COMMUNITY BENEFITS REPORT FOR THE FISCAL YEAR JULY 1, 2013 – JUNE 30, 2014

Prince George's Hospital Center
3001 Hospital Drive
Cheverly, Maryland 20785
301-618-2000

INTRODUCTION AND BACKGROUND:

HSCRC Community Benefit Report:

The Health Services Cost Review Commission's (HSCRC or Commission) Community Benefit Report, required under §19-303 of the Health General Article, Maryland Annotated Code, is the Commission's method of implementing a law that addresses the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals.

The Commission's response to its mandate to oversee the legislation was to establish a reporting system for hospitals to report their community benefits activities. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulated environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, and (3) hospital community benefit administration.

PRINCE GEORGE'S HOSPITAL CENTER:

Prince George's Hospital Center (PGHC) has been providing quality healthcare services to the southern Maryland region since 1944. Over the past 69 years, Prince George's Hospital Center has grown to become a major tertiary care center for the region and one of its largest employers. However, our greatest service to the community is that Prince George's Hospital Center is a private not-for-profit hospital with a tremendous public mission.

Prince George's Hospital Center was founded in 1944 and is an acute care teaching hospital and regional referral center located in Cheverly, Maryland. Prince George's Hospital Center is a member of the Dimensions Healthcare System.

Leadership: Chairman, Board of Directors – C. Phillip Nichols, Jr.
CEO – Neil J. Moore
Interim COO, DHS – John H. Spearman
COO, PGHC – K. Singh Taneja
Chief Nursing Officer – Candace Hanrahan

Location: 3001 Hospital Drive, Cheverly, Maryland 20785

Facility type: Acute care teaching hospital and regional referral center

No. of licensed beds: 214 (plus 60 bassinets)

No. of inpatient admissions: 11,293

No. of Employees: 1678

Specialty services:

A comprehensive range of inpatient and outpatient medical and surgical services including:

- Emergency and trauma services (designated Level II regional trauma center for southern Maryland)
- Critical care services
- Cardiac care services (comprehensive cardiac care – only program of its kind in the County)
    - Open-heart surgery
    - Two cardiac catheterization labs (diagnostic & therapeutic cardiac caths, cardiac stenting)
    - 10 bed CCU and 66 telemetry beds
    - Cardiac diagnostic evaluation center
    - Cardiac rehabilitation
- Laboratory and pathology testing
- Medical and surgical services (virtually all adult specialties performed)
- Maternal and child health
    - Labor and delivery postpartum units
    - Perinatal diagnostic center
    - Diabetes and pregnancy program
    - Neonatal intensive care unit (designated Level III, regional center for Prince George's County)
    - Inpatient pediatric unit
    - Chronic pediatric inpatient unit and outpatient program

Other specialty services:

- Ambulatory and outpatient services
    - Surgical short-stay center
    - Special procedures
    - Diabetes treatment center
    - Glenridge Medical Center (internal medicine, family practice, ob/gyn)
    - Rachel H. Pemberton Senior Health Center
    - Family Health and Wellness Center, Suitland, Maryland
- Behavioral health services
    - Inpatient psychiatric unit for adults
    - Hospital-based sexual assault center
    - Partial hospitalization program
    - Emergency psychiatric services
- Graduate medical education, internal medicine residency programs

Facilities:

- The Surgical Services and Critical Care Center Pavilion houses a 24 bed intensive care unit, 10 operating suites, a 15 bay Post Anesthesia Care Unit, 11 private room Short Stay Center, two state-of-the-art cardiac catheterization labs with 10 Transcare bays and 2 endoscopy suites with 9 recovery bays.
- The PGHC Emergency Department includes 15 acute care rooms, 4 hall area beds, a 4 bed resuscitation area, 2 isolation rooms, 2 dedicated trauma rooms, an 8 bed ambulatory emergency area, with 2 minor trauma/suture rooms and a designated ENT room, point-of-care testing, and a blood bank.
- PGHC also has a licensed, freestanding emergency department, located on the Bowie Health Center campus, with a total of 15 beds, including two cardiac rooms, 2 suture rooms, a GYN room, an isolation room, a stat lab, and radiology services.

Ownership:

- Prince George's Hospital Center is a member of Dimensions Healthcare System, the largest not-for-profit provider of health care services in Prince George's County. Dimensions Healthcare System also includes Laurel Regional Hospital, Laurel, Maryland, and Bowie Health Center, Bowie, Maryland.

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Please list the following information in Table I below. For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate during the most recent 12 month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all hospitals by the HSCRC.

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County	Percentage of Patients who are Medicaid Recipients, by County
214 Beds + 60 Bassinets	11,293	20743 20785 20747 20784 20706 20774 20737 20710 20746 20748 20745	Doctors Community Holy Cross Washington Adventist Southern Maryland Laurel Regional Fort Washington	10.8% (PGHC total patient pop.) PG County: 16% DC: 6.7%	36.5% (PGHC total patient pop., includes Medicaid pending) PG County: 24.9% DC: 5.0%

Table I

2. For purposes of reporting on your community benefit activities, please provide the following information:

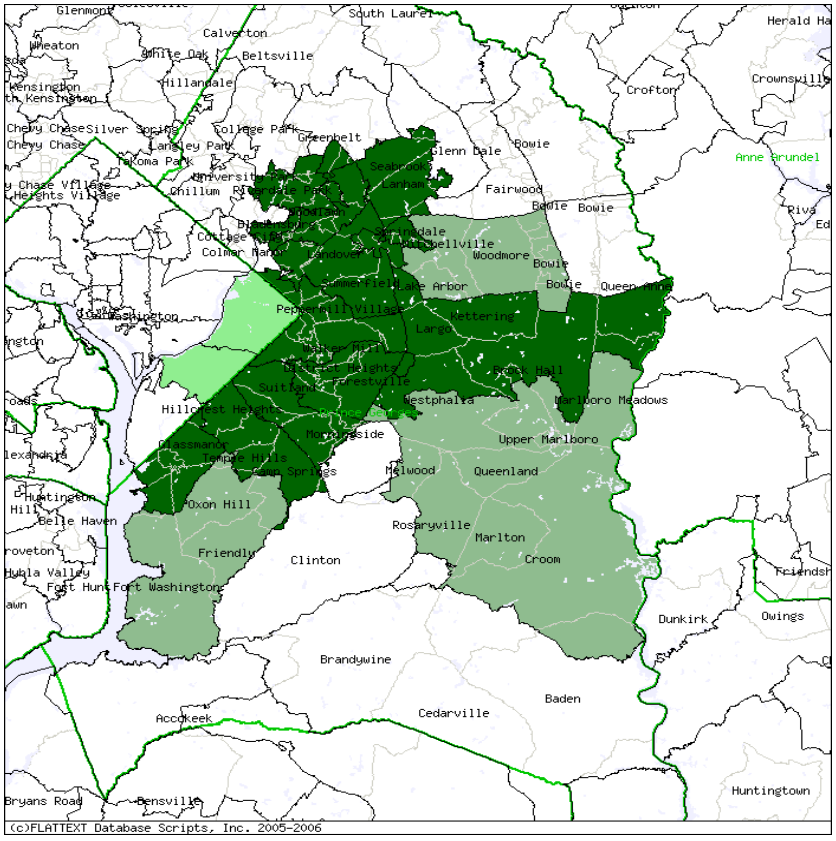
   a. Describe in detail the community or communities the organization serves. (For the purposes of the questions below, this will be considered the hospital's Community Benefit Service Area – "CBSA". This service area may differ from your primary service area on page 1.) This information may be copied directly from the section of the CHNA that refers to the description of the Hospital's Community Benefit Community.

PRINCE GEORGE'S COUNTY DEMOGRAPHICS:

The PGHC Primary Service Area is made up of 11 zip code areas within Western and Central Prince George's County.

PGHC's Primary Service Area differs from its Community Benefit Service Area (CBSA) in that its CBSA encompasses 19 zip code areas in Western and Central Prince George's County, patients from these zip code areas make up approximately 74.5% of PGHC's total inpatient and outpatient admissions. The PGHC CBSA also includes two zip code areas in the eastern portion of the District of Columbia (DC) – patients from this area make up 7.5% of PGHC's inpatient and outpatient admissions. An estimated 555,420 people make up the PGHC CBSA. The PGHC Prince George's County and DC CBSA has a population that is 78.8% African-Americans, 6.3% White (non-Hispanic) and reported as 10.8% of Hispanic origin, 2.1% of Asian origin, 2.1% of other ethnic origin.

COMMUNITY BENEFIT SERVICE AREA
FY 2014



COMMUNITY BENEFIT SERVICE AREA (74.5%)	
PG COUNTY REFERRAL AREA (67%)	
DC REFERRAL AREA (7.5%)	

(percent of inpatient and outpatient discharges)

b. In Table II, describe significant demographic characteristics and social determinants that are relevant to the needs of the community and include the source of the information in each response. For purposes of this section, social determinants are factors that contribute to a person's current state of health. They may be biological, socioeconomic, psychosocial, behavioral, or social in nature. (Examples: gender, age, alcohol use, income, housing, access to quality health care, education and environment, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary).

Some statistics may be accessed from the Maryland State Health Improvement Process, (http://dhmh.maryland.gov/ship/) and its County Health Profiles 2013, (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx), the Maryland Vital Statistics Administration (http://vsa.maryland.gov/html/reports.cfm), The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) (http://www.dhmh.maryland.gov/mhhd/Documents/1stResource_2010.pdf), the Maryland ChartBook of Minority Health and Minority Health Disparities, 3rd Edition (http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Chartbook%20of%20Minority%20Health%20and%20Minority%20Health%20Disparities%20Data,%20Third%20Edition%20(December%202012).pdf); Prince George's County Health Department, Health Report 2014 (http://www.princegeorgescountymd.gov/sites/Health/ContactUs/Publications/

Table II

Community Benefit Service Area(CBSA) Target Population (target population, by sex, race, and average age)	PGHC Total CBSA Population: 555,420 PG Cty CBSA Population: 496,286 DC CBSA Population: 59,134 Sex M – 46.6% F – 53.4% White (non-Hispanic)– 6.3% African-American – 78.8% Hispanic/Latino –10.8% Asian – 2.1% Other Race – 2.1% *Source:* ***PCA Executive Marketing Reporting (New Health Analytics) (2014)*** Prince George's County: % age < 18 years – 22.7% % age 65 and older – 10.8%

	DC: % age < 18 years – 17.2% % age 65 and older – 11.4% *Source: U.S. Census Bureau, State & County QuickFacts 2013*
Median Household Income within the CBSA (county level)	Prince George's County: $72,052 DC: $67,572 *Source: U.S. Census Bureau, 2013 ACS 1-Year Estimates*
Percentage of households with incomes below the federal poverty guidelines within the CBSA	Prince George's County: 7.1% DC: 15.7% *Source: U.S. Census Bureau, 2013 ACS 1-Year Estimates*
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links:	Prince George's County: 15.5% DC: 6.7% *Source: U.S. Census Bureau, 2013 ACS 1-Year Estimates*
Percentage of Medicaid recipients by County within the CBSA.	Prince George's County: 15.7% DC: 27.4% *Source: Community Health Status Report, 2009*
Life Expectancy by County within the CBSA.	Prince George's county: All Races: 79.2 years White: 80.3 Black: 78.4 *Source: Maryland Vital Statistics Profile: 2012* DC: 72 years *Source: Community Health Status Report, 2009*
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Prince George's County : 570.7/100,000 *Source: Maryland Vital Statistics Profile: 2012* DC: 812.74/100,000 *Source: CDC Final Data 2009*

Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources)	Risk factors for premature death in Prince George's County and DC: -- No exercise *PG: 26.3% DC: 22.2% -- Few fruits/vegetables PG: 72.1% DC: 68.1% -- Obesity *PG: 30.2% DC: 21.3% -- High blood pressure PG: 26.2% DC: 26.7% -- Smoker *PG: 16.9% DC: 20.4% -- Has diabetes PG: 11% DC: 7.8% -- HIV prevalence rate *PG: 1237.2/100,000 DC: 1,107/100,000 -- Violent crime rate PG: 865/100,000 DC: 1,400/100,000 *Source: Community Health Status Report, 2009* *Souce: *PrinceGeorge's CountyHealth Department, Health Report 2014*
Available detail on race, ethnicity, and language within CBSA.	*Please see charts on pages 10 and 11, which provide detail on race and ethnicity within the CBSA.*
Other Vulnerable populations	Vulnerable populations in Prince George's County: -- Are unemployed Prince George's County: 6.8% DC:8.9% *Source: County Health Rankings, 2014*
Other Access to primary care	Ratio of population to primary care physicians – Prince George's County – 1,804:1 DC: 854:1 Nat'l Benchmark –1051:1 (Prince George's County has substantially lower per capita numbers of primary care physicians when compared to neighboring jurisdictions.) *Source: County Health Rankings, 2014* Number of Safety Net Clinics – Prince George's County: 5 DC: 38 – 40 *Source: Prince George's County Health Improvement Plan 2011 to 2014*

Prince George's Hospital Center
Community Benefit Service Area (CBSA)
Target Population by Gender, Race, Age, and Uninsured

	PGHC CBSA Area	% of Total
2014 Total Population	555,420	100.0%
Total Male Population	258,815	46.6%
Total Female Population	296,603	53. 4%

Source: PCA Executive Marketing Reporting (New Health Analytics) (2014)

RACE/ETHNICITY

Race/Ethnicity Distribution

Race/Ethnicity	2014 Pop	% of Total	USA % of Total
White Non-Hispanic	34,780	6.3%	62.6%
Black Non-Hispanic	437,596	78.8%	13.2%
Hispanic	59,891	10.8%	17.1%
Asian & Pac. Isl. Non-Hispanic	11,649	2.1%	5.7%
All Others	10,564	2.1%	3.6%
TOTAL	555,420	100.0%	100.0%

Source: U.S. Census Bureau, ACS Community Survey (2013) and PCA Executive Marketing Reporting (New Health Analytics) (2014)

POPULATION DISTRIBUTION

Age Distribution

Age Group	2014 Pop	% of Total	USA % of Total
0 – 17	135,560	24.4%	23.3%
18 - 64	354,483	63.8%	62.6%
65 +	40,661	7.3%	14.1%
TOTAL	555,420	100.0%	100.0%

Source: U.S. Census Bureau, 2013 ACS and PCA Executive Marketing Reporting (New Health Analytics) (2014)

UNINSURED
% of Total Population

Race/Ethnicity	Prince George's County	Maryland	USA
Average, All Races	15.5%	10.2%	14.5%
White Non-Hispanic	1.2%	3.3%	12.9%
Black Non-Hispanic	6.6%	3.2%	17.1%
Hispanic	6.9%	2.9%	4.9%
Asian	0.7%	0.8%	14.6%
Some other race alone	4.2%	1.5%	1.5%

Source: U.S. Census Bureau, 2013 ACS

Prince George's Hospital Center
Vital Statistics Data

COMPARATIVE VITAL STATISTICS	PRINCE GEORGE'S COUNTY	MONTGOMERY COUNTY	STATE OF MARYLAND	*PG CTY % VARIANCE TO MONT CTY*	*PG CTY % VARIANCE TO STATE*
Age Adjusted Mortality Rates: 2009 - 2012					
All Causes of Death	718.5	514.7	714.5	*33.1%*	*0.56%*
Disease of the Heart	191.2	119.7	174.9	*45.9%*	*8.9%*
Malignant Neoplasms	165.2	126.7	166.8	*26.4%*	*-.96%*
Cerebrovascular Disease	35.2	27.5	37.4	*24.6%*	*-6.1%*
Diabetes Mellitus	27.6	13.2	19.9	*70.6%*	*32.4%*
Accidents	24.0	16.7	25.7	*35.9%*	*-6.8%*
Chronic Lower Respiratory Diseases	22.7	18.2	33.7	*22.0%*	*-39.0%*
Septicemia	16.3	10.6	14.1	*42.4%*	*14.5%*
Alzheimer's Disease	15.0	14.4	15.4	*4.1%*	*-2.3%*
Influenza and Pneumonia	13.5	13.1	16.1	*3.0%*	*-17.6%*
HIV	5.6	1.6	4.3	*111%*	*26.3%*
Nephritis, Nephrosis, and Neprotic Syndrome	14.6	8.6	12.1	*51.7%*	*18.7%*
Assault (Homicide)	10.4	2.4	7.5	*125%*	*32.4%*
Intentional Harm	5.7	7.0	8.8	*-20.5%*	*-42.8%*

Source: Maryland Vital Statistics Profile: 2012

Note: Age Adjusted Mortality Rates are adjusted to the standard U.S. 2000 population by the direct method per 100,000 population.

Community Challenges & Health Statistics:

Despite the higher than average median household income, educational attainment, and percentage of individuals in the work force represented by Prince Georgians in comparison with national figures, the County does contain several pockets of low socioeconomic status, particularly including the portions of the County that are inside the Beltway. According to the 2009 RAND Report "Assessing Health and Health Care in Prince George's County", the demographic characteristics in the County Public Use Microdata Areas (PUMAs), including PUMAs 1, 3, 4, and 7 within the Beltway, all report vulnerable populations with lower incomes, majority Black and growing Hispanic populations. The 2009 Community Health Status Report data reveal that medically

vulnerable Prince Georgian's (uninsured and Medicaid enrolled individuals) number approximately 297,784 or 35.7% of the total population.

According to the CDC document Summary Health Statistics of the U.S. Population: National Health Interview Survey being poor and uninsured are two of the strongest determinants of whether a person "did not receive medical care", or whether they "delayed" seeking care.

As a result, issues such as diabetes mortality, heart disease, hypertension, stroke, deaths from breast, colorectal and prostate cancers, HIV and infant mortality all represent significant health challenges for community members. Furthermore, persistent disparities in mortality and health status for several health indices are seen in various racial and ethnic populations. Among Prince George's residents, relatively high rates of asthma, obesity, and homicide are additional areas of concern. These are certainly planning considerations in this majority minority community. Additionally, the racial and ethnic minorities are approximately 2/3 of Prince George's County Medicaid beneficiaries. County and Maryland State health statistics are similar to national trends regarding the status of minority health.

IDENTIFICATION OF COMMUNITY HEALTH NEEDS:

PGHC management actively solicits information from the Prince George's County Health Department and other community-based organizations to assess the health needs in our community. PGHC representatives serve as members on a variety of healthcare focused community organizations and provide staff expertise and other resources, including hosting meetings at our facilities, and participating in events by providing the health screening services. Some of these organizations include:

- Prince George's Care Access Network Health Information and Resource Initiative (PG CAN)
- Health Action Forum of Prince George's County
- Prince George's Healthcare Action Coalition
- National Capital Area Breast Health Quality Consortium
- The Prince George's County Local Health Disparities Committee
- The Health Empowerment Network of Maryland, Inc. (HENM) - a Community Based Organization made up of partners such as the Prince George's County Health Department, University of Maryland Prevention Resource Center, Prince George's County Area Agency on Aging, Department of Health and Mental Hygiene, Integrity Health Partners and the City of Seat Pleasant, among others.
- Primary Care Coalition of Montgomery County
- Susan G. Komen Foundation

PGHC has partnered with community-based organizations to increase their capacity to provide services to the community. This includes providing healthcare providers at various Federally Qualified Health Centers (FQHC) sites in Prince George's County to facilitate access to sub-specialty services for uninsured and underinsured residents.

PGHC has also worked with local and state health officials to develop the Prince George's County and the State Health Improvement Plans and continues to work closely with the Health Department to implement programs that address the health plan goals.

PGHC has completed a formal community health needs assessment (CHNA), as required by the Patient Protection and Affordable Care Act. The CHNA, inclusive of the Implementation Strategy Plan, can be found in the next section of the report.

PGHC has also reviewed, sponsored, and/or collaborated on, a number of additional community needs assessments including the following reports:

- "Assessing Health and Health Care in Prince George's County", completed by the RAND Corporation (RAND) (February 2009)

- "Prince George's County Health Improvement Plan 2011 to 2014 – Blueprint for a Healthier Community", completed by the Prince George's County Government (September 2011)

- "Transforming Health in Prince George's County, Maryland: A Public Health Impact Study" completed by the University of Maryland School of Public Health (UM SPH) (July 2012)

The main findings of the 2009 RAND Report, the Prince George's County Report, and the 2012 UM SPH Public Health Impact Study are that there continues to be significant health disparities in Prince George's County and that the County lacks a robust primary care safety net. The mission of PGHC is to continue to provide high quality and efficient healthcare services to preserve, restore and improve health status in partnership with the community, and to continually seek to expand the health safety net available to the uninsured and vulnerable residents of the County.

In light of the above, the two largest community benefit expenditures made by PGHC are the mission-driven, non-reimbursed subsidies paid to its physicians, and charity care expenditures -- expenditures that both guarantee the continuation of the PGHC safety net mission.

II. COMMUNITY HEALTH NEEDS ASSESSMENT

According to the Patient Protection and Affordable Care Act ("ACA"), hospitals must perform a Community Health Needs Assessment (CHNA) either fiscal year 2011, 2012, or 2013, adopt an implementation strategy to meet the community health needs identified, and perform an assessment at least every three years. The needs assessment must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special

knowledge of or expertise in public health, and must be made widely available to the public.

For the purposes of this report, the IRS defines a CHNA as a:

> Written document developed for a hospital facility that includes a description of the community served by the hospital facility: the process used to conduct the assessment including how the hospital took into account input from community members and public health experts; identification of any persons with whom the hospital has worked on the assessment; and the health needs identified through the assessment process.

The written document (CHNA) must include the following:

A description of the community served by the hospital and how it was determined;

A description of the process and methods used to conduct the assessment, including a description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs. It should also describe information gaps that impact the hospital organization's ability to assess the health needs of the community served by the hospital facility. If a hospital collaborates with other organizations in conducting a CHNA the report should identify all of the organizations with which the hospital organization collaborated. If a hospital organization contracts with one or more third parties to assist in conducting the CHNA, the report should also disclose the identity and qualifications of such third parties;

A description of how the hospital organization took into account input from persons who represent the broad interests of the community served by the hospital facility, including a description of when and how the hospital consulted with these persons (whether through meetings, focus groups, interviews, surveys, written correspondence, etc.). If the hospital organization takes into account input from an organization, the written report should identify the organization and provide the name and title of at least one individual in such organizations with whom the hospital organization consulted. In addition, the report must identify any individual providing input who has special knowledge of or expertise in public health by name, title, and affiliation and provide a brief description of the individual's special knowledge or expertise. The report must identify any individual providing input who is a "leader" or "representative" of certain populations (i.e., healthcare consumer advocates, nonprofit organizations, academic experts, local government officials, community-based organizations, health care providers, community health centers, low-income persons, minority groups, or those with chronic disease needs, private businesses, and health insurance and managed care organizations);

A prioritized description of all the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs; and

A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

In order to meet the requirement of the CHNA for any taxable year, the hospital facility must make the CHNA widely available to the Public and adopt an implementation strategy to meet the health needs identified by the CHNA by the end of the same taxable year.

The IMPLEMENTATION STRATEGY must:

a. Be approved by an authorized governing body of the hospital organization;

b. Describe how the hospital facility plans to meet the health need; or

c. Identify the health need as one the hospital facility does not intend to meet and explain why it does not intend to meet the health need.

1. Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 4-5 within the past three fiscal years?

   __X__Yes

   ____No

   Provide date here. _06_/_07_ /_13_ (mm/dd/yy)

   If you answered yes to this question, provide a link to the document here.

   http://www.dimensionshealth.org/wp-content/uploads/2013/07/FINAL-PGHC-CHNA-REPORT.2013.pdf

2. Has your hospital adopted an implementation strategy that conforms to the definition detailed on page 5?

   _X__Yes

___No

If you answered yes to this question, provide the link to the document here.

http://www.dimensionshealth.org/wp-content/uploads/2013/11/PGHC-ISP-10-24-13.pdf

Multiple methods were used to study the significant health needs within PGHC hospital service area (HSA). Specifically, the PGHC CHNA included a six step process:

- Step 1: Analysis of PGHC hospital discharge data to identify the most frequent diseases within PGHC HSA.
- Step 2: Analysis of a household survey among Prince George's County resident in 2012 to evaluate resident's perception of health needs.
- Step 3: Professionally facilitated meeting among Prince George's County community leaders to get in-depth opinions of community health needs.
- Step 4: Professionally facilitated meeting among Prince George's County health experts to get in-depth opinions of community health needs.
- Step 5: Collection of the existing county, state, and national statistics of health needs as the reference to the PGHC CHNA findings.
- Step 6: Identification of top 3-5 significant health needs of PGHC HAS through the analyses from steps 1 - 5; recommendations of meaningful health improvement plans will be developed and discussed as well.
- Final CHNA that documents the CHNA methods, results, and recommendations.

Based on CHNA, PGHC developed an implementation strategy to address selected community health needs. The objective is to engage in community benefits activities that effectively improve community health.

The primary data sources were PGHC Inpatient, Outpatient, and Emergency Department (ED) Discharge Data from January 2010 through November 2012. These hospital discharge data provided detailed information on patients, including age, gender, ICD9 codes, as well as the zip codes of their residence.

The top zip codes listed in the PGHC CBSA represented 62% of all PGHC inpatient discharge data from 2010-2012, and hence were considered as PGHC Hospital Services Area (HSA). We summarized patient demographic characteristics and health insurance coverage, and calculated the ICD9 codes by frequency to identify the most common diseases reported in each of these three departments (i.e. inpatient, outpatient, and ED) at PGHC HSA (i.e. among the
listed zip codes).

Identified needs were reviewed, selected and prioritized for implementation based on community needs, existing programming, strengths, resource allocation, operational alignment and partnerships.

The three areas of focus identified for Prince George's Hospital Center for implementation of community health improvement programs and initiatives included:

- diabetes;
- heart disease; and
- pregnancy and childbirth complications.

These were then linked to key healthcare administration areas that included:

- health access and primary care;
- disease prevention and management; and
- health integration and coordination.

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?

a. Is Community Benefits planning part of your hospital's strategic plan?

_X__Yes

___No

b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and provide additional information if necessary):

i. Senior Leadership

1. __X_CEO
2. __X_CFO

3. __X__Other (please specify – COO, General Counsel, Vice President, Community Relations)

ii. Clinical Leadership

1. _X__Physician
2. ___Nurse
3. ___Social Worker
4. ___Other (please specify)

iii. Community Benefit Department/Team

1. __X_Individual (please specify 2.0)

2-FTE dedicated to Community Benefit

2. __X_Committee (please list members)
3. ___Other (please describe)

Committee: CEO, COO, CFO, General Counsel, VP – Reimbursement, VP –Medical Affairs, VP – Community Relations, System Controller, Director – Finance, Director – Strategic Planning, Community-Based Health Manager.

c. Is there an internal audit (i.e., an internal review conducted at the hospital) of the Community Benefit report?

Spreadsheet ___X__yes _____no

Narrative ___X__yes _____no

d. Does the hospital's Board review and approve the completed FY Community Benefit report that is submitted to the HSCRC?

Spreadsheet __X___yes _____no

Narrative __X___yes _____no

If you answered no to this question, please explain

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES
This Information should come from the implementation strategy developed through the CHNA process.

1. Please use Table III (see attachment) to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each initiative and how the results will be measured, time allocated to each initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on the measured outcomes, and the current FY costs associated with each initiative. Use at least one page for each initiative (at 10 point type). Please be sure these initiatives occurred in the FY in which you are reporting.
Please see attached examples of how to report.

For example: for each principal initiative, provide the following:

a. Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups.

b. Name of Initiative: insert name of initiative.

c. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics that will be used to evaluate the results (Use several pages if necessary)

d. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?

e. Key Partners in Development/Implementation: Name the partners (community members and/or hospitals) involved in the development/implementation of the initiative. Be sure to include hospitals with which your hospital is collaborating on this initiative.

f. How were the outcomes of the initiative evaluated?

g. Outcome: What were the results of the initiative in addressing the identified community health need, such as a reduction or improvement in rate? (Use data to support the outcomes reported). How are these outcomes tied to the objectives identified in item C?

h. Continuation of Initiative: Will the initiative be continued based on the outcome?

i. Expense: What were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.

Prince George's Hospital Center has implemented a number of community benefit initiatives and programs (see attached Table III). The current initiatives and programs are as follows:

- Sexual Assault / Sexual Abuse Program
- Community-Based Care Transition Program
- Prince George's / Wards 7 & 8 Community Breast Health Link
- Prince George's Health Enterprise Zone
- Area Agency on Agency Dental Program
- Diabetes Education

For the fiscal years ending June 30, 2013 and June 30, 2014 PGHC had total community benefit expenditures (as a percent of total operating expenditures) of 24.06% and 27.46%, respectively. Each year, PGHC's total CB expenditures rank as one of the highest for all hospitals in the State of Maryland. PGHC's fiscal year 2014 CB expenditures are primarily made up of mission-driven physician subsidies at $41,741,925 or 19.46% and charity care at $15,861,400 or 7.9% -- 27.36% total combined for the fiscal year ending June 30, 2014.

PGHC provided $57,603,325 in mission-driven physician subsidies and charity care in the fiscal year ending June 30, 2014. To fund this high level of physician subsidies and charity care, PGHC depends on State and County financial support. In light of PGHC's continued financial challenges and reliance on State and County financial resources, PGHC has limited funds or other resources to earmark for other high-level CB initiatives.

2. Were there any primary community health needs that were identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples include other social issues related to health status, such as unemployment, illiteracy, the fact that another nearby hospital is focusing on an identified community need, or lack of resources related to prioritization and planning.) This

information may be copied directly from the CHNA that refers to community health needs identified but unmet.

While the total range of community health needs is important, PGHC is not currently focusing on top health concerns identified by the CHNA such as respiratory health and septicemia due to the lack of available resources to make the most impactful changes in these areas. These needs did not emerge as community health needs focus areas, but they as well as other chronic diseases and co-morbidities will be taken into account and incorporated into the strategic plan where appropriate. PGHC currently provides emergency psychiatric, inpatient behavioral health and outpatient partial hospitalization services to assist with the mental health needs in the community. As a result, this area was not selected as one of the community health needs focus areas. Though these needs are not presently being addressed by PGHC as an area of focus, the hospital will explore opportunities to collaborate with other community and public health organizations such as the health department and federally qualified health centers to address these needs.

V. PHYSICIANS

1. As required under HG§19-303, provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand. The categories include: Hospital-based physicians with whom the hospital has an exclusive contract; Non-Resident house staff and hospitalists; Coverage of Emergency Department Call; Physician provision of financial assistance to encourage alignment with the hospital financial assistance policies; and Physician recruitment to meet community need.

DESCRIPTION OF PHYSICIAN SUBSIDIES AND THE GAPS IN THE AVAILABILITY OF SPECIALIST PROVIDERS TO SERVE THE UNINSURED:

An adequate supply of primary care physicians can reduce rates of complications that can result in high cost ED visits and hospitalizations. In recent years, the per-capita number of primary care physicians has declined in Prince George's County. Also, the per-capita number of primary care physicians in Baltimore, Howard, and Montgomery counties, and the District of Columbia, exceeded that of Prince George's County by one and a half to two times. Prince George's County also has substantially fewer specialists of all types compared with other jurisdictions. For 18 of 31 specialties, the per-capita supply of physicians in all surrounding jurisdictions exceeded the supply in Prince George's County by 125% or more.

Per the aforementioned 2009 RAND report, overall, the tendency of Prince George's County residents to use inpatient care within the County (or cross into the District of Columbia) or Montgomery County is strongly related to payor source. Inpatients with private insurance were least likely (26.1%) and patients with Medicaid were the most likely (61.7%) to be discharged from hospitals located in Prince George's County. Also, Prince George's Hospital Center discharges a disproportionate share of Medicaid patients suggesting that the Hospital serves as a defacto safety-net provider.

Per the Prince George's County Health Improvement Plan 2011 to 2014, there is only a small number federally qualified health centers (FQHC) and non-FQHC safety-net clinics within Prince George's County compared to neighboring jurisdictions. These clinics combined can provide care to only a fraction of the County's uninsured. Access to care is further exacerbated by the growing number of County private physicians unwilling to accept Medicaid/Medicare patients. Prince George's County is not a Health Profession Shortage Area, although small portions of the County (primarily within PGHC's CBSA) are federally designated as medically underserved areas or underserved populations. Per the Report, when comparing Prince George's County health resources to those of neighboring jurisdictions, the differences are remarkable:

Jurisdiction	Number of uninsured Under Age 65*	Number of Safety Net Clinics	Number of Primary Care Physicians per 100,00 Population (2011)**
Prince George's County	92,275	5	72.5
Montgomery Count	77,902	11	175
Baltimore County	56,832	44***	135
Washington, D.C.	24,746	38 - 40	210

* ACS Community Survey (2013)
**Health Indicators Warehouse (http://www.healthindicators.gov/), retrieved December 14, 2014
***Mid-Atlantic Community Health Center Association (1/2009)
****RAND Report (Area Resource File 2005 and U.S. Census Bureau)

In light of the County's high uninsured or underinsured population providing little or no reimbursement, the County's level of private-practice primary care doctors and primary care clinics has not kept pace with the health care needs of County residents. The capacity of community-based care, including safety-net clinics, remains severely limited. This lack of primary care services and patient "medical homes" has resulted in increased use of the Hospital's emergency departments and other specialty health care services. For the fiscal year ending June 30, 2013, PGHC had a patient and third party payer mix that included 57.9% Medicaid and uninsured self-pay patients.

Category 1 – Hospital-Based Physician Subsidies

PGHC's emergency departments, and other specialties including intensive care, obstetrics/gynecology, anesthesia, cardiology, internal medicine, psychiatry, pathology, and radiology, are staffed by Hospital-based physicians, with whom the hospital has exclusive contracts, seeking guaranteed levels of compensation through hospital provided subsidies. The subsidies cover gaps in physician income that are the outcome of PGHC's disproportionate share of underinsured or uninsured patients.

Although such care in this setting is likely to be more expensive and less-clinically appropriate than care in other settings, by providing emergency and other specialty services to the County's uninsured and underinsured population, PGHC provides an ongoing community benefit to residents unable to obtain much needed health care services.

Category 4 – Physician Provision of Financial Assistance to Align with the Financial Assistance Policy (FAP)

The provision of physician reimbursement subsidies to cover free or discounted care through the Hospital's FAP is consistent, appropriate and essential to the execution of the Hospital's mission, vision, and values, and is consistent with its tax-exempt, charitable status.

Category 5 – Physician Recruitment to Meet Community Need

The PGHC physician subsidies also include expenses incurred for ongoing physician recruitment.

Prince George's County has far fewer primary care providers for the population compared to surrounding counties and the State. The areas with the highest primary care need are within the Beltway and in the southern region of the County. Although Prince George's County lacks a sufficient primary care safety-net infrastructure and has one of the largest uninsured populations in the State, PGHC's mission provides that all patients should receive the highest level of care regardless of economic standing. As mentioned, PGHC's physician subsidies outlined in category C of the CB Inventory Sheet are primarily subsidies to cover the compensation of Hospital-based physicians with whom the Hospital has exclusive contracts.

VI. APPENDICES

To Be Attached as Appendices:

1. Describe your Financial Assistance Policy (FAP):
    a. Describe how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's FAP. (label appendix I)

For ***example***, state whether the hospital:

- Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
    - in a culturally sensitive manner,
    - at a reading comprehension level appropriate to the CBSA's population, and
    - in non-English languages that are prevalent in the CBSA.

- posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
- provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
- provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
- includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills; and/or
- discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

b. Include a copy of your hospital's FAP (label appendix II).
c. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) (label appendix III).

2. Attach the hospital's mission, vision, and value statement(s) (label appendix IV).

1.

a. APPENDIX I -- FINANCIAL ASSISTANCE PROGRAM

PGHC has a long tradition of serving the poor, the needy, and all who require health care services. However, the Hospital alone cannot meet every community need. We practice effective stewardship of resources in order to continue providing accessible and effective health care services. In keeping with effective stewardship, the provision for financial assistance is budgeted annually. PGHC continues to play a leadership role in the community by helping to promote community-wide responses to patient needs, in partnership with government and private organizations.

In order to promote the health and well-being of the community served, individuals with limited financial resources who are unable to access entitlement programs are eligible for free or discounted health care services based on established criteria. An eligibility criterion is based upon the Federal Poverty guidelines and is updated annually in conjunction with the published updates by the United States Department of Health and Human Services. All open self-pay balances are considered for financial assistance. If a determination is made that the patient has the ability to pay all or a portion of the bill, such a determination does not prevent a reassessment of the person's ability to pay at a later date.

To be considered for financial assistance, the patient must cooperate with the facility to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for his or her health care, such as Medicaid. Patients are responsible for completing the required application forms and cooperating fully with the information gathering and assessment process, in order to determine eligibility for financial assistance.

Appropriate signage is visible in the facility in order to create awareness of the financial assistance program and the assistance available. Signage is posted in all patient intake areas, including, but not limited to, the Emergency Department, the Billing Office, and the Admission/Patient Registration areas. Information such as brochures is included in patient services/information folders and/or at patient intake areas. All public information and/or forms regarding the provision of financial assistance use languages that are appropriate for the facility's service area in accordance with the State's Language Assistance Services Act.

The necessity for medical treatment of any patient is based on the clinical judgment of the provider without regard to the financial status of the patient. All patients are treated with respect and fairness regardless of their ability to pay.

b. APPENDIX II -- FINANCIAL ASSISTANCE PROGRAM POLICY (Attached)

c. APPENDIX III – PATIENT INFORMATION SHEET (Attached)

2. Attach the hospital's mission, vision, and value statement(s) (label appendix IV).

APPENDIX IV – MISSION, VISION AND VALUES STATEMENT (Attached)

Description of the PGHC Mission, Vision and Value Statements:

- The mission of PGHC is to provide comprehensive health care with the highest quality to residents, and others who use our services while strengthening our relationships with universities, research and health care organizations to ensure best in class patient care.

- The vision of PGHC is to be recognized as a premier regional health care system.

- The values of PGHC include respect, excellent service, personal accountability, quality, open communication, innovative environment, and safety.

TABLE III

HOSPITAL COMMUNITY BENEFIT PROGRAMS AND INITIATIVES

APPENDIX II

FINANCIAL ASSISTANCE PROGRAM POLICY #210-01

APPENDIX III

PATIENT INFORMATION SHEET
"WHAT YOU SHOULD KNOW AS A PATIENT"

APPENDIX IV

MISSION, VISION, AND VALUES STATEMENT #200-24