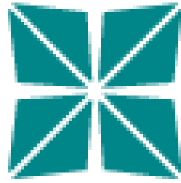


COMMUNITY BENEFITS REPORT FOR THE FISCAL YEAR JULY 1, 2015 – JUNE 30, 2016

Laurel Regional Hospital

7300 Van Dusen Road
Laurel, Maryland 20707
301-725-4300

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 benefit activities. The guidelines and inventory spreadsheet were guided, in part, by the VHA, Catholic Health Association (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.

LAUREL REGIONAL HOSPITAL:

Laurel Regional Hospital (LRH) was founded in 1978 and is a not-for-profit, full-service community hospital serving residents of Prince George's County and portions of Anne Arundel, Howard, and Montgomery counties. Laurel Regional Hospital is conveniently located in Laurel, Maryland and is a member of Dimensions Healthcare System (DHS). In addition to providing high quality, efficient healthcare services, Laurel Regional Hospital also offers a variety of free health, wellness, and education programs to the communities it serves.

Leadership: Chairman, DHS Board of Directors – The Honorable C. Philip Nichols, Jr.

Chairman, LRH Board of Directors - Ulric Donawa

DHS President & CEO – Neil Moore, MBA, MPA, MPH

DHS, Senior Vice President/Chief Operating Officer - Sherry Perkins PhD, RN

President, LRH (Interim) – Trudy Hall, M.D.

Chief Nursing Officer – Fe Nieves-Khouw

Location: 7300 Van Dusen Road, Laurel, Maryland 20707

Facility type: Full-service community hospital

Licensed Bed Designation: 134

Included are: 60 - Inpatient Acute
28 - Inpatient Medical Rehabilitation
46 - Special Hospital (Chronic)

Inpatient Admissions for FY 2016: 3983, plus 164 births

No. of employees: 517

Services:

Laurel Regional Hospital provides a comprehensive range of inpatient and outpatient services including:

- Behavioral Health Services (with an inpatient psychiatric unit for adults and outpatient partial hospitalization program)
- Cardiopulmonary Services (Echo, EKG, Stress tests, EEG, PFT)
- Diabetes Services (inpatient and outpatient services)
- Critical Care Services (includes -bed intensive care unit)
- Emergency Services (24-hour emergency care)
- Infusion Services (outpatient intravenous infusion services)
- Medical / Surgical Services (virtually all adult specialties performed)
- Physical Rehabilitation (only hospital-based accredited inpatient rehabilitation unit in Prince George's County)
- Pulmonary Rehabilitation (outpatient pulmonary rehabilitation program)
- Sleep Wellness Center (sleep medicine services)
- Specialty Care Unit (chronic care specialty unit providing comprehensive nursing care in a full-service hospital environment)
- Wound Care & Hyperbaric Medicine Center (wound treatment and healing services)

Facilities:

- The emergency department includes 14 acute rooms; 10 intermediate rooms; 6 fast track rooms (ambulatory care) and one resuscitation/trauma room; 4 isolation rooms and 3 more that can be converted to negative pressure isolation rooms; POC (Point of Care) lab, and blood bank located in the main lab.

- In-house Infusion Services (3 chairs).

- In-house Specialty Care Unit includes 46 beds.

- Surgical services houses 3 operating suites, a 10-bed intensive care unit and 2 endoscopy suites.

Ownership:

Laurel Regional Hospital is a member of Dimensions Healthcare System, the largest not-for-profit provider of healthcare services in Prince George's County. Dimensions Healthcare System also includes Prince George's Hospital Center, Cheverly, 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.

Table I

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:
134		20707 20708 20705 20706 20723 20724 20740 20904 20770 20784 20866 20774	Washington Adventist Howard County General Montgomery General Doctors Community Holy Cross Prince George's Hospital Center	LRH total patient population: 12% Prince George's: 64.6% DC: 2.4% Other: 33.0%	LRH total patient population: 22.4% Prince George's: 62.1% DC: 2.4% Other: 35.5%

PRIMARY SERVICE AREA DEMOGRAPHICS:

Laurel Regional Hospital's (LRH) Primary Service Area (PSA) consists of 12 zip code areas within northern Prince George's County and portions of Anne Arundel, Howard and Montgomery counties.

The counties within the LRH PSA are affluent: Howard County being the wealthiest with a median household income of $128,398. Montgomery County has the largest population with an estimated 1,040,116 residents. Prince George's County has the largest African American population at 63.8 percent, making it one of the few majority-minority counties in Maryland. All counties within the LRH PSA have also experienced growth in Hispanic or Latino populations with Montgomery County (17.9%) and Prince George's County (15.9%) seeing the largest growth. Much like other counties throughout Maryland and the nation, each of these counties face challenges geared towards the administration of health services. The bulk of those challenges are due to the lack of access to health care (especially primary care), a high uninsured population, and disparate health among ethnic groups.

For all counties within the LRH PSA, smoking, obesity, high blood pressure and diabetes are significant health risk factors with Prince George's, Montgomery and Anne Arundel counties experiencing the highest percentages of premature deaths due to these conditions (*County Health Rankings 2016*). It is also important to note here that Prince George's County represents the largest portion of the PSA and faces the greatest health challenges when compared to neighboring counties. Data provided in this report will show that within the service area, socioeconomic status and healthcare access affect health outcomes and contribute to disproportionate care within the population.

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.

Much like the LRH PSA, the LRH Community Benefit Service Area (CBSA) also covers portions of four different counties. However LRH's CBSA differs from its PSA in that it expanded in FY2016 to encompass 27 zip codes. The zip code areas in the LRH CBSA are: 20705, 20706, 20707, 20708, 20715, 20716, 20720, 20721, 20723, 20724, 20737, 20740, 20743, 20747, 20770, 20774, 20782, 20783, 20784, 20785, 20794, 20866, 20904, 20906, 21045, 21061 and 21144. Eighteen of these zip codes are in Prince George's County, three in Anne Arundel County, three in Howard County and three in Montgomery County.

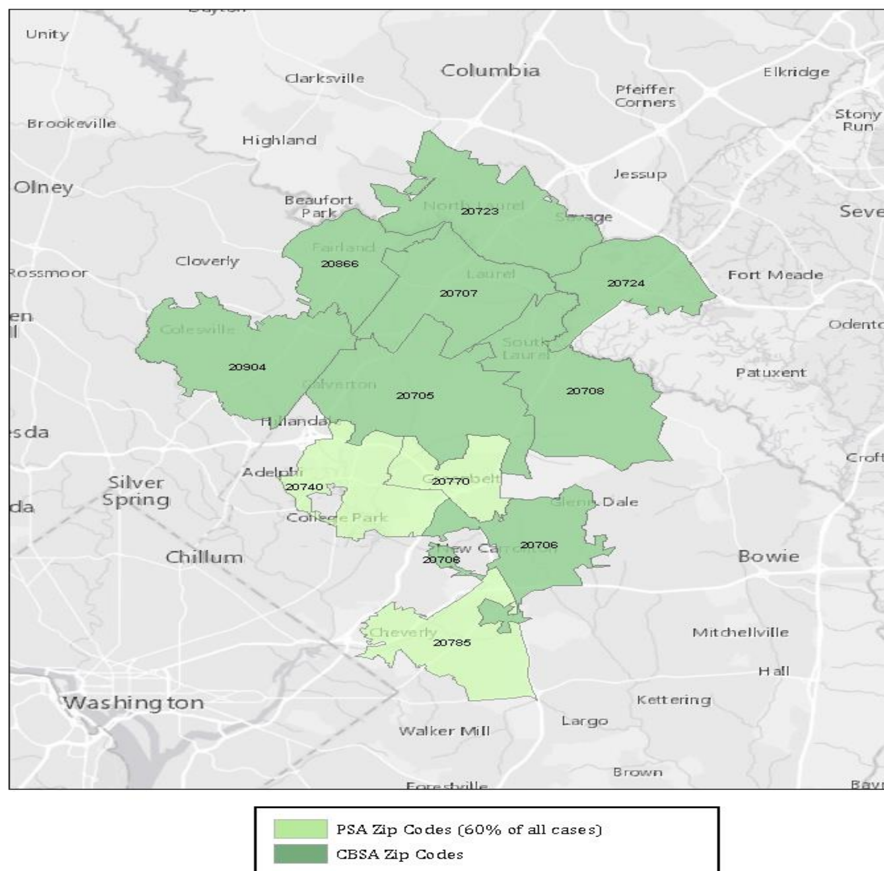
Patients from these zip code areas make up approximately 75% of LRH's total inpatient

and outpatient admissions. Patients from Prince George's County represent about 47% of these admissions while patients from Anne Arundel, Montgomery, and Howard counties represent 6.6%, 5%, and 2.8% respectively. More than 261,000 people make up the LRH CBSA: 45.8% are African-American, 20.7% White (non-Hispanic), 18.6% of Hispanic origin, 11.6% of Asian origin and 0.3% are of other ethnic origin.

In terms of identified need, it should be noted here again that the zip code areas in Prince George's County have been identified to have the greatest need for health services geared towards improving health status and disparities. At 9.3%, Prince George's County has the highest percentage of households with incomes below the federal poverty level as well as higher percentages of uninsured (10.9%), Medicaid recipients (31.6%) and the second highest mortality rate (593.6/100,000 people). As will be discussed later in this report, Prince George's County has been the focal point of a number of studies to improve access to care and health outcomes.

LRH COMMMUNITY BENEFIT SERVICE AREA FY 2016

Community Benefit Service Area
FY 2016



LRH Primary Service Area (PSA) 2016 Total LRH Cases (all counties) 2016: **4,291**				
ZIP	**NAME**	**COUNTYNAME**	**# Cases**	**% of Total Cases**
20707	Laurel	Prince George's Co	781	18.2%
20708	Laurel	Prince George's Co	536	12.5%
20705	Beltsville	Prince George's Co	431	8.0%
20724	Laurel	Anne Arundel County	320	7.5%
20904	Silver Spring	Montgomery County	151	3.5%
20706	Lanham	Prince George's Co	125	2.9%
20723	Laurel	Howard County	119	2.8%
20770	Greenbelt	Prince George’s Co	72	1.7%
20866	Burtonsville	Montgomery County	65	1.5%
20774	Upper Marlboro	Prince George’s Co	60	1.4%
20784	Hyattsville	Prince George’s Co	59	1.4%
20740	College Park	Prince George’s Co	58	1.4%
Running Total			**2,628**	**61.2%**

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.)

Table II

Community Benefit Service Area(CBSA) Target Population (target population, by sex, race, and average age)	CBSA Population: 248,025 Sex M – 47.7% F – 52.3% White (non-Hispanic)– 23.4% African-American – 45.8% Hispanic/Latino –16.5% Asian –11% Multiple Race – 2.7% Other Race –.3% *Source: PCA Executive Marketing Reporting (New Health Analytics) (2016)*
Median Household Income within the CBSA (county level)	Prince George’s County: $76,741 Anne Arundel County : $91,230

	Howard County: $110,892 Montgomery County: $98,917 ***Source: US Census Bureau,*** 2015 American Community Survey 1-Year Estimates
Percentage of households with incomes below the federal poverty guidelines within the CBSA	**County level** Prince George's County: 9.3% Anne Arundel County : 5.6% Howard County: 4.5% Montgomery County: 7.5% ***Source: US Census Bureau,*** 2015 American Community Survey 1-Year Estimates
Please estimate the percentage of uninsured people by County within the CBSA.	Prince George's County: 17% Anne Arundel County : 9% Howard County: 8% Montgomery County: 12% ***Source: County Health Rankings, Maryland Data, 2016***
Percentage of Medicaid recipients by County within the CBSA.	Prince George's: 31.6% Anne Arundel: 27.3% Howard: 21.7% Montgomery: 25.3% Source: U.S. Census Bureau, 2015 American Community Survey 1-Year Estimates
Life Expectancy by County within the CBSA.	**All races (White & Black)** Prince George's County: 80 years Anne Arundel County : 79.8 years Howard County: 83 years Montgomery County: 84.6 years ***Source: Maryland Vital Statistics Annual Report, 2014***
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Prince George's County : 593.6/100,000 Anne Arundel County : 735.5/100,000 Howard County: 522.5/100,000

<table>
<tr><td></td><td>Montgomery County: 573.2/100,000

Source: Maryland Vital Statistics Profile: 2014</td></tr>
<tr><td>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)

PG – Prince George’s

AA – Anne Arundel

H- Howard

M- Montgomery</td><td>Risk factors for premature death in CBSA Counties:

<table>
<tr><th></th><th>PG</th><th>AA</th><th>H</th><th>M</th></tr>
<tr><td>No exercise</td><td>24%</td><td>21%</td><td>18%</td><td>18%</td></tr>
<tr><td>Food Environment Index*</td><td>7.5</td><td>8.6</td><td>9.1</td><td>9.2</td></tr>
<tr><td>Obesity</td><td>33%</td><td>28%</td><td>23%</td><td>19%</td></tr>
<tr><td>High blood pressure</td><td>26.2%</td><td>28.2%</td><td>19.8%</td><td>22.4%</td></tr>
<tr><td>Smoker</td><td>13%</td><td>16%</td><td>10%</td><td>8%</td></tr>
<tr><td>Diabetes</td><td>11.4%</td><td>9.4%</td><td>8%</td><td>7.6%</td></tr>
</table>
Source: County Health Rankings, Maryland Data, 2016 and CDC, Data and Statistics (2012)
*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)</td></tr>
<tr><td>Other

Vulnerable populations</td><td>Vulnerable populations in Prince George’s County: Are unemployed

Prince George’s County: 5.9%

Anne Arundel County : 5.2%

Howard County: 4.4%

Montgomery County: 4.4%

Source: County Health Rankings 2016</td></tr>
<tr><td>Other

Access to primary care</td><td>Ratio of population to primary care physicians:

Prince George’s County – 1,860:1

Anne Arundel County - 1,390:1

Howard County- 510:1

Montgomery County – 720:1

Nat’l Benchmark – 1,040:1

(Prince George’s County has substantially lower per capita numbers of primary care physicians when compared to neighboring jurisdictions.)

Source: County Health Rankings 2016</td></tr>
</table>

Laurel Regional Hospital Community Benefit Service Area (CBSA)
Target Population by Gender, Race, Age

Gender	**CBSA Area**	**% of Total**
2015* Total Population	248,025	100%
Total Male Population	118,349	47.7%
Total Female Population	129,676	52.3%

Source: PCA Executive Marketing Reporting (New Health Analytics) (2016)

Race/Ethnicity	**2015 Population**	**% of Total**	**USA % of Total**
White (Non-Hispanic)	58,146	23.4%	73.1 %
Black (Non-Hispanic)	113,590	45.8%	12.7%
Hispanic	41,038	16.5%	17.6%
Asian (Non-Hispanic)	27,232	11%	5.4%
All Others	7,463	3.2%	4.8%
Total	248,025	100%	

Source: U.S. Census Bureau, 2014 ACS

Age Distribution	**2015 Population**	**% of Total**	**USA % of Total**
Ages 0-17	60,330	24.3%	22.9%
Ages 18-64	158,913	64.1%	62.2%
Ages 65 and over	28,782	11.6%	14.9%
Total	248,025	100%	

Source: U.S. Census Bureau, 2015 ACS and PCA Executive Marketing Reporting (New Health Analytics) (2016)

Laurel Regional Hospital Community Benefit Service Area (CBSA)
Target Population Uninsured & Vital Statistics Data

Uninsured by County	**Prince George's**	**Anne Arundel**	**Howard**	**Montgomery**	**Maryland**	**USA % of Total**
Average, All Races	10.9%	5%	4.2%	8.2%	6.6%	9.4%
White (Non-Hispanic)	6.7%	4.2%	3.3%	5.3%	4.6%	8.4%
Black (Non-Hispanic)	6.9%	5.3%	5.4%	9.2%	6.8%	11%
Hispanic	32.5%	18.6%	18.3%	21.7%	23.6%	19.5%
Asian	9.6%	11.1%	5.7%	7.2%	7.6%	7.8%
Some other race alone	37.4%	23.6%	14.7%	27.7%	30.9%	21.4%

Source: U.S. Census Bureau, 2015 ACS, 1-Year Estimates

Community Challenges & Health Statistics:

Table II and subsequent data tables provide a comparative analysis of the demographic characteristics of the counties within the CBSA. However, since the larger portion of the LRH CBSA is within Prince George's County, the remainder of this report will focus on the health status and needs of Prince George's County residents.

In comparison with national figures, despite the higher than average median household income, educational attainment, and the percentage of Prince Georgians represented in the work force, the County does contain several pockets of low socioeconomic status, particularly those 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 of which are Black and growing Hispanic populations. The 2009 Community Health Status Report data reveals that medically vulnerable Prince Georgian's (uninsured and Medicaid enrolled individuals) account for 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. In its *Health Report 2015*, the Prince George's County Health Department reported that in 2013, an estimated 15.5% of the county's population lacked health insurance, a major barrier to accessing care with the largest group being adults

Comparative Vital Statistics	Prince George's County	Anne Arundel County	Howard County	Montgomery County	Maryland
Age Adjusted Mortality Rates: 2011 - 2013					
All Causes of Death	678.7	714.1	562.6	493.0	701.1
Disease of the Heart	172.5	163.0	125.2	110.7	162.0
Malignant Neoplasms	156.5	167.3	135.3	121.7	169.9
Cerebrovascular Disease	35.1	37.2	32.0	25.2	36.3
Diabetes Mellitus	28.3	19.4	10.3	12.6	19.2
Accidents	25.2	25.1	16.8	17.0	26.6
Chronic Lower Respiratory Diseases	18.9	36.4	21.0	17.4	31.1
Septicemia	15.1	14.8	11.6	11.3	14.9
Alzheimer's Disease	13.5	12.5	16.8	12.0	14.3
Influenza and Pneumonia	14.0	18.9	16.9	12.9	16.0
HIV	4.3	***	***	1.4	3.4
Nephritis, Nephrosis, and Neprotic Syndrome	13.1	10.1	10.6	7.4	11.3
Assault (Homicide)	7.5	2.5	***	2.2	7.0
Intentional Harm	5.8	10.5	7.8	7.0	9.2

Source: Maryland Vital Statistics Profile: 2014

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

(ages 18-64) at 21.1%. However, with the implementation of the Affordable Care Act, in 2015, the county's health department now reports that 99,834 Prince George's County residents have enrolled in health insurance through Maryland's ACA health exchange; that is approximately 1 out of every 9 people in the county.

Deaths due to diabetes, heart disease, hypertension, stroke, HIV, breast, colorectal and prostate cancers, as well as infant mortality continue to represent significant health challenges for Prince George's community residents. The Prince George's County Primary Healthcare Strategic Plan (2015) found that although Prince George's County residents experience higher rates of asthma, diabetes, hypertension, heart disease, and cancer when compared to state averages and rates, these rates were often higher within the African American population. Significant disparities in mortality and health status for several health indices are evident with various racial and ethnic populations. An example can be seen with the relatively higher rates of obesity and homicide, additional areas of concern and certainly planning considerations in this majority-minority community. It must also be noted that the racial and ethnic minorities within Prince George's County makeup approximately 2/3 of County Medicaid beneficiaries. Both Prince George's County and Maryland State health statistics are similar to national trends regarding the status of minority health.

Furthermore, many county residents struggle with mental health issues. In 2013, over 12% of adults reported at least eight poor mental health days within the past thirty days. In 2013, 53 residents lost their lives due to suicide. In 2014, the Health Department began a behavioral health work group with community partners to ensure more coordinated care for county residents. In 2015 this group began conducting an assessment of community mental health services, however, the results of these assessments is still pending.

IDENTIFICATION OF COMMUNITY NEEDS:

LRH is improving and adapting current health programs into sustainable community-based programs to positively impact the overall health and wellness of the community. This service expansion and adaptation is being achieved through collaborative partnerships with community organizations as well as state and local health agencies. LRH management actively solicits information from community stakeholders and other community-based organizations to assess the health needs in our community. LRH representatives serve as members of a variety of healthcare focused community organizations and provide staff expertise and other resources, including hosting meetings at our facility and the provision of health screening services at local community events. Some of these organizations include:

- Prince George's Health Enterprise Zone
- Prince George County Health Department Community Care Coordination Team
- Totally Linking Care – Maryland Coalition
- 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

In addition, LRH partnered with Laurel TV to produce and present *Laurel Health Watch*, a public broadcast series providing health information and education covering a variety of topics related to health concerns and needs in Laurel, Maryland and the communities served by Laurel Regional Hospital. Laurel TV is the City of Laurel, Maryland's public access station, a service of the city of Laurel's Department of Communications, serving the city's 26,000 residents.

LRH continues to build more community partnerships to improve community benefit. LRH is developing more health initiatives geared towards promoting prevention and raising awareness on risks associated with health conditions such as asthma, diabetes, and mental health.

LRH has also worked with local and state health officials to develop the Prince George's County and the State Health Improvement Plans. LRH also continues to work closely with the Health Department to implement programs that address the county's health plan goals, such as the Prince George's County Primary Care Strategic Plan, issued in 2015.

LRH 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.

LRH 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)

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 as well as 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-LRH-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/LRH-ISP-10-22-13.pdf

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, SVP, Strategy, VP 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 FTE)

1-FTE dedicated to Community Benefit

2. __X_Committee (please list members)

3. ___Other (please describe)

Committee: CEO, COO, CFO, CMO, CNO, General Counsel, VP Reimbursement, VP Medical Affairs, , Director Finance, SVP, Strategy, 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. COMMUNITY BENEFIT EXTERNAL COLLABORATION

External collaborations are highly structured and effective partnerships with relevant community stakeholders aimed at collectively solving the complex health and social problems that result in health inequities. Maryland hospital organizations should demonstrate that they are engaging partners to move toward specific and rigorous processes aimed at generating improved population health. Collaborations of this nature have specific conditions that together lead to meaningful results, including: a common agenda that addresses shared priorities, a shared defined target population, shared processes and outcomes, measurement, mutually reinforcing evidence based activities, continuous communication and quality improvement, and a backbone organization designated to engage and coordinate partners.

a. Does the hospital organization engage in external collaboration with the following partners:

__X__Other hospital organizations
__X__ Local Health Department

__X__ Local health improvement coalitions (LHICs)
__X__ Schools
__X__ Behavioral health organizations
__X__ Faith based community organizations
__X__ Social service organizations

b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct the CHNA. Provide a brief description of collaborative activities with each partner (please add as many rows to the table as necessary to be complete)

Organization	**Name of Key Collaborator**	**Title**	**Collaboration Description**
Totally Linking Care Maryland	Camille Bash	Member & CFO, Doctors Community Hospital	Coalition of hospitals to improve health outcomes in Southern Maryland
Prince George's County Health Department	Pamela Creekmur	Health Officer, Prince George's County Health Department	LHIC, Community Care Coordination Team; Health Enterprise Zone
Prince George's County Schools	Yolanda Tully	Director, Youth Career Connect, Prince George's Economic Development Corp.	Career development program in partnership with Blandensburg High School, Health Care Career Academy and others
Medical Mall Health Services	Tim McNeill	President	Care transitions
First Baptist Church of Glenarden	Cheryl Cook	Health Ministries Director	Health Promotion & Education; Health Screenings
Prince George's County Housing and Community Development	Michael Jackson	Project Manager	Health Education Programs

c. Is there a member of the hospital organization that is co-chairing the Local Health Improvement Coalition (LHIC) in the jurisdictions where the hospital organization is targeting community benefit dollars?

_____yes __X___no

d. Is there a member of the hospital organization that attends or is a member of the LHIC in the jurisdictions where the hospital organization is targeting community benefit dollars?

__X__yes _____no

V. 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.

Laurel Regional Hospital participates in a number of community benefit initiatives and programs (see attached Table III). Some of these current initiatives and programs include:

- Community Health Education Programs
- Blood Pressure Screening & Education Program

For the fiscal years ending June 30, 2015 and June 30, 2016 LRH had total community benefit expenditures (as a percent of total operating expenditures) of 15.02%, and 24% respectively. Each year, LRH's total CB expenditures rank as one of the highest for all hospitals in the State of Maryland. LRH's fiscal year 2016 CB expenditures are primarily made up of mission-driven physician subsidies at $20,154,338.00 or 21% and charity care at $2,869,600.00 or 3%.

In addition, LRH established community based physician services to expand access to care and address critical needs identified in the CHNA. For example the establishment of a new pulmonary practice in Laurel, Maryland and the expansion of the sleep medicine program addressed the implementation plan strategy to improve quality of life for patients with COPD and asthma in the Greater Laurel community. Through the outpatient practice LRH is able to provide health and wellness education information and services in community-based settings to increase health awareness and knowledge about asthma, COPD, physical rehabilitation and smoking cessation.

LRH provided a total of $23,023,938.00 in mission-driven physician subsidies and charity care in the fiscal year ending June 30, 2016. To fund this high level of subsidies and charity care, LRH depends on State and County for financial support. However, during the past year, there has been a decrease in State subsidies, which has required LRH to provide critical services as community benefit services funded from operations. Heavy reliance on dwindling state and county financial resources leaves LRH with very limited funds and/or resources to embark on other high-level CB initiatives. Nevertheless, LRH works consistently to support the needs of its community and regularly partners with community organizations to provide services that meet its CHNA goals.

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, LRH is not currently focusing on top health concerns identified by the CHNA (heart and kidney failure) due to lack of resources necessary 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 with other chronic diseases and co-morbidities, will be taken into account and incorporated into the strategic plan where appropriate. LRH will also 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. It should be noted that LRH coordinates with other system facilities including Prince George's Hospital Center to develop and implement programs and services that address its community health needs. For example, LRH coordinates with PGHC to ensure timely access to higher-level cardiac and stroke program services for the residents of Laurel and surrounding communities.

VI. 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.

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.

Per the Prince George's County Health Improvement Plan 2011 to 2014, there are only a small number of 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 LRH's CBSA) are federally designated as medically underserved areas or underserved populations.

Table IV – Physician Subsidies

Category of Subsidy	**Explanation of Need for Service**
Hospital-Based physicians	LRH's emergency departments, and other specialties including intensive care, anesthesia, cardiology, endocrinology, internal medicine, neurology, orthopedics, otolaryngology psychiatry, pathology, physical medicine and radiology, are staffed by Hospital-based physicians, with whom the hospital has exclusive contracts, seeking guaranteed levels of compensation through hospital provided subsidies. By providing emergency and other specialty services to the County's uninsured and underinsured population, LRH provides an ongoing community benefit to residents unable to obtain much needed health care services.
Non-Resident House Staff and Hospitalists	The subsidies cover gaps in physician services due to lack of adequate community providers who practice within the hospital. Additionally the hospital supports a disproportionate share of underinsured or uninsured patients.

Coverage of Emergency Department Call	The subsidies cover gaps in physician income that are the outcome of PGHC's disproportionate share of underinsured or uninsured patients.
Physician Provision of Financial Assistance	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.
Physician Recruitment to Meet Community Need	The LRH 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, LRH's mission provides that all patients should receive the highest level of care regardless of economic standing. LRH'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.
Other – (provide detail of any subsidy not listed above – add more rows if needed)	

VII. APPENDICES

<u>To Be Attached as Appendices</u>:

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).

APPENDIX I

FINANCIAL ASSISTANCE PROGRAM

LRH 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. LRH 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. Eligibility criteria are based upon the Federal Poverty guidelines and 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.

APPENDIX II

FINANCIAL ASSISTANCE PROGRAM POLICY #210-01

APPENDIX III

1). PATIENT INFORMATION SHEET

2). "WHAT YOU SHOULD KNOW AS A PATIENT"

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APPENDIX IV

MISSION, VISION AND VALUES STATEMENT #200-24

Mission

Within the Dimensions Healthcare System, it is our mission to provide comprehensive health care of 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.

Vision

To be recognized as a premier regional health care system.

Values

Dimensions Healthcare System:

- Respects the dignity and privacy of each patient who seeks our service.
- Is committed to excellent service which exceeds the expectations of those we serve.
- Accepts and demands personal accountability for the services we provide.
- Consistently strives to provide the highest quality work from individual performance.
- Promotes open communication to foster partnership and collaboration.
- Is committed to an innovative environment; encouraging new ideas and creativity.
- Is committed to having its hospitals meet the highest standards of safety.

TABLE III

HOSPITAL COMMUNITY BENEFIT PROGRAMS AND INITIATIVES