer of New Hospital:** Entities seeking approval to proceed with development of a new hospital and takeover of the restructured system assets should present Primary Stakeholders with firm financing and operational proposals; and
6. **Final Stakeholder and Regulatory Approval of New Inpatient Facility:** The entity receiving preliminary development plan approval should submit its comprehensive hospital development proposal to the appropriate regulatory bodies and stakeholders.

FINANCING STRATEGIES

There are two distinct phases involved in moving towards an improved and more accessible delivery system for Prince George's County and its residents. The first phase addresses the opportunity to strengthen current facility operations. The second phase involves the development and opening of a new hospital within the County to serve as a magnet for tertiary care and potential research dollars. This section will address the project financing for the restructuring of the assets.

In developing the sources and uses of funds associated with the restructuring project, the Authority made a set of underlying assumptions regarding the assets and their control.

1. The Primary Stakeholders will use available resources to stabilize and strengthen current facility operations. This will be done through the existing legal framework that allows Dimensions or other appropriate operator to manage these facilities. However, as noted in prior analyses, the Primary Stakeholders have a range of options on how these facility operations are actually structured and managed. The Primary Stakeholders and the bond trustee should determine which, if any, of these prior recommendations should be implemented;
2. Because the healthcare facilities are actually owned by the County, a transfer can occur at any time and to any entity if there is agreement between the Primary Stakeholders and bond trustees. The decision to transfer assets should be made in conjunction with the final selection of a strategic partner who will guide the overall development of the new healthcare system. Once this selection is made, stakeholders can determine if assets should be transferred to the new strategic partner or to another purchaser who has expressed interest in a specific facility. The Primary Stakeholders will need to consider various regulatory requirements and fiscal implications as the final transfer decision is made; and
3. Regardless of how the facility oversight might ultimately be reconfigured, the current operator will have the obligation to cooperate in initiatives designed to renegotiate and otherwise resolve existing fiscal liabilities that impair the marketability of the existing facilities.

“GLIDE PATH” AND IMPLEMENTATION OPTIONS

All stakeholders recognize the continuing challenges now facing these facilities. Despite good faith efforts, these problems have only increased in magnitude over the last decade and current operations are fragile at best. It is therefore critically important that the right “glide path” be chosen as the full range of assets are repositioned and ultimately transferred. On one hand, essential services must be maintained during the transitional period. At the same time, immediate steps are needed to stabilize fiscal conditions at Laurel and Cheverly while also cutting current operating losses.

The Authority therefore recommends that any asset transfer be undertaken in a manner that accommodates key clinical and fiscal considerations. First and foremost, patients

must have continued access to needed inpatient and outpatient services throughout the transition period. To accomplish this, available funding must be made available to cover operating losses while, at the same time, definitive steps are taken to minimize such losses. However, some services may simply be unsustainable under current market conditions. Patients needing these services will need to be transferred to alternative care sites.⁵ There are, however, a range of services that simply cannot be provided elsewhere until new facilities are available. Trauma, obstetrics, and a range of surgical and mental health services will presumably be provided through this transitional period. See, Attachment F – Critical Inpatient and Ambulatory Service Summary.

These changes will give the Primary Stakeholders the opportunity to evaluate a series of potential partners for the new healthcare system. In addition to evaluating the financing proposals needed to support the replacement hospital construction, any proposed alliance should consider the capacity and interest of each partner to encourage the fullest possible implementation of the RAND Report recommendations. A key here is to evaluate the extent to which the new healthcare operator will be able to attract and retain physicians willing to staff community clinics and other ambulatory sites. Training programs, research opportunities, and other practice supports may provide key incentives in this regard. It is possible that this alliance will find means of encouraging joint projects with federally qualified health centers, large physician practice groups, and other entities that have submitted proposals during the Authority process. Available funding and technical support may also be available through the Maryland Community Health Resources Commission and other sources.

⁵ Because of changes in the availability of Medical Assistance funding for certain sub-acute care settings, it may not be feasible to maintain the full range of services at Gladys Noon Spellman or Larkin Chase Nursing Centers.

POTENTIAL IMPLEMENTATION TIMELINE

1. Restructuring the County’s Hospital Operations

Implementation Period: June 15, 2010 through November 15, 2010

Overall Goal: Develop and implement a cost containment plan to reduce operating losses across all Dimensions-managed facilities and develop a strategic modernization plan supporting the development of new state-of-the-art health care facilities.

Action Item	Approximate Date Due
<p>“Primary stakeholders” (County, State, and bond trustee representatives) and the “current operator” (Dimensions) each appoint a senior representative to implement a restructuring process that:</p> <ul style="list-style-type: none"> a. Addresses current management operations and cost containment options; b. Identifies additional staff support for implementing transition plans. 	<p>June 15, 2010</p>
<p>The County and State amend the existing MOU to support implementation of the restructuring plan and transfer of assets.</p> <ul style="list-style-type: none"> a. The MOU will articulate a joint strategic vision for the new health care system. Specific provisions should address: <ul style="list-style-type: none"> (1) Means of maintaining communications with bond trustee counsel and the current operator of County facilities;; (2) Continuation of grants and other long-term funding arrangements that will continue to be available to support the strategic plan; and (3) Strategies for primary stakeholders to monitor and, where necessary, approve, the implementation of the long-term strategic plan. 	<p>July 15, 2010</p>

The current operator retains the management resources needed to implement cost containment and restructuring objectives:.

August 1, 2010

- a. During the first six months of the transitional period; and
- b. A longer term budget for the remainder of the transitional period during fiscal years 2011 and 2012.

Following consultation with primary stakeholders, the current operator begins to implement the restructuring plan and:

September 15, 2010

- c. Support community-based improvements in accordance with the RAND Report;
- d. Strengthen Cheverly's clinic capacity; and
- e. Adopt needed cost containment strategies to stabilize current fiscal operations.

The current operator reports to primary stakeholders on:

November 15, 2010

- a. Needed revisions to the 2011 and 2012 cost containment budget;
- b. The outcome of the asset transfer process; and
- c. Further plans for integrating current operations into the new health care system.

2. Transferring Assets to New Ownership

Implementation Period: June 15, 2010 through October 1, 2010

Overall Goal: Consistent with the legislative mandate, transfer ownership and control of the County's health care system assets to Dimensions so that (i) there is access to a broader range of financing options; (ii) efforts to restructure and expand ambulatory services on the Cheverly campus can proceed; and (iii) the sale or transfer of all system assets can be effectuated.

Action Item	Approximate Date Due
The Prince George’s County Attorney, in consultation with the State and bondholders, will develop a workplan leading to the transfer of full ownership of health care system assets by October 1, 2010.	June 15, 2010
<p>Primary stakeholders will identify:</p> <ul style="list-style-type: none"> a. The key strategic partner who will guide the design of the new health care system for the County; b. Which assets will be transferred to Dimensions; c. Which, if any, assets will be transferred to “partial system” respondents seeking control of a particular asset; and d. Key steps that the current operator should take in order to support the development of a new health care system. 	August 1, 2010
All system assets are transferred to Dimensions and, if appropriate, to other “partial system” respondents.	October 1, 2010

3. Long-Term Implementation of the Strategic Plan for New Community-Based and Inpatient Capacity

Implementation Period: September 1, 2010 through May 1, 2014

Overall Goal: Following the formal transfer of assets, new health care facility operators will leverage public and private sector financing to develop a range of inpatient and outpatient services to serve the Prince George’s County region.

Action Item	Approximate Date Due
<ul style="list-style-type: none"> a. The County finalizes plans to transfer assets to Dimensions and / or “partial system respondents. b. The current operator begins implementation of plans to strengthen community based services on the Cheverly site. c. 	September 1, 2010
Following completion of the County and State review of all options, the key strategic partner receiving preliminary support for developing a new	December 1, 2010

hospital will:

- a. Present firm financing proposals in support of the development plan;
- b. Outline general plans to incorporate existing assets into the new health care system.

The key strategic partner will submit a preliminary hospital development proposal to the primary stakeholders and to the appropriate regulatory agencies.. .

May 1, 2011

- a. The proposal will identify what services are to be transferred from existing facilities including but not limited to trauma services.

Regulatory agencies will complete any necessary reviews of the consolidated operation proposals. The new hospital opens for services.

September 1, 2011

January 1 2014

Consistent with the overall strategic plan, existing inpatient services at Laurel Regional Hospital and Prince George's General Hospital are transferred to the new inpatient facility.

May 1, 2014

CONCLUSION

Selling all of the components of the Prince George's County Health system is not possible at this time for financial, logistical and clinical reasons. However, the Authority believes that these recommendations can effectively reconfigure, rebase, and modernize healthcare services for the Prince George's County region by 2015. Individual providers will have incentives to build their practices here. Existing month to month grants for current operations will be eliminated. Modern community programs will emerge to serve newly insured patients across the region. And finally, a state-of-the-art hospital will become available to meet the needs of Prince George's County citizens.

ATTACHMENT A

Prince George's County Hospital Authority Enabling Statute
Md. Health-General Art. Section 24-1602(c) Code Ann. (2009 Repl. Vol.)

§24-1602. IN EFFECT

// EFFECTIVE UNTIL MAY 22, 2010 PER CHAPTER 680 OF 2008 //

(a) There is a body corporate and politic known as the Prince George's County Hospital Authority.

(b) The mission of the Authority is to:

(1) Establish and implement an open, transparent, and competitive bidding process for the purpose of transferring the Prince George's County healthcare system to one or more new owners; and

(2) Extend the bidding process:

(i) As necessary to fulfill the purposes of this subtitle; and

(ii) In a manner consistent with the purposes of this subtitle.

(c) The new owner or owners selected through the competitive bidding process under this subtitle shall:

(1) Provide access to, improve, and deliver high quality, community-oriented health and hospital services in the county that meet the healthcare needs of residents of the county and surrounding jurisdictions in a manner consistent with principles of State health planning law under Title 19, Subtitle 1 of this article; and

(2) Be a financially self-sustaining entity or entities capable of:

(i) Operating and achieving the goals set forth in item (1) of this subsection independently of the State and the county;

(ii) Developing a plan to satisfy any liabilities, including long-term bond indebtedness, pension obligations, malpractice liabilities, and any encumbrances placed by Dimensions arising from the healthcare facilities, assets, leasehold rights, liabilities, or operations held or operated by Dimensions;

(iii) Covering the operating and capital expenses arising from the Prince George's County healthcare system; and

(iv) Achieving access to long-term capital resources.

ATTACHMENT B

2002 Prince George's Hospital System Improvement Task Force Summary

Members

Dr. George S. Malouf, Chair

The Hon. Dorothy Bailey

Dr. Georges C. Benjamin

Mr. Robert G. Brewer, Esq.

Mr. Robert A. Chrencik

Mr. Alvin C. Collins

The Hon. Ulysses Currie

The Hon. Wayne Curry

The Hon. Barbara A. Frush

Mr. Larry L. Grosser

Ms. Debra B. Humpries

Mr. Gary Michael

Ms. Shirley H. Morgan

Ms. Robin O. Oegerle

Mr. K. Mark Puente

Ms. Sylvia Quinton, Esq.

The Hon. Howard P. Rawlings

Ms. Sheila K. Riggs

Rev. Robert J. Williams

Ms. Phyllis Wingate-Jones

Dr. Melville Wyche

2002 Report

In response to Dimensions Hospital System's serious financial difficulties, the Maryland General Assembly established the Prince George's Hospital System Improvement Task Force. The Task Force was charged with identifying strategies to help the System achieve long-term financial stability.

The Task Force carefully assessed the Dimensions' financial status, steps taken to stem financial losses and the contextual factors contributing to its continued difficulties (e.g. highly competitive healthcare market in Maryland, weak physician network, outdated equipment and facilities, etc.). Based on this assessment, it issued the following recommendations:

Short-Term Recommendations

Provision of immediate financing by the State and County to insure continued access to care

Under the terms of the Fiscal 2003 Budget Bill, the State committed to provide continued funding (\$3M) to the hospital system, conditional on the provision of matching funds from Prince George's County. The Task Force recommended that the County provide these funds and that the grants be used exclusively to fulfill hospital system's mission to the public.

Long-Term Recommendations

1. Improved Access to Long-Term Debt

As part of its agreement with Dimensions, the County retained ownership of the grounds and facilities that comprise the system. This arrangement, whereby

Dimensions leased back the land, served as a major obstacle to the long-term financial stability of the hospital system. Unable to rely on these assets as collateral, Dimensions could not secure necessary funding to make necessary capital improvements and adequately sustain operations. The Task Force recommended that the County and the hospital system develop a new agreement to transfer ownership of these assets to allow for needed financial restructuring and an improved position in the bond market.

2. Ongoing Operating Support

Under the lease agreement, the County had the option to make an annual indigent care payment to the hospital system. The Task Force recommended continuation of this payment even in the case of dissolution of the lease agreement to assist the hospital system in achieving financial stability.

a. Capital Support from the County and the State

In order to assist the hospital system in meeting its mission of providing quality healthcare services to the public, the Task Force recommended that the County and State provide capital support. The Task Force noted that such support was essential to the success of other public-to-independent non-profit conversions.

b. Sale and Merger Opportunities

Merger proposals should be sought from established entities with a proven track record that can provide continued indigent care and quality healthcare in general.

c. Restructuring of Hospital System's Board

The Task Force noted the failure of the hospital system's board structure to include important stakeholders from the community. Recognizing that the structure of the board is mandated by the terms of the lease agreement with the County, the Task Force recommended a restructuring as either an amendment to the agreement or the establishment of a new board in the case of termination. In either case, the Task Force encouraged expansion of the board, reduction in the number of designated positions, and a substantial change to the composition of its membership. The Task Force emphasized the importance of recruiting board members able to facilitate the development of strong relationships with business leaders, community groups and elected officials.

d. Development of a Long-Term Clinical Services Plan

In order to strengthen clinical service provision, the Task Force recommended possible affiliations with other healthcare entities, particularly academic medical centers.

e. Study Panel on the Funding Needs of Trauma Centers

The General Assembly established a study panel to examine the operating budget need of the regional trauma centers in the state. The Task Force encouraged careful consideration of the panel's recommendations by the State to insure that residents have continued access to high-quality emergency care.

f. Development of an Optimal Rate Structure in collaboration with HSCRC

In order to maximize revenue and maintain a competitive position in the market, the Task Force recommended close collaboration between the hospital system and the Health Services Cost Review Commission to develop an appropriate rate structure.

g. Medicaid Rate Enhancement

The coupling of high rates of uncompensated care with low Medicaid rates has necessitated the subsidizing of physicians by the hospital system in order to maintain its physician network. The Task Force encouraged continued Medicaid fee enhancement by the State to include specialty physicians.

ATTACHMENT C

2005 Dimensions Oversight Working Group Report Summary

Members

Morton I. Rapoport, MD, Chairman

Miza H. A. Baig, MD

The Honorable Ulysses Currie

Councilman David C. Harrington

Councilman Thomas R. Hendershot

Pamela H. Piper

Nelson J. Sabatini

Irving W. Kues (*ex officio*)

After the 2002 report was issued, Dimensions' financial difficulties continued. The Dimensions Oversight Committee, a partnership between the County and the State, was formed in 2004 in an effort to stabilize the system. The Committee issued its final report in January 2005. The report noted the underlying causes of the system's financial crisis, namely poor leadership and management and the provision of inadequately supported public health services.

The State and County provided bailout funds to insure the system's continued operation but these measures failed to solve the issue of long-term financial sustainability. The report noted the delay in capital support, one of the 2002 recommendations, and its negative impact on the system's market competitiveness. In addition, it cited a study by the Maryland Health and Higher Educational Facilities Authority that warned of the system's imminent collapse.

In response to the crisis, the Oversight Committee hired a management consultant to take immediate steps to stabilize the system. The firm made important changes to management, reduced staff, and instituted administrative changes geared toward improving the system's long-term viability.

In addition to these changes, the Oversight Committee issued several recommendations:

1. Continue contract with external managements support to complete turnaround process

The Oversight Committee emphasized the long-term nature of the improvements needed and recommended that the management consultant firm continue its work to stabilize the system beyond the short term.

2. Terminate the relationship between Prince George's County and Dimensions Health Corporation
3. Immediately create a revenue source to support system operations. Access to reliable public funding will be critical to the hospital system turnaround. In addition to state funding, the Committee offered several suggestions including the creation of a special tax district and compensation from the District of Columbia for provision of care to its residents.
4. The development of a consensus between the County Executive and County Council regarding the future of the system The Oversight Committee suggested several options including County ownership, merger with an existing health system, and sale to a third party and a return to public hospital operation.

ATTACHMENT D

2009 RAND Report Summary

Authors

NICOLE LURIE

KATHERINE HARRIS

REGINA SHIH

TEAGUE RUDER

JOIE ACOSTA

AMBER PRICE

JANICE BLANCHARD

In 2008, the Prince George's County Council commissioned the RAND Corporation to provide an assessment of the health and healthcare services of the County. The report was issued in 2009 and included analyses of the demographic and health characteristics of residents, healthcare system access and capacity, and hospital and emergency service utilization.

Demographic and Health Characteristics

Demographic

Although the average age has increased over time, the County had a greater proportion of residents under age 40 (58.5 percent) than surrounding jurisdictions according to 2006 data. There is considerable socioeconomic diversity, with significantly higher median household incomes in the regions outside the Beltway compared to those inside the Beltway. Similar patterns are found in educational attainment and rates of unemployment.

In terms of ethnic makeup, the report noted the high proportion of wealthy blacks living in the County in comparison to the rest of the State. Another important demographic change has been the rapid increase in the proportion of Hispanic residents, from 7.1 to 11.7 percent in the period between 2000 and 2006. Finally, a very high percentage (61.2 percent) of County residents commutes outside of the County for work, particularly to Virginia and DC. Many workers have commute times of 60 minutes or longer. These commuting patterns may result in residents of the County visiting physicians in other jurisdictions.

The authors conducted a comprehensive analysis of health status based on studies conducted by RAND as well as analysis of existing data sets. In comparison to surrounding jurisdictions, County residents were more likely to report a diabetes

diagnosis such as diabetes. These data also indicate higher rates of overweight and obesity. Health status varied by both socioeconomic and education level. For instance, heart disease, cerebrovascular disease and disability were more common among those with household incomes lower than \$50,000.

Examination of cancer data highlighted racial disparities in access to care. Despite low incidence rates of cancer among blacks, mortality rates are high which may indicate poor screening and detection rates.

Infant mortality in the County was higher than most surrounding jurisdictions, except for the District of Columbia. The rate exceeded the national average.

Although less likely to engage in high-risk health behaviors such as heavy drinking, County residents were also less likely to engage in positive health behaviors such as vaccines and mammograms than their counterparts in other Counties. Among residents, insured individuals were significantly more likely to have accessed preventive healthcare services than uninsured individuals.

Capacity and Access in the County Healthcare System

In its analysis of access to care, the report noted two key findings. First, Prince George's County residents are much more likely to be uninsured compared to residents in surrounding counties. Second, there are an insufficient number of primary care physicians to meet the County's needs. There are lower concentrations of physicians in areas with high rates of preventable hospitalizations and emergency room visits. The report also noted lower numbers of specialists in comparison to surrounding jurisdictions.

Although the County has sufficient hospital capacity, the report noted the lack of a primary care safety net. For example, the County has only one federally qualified health center (FQHC) to serve the needs of uninsured and low-income residents. Although there are approximately 80,000 uninsured residents in the County, the existing FQHC, Greater Baden Medical Services, provides care to only a small proportion. Additional safety net providers are Catholic Charities and the primary care clinic located at the Prince George's Hospital Center. RAND theorized that FQHCs in neighboring counties and the District of Columbia are providing care to many uninsured Prince George's residents.

Patterns of Hospital and Emergency Department Use

RAND's analysis of utilization patterns highlighted the high proportion of residents utilizing hospital and emergency department services outside of the County. For instance, among inpatients who resided in Prince George's County, 37.3 percent were discharged from Prince George's County hospitals. This is in marked contrast to Montgomery County and the District of Columbia where 77.0 and 92.4 percent of residents were hospitalized in their home county, respectively.

Additional analyses indicated a strong relationship between tendency to seek care outside of the county and payer source. That is, inpatients with private insurance were the least likely to utilize County inpatient services. Inpatient service utilization rates were much higher for Medicaid recipients and the uninsured.

In addition, the report noted high rates of hospital service provision in instances where primary care would have been more appropriate and more cost effective. These rates

were highest in those regions of the County with low per capita supply of pediatricians and adult primary care physicians.

Policy Implications

1. Strengthening the Prince George's ambulatory safety net is an urgent concern.

In order to reduce the number of potentially preventable hospitalizations and emergency department visits as well as health disparities between low- and high-income residents, the County must strengthen its ambulatory care safety net. Incentives that will bring additional primary care providers to the County to practice should be given careful consideration.

2. Out-of-County use of inpatient and emergency care by Prince George's residents has economic and political consequences.

The report found that large numbers of residents sought care outside of the County. This pattern of utilization results in lost revenue to County hospitals, lost revenues to the local businesses that serve them and lost jobs for County residents. Further, uncompensated care costs of uninsured County residents may lead to political tension.

3. Improving the health status of Prince George's County residents will require a variety of strategies, including improvements to the public health system.

In order to maximize health improvements of the County's population, the report authors encouraged strengthening of the public health system in addition to the personal healthcare system as well developing approaches to address non-medical health determinants.

ATTACHMENT E

Prince George's County Council Resolution 12
(Adopted April, 2010)

COUNTY COUNCIL OF PRINCE GEORGE'S COUNTY, MARYLAND 2010 Legislative Session

Resolution No. _____ CR-12-2010

Proposed by: Council Member Dean

Introduced by: Council Members Dean, Turner, Bland, Harrison, Olson,
Dernoga, and Campos

Date of Introduction: February 16, 2010

RESOLUTION

A RESOLUTION concerning Healthcare

For the purpose of expressing the County Council's support for the findings and potential next steps articulated in the Assessing Health and Healthcare in Prince George's County RAND Health Report.

WHEREAS, the quality of life in our nation is compromised by healthcare disparities which are more prevalent in Prince George's County due to the disproportionate presence of chronic disease coupled with the unavailability of access to quality healthcare services;

WHEREAS, the number of Prince George's County residents suffering from chronic conditions such as diabetes, asthma, and obesity significantly outpace neighboring jurisdictions; and

WHEREAS, approximately 80,000 adult residents of Prince George's County are medically uninsured; and

WHEREAS, Prince George's County has less than half the number of primary healthcare physicians per capita compared with Montgomery County, Howard County, Baltimore County, and the District of Columbia; and

WHEREAS, hospital capacity in Prince George's County has kept pace with population numbers yet the County has a relatively low per capita supply of medical/surgical, obstetric, pediatric services, and psychiatric beds; and

WHEREAS, the Prince George's County Council sought a clearer understanding of these healthcare challenges and commissioned a study by the RAND Health division of the RAND Corporation to analyze the County's healthcare needs and its current capacity to meet these healthcare demands; and

WHEREAS, beginning in 2008 RAND Health evaluated the demographic and healthcare characteristics of Prince George's County residents; the healthcare

system access and capacity; and patterns of hospital and emergency department use; and

WHEREAS, in February 2009 RAND Health representatives presented its final report and summary titled "Assessing Health and Healthcare in Prince George's County RAND Health Report" (hereinafter referred to as "the RAND Report") to the Prince George's County Council meeting as the Board of Health; and

WHEREAS, the RAND Report contained a number of findings and action steps to improve the overall quality of health and healthcare services in Prince George's County; and

WHEREAS, the RAND report found that high rates of out-of-County care, both compensated and uncompensated, results in damaging economic consequences; and

WHEREAS, the RAND report found that there was a disproportionate availability of primary care physicians in areas of the County; and

WHEREAS, the RAND report found that strengthening the Prince George's County ambulatory care safety net is an urgent concern; and

WHEREAS, the RAND Report found that there is only one federally qualified health center (FQHC) in Prince George's County to meet the needs of the 80,000 uninsured Prince George's County residents; and

WHEREAS, the RAND report found that the absence of a safety net threatens to perpetuate healthcare disparities and lead to greater preventable use of care in expensive hospital settings; and

WHEREAS, the RAND Report identified large disparities within the County that combined with low primary care capacity amplifies the critical need for the establishment of a primary care safety net; and

WHEREAS, the County Council as the Board of Health is authorized to enact laws for the protection and promotion of public health; and

NOW, THEREFORE, BE IT RESOLVED by the County Council of Prince George's County, Maryland, that County Council recognizes the shared responsibility with the State of Maryland to provide access to quality healthcare services in the County; and

NOW, THEREFORE, BE IT RESOLVED by the County Council of Prince George's County, Maryland, that Prince George's County Council is supportive of providing access to quality healthcare services in the County by providing a world class healthcare system offering superior healthcare and emergency service to the citizens and residents of Prince George's County and the greater Maryland community; and

BE IT FURTHER RESOLVED that the Prince George's County Council hereby supports the RAND Health findings stated above and published in detail in the RAND Report as a measure to improve access to and the overall condition of healthcare in Prince George's County.

Adopted this 6th day of April, 2010.

COUNTY COUNCIL OF PRINCE
GEORGE'S COUNTY, MARYLAND

BY: Thomas E. Dernoga Chair

ATTEST:

Redis C. Floyd
Clerk of the Council

ATTACHMENT F

Critical Inpatient and Public Health Service Recommendations by Doctors Donald Wilson and Joseph Wright, Authority Members

1. A track record of successfully running a large multi-disciplinary health system including:

b) Acute medical/surgical care

- > Experience with the Hospitalist model for inpatient service delivery
- > Experience with minimally invasive and day surgery programs
- > Geriatrician

c) Pediatrics/OBS-GYN

- > Experience with perinatology and high risk pregnancy services
- > Prenatal care outreach to stem the out-county flow of normal deliveries
- > Level III Neonatal Intensive Care Unit management experience
- > Pediatric short stay capability

d) Sub-specialty care

- > Ability to manage common complications of chronic disease conditions through access to a sub-specialty care network
- > Ability to diagnose and stabilize acute exacerbations of chronic disease conditions
- > Adult critical care capability

e) Trauma/Emergency care

- > Level I Trauma Center capability per American College of Surgeons verification standards
- > Acute Care imaging capabilities commensurate with above
- > Experience with managing a sexual abuse nurse examiner (SANE) programs [An existing function]

f) Mental Health

- > Experience with delivery of acute, inpatient and outpatient psychiatric services
- > Integration of behavioral health needs as part of an overall neurosciences strategy
- > Experience working with related agencies and institutions re: commitment, disposition and long term placements

g) Rehabilitation

- > Experience with inpatient and outpatient rehabilitation services, especially including ambulatory physical therapy, occupational therapy and speech/language therapy

h) Ambulatory programs reflecting the above

- > Experience with community-based outpatient, urgent care, and/or ambulatory specialty care service delivery models.
- > Strong consideration for experience with mobile medicine and/or telemedicine models for enhancing access.

i) Health wellness, screening, and prevention programs

- > Ability to articulate a comprehensive vision for linkage of an acute care hospital system with a community/county/regional strategy for improving health indicators through health promotion/disease prevention programs

2) Demonstrated success in meeting satisfactory metrics against recognized clinical quality performance and patient satisfaction benchmarks, e.g.

- > National Quality Forum
- > JACHO
- > Leapfrog
- > Picker

3) Demonstrated success in recruiting/retaining a diversified, high quality medical staff.

- > Demonstration of past work with academic entities and experience in recruiting and retaining highly qualified medical staff as measured by ratio of board eligible to board certified physicians.
- > Willingness to acknowledge regional market value of clinical/education/research skill sets associated with

competitively attracting and retaining highly qualified professionals to the medical staff.

4) Demonstrated success in providing medical/healthcare to a diverse population.

- > Demonstration of a successful track record in service delivery to ethnically diverse and economically stratified communities of color.
- > Experience with offering and managing interpreter services

5) A Mission, Vision, and Values Statement that is supportive of Prince George's community, patient and physician base.

- > Demonstration of having extended due diligence to understand the unique history and evolution of the population demographic in Prince George's County.
- > Understanding of the relevance of the hospital system as an important linchpin in a regional system of care intimately linked to two major metropolitan communities.

6) Experience with GME Programs

- > Demonstration of direct experience in managing a full complement of residency training programs either as a flagship entity or as an affiliate training location.
- > Demonstration of familiarity with the core competencies associated with offering graduate medical education and the Accreditation Council on Graduate Medical Education – Residency Review Committee (ACGME-RRC) requirements for implementing training programs.

7) An understanding of the role of education in delivery high quality care

- > Professional education, i.e. Continuing Medical Education (CME)
- > Graduate Medical Education (GME)
- > Public/consumer education, including community-based health education

- 8) A vision for engaging the community in the delivery and improvement of healthcare
- > Ref. # 1h above; must coordinate hospital system vision with population-based health/public health vision of other critical stakeholders including the Maryland Department of Health and Mental Hygiene (DHMH), the Prince George's County Health Department, National Capital Region Council of Governments, etc.
 - > Hospital System leadership must be highly visible, credible and transparent to the community in terms of long range goals and objectives for improving health outcomes.
- 9) A vision for partnering with other institutions and/or state agencies to enhance effectiveness of products.
- > Ref. #8 above; demonstrated track record of inter-institutional research and/or programmatic collaboration that has resulted in advancing science and community benefit.
 - > Track record of successful governmental or private sector grant procurement to resource necessary products and services with a plan to continue to leverage such.
- 10) A successful track record in turnaround management in healthcare. A demonstrated sensitivity to mission mindedness in turnaround management.
- > Demonstration of prior work with other challenged hospital systems and/or management of health services in a similar environment.
 - > Willingness to 'stay the course' without evidence of leadership turnover or 'skittishness' prior to satisfactorily getting the job done.
- 11) In the quest to improve financial performance, it is most important to avoid losing sight of the service mission.
- > No margin, no mission; however, must be of the mind at the outset that provision of high quality service trumps profitability out of the gate, and, potentially, for an extended period thereafter. Willingness and conviction to stay the pre-determined course is critical. To not do such would risk credibility and setting back the restorative process irreparably.
- 12) Financially strong enough to make capital investments beyond what will be provided as part of the "deal".

- > A track record of responsible fiscal stewardship and financial strength as measured by bond rating.
- > Demonstration of available assets to bring to the table and a creative strategic plan for their use.
- > A positive investment portfolio

13) Comprehensive leadership/staff transition plan assuming layoffs or other changes will be required

- > Demonstration of prior history of dealing with workforce challenges, including union negotiations, RIFs and organizational restructuring.

14) Consider the extent to which the new owners will be a good fit in this community

- > Perception will be critically important; successful new owner **must** literally and immediately become an engaged part of the community, and not limited to the healthcare domain. The role of the Hospital System in business development, social programming and general self-determination for the County is perhaps the most essential intangible characteristic to be assessed.

15) Financial metrics must be strong in every respect

- > Ref. #12 above; capital reserves, endowment, operational days cash on hand and philanthropic potential must all be pointed in the positive direction

16) IT systems issues will likely require attention; competency in this domain is critical.

- > There must be experience and facility with managing the informatics of a 21st century medical center, i.e. Computerized Physician Order Entry (CPOE), Electronic Medical Record (EMR), Computers on Wheels (COWS) and mobile workstations for rounds and bedside registration, Picture Archiving and Communication System (PACS) for radiology, etc.

- > A Chief Informatics Officer with deep healthcare experience is an essential function

17) A record of having dealt with complex governance oversight arrangements, so as not to be overwhelmed by the complexity of the management environment will be helpful.

- > Speaks for itself; the Government and External Affairs function will be a very important role in the chief executive leadership structure.

Donald E. Wilson, M.D., MACP and Joseph L. Wright, M.D., M.P.H., FAAP

July 24, 2008

ATTACHMENT G

Summary of Proposals

	Bidders		
	Dimensions Healthcare System/Newco	Southern Maryland (Michael Chiaramonte)	Anne Arundel
Asset(s)	System	Bowie Campus	System
Total Grants	Existing	NA	Existing
Consideration	Cash	Cash	NA
Structure	Asset purchase	Asset purchase	Asset purchase
Financing Required	Yes	Yes	Yes
Major Liabilities Included	Bond debt will be retired at closing. Underfunded pension liability to continue to be paid.	None	None
Diligence Required	None	1-3 months	4 months
Quality of Care	Enhancing cardiac surgery program, and expanding medical education	TBD	Improved access through enhanced ambulatory services.
Key Attributes	Most familiar with current operations within existing facilities. Articulated elements of DHS vision statement that was a precursor to some Rand Report recommendations. Implement larger ambulatory center rollout	Developed financing plan. Would partner with other health care providers that would assume key clinical responsibilities. Early focus on Bowie campus; flexible approach to supporting new health care system for region.	Growing presence in region with established track record and provider network. Primary focus on Bowie sub region but would assume management of all assets. Compelling regional healthcare strategy "Vision 2020".
Other	\$100MM contribution in equity and debt from CHCS (partner) to revitalize system.	Regulatory conditions. Also interested in alternate financing and ownership role for new hospital.	Management services agreement with potential for acquisition of all assets. Regulatory conditions.

In addition to the three entities in the chart, above, expressions of interest were received from the following:

Entity	Interest
HealthSouth	Purchase of 28 rehabilitation beds at Laurel
Physicians Group of Laurel	Lease/Purchase of Laurel Regional Hospital
Rockledge Realty Partners	Purchase of Bowie Medical Office Building
Solomon, MD	Purchase of Bowie Medical Office Building

Although Washington Adventist Hospital expressed initial interest in purchasing the Bowie Campus and Laurel Regional Hospital, they did not participate in the second round of negotiations. In addition, the University of Maryland Medical System submitted a letter to the Authority outlining their general interest in these ongoing efforts to address the County's health care needs. However, they did not submit further documentation concerning this matter.

SIGNATURE PAGE

Kenneth E. Glover, Chairperson

Donald E. Wilson, M.D., MACP, Vice-Chairperson

Stan Derwin Brown, Esq.

Andrea Leahy-Fuchek, Esq.

Thomas M. Himler

Karen Johnson Shaheed, Esq.

Joseph L. Wright, M.D., M.P. H., FAAP

All signatures, above, were affixed the 21st day of May, 2010, in a Public Session of the Prince George's County Hospital Authority.