Prince George's Hospital Center

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

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:

Located in Cheverly, Maryland, Prince George's Hospital Center (PGHC) is a private not-for-profit acute care teaching hospital and regional referral center which has been providing quality healthcare services to the southern Maryland region since 1944. Over the past 70 years, Prince George's Hospital Center has grown to become the region's major tertiary care center and one of its largest employers. Prince George's Hospital Center is a member of the Dimensions Healthcare System (DHS).

Leadership:

Chairman, Board of Directors, DHS – C. Phillip Nichols, Jr.
Chairwoman, Board of Directors, PGHC –Tawanna P. Gaines
CEO – Neil J. Moore
COO, DHS – Sherry Perkins
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: 237 (plus 52 bassinets)

No. of inpatient admissions: 12,241, plus 2074 births

No. of Employees: 1712

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
    - Dimensions Surgery Center (a freestanding ambulatory surgery center located on the Bowie Health Campus)
    - Gladys Spellman Family Health and Wellness Center, Cheverly, Maryland (formerly the Glenridge Medical Center). Family Medicine Practice (located at the Gladys Spellman Family Health and Wellness Center, Cheverly, Maryland)
    - Rachel H. Pemberton Senior Health Center, Brentwood, Maryland
    - 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
- Domestic Violence and Sexual Assault Center
- Graduate medical education, internal medicine and family 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, a 16-bed distinct observation unit 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 in Laurel, Maryland, and Bowie Health Center in 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

237 Beds + 52 Bassinets	14,270	20785 20743 20747 20774 20784 20706 20019 20710 20721 20737 20746	Doctors Community Holy Cross Washington Adventist Southern Maryland Laurel Regional Fort Washington	19% (PGHC total patient pop.) PG County: 78% DC: 10.6%	33% (PGHC total patient pop., includes Medicaid pending) PG County: 79% DC: 14%

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.

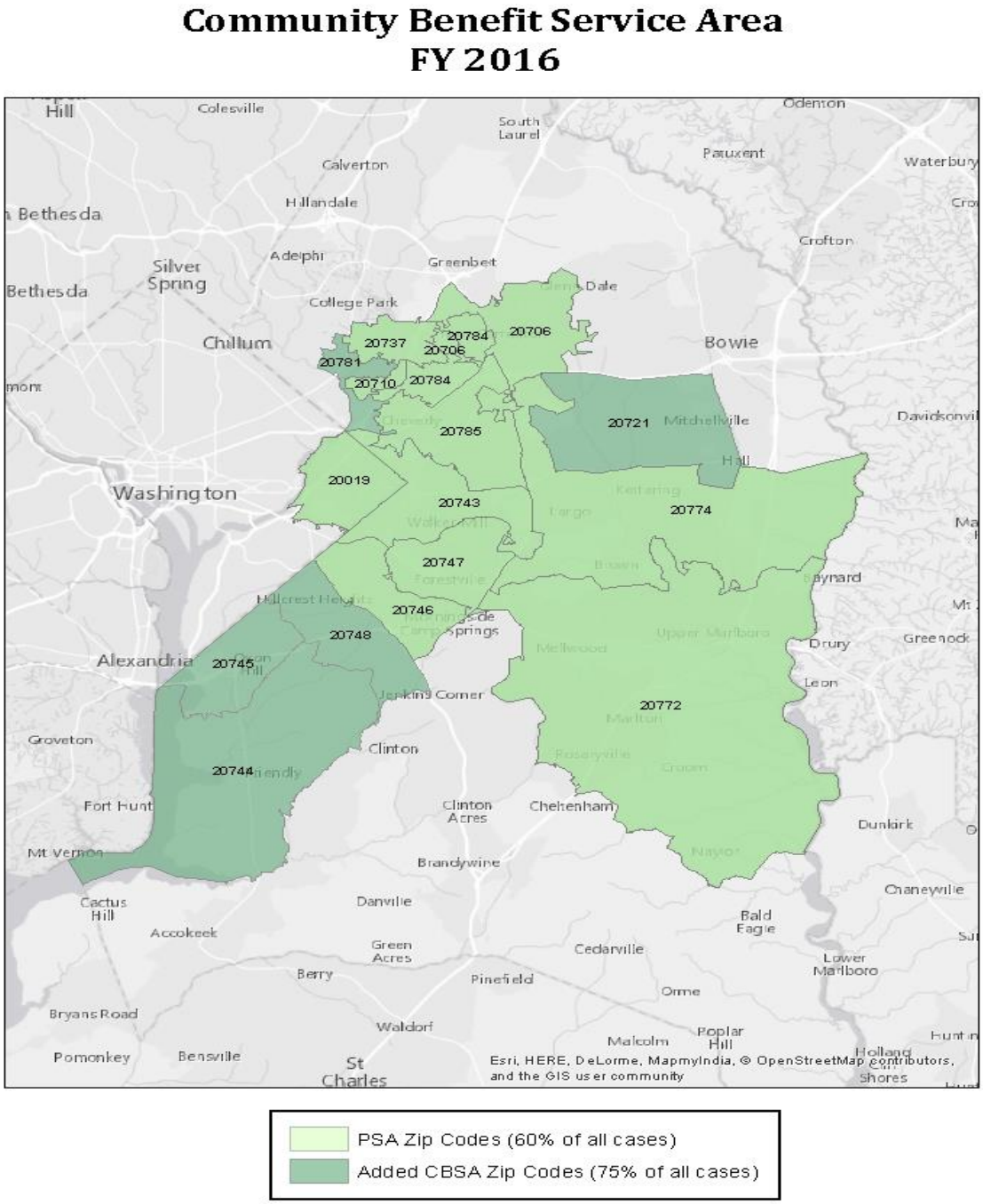
PRINCE GEORGE'S COUNTY DEMOGRAPHICS:

The PGHC Primary Service Area consists of 11 zip codes 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 16 zip codes in Western and Central Prince George's County. Patients from these 16 zip code areas make up approximately 75% of PGHC's total inpatient and outpatient admissions. The PGHC CBSA also includes one zip code area 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: 78.8% are African-Americans, 6.3% White (non-

Hispanic), 10.8% of Hispanic origin, 2.1% of Asian origin, and 0.1% of other ethnic origin.

PGHC COMMUNITY BENEFIT SERVICE AREA
FY 2016



PGHC Primary Service Area (PSA) 2016 Total PGHC Cases (all counties) 2016: **14,320**				
ZIP	**NAME**	**COUNTYNAME**	**# Cases**	**% of Total Cases**
20785	Hyattsville	Prince George's Co	1,700	11.9%
20743	Capitol Heights	Prince George's Co	1,664	11. 6%
20747	District Heights	Prince George's Co	910	6.4%
20774	Upper Marlboro	Prince George's Co	814	5.7%
20784	Hyattsville	Prince George's Co	771	5.4%
20706	Lanham	Prince George's Co	731	5.1%
20019	Washington	District of Columbia	624	4.4%
20710	Bladensburg	Prince George's Co	410	2.9%
20721	Bowie	Prince George's Co	383	2.7%
20737	Riverdale	Prince George's Co	371	2.6%
20746	Suitland	Prince George's Co	369	2.6%
Running Total			**8747**	**61.1%**
PGHC Community Benefits Service Area (CBSA) Area 2016 (includes all above zip codes, adds below zip codes)				
20708	Laurel	Prince George's Co		
20716	Bowie	Prince George's Co		
20744	Fort Washington	Prince George's Co		
20745	Oxon Hill	Prince George's Co		
20748	Temple Hills	Prince George's Co		
20770	Greenbelt	Prince George's Co		
20772	Upper Marlboro	Prince George's Co		
20781	Hyattsville	Prince George's Co		
CBSA list represents approximately 75% of cases				

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://dhmh.maryland.gov/vsa/SitePages/Home.aspx), The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) http://dhmh.maryland.gov/mhhd/Documents/Maryland_Health_Disparities_Plan_of_Action_6.10.10.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 2015; http://www.pgchealthzone.org/ , Prince George's County Health Improvement Plan 2011 to 2014 (http://www.princegeorgescountymd.gov/sites/Health/About/Documents/Health-LocalhealthPlanPrefinal.pdf); Prince George's Primary Care Strategic Plan (http://www.princegeorgescountymd.gov/sites/ExecutiveBranch/CommunityEngagement/RegionalMedCtr/Documents/Primary_Healthcare_Strategic_Plan.pdf

Table II

Community Benefit Service Area(CBSA) Target Population (target population, by sex, race, and average age)	PGHC Total CBSA Population: 561,920 PG Cty CBSA Population: 502,128 DC CBSA Population: 59,792 Sex M – 46.8% F – 53.2% White (non-Hispanic)– 6.3% African-American – 77% Hispanic/Latino –11.9% Asian – 2.3% Other Race – 0.2% *Source:* ***PCA Executive Marketing Reporting (New Health Analytics) (2016)*** **Prince George's County:** % age < 20 years – 25.5% % age 65 and older – 11.7% **District of Columbia (DC):** % age < 20 years – 20.8% % age 65 and older – 11.5% *Source: U.S. Census Bureau, 2015 ACS 1-Year Estimates*
Median Household Income within the CBSA (county level)	Prince George's County: $74,260 DC: $70,848 *Source: U.S. Census Bureau, 2015ACS 1-Year Estimates*
Percentage of households with incomes below the federal poverty guidelines within the CBSA	Prince George's County: 6.8% DC: 14.3% *Source: U.S. Census Bureau, 2015 ACS 1-Year Estimates*
Please estimate the percentage of uninsured people by County within the CBSA	Prince George's County: 13.8% DC: 5.8% *Source: U.S. Census Bureau, 2015 ACS 1-Year Estimates*

Percentage of public health insurance coverage recipients by County within the CBSA.	Prince George's County: 27.3% DC: 35.1% *Source: U.S. Census Bureau, 2015 ACS 1-Year Estimates*
Life Expectancy by County within the CBSA.	Prince George's county: All Races: 80.0 years White: 80.7 Black: 78.3 *Source: Maryland Vital Statistics Profile: 2014* DC: 77.5 years *Source: District of Columbia Community Health Needs Assessment, 2013*
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Prince George's County : All Races: 593.6/100,000 White: 643.8/100,000 Black: 602.9/100,000 Asian/Pacific Islander: 273.5/100,000 Hispanic: 131.1/100,000 *Source: Maryland Vital Statistics Profile: 2014* DC: 743.8/100,000 *Source: CDC* Mortality Multiple Cause Micro-data Files *Final Data 2014*
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: -- Physical Inactivity PG: 24% DC: 17% -- Food Environment Index PG: 7.5 DC: 8.0 -- Adult Obesity PG: 33% DC: 22% -- High blood pressure PG: 26.2% **DC: 29.4% -- Adult Smoker PG: 13% DC: 16% -- Has diabetes PG: 10.4% **DC: 8.5% -- HIV prevalence rate *PG: 787.2/100,000 **DC: 2540.5/100,000 -- Violent crime rate PG: 624/100,000 DC: 1,259/100,000 *Source: County Health Rankings, 2016; *Prince George's County Health Department, Health Report 2015; Robert Wood Johnson Foundation, State of Obesity, http://stateofobesity.org/files/stateofobesity2016.pdf(retrieved December 8, 2016)*D.C. Department of Health: Annual Epidemiology & Surveillance Report (December 2013);*
Available detail on race, ethnicity, and language within CBSA.	*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: 5.9% DC: 7.8% *Source: County Health Rankings, 2016*

Other Access to primary care	Ratio of population to primary care physicians – Prince George's County – 1,860:1 DC: 860:1 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, 2016* 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
2015 Total Population	**561,920**	**100.0%**
Total Male Population	**263,230**	**46.8%**
Total Female Population	**298,690**	**53. 2%**

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

RACE/ETHNICITY	**Race/Ethnicity Distribution**		
Race/Ethnicity	**2015 Pop**	**% of Total**	**USA % of Total**
White Non-Hispanic	**35,376**	**6.3%**	**73.1%**
Black Non-Hispanic	**432,810**	**77%**	**12.7%**
Hispanic	**66,756**	**11.9%**	**17.6%**
Asian & Pac. Isl. Non-Hispanic	**13,227**	**2.3%**	**5.4%**
All Others	**12,426**	**22%**	**4.8%**
TOTAL	**561,920**	**100.0%**	

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

POPULATION DISTRIBUTION	**Age Distribution**		
Age Group	**2015Pop**	**% of Total**	**USA % of Total**
0 – 17	**134,619**	**24.0%**	**22.9%**
18 - 64	**358,449**	**63.8%**	**62.2%**
65 +	**68,852**	**12.3%**	**14.9%**
TOTAL	**561,920**	**100.0%**	**100.0%**

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

UNINSURED *% of Total Population*			
Race/Ethnicity	**Prince George's County**	**Maryland**	**USA**
Average, All Races	**13.8%**	**9.0%**	**13%**
White Non-Hispanic	**6.6%**	**5.3%**	**9.0%**
Black Non-Hispanic	**9.1%**	**9.5%**	**15.3%**
Hispanic	**38.7%**	**28.3%**	**25.8%**
Asian	**14.8%**	**11.3%**	**12.5%**
Some other race alone	**42.9%**	**35.9%**	**28.9%**

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

Prince George's Hospital Center
Vital Statistics Data

Community Challenges & Health Statistics:

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: 2012-2014					
All Causes of Death	**678.7**	**493.0**	**701.1**	***27.2%***	***-22.4%***
Disease of the Heart	**172.5**	**110.7**	**169.9**	***36.3%***	***2.6%***
Malignant Neoplasms	**156.5**	**121.7**	**162.0**	***20.9%***	***-3.8%***
Cerebrovascular Disease	**35.1**	**25.2**	**36.3**	***24.3%***	***-4.3%***
Diabetes Mellitus	**28.3**	**12.6**	**19.2**	***50.4%***	***27.9%***
Accidents	**25.2**	**17.0**	**26.6**	***34.6%***	***-3.1%***
Chronic Lower Respiratory Diseases	**18.9**	**17.4**	**31.1**	***6.9%***	***-62.1%***
Septicemia	**15.1**	**11.3**	**14.9**	***26.7%***	***3.4%***
Alzheimer's Disease	**13.5**	**12.0**	**14.3**	***7.2%***	***-5.8%***
Influenza and Pneumonia	**14.0**	**12.9**	**16.0**	***13.7%***	***-13.7%***
HIV	**4.3**	**1.4**	**3.4**	***71.7%***	***28.3%***
Nephritis, Nephrosis, and Neprotic Syndrome	**13.1**	**7.4**	**11.3**	***41.0%***	***14.9%***
Assault (Homicide)	**7.5**	**2.2**	**7.0**	***76.1%***	***14.8%***
Intentional Self-Harm (Suicide)	**5.8**	**7.0**	**9.2**	***-25.9%***	***-55.2%***

Source: Maryland Vital Statistics Annual Report: 2014

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

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 (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 HEALTH NEEDS:

PGHC's management actively solicits information from the Prince George's County Health Department and other community-based organizations to assess health needs in the 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 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
- Susan G. Komen Foundation

Through the provision of healthcare providers and other support staff, PGHC has also partnered with community-based organizations in efforts to increase their capacity in providing services to the community. This includes facilitating access to sub-specialty services for uninsured and underinsured residents at various Federally Qualified Health Centers (FQHC) including Community Clinic, Inc., Greater Baden Medical Services, and the Pregnancy Aid Center.

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

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)

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

that 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

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. _X__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. __Committee (please list members)

3. ___Other (please describe)

Committee: CEO, COO, CFO, CMO, CNO, General Counsel, VP Reimbursement, VP Medical Affairs, VP – Community Relations, 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
Access to Wholistic and Productive Living Institute	Dr. Bettye Muwwakkil	Chief Executive Officer	Partner on grant initiatives – Bright Beginnings
First Baptist Church of Glenarden	Cheryl Cook	Health Ministries Director	Health Promotion & Education; Health

			Screenings
Prince George's County Department of Family Services/Department of Aging	Cathy Stasny	Registered Dietitian	Dental program for seniors

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.

Prince George's Hospital Center has implemented a number of community benefit initiatives and programs (see attached Table III). Some of these current initiatives and programs include:

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

For the fiscal years ending June 30, 2015 and June 30, 2016 PGHC had total community benefit expenditures (as a percent of total operating expenditures) of 28.96% and 15.22%, 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 2016 CB expenditures are primarily made up of mission-driven physician subsidies at $30,275,762 or 11.51% and charity care at $9,769,558.00 or 3.71%.

PGHC provided $40,045,320 in mission-driven physician subsidies and charity care in the fiscal year ending June 30, 2016. To fund this high level of physician subsidies and charity care, PGHC depends on State and County for financial support. Heavy reliance on dwindling state and county financial resources leaves PGHC with very limited funds and/or resources to embark on other high level CB initiatives. Nevertheless, PGHC 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, during this reporting cycle PGHC is not currently focusing on top health concerns identified by the CHNA (respiratory health and septicemia) due to the lack of available 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, were taken into account and incorporated into the strategic plan where appropriate.

It must also be noted that PGHC currently provides emergency psychiatric, inpatient behavioral health and outpatient partial hospitalization services to assist with the mental health needs of the community. Because of these services, mental health was not selected as one of the focus areas for the CHNA. However, as part of its work with the Prince George's Health Enterprise Zone and the Community Care Coordination Team, DHS has developed a plan to test and implement a model designed to incorporate behavioral services as part of its specialty care practices. DHS will also coordinate with patient-centered medical homes to test the impact of coordinated primary care, specialty and behavioral health services on chronic disease management.

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. 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

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. For the fiscal year ending June 30, 2015, PGHC had a patient and third party payer mix that included 48% Medicaid and uninsured self-pay patients. Although, expanded coverage under the ACA has reduced the uninsured and underinsured population, there remain a significant number of uncovered lives in the PGHC service area. 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.

Table IV – Physician Subsidies

Category of Subsidy	**Explanation of Need for Service**
Hospital-Based physicians	PGHC's emergency departments, and other specialties including intensive care, obstetrics/gynecology, neonatology, anesthesia, cardiology, endocrinology, family medicine, internal medicine, neurosurgery, 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. 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.
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	Recent studies have demonstrated an inadequate number of primary care and specialty providers to serve residents in the hospital primary service area. Physician recruitment subsidies are needed to recruit qualified providers to serve the community. 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. 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.
Other – (provide detail of any subsidy not listed above – add more rows if needed)	

VII. 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).

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.

APPENDIX II

FINANCIAL ASSISTANCE PROGRAM POLICY #210-01

APPENDIX III

1). PATIENT INFORMATION SHEET

2). “WHAT YOU SHOULD KNOW AS A PATIENT”

APPENDIX IV

MISSION, VISION AND VALUES STATEMENT

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