COMMUNITY BENEFIT NARRATIVE REPORTING
DOCTORS COMMUNITY HOSPITAL

DECEMBER 15, 2012

Effective for FY2012 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

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BACKGROUND

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.

<u>Reporting Requirements</u>

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:
219	12052			Prince George' County: 20%	Prince George's County: 7%
				source: http://www.countyhealthrankings.org/app/maryland/2012/measures/additional/3/data	
		20706	20706		
			HOLY CROSS OF SILVER SPRING		
			LAUREL REGIONAL HOSPITAL		
			PRINCE GEORGE'S HOSPITAL CENTER		
			WASHINGTON ADVENTIST		
		20784	20784		
			PRINCE GEORGE'S HOSPITAL CENTER		
		20774	20774		
			HOLY CROSS OF SILVER SPRING		
			PRINCE GEORGE'S HOSPITAL CENTER		
		20743	20743		
			Adven. Rehab. Hospital of Maryland		
			PRINCE GEORGE'S HOSPITAL CENTER		
		20785	20785		
			PRINCE GEORGE'S HOSPITAL CENTER		
		20770	20770		
			LAUREL REGIONAL HOSPITAL		
			WASHINGTON ADVENTIST		
		20721			
		20737	20737		
			PRINCE GEORGE'S HOSPITAL CENTER		
			WASHINGTON ADVENTIST		
		20715	20715		
			ANNE ARUNDEL MEDICAL CENTER		
			JOHNS HOPKINS		
		20747	20747		
			PRINCE GEORGE'S HOSPITAL CENTER		
			SOUTHERN MARYLAND		

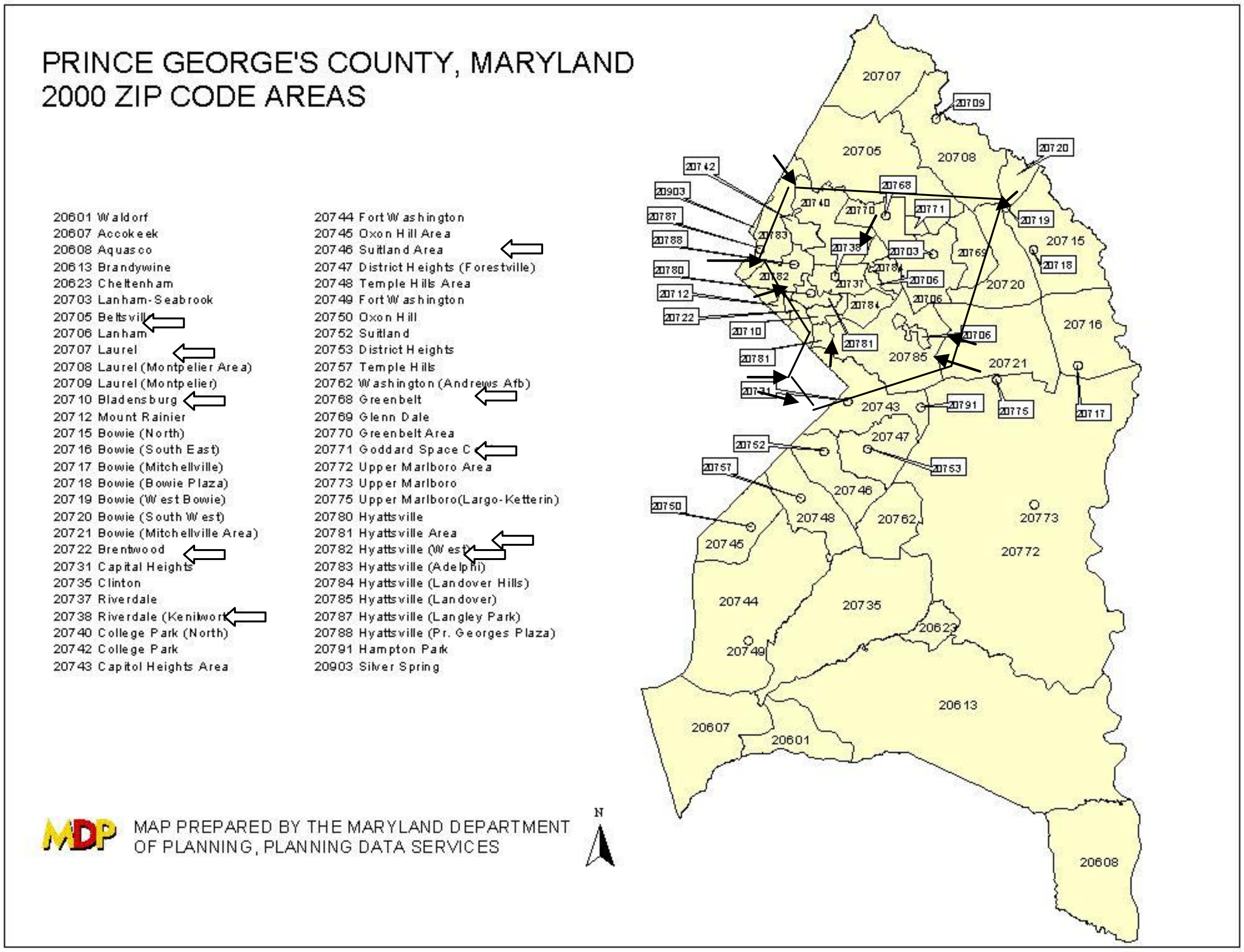

Figure 1 Prince George's County by Zip Code (Zip Codes with 60% of discharges)

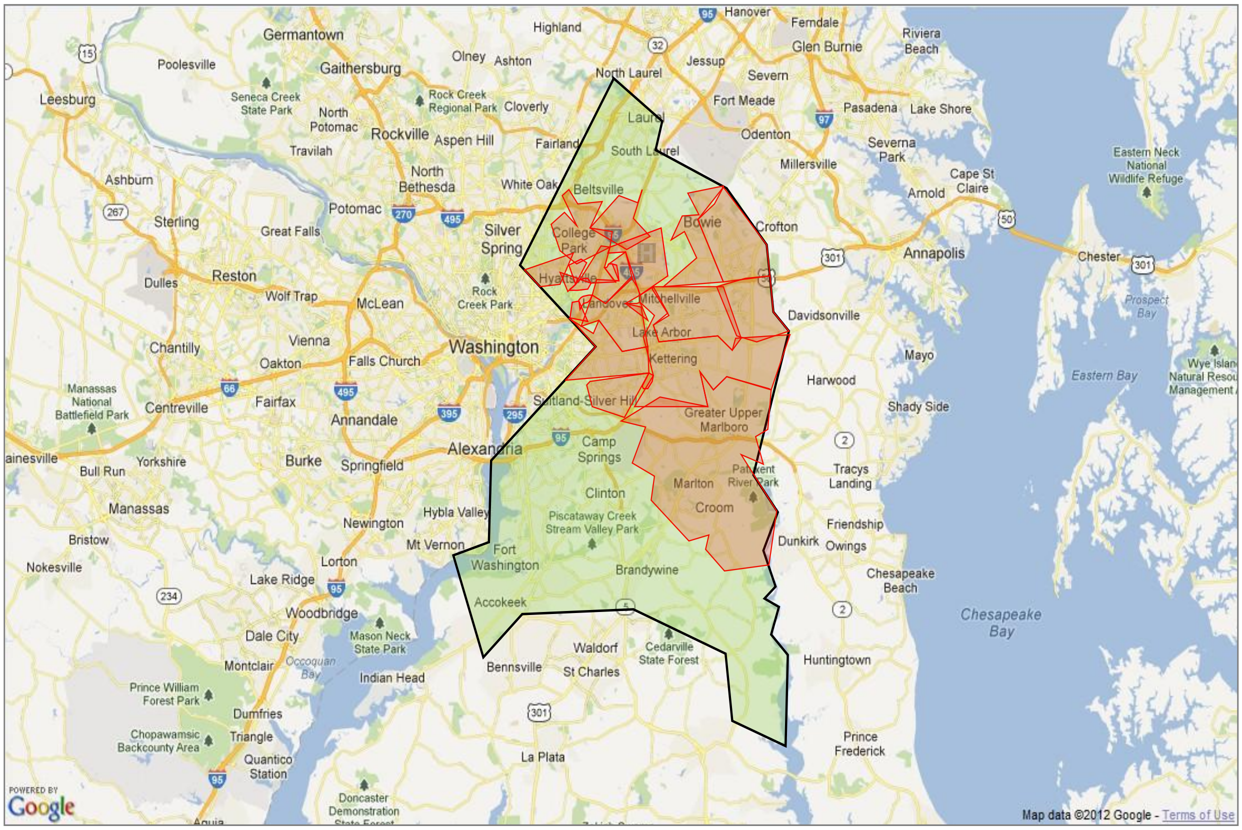

Figure 2: Doctors Community Hospital Catchment

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. Please describe in detail.)

(1) General Description of the Prince George's County that encompasses the majority of Doctors Community Hospital's Community Benefit Service Area.

Doctors Community Hospital serves a large portion of Prince George's County residents. Prince George's County consists of 93% of our *Community Benefit Service Area (CBSA).* An estimated 834,000 residents live in Prince George's County, or 15% of Maryland's residents.

Over 54,000 patients were seen in FY2012 at Doctors Community Hospital, of which 50,884 patients live in Prince George's County catchment area (see Figure 2). Seven percent of our patients come from outside of Prince George's County.

Per the County Health Rankings Figure 3, our CBSA has an average household income of $69,524 about average for the state. The population is 66% African American while the state is 29% African American. Other demographics, health outcomes, and the social/economic factors are noted in Figure 3 on the next page.

	Prince George's County	Maryland
Demographics		
Population	834,560	5,699,478
% below 18 years of age	25%	24%
% 65 and older	10%	12%
% African American	66%	29%
% American Indian and Alaskan Native	1%	0%
% Asian	4%	5%
% Native Hawaiian/Other Pacific Islander	0%	0%
% Hispanic	14%	7%
% not proficient in English	9%	6%
% Females	52%	52%
% Rural	3%	14%
Health Outcomes		
Diabetes	11%	9%
HIV prevalence rate	778	
Health Care		
Mental health providers	4,973:1	1,617:1
Health care costs	$8,110	$9,044
Uninsured adults	20%	16%
Could not see doctor due to cost	14%	11%
Dentists	1,949:1	1,789:1
Social & Economic Factors		
Median household income	$69,524	$68,933
High housing costs	44%	37%
Children eligible for free lunch	37%	33%
Illiteracy	21.9%	11.2%
Homicide rate	18	10
Physical Environment		
Commuting alone	64%	73%
Access to healthy foods	91%	61%

Figure 3: Prince George's County Data provided by County Health Rankings (http://www.countyhealthrankings.org/print/node/1343/other-measures)

(2) General Description, by Zip Code, of the communities that comprise the majority of Doctors Community Hospital's Community Benefit Service Areas

- ***Lanham, Maryland – Zip Code 20706***

Lanham is an unincorporated community and census-designated place in Prince George's County, Maryland, in the United States.[1] As of the 2010 census it had a population of 10,157.[2] The terminal of the Washington Metro's Orange Line, as well as an Amtrak station, are across the Capital Beltway in New Carrollton, Maryland. Doctors Community Hospital is located in Lanham.[3])

Demographics

According to the U.S. Census Bureau, Lanham has a total area of 3.6 square miles (9.2 km2), of which 3.5 square miles (9.1 km2) is land and 0.02 square miles (0.05 km2), or 0.54%, is water.[5]

The racial mix of the population is Black alone - 11,534 (59.4%), Hispanic - 3,310 (17.0%), White alone - 2,455 (12.6%), Asian alone - 1,547 (8.0%), two or more races - 549 (2.8%), American Indian alone - 15 (0.08%), and other race alone - 4 (0.02%).

References

1. U.S. Geological Survey Geographic Names Information System: Lanham, Maryland
2. "Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data (DP-1): Lanham CDP, Maryland". U.S. Census Bureau, American Factfinder. http://factfinder2.census.gov. Retrieved December 20, 2011.
3. "Doctors Community Hospital". *Doctors Community Hospital website*. Doctors Community Hospital. 2009-01-29. http://www.dchweb.org/.
4. "National Register Information System". *National Register of Historic Places*. National Park Service. 2010-07-09. http://nrhp.focus.nps.gov/natreg/docs/All_Data.html.
5."Geographic Identifiers: 2010 Demographic Profile Data (G001): Lanham CDP, Maryland". U.S. Census Bureau, American Factfinder. http://factfinder2.census.gov. Retrieved December 20, 2011.

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- ***Cheverly, Maryland – Zip Code 20784***

In its over 80 years, the **Town of Cheverly** has grown from farmland to a small livable community just minutes from the Nation's Capitol. Cheverly is 1.27 square miles in area, and the 2010 U.S. Census survey counted a population of 6,173 residents.

The Town is located in the western portion of Prince George's County, Maryland, just a mile from the northeastern Washington, D.C. border. Cheverly largely lies between two major road arteries -- the Baltimore-Washington Parkway and Maryland Route 50. Established as a planned residential community, Cheverly is convenient to Washington, D.C. by Metro bus and rail, and to retail shopping centers in the surrounding communities.

<u>Demographics</u>

Cheverly is home to the Prince George's Hospital Center and the Publick Playhouse for the Performing Arts.[3] Cheverly's ZIP codes are 20784 and 20785. As of the census[5] of 2000, there were 6,433 people, 2,258 households, and 1,637 families residing in the town. The population density was 4,769.9 people per square mile (1,839.8/km²). There were 2,348 housing units at an average density of 1,741.0 per square mile (671.5/km²). The racial makeup of the town was 33.86% White, 56.79% African American, 0.17% Native American, 2.50% Asian, 0.03% Pacific Islander, 3.22% from other races, and 3.44% from two or more races. Hispanic or Latino of any race were 6.76% of the population.

There were 2,258 households out of which 39.8% had children under the age of 18 living with them, 48.8% were married couples living together, 17.1% had a female householder with no husband present, and 27.5% were non-families. 20.4% of all households were made up of individuals and 4.7% had someone living alone who was 65 years of age or older. The average household size was 2.85 and the average family size was 3.30.

References

1. U.S. Geological Survey Geographic Names Information System: Cheverly, Maryland
2. "Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data (DP-1): Cheverly town, Maryland". U.S. Census Bureau, American Factfinder. http://factfinder2.census.gov. Retrieved December 9, 2011.
3. "Publick Playhouse". Maryland-National Capital Park and Planning Commission. http://www.pgparks.com/places/artsfac/publick.html.]
4. "US Gazetteer files: 2010, 2000, and 1990". United States Census Bureau. 2011-02-12. http://www.census.gov/geo/www/gazetteer/gazette.html. Retrieved 2011-04-23.
5. "American FactFinder". United States Census Bureau. http://factfinder.census.gov. Retrieved 2008-01-31.

6. a b "Community Summary Sheet, Prince George's County". Cheverly, Maryland. Maryland State Highway Administration, 1999. 2008-05-10. http://www.sha.maryland.gov/oppen/pg_co.pdf.
7. M-NCPPC Illustrated Inventory of Historic Sites (Prince George's County, Maryland), 2006.

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- ***Landover, Maryland – Zip Code 20785***

Landover is an unincorporated community and census-designated place in Prince George's County, Maryland, United States.[1] As of the 2010 census it had a population of 23,078.[2] Landover was named for the town of Llandovery, Wales.[3] Landover is located at 38°55′28″N 76°53′15″W38.9244°N 76.8876°W. According to the U.S. Census Bureau, it has area of 4.07 square miles (10.55 km^2), of which 0.004 square miles (0.01 km^2), or 0.13%, is water.[4]

Demographics

Landover's health insurance coverage is 51.5% private, 33.2% public assistance and 17.2% uninsured. There are 12% of the families and 4.7% of married couples below the poverty levels.

References

1.U.S. Geological Survey Geographic Names Information System: Landover, Maryland
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3."Profile for Landover, Maryland, MD". ePodunk. http://www.epodunk.com/cgi-bin/genInfo.php?locIndex=2651. Retrieved August 25, 2012.
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- ***Greenbelt, Maryland – Zip Code 20770***

  The **Greenbelt Historic District** is a national historic district located in Greenbelt, Prince George's County, Maryland, United States. The district preserves the center of one of the few examples of the Garden City Movement in the United States. With its sister cities of Greenhills, Ohio and Greendale, Wisconsin, Greenbelt was intended to be a "new town" that would start with a clean slate to do away with problems of urbanism in favor of a suburban ideal. Along with the never-commenced town of Greenbrook, New Jersey, the new towns were part of the New Deal public works programs.[3]

  Demographics

  As of 2010 Greenbelt had a population of 23,068. The racial and ethnic composition of the population was 25.9% non-Hispanic white, 47.0% non-Hispanic black, 0.3% Native American, 2.6% Asian Indian, 7.1% other Asian, 0.1% Pacific Islander, 0.3% non-Hispanic of some other race, 3.3% from two or more races and 14.3% Hispanic or Latino of any race.[11]

  As of the census[9] of 2000, there were 21,456 people, 9,368 households, and 4,965 families residing in the city. The population density was 3,586.6 people per square mile (1,385.3/km²). There were 10,180 housing units at an average density of 1,701.7 per square mile (657.3/km²). The racial makeup of the city was 39.74% White, 41.35% African American, 0.23% Native American, 12.05% Asian, 0.05% Pacific Islander, 3.11% from other races, and 3.47% from two or more races. Hispanic or Latino of any race were 6.45% of the population.

  There were 9,368 households out of which 26.9% had children under the age of 18 living with them, 33.1% were married couples living together, 15.0% had a female householder with no husband present, and 47.0% were non-families. 35.0% of all households were made up of individuals and 5.8% had someone living alone who was 65 years of age or older. The average household size was 2.29 and the average family size was 3.00.

  In the city the population was spread out with 21.9% under the age of 18, 12.5% from 18 to 24, 39.1% from 25 to 44, 19.8% from 45 to 64, and 6.7% who were 65 years of age or older. The median age was 32 years. For every 100 females there were 91.8 males. For every 100 females age 18 and over, there were 88.2 males.

  The median income for a household in the city was $46,328, and the median income for a family was $55,671. Males had a median income of $39,133 versus $35,885 for females. The per capita income for the city was $25,236. About 6.0% of families and 10.2% of the population were below the poverty line, including 12.7% of those under age 18 and 7.2% of those age 65 or over.

  References

1."National Register Information System". National Register of Historic Places. National Park Service. 2008-04-15. http://nrhp.focus.nps.gov/natreg/docs/All_Data.html.
2.a b "Greenbelt, Maryland Historic District". National Historic Landmark summary listing. National Park Service. http://tps.cr.nps.gov/nhl/detail.cfm?ResourceId=2203&ResourceType=District. Retrieved 2008-03-03.
3. "Greenbelt Historic District". National Historic Landmarks in Maryland listing. Maryland Historical Trust. http://www.mht.maryland.gov/nr/NRDetail.aspx?HDID=658&FROM=NRNHLList.aspx. Retrieved 2008-06-13.
4. National Register of Historic Places Inventory-Nomination: PDF (32 KB), National Park Service, , 19 and Accompanying photos, exterior and interior, from 19 PDF (32 KB)
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- ***Capitol Heights, Maryland – Zip Code 20743***

Capitol Heights is a town in Prince George's County, Maryland, United States.[1] The population was 4,337 at the 2010 census.[2] Development around the Capitol Heights Metro station has medical facilities and eateries to support the community. The Washington Redskins football stadium is just to the east of Capitol Heights, near the Capital Beltway (I-95/495) and Hampton Mall shopping center which has a new hotel and eateries. The town borders Washington, D.C.

Demographics

As of the census[4] of 2000, there were 4,138 people, 1,441 households, and 1,014 families residing in the town. The population density was 5,047.3 people per square mile (1,948.4/km²). There were 1,603 housing units at an average density of 1,955.2 per square mile (754.8/km²). The racial makeup of the town was 92.85% Black or African American, 4.81% White, 0.27% Native American, 0.36% Asian, 0.36% from other races, and 1.35% from two or more races. Hispanic or Latino of any race were 0.87% of the population.

There were 1,441 households out of which 37.5% had children under the age of 18 living with them, 35.2% were married couples living together, 28.5% had a female householder with no husband present, and 29.6% were non-families. 25.7% of all households were made up of individuals and 8.0% had someone living alone who was 65 years of age or older. The average household size was 2.87 and the average family size was 3.41.

In the town the population was spread out with 30.8% under the age of 18, 6.9% from 18 to 24, 32.6% from 25 to 44, 21.4% from 45 to 64, and 8.3% who were 65 years of age or older. The median age was 34 years. For every 100 females there were 84.8 males. For every 100 females age 18 and over, there were 78.8 males.

The median income for a household in the town was $46,667, and the median income for a family was $53,826. Males had a median income of $36,950 versus $35,225 for females. The per capita income for the town was $18,932. About 9.3% of families and 11.4% of the population were below the poverty line, including 15.8% of those under age 18 and 9.6% of those age 65 or over.

References

1. U.S. Geological Survey Geographic Names Information System: Capitol Heights, Maryland

2."Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data (DP-1): Capitol Heights town, Maryland". U.S. Census Bureau, American Factfinder. http://factfinder2.census.gov. Retrieved December 8, 2011.

3. "US Gazetteer files: 2010, 2000, and 1990". United States Census Bureau. 2011-02-12. http://www.census.gov/geo/www/gazetteer/gazette.html. Retrieved 2011-04-23.

4."American FactFinder". United States Census Bureau. http://factfinder.census.gov. Retrieved 2008-01-31.

5. "Chad Scott". databaseFootball.com. http://www.databasefootball.com/players/playerpage.htm?ilkid=SCOTTCHA01. Retrieved November 6, 2012.

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- ***Kettering, Maryland – Zip Code -20774***

Kettering is an unincorporated area and census-designated place (CDP) in Prince George's County, Maryland, United States.[1] The population was 12,790 at the 2010 census,[2] primarily African-American. The name Kettering was created by a suburban housing developer in the 1960s when development began. Kettering is adjacent to Prince George's Community College, the upscale gated community of Woodmore, Six Flags America, Evangel Temple megachurch, and the community of Largo at the end of the Washington Metro Blue Line. Watkins Regional Park in Kettering offers a large playground, a colorful carousel, miniature golf, a miniature train ride, and various animals.

Kettering is located at 38°53′42″N 76°47′47″W38.895012°N 76.796471°W.[3] According to the United States Census Bureau, the CDP has a total area of 5.5 square miles (14 km^2), all of it land.

Demographics

As of the census[4] of 2000, there were 11,008 people, 3,814 households, and 2,955 families residing in the CDP. The population density was 2,016.5 people per square mile (778.4/km²). There were 3,958 housing units at an average density of 725.0/sq mi (279.9/km²). The racial makeup of the CDP was 5.78% White, 90.62% African American, 0.19% Native American, 1.24% Asian, 0.47% from other races, and 1.71% from two or more races. Hispanic or Latino of any race were 0.95% of the population.

There were 3,814 households out of which 36.3% had children under the age of 18 living with them, 50.0% were married couples living together, 23.3% had a female householder with no husband present, and 22.5% were non-families. 18.4% of all households were made up of individuals and 1.7% had someone living alone who was 65 years of age or older. The average household size was 2.86 and the average family size was 3.24.
In the CDP the population was spread out with 26.6% under the age of 18, 7.1% from 18 to 24, 30.6% from 25 to 44, 29.1% from 45 to 64, and 6.6% who were 65 years of age or older. The median age was 37 years. For every 100 females there were 81.3 males. For every 100 females age 18 and over, there were 75.8 males.

The median income for a household in the CDP was $78,735, and the median income for a family was $82,777. Males had a median income of $47,059 versus $45,243 for females. The per capita income for the CDP was $30,398. About 0.8% of families and 1.9% of the population were below the poverty line, including 1.9% of those under age 18 and 2.0% of those age 65 or over.

References

1.U.S. Geological Survey Geographic Names Information System: Kettering, Maryland
2."Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data (DP-1): Kettering CDP, Maryland". U.S. Census Bureau, American Factfinder. http://factfinder2.census.gov. Retrieved December 20, 2011.
3."US Gazetteer files: 2010, 2000, and 1990". United States Census Bureau. 2011-02-12. http://www.census.gov/geo/www/gazetteer/gazette.html. Retrieved 2011-04-23.
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- ***Bowie, Maryland – Zip Code 20721***

Bowie is a city of 54,727 residents, according to the 2010 Census, located in Prince George's County, and convenient to Washington, DC, Annapolis, and Baltimore. The city consists of approximately 18-square miles. There are more than 1,100 acres set aside as parks or as preserved open space, including over 22 miles of paths and trails, and 75 ball fields. Bowie has a nonpartisan city government directed by a mayor and six council members. The City Council meets on the first and third Mondays of most months in sessions that are open to the public.

Bowie is a city in Prince George's County, Maryland, United States.[1] The population was 54,727 at the 2010 census. Bowie has grown from a small railroad stop to the largest municipality in Prince George's County, and the fifth most populous city[2] and third largest city by area in the state of Maryland.

Bowie is located at 38°57′53″N 76°44′40″W38.96472°N 76.74444°W (38.964727, -76.744531).[12] According to the city's 2009 State of the Environment report, the city has a total area of 18 square miles (47 km^2), of which 0.04 square miles (0.10 km^2), or 0.12%, is water.[13]

Demographics

As of the 2010 Census, Bowie had a population of 54,727. 99.5% of the population lived in households with a total of 19,950 households. The racial and ethnic composition of the population was 38.9% non-Hispanic white, 47.9% non-Hispanic black, 0.3% Native American, 4.1% Asian, 0.1% Pacific Islander, 1.9% from some other race and 3.6% from two or more races. 5.6% of the population was Hispanic or Latino of any race.[14]

As of the census[15] of 2010, there were 54,727 people, 18,188 households, and 13,568 families residing in the city. The population density was 3,121.9 people per square mile (1,205.5/km^2). There were 18,718 housing units at an average density of 1,162.5 per square mile (448.9/km^2).

The racial makeup of the city was:
41.40% (Non-Hispanic) White
48.70% Black or African American
2.95% Asian
2.92% Hispanic or Latino (of any race)
2.30% from two or more races
0.93% Other races
0.30% Native American
0.03% Pacific Islander

There were 18,188 households out of which 37.7% had children under the age of 18 living with them, 60.0% were married couples living together, 11.0% had a female householder with no husband present, and 25.4% were non-families. 19.7% of all households were made up of individuals and 5.2% had someone living alone who was 65 years of age or older. The average household size was 2.74 and the average family size was 3.16.

In the city the population was spread out with 26.9% under the age of 18, 5.7% from 18 to 24, 34.9% from 25 to 44, 23.0% from 45 to 64, and 9.4% who were 65 years of age or older. The median age was 36 years. For every 100 females there were 91.5 males. For every 100 females age 18 and over, there were 87.3 males.

According to a 2007 estimate, the median income for a household in the city was $99,105, and the median income for a family was $109,157.[16] Males had a median income of $52,284 versus $40,471 for females. The per capita income for the city was $30,703. About 0.7% of families and 1.6% of the population were below the poverty line, including 1.0% of those under age 18 and 1.8% of those age 65 or over.

Rank by Per Capita Income in Prince George's County: 7
Rank by Per Capita Income in Maryland: 65

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- ***Riverdale, Maryland – Zip Code 20737***

Riverdale Park is a town in Prince George's County, Maryland, United States.[1] The population was 6,956 at the 2010 census.[2] Riverdale Park is located at 38°57′46″N 76°55′47″W38.96278°N 76.92972°W (38.962810, -76.929699)[3]. According to the United States Census Bureau, the town has a total area of 1.7 square miles (4.3 km^2), of which 0.03 square miles (0.07 km^2), or 1.50%, is water.[4]

Demographics

As of the census[5] of 2000, there were 6,690 people, 2,172 households, and 1,437 families residing in the town. The population density was 4,212.7 people per square mile (1,624.5/km²). There were 2,321 housing units at an average density of 1,461.5 per square mile (563.6/km²). The racial makeup of the town was 39.91% White, 38.51% African American, 0.49% Native American, 4.25% Asian, 0.12% Pacific Islander, 12.99% from other races, and 3.74% from two or more races. Hispanic or Latino of any race were 28.27% of the population.

There were 2,172 households out of which 38.4% had children under the age of 18 living with them, 42.0% were married couples living together, 16.4% had a female householder with no husband present, and 33.8% were non-families. 23.9% of all households were made up of individuals and 4.1% had someone living alone who was 65 years of age or older. The average household size was 3.06 and the average family size was 3.60.

In the town the population was spread out with 28.7% under the age of 18, 12.2% from 18 to 24, 38.7% from 25 to 44, 15.6% from 45 to 64, and 4.9% who were 65 years of age or older. The median age was 29 years. For every 100 females there were 110.6 males. For every 100 females age 18 and over, there were 109.3 males.

The median income for a household in the town was $44,041, and the median income for a family was $49,904. Males had a median income of $30,053 versus $30,200 for females. The per capita income for the town was $19,293. About 9.0% of families and 12.0% of the population were below the poverty line, including 16.0% of those under age 18 and 7.2% of those age 65 or over.

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- ***Districts Heights, Maryland – Zip Code 20747***

District Heights is an incorporated city in Prince George's County, Maryland, United States, located near Maryland Route 4.[1] The population was 5,837 at the 2010 census. For more information, see the separate articles on Forestville, Maryland and Suitland.

District Heights is 9.85 miles (15.85 km) away from central Washington, D.C. District Heights is located at 38°51′34″N 76°53′21″W38.85944°N 76.88917°W (38.859545, −76.889139)[2]. According to the United States Census Bureau, the city has a total area of 0.9 square miles (2.3 km^2), all of it land.

Demographics

As of the 2010 Census the population of District Heights was 5,837. The racial and ethnic composition of the population was 4.25% non-Hispanic white, 89.5% non-Hispanic black, 0.2% Native American, 0.6% Asian, 1.15 from some other race and 1.9% from two or more races. 3.7% of the population was Hispanic or Latino or any race.[3]

As of the census[4] of 2000, there were 5,958 people, 2,070 households, and 1,538 families residing in the city. The population density was 6,649.1 people per square mile (2,556.0/km²). There were 2,170 housing units at an average density of 2,421.7 per square mile (930.9/km²). The racial makeup of the city was 9.20% White, 87.95% African American, 0.12% Native American, 0.86% Asian, 0.20% from other races, and 1.68% from two or more races. Hispanic or Latino of any race were 0.49% of the population.

There were 2,070 households out of which 38.3% had children under the age of 18 living with them, 39.6% were married couples living together, 28.2% had a female householder with no husband present, and 25.7% were non-families. 22.1% of all households were made up of individuals and 5.0% had someone living alone who was 65 years of age or older. The average household size was 2.88 and the average family size was 3.36.

In the city the population was spread out with 30.8% under the age of 18, 8.3% from 18 to 24, 29.3% from 25 to 44, 23.6% from 45 to 64, and 8.0% who were 65 years of age or older. The median age was 34 years. For every 100 females there were 84.9 males. For every 100 females age 18 and over, there were 76.1 males.

The median income for a household in the city was $52,331, and the median income for a family was $61,220. Males had a median income of $37,129 versus $32,443 for females. The per capita income for the city was $21,190. About 4.5% of families and 5.9% of the population were below the poverty line, including 9.0% of those under age 18 and 6.1% of those age 65 or over.

References

1. U.S. Geological Survey Geographic Names Information System: District Heights, Maryland
2. "US Gazetteer files: 2010, 2000, and 1990". United States Census Bureau. 2011-02-12. http://www.census.gov/geo/www/gazetteer/gazette.html. Retrieved 2011-04-23.
3. 2010 general profile of population and housing characteristics of District Heights from the US Census
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Sources of Information

Retrieved from http://en.wikipedia.org/wiki/District_Heights,_Maryland.

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 Plan (http://dhmh.maryland.gov/ship/) and its County Health Profiles 2012 (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx) , the Maryland Vital Statistics Administration (http://dhmd.maryland.gov/html/reports.cfm), The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) (http://www.dhmh.maryland.gov/mhhd/Documents/1stResource_2010.pdf), the Maryland ChartBook of Minority Health and Minority Health Disparities, 2nd Edition (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf)

Table II : Prince George's County

Characteristic or determinant	**Response County/Value**		**Source**
Community Benefit Service Area(CBSA) Target Population:	**Prince George's County:**		Healthy Communities Institute: http://admin.dchweb.thehcn.net/index.php?module=DemographicData&type=user&func=ddview&varset=1&ve=text&pct=2&levels=1
target population,	Target Population	870,792	
by sex,	By Sex		
	Male	419,769	
	Female	451,023	
by race,	Race:		From secondary sources of:
	White	157,154 (18.05%)	
		564,015 (64.77%)	Demographics information provided by Claritas, under these terms of use.
	African American	35,788 (4.11%)	
	Asian		
		109,835 (13.07%)	

by ethnicity and	Other Ethnicity Hispanic/Latin Not Hispanic/Latin	141,421 (16.24%) 729,371 (83.76%) 218,488	
by average age	Ages: under 18 (not our patients) 18+ 25+ 65+ Average Median Age	652,308 564,200 82,644 35.30	
Median Household Income within the CBSA	20706 20715 20720 20721 20737 20740 20743 20747 20770 20772 20774 20784 20785 Prince George's	$70,386 $90,599 $100,074 $115,858 $55,125 $62,118 $53,202 $55,277 $57,623 $89,992 $86,554 $56,168 $53,627 $67,886	
Percentage of households with incomes below the federal poverty guidelines within the	Zip Code 20706 20715	Number 483 0.23% 111 0.05%	

CBSA	20720 20721 20737 20740 20743 20747 20770 20772 20774 20784 20785 Prince George's (total families 212,205	107 0.05% 66 0.03% 365 0.17% 129 0.06% 834 0.39% 709 0.33% 121 0.06% 188 0.09% 155 0.07% 509 0.24% 767 0.36% 9,731 5% 4.59%	
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	Adults without Health Insurance by Race/Ethnicity	19.1%	**URL of Source:** http://www.census.gov/acs/www/
Percentage of Medicaid recipients by County within the CBSA.	Prince George's County	13%	http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_09_1YR_B27007&prodType=table
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/SitePages/objective1.aspx and county profiles: http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	Prince George's County	77.5 in 2008-2009 77.8 in 2008-2010	http://dhmh.maryland.gov/ship/PDFs/CLD%20Objective%201%20Life%20Expectancy.pdf

Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).

Table 3.7 Unadjusted Mortality Rates per 100,000 for All Causes, Top Five Leading Causes of Death, and Remaining Other Causes Among Adult Prince George's Residents Age 65 and Older in 2006

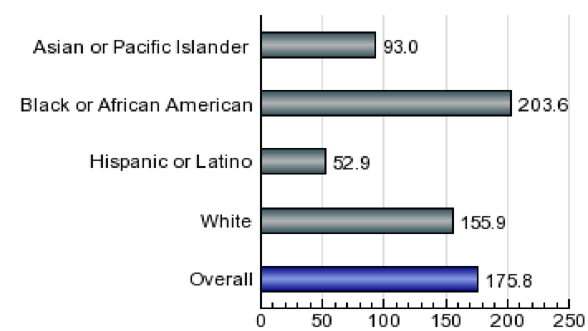
	Region	All Causes	Heart Disease	Cancer	Cerebro-vascular Disease	Diabetes	Chronic Lower Respiratory Disease	Other Causes	Total Population, Age 65+
Prince George's County		4380.7	1418.0	1005.0	213.4	174.8	155.6	1413.9	72,637
Inside Beltway	North PUMA 1	4361.2	1453.7	985.3	129.2	242.3	145.4	1405.3	6,191
Inside Beltway	North Central PUMA 3	4154.8	1446.0	916.5	173.1	152.8	142.6	1323.8	9,820
Inside Beltway	South Central PUMA 4	4743.6	1570.5	1121.8	170.9	267.1	160.3	1453.0	9,360
Inside Beltway	South PUMA 7	4429.4	1503.7	1119.0	221.5	244.8	128.2	1212.2	8,579
Outside Beltway	North PUMA 2	3854.1	1023.7	808.7	301.1	103.2	189.3	1428.1	11,624
Outside Beltway	Central PUMA 5	4160.4	1215.2	1072.3	214.5	150.1	135.8	1372.5	13,989
Outside Beltway	South PUMA 6	4948.8	1759.2	1024.9	229.5	137.7	175.9	1621.6	13,074
Total number of deaths in county, Age 65+		3182	1030	730	155	127	113	1027	

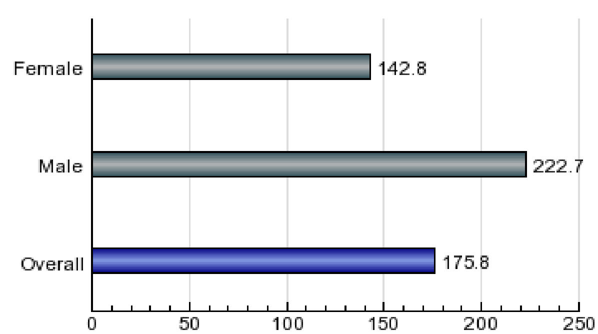
SOURCE: Deaths--Maryland Department of Health and Hygiene Vital Statistics Administration, *http://www.vsa.state.md.us/html/reports.html*; Population denominator for mortality rate calculation—2006 American Community Survey.

PUMA rate ≥ 50% below County rate | PUMA rate 25% to 50% below County rate | PUMA rate 25% above or below County rate | PUMA rate 25% to 50% above County rate | PUMA rate ≥ 50% above County rate

Key diagnosis that Doctors Community Hospital has initiatives to serve the community.

Age-Adjusted Death Rate per 100,000 due to Coronary Heart Disease in Prince George's County by Race and by Sex





http://www.princegeorgescountymd.gov/pgcha/pdfs/rand-assessing-health-care.pdf

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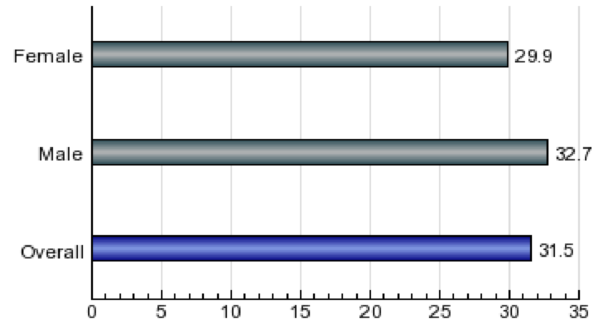
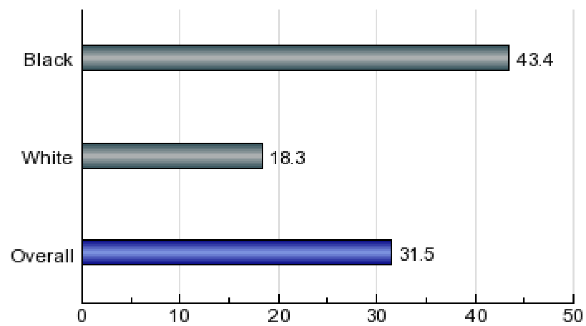
URL of Data: http://wonder.cdc.gov/ucd-icd10.html

http://admin.dchweb.thehcn.net/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=4142713

Age-Adjusted Death Rate Per 100,000 due to Diabetes by Sex and by Race

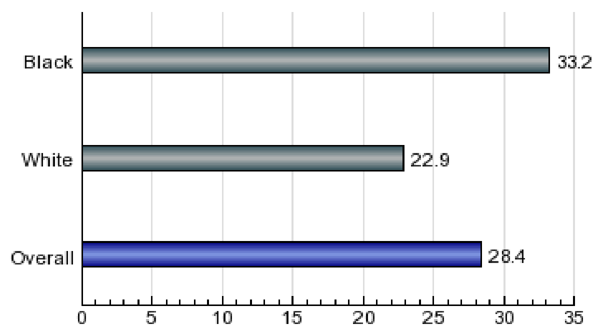




URL of Data: http://wonder.cdc.gov/ucd-icd10.html

http://admin.dchweb.thehcn.net/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=238876

Age-Adjusted Death Rate per 100,000 due to Breast Cancer by Race



URL of Data: http://statecancerprofiles.cancer.gov/deathrates/deathrat...

http://admin.dchweb.thehcn.net/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=236510

<table>
<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)

See SHIP website for social and physical environmental data and county profiles for primary service area information:

http://dhmh.maryland.gov/ship/SitePages/measures.aspx</td>
<td>In Prince George's County, 91% of the residents have access to health food outlets, which is above the 61% Maryland ranking. Within the CBSA there are many varieties of food outlets.</td>
<td>91%</td>
<td>County Health Rankings 2012

http://www.countyhealthrankings.org/print/node/1343/other-measures</td>
</tr>
<tr>
<td>Available detail on race, ethnicity, and language within CBSA.

See SHIP County profiles for demographic information of Maryland jurisdictions.</td>
<td colspan="2">
<table>
<tr><th></th><th>Prince George's County</th></tr>
<tr><td>Demographics</td><td></td></tr>
<tr><td>Population</td><td>834,560</td></tr>
<tr><td>% below 18 years of age</td><td>25%</td></tr>
<tr><td>% 65 and older</td><td>10%</td></tr>
<tr><td>% African American</td><td>66%</td></tr>
<tr><td>% American Indian and Alaskan Native</td><td>1%</td></tr>
<tr><td>% Asian</td><td>4%</td></tr>
<tr><td>% Native Hawaiian/Other Pacific Islander</td><td>0%</td></tr>
<tr><td>% Hispanic</td><td>14%</td></tr>
<tr><td>% not proficient in English</td><td>9%</td></tr>
<tr><td>% Females</td><td>52%</td></tr>
<tr><td>% Rural</td><td>3%</td></tr>
</table>
</td>
<td>County Health Rankings 2012

http://www.countyhealthrankings.org/print/node/1343/other-measures</td>
</tr>
<tr>
<td>Other - Diabetes</td>
<td>Doctors Community Hospital serves diabetes patients. This county has 11% of its population</td>
<td>11%</td>
<td>County Health Rankings 2012

http://www.countyhealthrankings.org/print/no</td>
</tr>
</table>

	affected by diabetes, as compared to 9% in Maryland.		de/1343/other-measures
Other - Illiteracy	This county has a 22% illiteracy rate as compared to 11% in Maryland. Doctors Community Hospital attends community health fairs in diabetes and breast care for the patients.	22%	County Health Rankings 2012 http://www.countyhealthrankings.org/print/node/1343/other-measures

Table II Supplemental – County Health Rankings Reflects Prince George's County at less than the 50% in most categories

	Prince George's County	Error Margin	National Benchmark*	Maryland		Rank (of 24)
Health Outcomes						15
Mortality						17
Premature death	8,258	8,041-8,476	5,466	7,428		
Morbidity						14
Poor or fair health	13%	12-14%	10%	13%		
Poor physical health days	3.0	2.8-3.3	2.6	3.1		
Poor mental health days	3.0	2.7-3.3	2.3	3.3		
Low birth weight	10.5%	10.3-10.7%	6.0%	9.2%		
Health Factors						17
Health Behaviors						10
= 100 cigarettes and currently smoking "Adult smoking	15%	14-17%	14%	17%		
= 30"Adult obesity	34%	32-36%	25%	28%		
Physical inactivity	25%	23-26%	21%	24%		
Excessive drinking	9%	8-11%	8%	15%		
Motor vehicle crash death rate	16	15-17	12	12		
Sexually transmitted infections	636		84	422		
Teen birth rate	38	37-38	22	33		
Clinical Care						17

Uninsured	16%	15-17%	11%	13%		
Primary care physicians**	1,304:1		631:1	824:1		
Preventable hospital stays	56	55-58	49	66		
Diabetic screening	76%	74-77%	89%	81%		
Mammography screening			74%	68%		
Social & Economic Factors						16
High school graduation	73%			82%		
Some college	58%	57-60%	68%	66%		
Unemployment	7.4%		5.4%	7.5%		
Children in poverty	12%	10-15%	13%	13%		
Inadequate social support	23%	21-25%	14%	20%		
Children in single-parent households	43%	41-44%	20%	33%		
Violent crime rate	865		73	620		
Physical Environment						23
Air pollution-particulate matter days	4		0	4		
Air pollution-ozone days	29		0	16		
Access to recreational facilities	7		16	12		
Limited access to healthy foods	5%		0%	4%		
Fast food restaurants	71%		25%	59%		

* 90th percentile, i.e., only 10% are better

** this data was updated on Nov. 1, 2012. Please see http://www.countyhealthrankings.org/node/8939 for more information.

Note: Blank values reflect unreliable or missing data

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http://www.countyhealthrankings.org/print/node/1343/other-measures

/county/snapshots/2012/24/033/county/snapshots/2012/24/033

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 and as described in Health General 19-303(a)(4), a community health needs assessment is a written document developed by a hospital facility (alone or in conjunction with others) that utilizes data to establish community health priorities, and includes the following:

(1) A description of the process used to conduct the assessment;
(2) With whom the hospital has worked;
(3) How the hospital took into account input from community members and public health experts;
(4) A description of the community served; and
(5) A description of the health needs identified through the assessment process (including by race and ethnicity where data are available).

Examples of sources of data available to develop a community needs assessment include, but are not limited to:

(1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP)(http://dhmh.maryland.gov/ship/);
(2) SHIP's CountyHealth Profiles 2012 (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx);
(3) the Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(4) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(5) Local Health Departments;
(6) County Health Rankings (http://www.countyhealthrankings.org);
(7) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(8) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(9) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(10) Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(11) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(12) For baseline information, a Community health needs assessment developed by the state or local health department, or a collaborative community health needs assessment involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(13) Survey of community residents; and
(14) Use of data or statistics compiled by county, state, or federal governments.

1. **Identification of community health needs:**

Describe in detail the process(s) your hospital used for identifying the health needs in your community and the resource(s) used.

Doctors Community Hospital is engaged in a few processes to identify the health needs in the Prince George's County. We use a range of assessment tools to serve our patients and identify areas that are not being served in our community. Since 2010 we have solicited input from our physicians using the Physicians Needs Assessment. In addition, we continue to review our patient survey information to glean areas of need. Finally, we attend and participate in community functions such as health fairs and health committees to again understand areas of concern that can be met by our hospital.

The Community Health Needs Assessment Committee is working towards the compliance with the Federal IRS requirements with our first step of completing the Community Physician Survey. The next step is the Community Health Needs Assessment scheduled for early spring 2013.

<u>Transitional Care Department</u>
As of October 2011, Doctors Community Hospital initiated a new department: Transitional Care. This new department's focus is to work with patients who are frequently re-admitted. The staff talks with patients who frequently arrive at the emergency room for a readmission to discuss the barriers to remaining healthy at home. In the first year, this department reduced 179 re-admissions by assisting patients in understanding their medical education to care for themselves at home.

<u>Utilization Review Committee</u>
In 2011, Doctors Community Hospital initiated a Utilization Review Committee to further understand the needs of the inpatients and their physicians: attending, referring and consulting. This group reviews inpatients with chronic health issues to assist in educating the patient and physicians on how to care for patients at home while reducing unnecessary admissions after discharge.

<u>The Prince George's County Health Action Plan 2012 is located in Appendix V.</u>
In addition, the Prince George's County Health Improvement Plan 2011-2014: Blueprint of Healthy Prince George's County is located in Appendix VI.

Our Chief Operating Officer is a chair of one of the committees of the Prince George's County Health Care Coalition. By participating in this symposium, our hospital is able to evaluate how we can support our community.

The full document is in Appendix V; however the Mission statement is below.

Mission

> To improve the health of the residents of Prince George's County by increasing access to care, promoting collaboration among health care providers and key stakeholders, and integrating and coordinating patient care to reduce duplication of and enhance seamless health service delivery.

The foundation of our efforts is the use of evidence-based best practices to reduce the overall cost of care while optimizing efficiency, effectiveness and productivity.

Prince George's County Health Improvement Plan Priority Areas

- Ensure that residents receive the health care they need, particularly low income, uninsured/underinsured adults and children
- Prevent and control chronic disease In Prince George's County
- Improve reproductive health care and birth outcomes for women in Prince George's County, particularly among African American women
- Prevent and control infectious disease In Prince George's County
- Ensure that Prince George's County physical environments are safe and support health, particularly in at-risk communities
- Ensure that Prince George's County social environments are safe and support health By 2015, enhance the health information technology infrastructure of Prince George's County in order to increase reimbursements for care, improve patient care, and address disparities.
- By 2020, obtain public health accreditation of the Health Department.
- By 2020, build a comprehensive integrated community-oriented health care system that meets the needs of all County residents

Throughout 2011- 2015, work with partners to implement strategies that attract more licensed medical professionals and other health care workers to the County in order to address the severe health care workforce shortage

Sources of Information

Retrieved on October 8, 2012 from the Prince George's County website:http://www. princegeorgescountymd.gov/Government/AgencyIndex/Health/improvement.asp.

<u>Blueprint for a Healthier Prince Georges 2011-2014</u>

We are using this document from the county to update our hospital's strategic plan. Appendix VI has the plan; however, here is the introduction of the document.

At the heart of any community's success and prosperity is the health of its residents. When people have access to affordable health care, safe neighborhoods, a clean environment, and opportunities for physical activity, recreation, nutritious foods, and other resources that contribute to a healthy lifestyle, they are more equipped to excel in school, thrive in the workforce, and fulfill their civic responsibilities.

This Plan was prepared by the Prince George's County Health Department with the assistance of numerous stakeholders. These include the County Council serving as the Board of Health, the Maryland Department of Health And Mental Hygiene, the Community Transformation Coalition and other health organizations concerned about the health status and health system needs of this County.

The Plan addresses our County's most pressing and immediate health needs as well as overarching concerns for the health stakeholder community as a whole. Collectively, the priorities, objectives, and strategies are ambitious and cover a broad array of health issues. Included are initiatives and programs specific to individual agencies as well as strategies that address policy and systems changes and that reflect social determinants of health. We also considered the key concepts that underscore the "Place Matters Initiative" launched by the Joint Center for Political and Economic Studies – Health Policy Institute. The year 2014 was selected as the target year for most of our objectives for three reasons: 1) to be in alignment with the Maryland State SHIP Target dates and projected improvements, 2) to allow us the opportunity to evaluate our progress and make adjustments to the Plan at the halfway point toward meeting Healthy People 2020 goals and 3) to enable us to assess our priorities as they relate to planned health care reform for the nation.

Since no organization alone can perform all of the activities listed, the Plan relies extensively on existing partnerships and the forging of new alliances among many community groups and agencies. In addition, a robust and on-going search for funding and other resources will be required.

There is already tremendous enthusiasm, optimism and resolve among our key health stakeholders to make this Plan succeed in creating a healthier Prince George's County. While the work will be challenging, the benefits will be great.

Physician Needs Assessment

In October 2010 we issued and received back an assessment by our community physicians. This assessment gave us some suggested directions that we could follow to support the patients that are seen by our community physicians.

County Health Rankings

In 2011 we began reviewing our county's results in the County Health Rankings. As a result, we continue to validate our focus on diabetes and breast care.

Komen Foundation Provides Prince George's County Residents with Evaluations

In 2012, we received a Komen grant to support community in encouraging the breast evaluations, regardless of income levels. The hospital is funding over $1,000,000 in free care over 3 years with a matching of $1,000,000 from Komen Foundation.

Healthy Communities Institute
In 2012, we began the addition to our website that includes Prince George's County data so our residents and physicians can access that data. By the spring of 2013, our hospital's data will be included to provide our customers with the data needed to evaluate our hospital. We expect this data will result in our patients and physicians utilizing our services more than before 2013.

Data Gaps Identified
Our strategic team is frequently searching for committees to participate in and other web sites that offer comparative data to ensure we are focused on the right solutions for our patients and physicians. Data on zip codes within Prince George's County is not readily available; however, Healthy Communities Institute is developing such data. Once we can focus our efforts by zip code within our County, Doctors Community Hospital will be able to more fully participate with the community.

The Hispanic population is growing with Prince George's County and the understanding of the health needs on this group is yet to be well documented.

2. **In seeking information about community health needs, what organizations or individuals outside the hospital were consulted?**

Include representatives of diverse sub-populations within the CBSA, including racial and ethnic minorities (such as community health leaders, local health departments, and the Minority Outreach & Technical Assistance program in the jurisdiction).

In 2012, the following external participants were contacted and participated in surveys, committee meetings, and functions.

Local Government and Health Departments
Honorable Rashurn L. Baker, III, County Executive, Prince George's County
Pamela B. Creekmur, Health Officer, Prince George's County

Local Physicians:
Dr. Rakesh Arora, President DCH Medical Staff, Bowie, Maryland
Dr. Don Yablonowitz, Chairman DCH Utilization Review Committee
Dr. Madhu K. Mohan, Endocrinologist, Riverdale, Maryland

Minority Outreach
Charlene Dukes, PhD, President Prince George's Community College
Dwayne Leslie, General Conference of Seventh Day Adventist, Silver Spring, Maryland

Community Leaders
Rene LaVigne, Presidnet and CEO, Ironbow Technology, Largo, Maryland
Ms Joanne Goldsmith, retiree, Doctors Community Hospital

Charles Dukes, Jr. W.F. Chesley Real Estate, Crofton, Maryland
Robert Bonaventure, retiree, Accokeek, Maryland
Timothy J. Adams, President, SA-Tech, Largo, Maryland
Richard J. Ham, Champion Realty Title, Annapolis, Maryland
Michael Errico, Davidsonsville, Maryland

<u>Breast Center Initiative Community Leaders</u>
Dr Hampton: Professional fees for reading screens paid by Komen
CBCC shares costs of Community Navigator, Van access, and Van
AWCAA shares cost of Community Navigator

<u>Surgical Services Improvements Physician Leaders</u>
Dr.Richardo Scartascini, OB-GYN, Greenbelt, Maryland
Dr. Jonah Murdock, Urologist, Greenbelt, Maryland
Capital Orthopedics Group, Lanham, Maryland

<u>Technical Assistance</u>
Jenny Belforte, MPH, Account Manager, Healthy Communities Institute
The Advisory Board staff for Crimson Quality and Utilization Products
Intellimed Software for Utilization “
County Health Rankings for services offered to residents in the county

<u>Websites Visited and Reports Used for Additional Data:</u>
Centers for Disease Control and Prevention
Centers for Medicare and Medicaid – Readmission Reports
US Health and Human Services - Hospital Compare
Maryland Vital Statistics Administration
Prince George’s County Government
Prince George’s County Health Department
Rand Report on Prince George’s County
Blue Print for Health Prince George’s County
University of Maryland Report on Prince George’s County Health Environment

3. **When was the most recent needs identification process or community health needs assessment completed?**

(This refers to your *current* identification process and may not yet be the CHNA required process)

Provide date here. 05/_21 /_11 *(mm/dd/yy)*

4. **Although not required by federal law until 2013, has your hospital conducted a Community Health Needs Assessment that conforms to the definition on the previous page within the past three fiscal years?**

**Please be aware, the CHNA will be due with the FY 2013 CB Report.

___Yes
_X_No, *following the IRS guidelines, the CHNA will be completed in the Spring 2013*.

If you answered yes to this question, please provide a link to the document or attach a PDF of the document with your electronic submission.

Our Community Health Needs Assessment is scheduled for early 2013, with guidance from our CHNA Committee, led by Vice President of Foundation, on how to best capture the best results.

- *Phase I, data collection, will be completed by February 2013.*
- *Phase II of data analysis will be completed by April 2013.*
- *Phase III, updating our strategic plan with goals and budget projections*

All to be completed by June 2013 in time for our new Fiscal Year.

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)
         a. Vice President, Foundation
         b. COO,
         c. CNO,
         d. CMO,
         e. CIO,
         f. VP HR

   ii. Clinical Leadership

      1. _X__Physician (CMO, Utilization Review)
      2. _X__Nurse (CNO, Director, Nursing)
      3. _X__Social Worker
      4. _X__Other (Director of Transitional Care)

   iii. Community Benefit Department/Team

      1. _X__Individual (Community Resource Coordinator 1 FTE, Director, Volunteers and Community Relations 1 FTE,)
      2. _X_Committee (Executive Team: CEO, VP Foundation, COO, CFO, CNO, CMO, CIO, VP HR, Directors Marketing, Physician Integration, Transitional Care, Physician Liaison, Social Worker, Nursing Leadership, Utilization Review Committee)
      3. _X_Other (Director of Decision Support and Reimbursement)

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

Conducted by the Community Benefits Department and Team

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

Review is done after submission at the first Board meeting in January 20XX.

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

1. **Please use Table III (see Table Section) to provide a clear and concise description of the needs identified:**

   In the process described above, the initiative undertaken to address the identified need, the amount of time allocated to the initiative, the key partners involved in the planning and implementation of the initiative, the date and outcome of any evaluation of the initiative, and whether the initiative will be continued. Use at least one page for each initiative (at 10 point type).

For example: for each major initiative where data is available, provide the following:

a. Identified need: This includes the community needs identified in your most recent community health needs assessment as described in Health General 19-303(a)(4). 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 and how it is intended to address the identified need. (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. Date of Evaluation: When 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 when available).

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.

2. Were there any primary community health needs that were identified through a community needs assessment 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.)

   Yes, illiteracy was identified in Prince George's County and Doctors Community Hospital will continue to work with the county officials on different committees to see how we can assist.

V. PHYSICIANS

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

The Utilization Committee and Medical Staff Committee continue to identify gaps in the availability of specialist providers to serve the uninsured in Prince George's County. Programs that are being evaluated include the following:

- *Orthopedics*
- *Thoracic services*
- *Limited health services for the homeless*
- *Limited health services for undocumented resident*
- *Limited health services for the elderly with family working outside the county*
- *Limited availability of primary care physicians*

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.

- *DCH acquired the 50+ Hospital-based physicians to care for inpatients, since the limited number of community physicians are not able to see outpatients and attend to their inpatients.*
- *DCH spent millions of dollars on emergency department on-call coverage since Prince George's County has a limited number of primary care physicians and patients flock to the emergency departments for care. DCH has over 30 contracts for the variety of specialties.*
- *DCH offered Medical Directorships to ensure that physicians participate in the leadership of the hospital and the services offered to the county's residents.*
- *DCH offered the payment to nursing homes and some physicians to care for patients who are uninsured in order to keep the patients out of the inpatient setting.*

VI. APPENDICES

To Be Attached as Appendices:

1. Appendix I: 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)

Doctors Community Hospital does the following to ensure patients are aware of our financial policies:

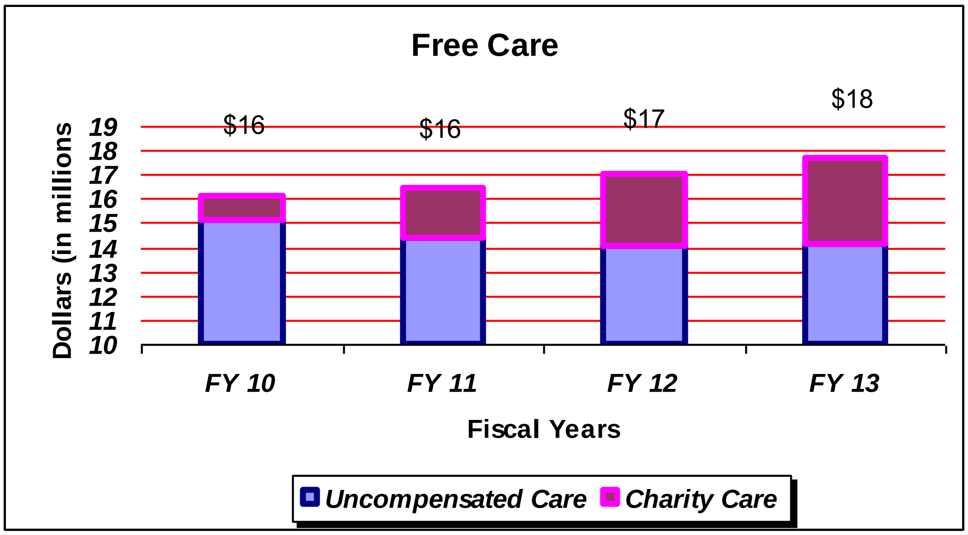
- *Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):*
  - *in a culturally sensitive manner,*
  - *at a reading comprehension level appropriate to the CBSA's population, and*
  - *in non-English languages that are prevalent in the CBSA.*
- *Posts its FAP, or a summary 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;*
- *Offers assistance in completing government and DCH financial assistance paperwork, a the cost of DCH, and*
- *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.*

Processes for Charity Care:

- *Notification Procedures regarding Charity care:*
- *There are signs posted in the Emergency Department, and all Admissions areas of the hospital.*
- *Each patient is given a brochure with the following information at time of admission and a copy is sent with any bills:*
- *There is a Spanish version of the brochure available as well.*
- *Financial Assistance*
- *Financial Assistance is available for patients who receive urgent or emergency services and do not have health insurance including Medicaid. Free care is provided for patients whose gross family income is at or below 200 percent of the Federal Poverty Guidelines. A 25-percent discount will be applied to qualified patients whose gross family income is above 200 percent of the Federal Poverty Guidelines.*
- *Financial Assistance applications may be obtained at the Emergency Registration or Outpatient Registration Departments or by calling the Business Office at 301-552-8186.*

- *Upon request, an application will be mailed to the patient. To qualify, the applicant must also provide proof of family income and expenses.*
- *Maryland Medical Assistance*
- *Doctors Community Hospital provides case workers to assist patients with Maryland Medical Assistance applications who have received Inpatient or Emergency Outpatient care. Patients who have received Inpatient care and do not have insurance may contact one of the phone numbers listed below:*
- *Annually we have an announcement posted in the local newspapers as well.*

History of Uncompensated Care- Chart



2. Appendix II: Include a copy of your hospital's FAP (label appendix II).

See Attached PDF

3. **Appendix III: Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) (label appendix III).**

See Attached PDF

4. **Appendix IV: Attach the hospital's mission, vision, and value statement(s) (label appendix IV).**

Description of Doctors Community Hospital Mission, Vision & Values

The main purpose of our hospital is to provide quality healthcare to our surrounding community, we have dedicated ourselves to doing just that. We have pledged to always do that to the best of our ability by providing a quality healthcare team, with quality tools, equipment and education.

The **Mission** of Doctors Community Hospital is

"**D**edicated to **C**aring for Your **H**ealth."

Our **Vision** is to

"Continuously strive for excellence in service and clinical quality to distinguish us with our patients and other customers."

Our **Values** are vested in the word SERVICE.

S - Safety
E - Excellence
R - Respect
V - Vision
I - Innovation
C - Compassion
E - Everyone

5. **Appendix V: Prince George's County Health Action Plan**
http://www.princegeorgescountymd.gov/Government/AgencyIndex/Health/improvement.asp

See Attached PDF

6. **Appendix VI: Blueprint for a Healthy Prince George's County, 2011 – 2014**
http://www.princegeorgescountymd.gov/Government/AgencyIndex/Health/improvement.asp

See Attached PDF

7. Appendix VII: Detailed Description, by Zip Code, of the communities that comprise the majority of Doctors Community Hospital's Community Benefit Service Areas

- ***Lanham, Maryland – Zip Code 20706***

Lanham is an unincorporated community and census-designated place in Prince George's County, Maryland, in the United States.[1] As of the 2010 census it had a population of 10,157.[2] The terminal of the Washington Metro's Orange Line, as well as an Amtrak station, are across the Capital Beltway in New Carrollton, Maryland. Doctors Community Hospital is located in Lanham.[3])

According to the U.S. Census Bureau, Lanham has a total area of 3.6 square miles (9.2 km2), of which 3.5 square miles (9.1 km2) is land and 0.02 square miles (0.05 km2), or 0.54%, is water.[5]

Demographics

The racial mix of the population is Black alone - 11,534 (59.4%), Hispanic - 3,310 (17.0%), White alone - 2,455 (12.6%), Asian alone - 1,547 (8.0%), two or more races - 549 (2.8%), American Indian alone - 15 (0.08%), and other race alone - 4 (0.02%).

Shoppers Food & Pharmacy, software company Vocus, media company Radio One and publisher Rowman & Littlefield are based in Lanham. Washington Bible College, Capital Bible Seminary, Equip Institute are located in this community.

References

1. U.S. Geological Survey Geographic Names Information System: Lanham, Maryland
2. "Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data (DP-1): Lanham CDP, Maryland". U.S. Census Bureau, American Factfinder. http://factfinder2.census.gov. Retrieved December 20, 2011.
3. "Doctors Community Hospital". *Doctors Community Hospital website*. Doctors Community Hospital. 2009-01-29. http://www.dchweb.org/.
4. "National Register Information System". *National Register of Historic Places*. National Park Service. 2010-07-09. http://nrhp.focus.nps.gov/natreg/docs/All_Data.html.
5. "Geographic Identifiers: 2010 Demographic Profile Data (G001): Lanham CDP, Maryland". U.S. Census Bureau, American Factfinder. http://factfinder2.census.gov. Retrieved December 20, 2011.

Sources of information

Retrieved from http://en.wikipedia.org/wiki/Lanham,_Maryland
Retrieved from http://www.city-data.com/city/Lanham-Seabrook-Maryland.html

- ***Cheverly, Maryland – Zip Code 20784***

In its over 80 years, the **Town of Cheverly** has grown from farmland to a small livable community just minutes from the Nation's Capitol. Cheverly is 1.27 square miles in area, and the 2010 U.S. Census survey counted a population of 6,173 residents.

The Town is located in the western portion of Prince George's County, Maryland, just a mile from the northeastern Washington, D.C. border. Cheverly largely lies between two major road arteries -- the Baltimore-Washington Parkway and Maryland Route 50. Established as a planned residential community, Cheverly is convenient to Washington, D.C. by Metro bus and rail, and to retail shopping centers in the surrounding communities.

Cheverly was begun as a planned suburb in the early 1900s. The Cheverly area was first platted in 1904 for a 93-acre (380,000 m2) community called Cheverly Gardens. The land was subsequently purchased in 1918 by Robert Marshall, president of the Washington Suburban Realty Company. The Cheverly subdivision platted by Marshall was developed around the 1839 Magruder family homestead known as Mount Hope. Marshall became the first resident of Cheverly by taking up residence in the restored homestead in 1919. In 1923, the first road, now known as Cheverly Avenue, was completed and paved to connect the Pennsylvania Railroad line to Landover Road. 34 developer-built houses were constructed between 1921 and 1925. Most of the early houses were mail-order designs from Sears & Roebuck and the McClure Homes Company. Marshall lost control of the Washington Suburban Realty Company in 1927. Harry Wardman assumed the position until the company’s bankruptcy in 1929 due to the stock market crash.[6]

Incorporation was granted in 1931 to address concerns for better roads and services. During the 1930s and 1940s, the streets were improved and lighting enhanced, and the number of residences increased from 135 to 650. Residential construction continued through the 1960s, creating a varied housing stock of early Cape Cod houses, with later ranch and split-level types. Two garden-style apartment complexes (Cheverly Terrace and Hanson Arms) were constructed in the early 1960s along Landover Road near the US Route 50 interchange. The community center, town hall, and park facility was built in 1978. Industrial property was established in 1958 on the west side of town and adjacent to Route 50.[6]

On April 29, 2006, the community held a 75th anniversary celebration at the town community center. The historic home Mount Hope has been the town's official symbol since 1931.

<u>Demographics</u>

Cheverly is home to the Prince George's Hospital Center and the Publick Playhouse for the Performing Arts.[3] Cheverly's ZIP codes are 20784 and 20785. As of the census[5] of 2000, there were 6,433 people, 2,258 households, and 1,637 families residing in the town. The population density was 4,769.9 people per square mile (1,839.8/km²). There were 2,348 housing units at an average density of 1,741.0 per square mile (671.5/km²). The racial makeup of the town was 33.86% White, 56.79% African American, 0.17% Native American, 2.50% Asian, 0.03% Pacific Islander, 3.22% from other races, and 3.44% from two or more races. Hispanic or Latino of any race were 6.76% of the population.

There were 2,258 households out of which 39.8% had children under the age of 18 living with them, 48.8% were married couples living together, 17.1% had a female householder with no husband present, and 27.5% were non-families. 20.4% of all households were made up of individuals and 4.7% had someone living alone who was 65 years of age or older. The average household size was 2.85 and the average family size was 3.30.

References

1. U.S. Geological Survey Geographic Names Information System: Cheverly, Maryland
2. "Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data (DP-1): Cheverly town, Maryland". U.S. Census Bureau, American Factfinder. http://factfinder2.census.gov. Retrieved December 9, 2011.
3. "Publick Playhouse". Maryland-National Capital Park and Planning Commission. http://www.pgparks.com/places/artsfac/publick.html.]
4. "US Gazetteer files: 2010, 2000, and 1990". United States Census Bureau. 2011-02-12. http://www.census.gov/geo/www/gazetteer/gazette.html. Retrieved 2011-04-23.
5. "American FactFinder". United States Census Bureau. http://factfinder.census.gov. Retrieved 2008-01-31.
6. a b "Community Summary Sheet, Prince George's County". Cheverly, Maryland. Maryland State Highway Administration, 1999. 2008-05-10. http://www.sha.maryland.gov/oppen/pg_co.pdf.
7. M-NCPPC Illustrated Inventory of Historic Sites (Prince George's County, Maryland), 2006.

Sources of Information

Retrieved from http://www.cheverly-md.gov/Pages/index

Retrieved from http://en.wikipedia.org/wiki/Cheverly,_Maryland.

- ***Landover, Maryland – Zip Code 20785***

Landover is an unincorporated community and census-designated place in Prince George's County, Maryland, United States.[1] As of the 2010 census it had a population of 23,078.[2] Landover was named for the town of Llandovery, Wales.[3]

Landover is located at 38°55′28″N 76°53′15″W38.9244°N 76.8876°W. According to the U.S. Census Bureau, it has an area of 4.07 square miles (10.55 km^2), of which 0.004 square miles (0.01 km^2), or 0.13%, is water.[4]

Though small, Landover houses many neighborhoods, which include Glenarden, Brightseat, Ardmore, Palmer Park, Kentland, Dodge Park, Columbia Park, Willow Hills(Hill Rd), Belle Haven, Lansdowne, and Village Green. Metrorail's Orange Line passes through the community. Landover Hills is a separate, incorporated community a few miles away. Landover is the birthplace of the late Len Bias. The Prince Georges County Sports and Learning Complex is in Landover.

Giant Food has its headquarters in a location in unincorporated Prince George's County near Landover.[5] Landover also had career based colleges such as Fortis College [9] that offers programs as a bio-technician, medical assisting and medical coding and billing.
Shopping and Crime

References

1.U.S. Geological Survey Geographic Names Information System: Landover, Maryland
2. "Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data (DP-1): Landover CDP, Maryland". U.S. Census Bureau, American Factfinder. http://factfinder2.census.gov. Retrieved December 20, 2011.
3."Profile for Landover, Maryland, MD". ePodunk. http://www.epodunk.com/cgi-bin/genInfo.php?locIndex=2651. Retrieved August 25, 2012.
4. "Geographic Identifiers: 2010 Demographic Profile Data (G001): Landover CDP, Maryland". U.S. Census Bureau, American Factfinder. http://factfinder2.census.gov. Retrieved December 20, 2011.
5. "Facility Locations." Giant Food. Retrieved on September 6, 2011. 8301 Professional Place, Suite 115 Landover, MD 20785."
6. "National Register Information System". National Register of Historic Places. National Park Service. 2010-07-09. http://nrhp.focus.nps.gov/natreg/docs/All_Data.html.
7."Harlem Renaissance Festival". Festival Media Corporation. http://www.festivals.com/viewevent.aspx?eventid=2aWwZDqLM2w%3D. Retrieved August 24, 2012.
8."Prince George's County Public Schools". Prince George's County Public Schools. http://www1.pgcps.org/. Retrieved August 24, 2012.

9. Fortis College - Landover
10.U.S. Census Bureau.http://www.census.gov/prod/www/abs/decennial/index.html.Retrieved 2010-07-17.

Sources of Information

Retrieved from http://en.wikipedia.org/wiki/Landover,_Maryland.

- ***Greenbelt, Maryland – Zip Code 20770***

The **Greenbelt Historic District** is a national historic district located in Greenbelt, Prince George's County, Maryland, United States. The district preserves the center of one of the few examples of the Garden City Movement in the United States. With its sister cities of Greenhills, Ohio and Greendale, Wisconsin, Greenbelt was intended to be a "new town" that would start with a clean slate to do away with problems of urbanism in favor of a suburban ideal. Along with the never-commenced town of Greenbrook, New Jersey, the new towns were part of the New Deal public works programs.[3]

Greenbelt's center has survived with few alterations compared with its sister towns. It was designated a National Historic Landmark in 1997.[2][4]

In April 1935 Congress passed the Emergency Relief Appropriation Act, intended to counter the effects of the Great Depression through the appropriation of $5 billion for jobs programs. As a result, President Franklin Delano Roosevelt established the Resettlement Administration (RA) to coordinate federal efforts concerning housing and land, placing particular emphasis on rural poverty. While the focus of the RA remained primarily rural, it was also charged with resettling farm workers who were leaving agriculture in search of industrial work. New towns were seen as a solution to this problem, to be built outside urban areas and surrounded by healthful green belts of preserved land. As many as 3000 of these towns were initially envisioned. 100 cities were studied for new towns, eventually narrowing to 25. Four sites were picked for the first trials: Washington, D.C, Milwaukee, Wisconsin, Cincinnati, Ohio and New Brunswick, New Jersey. The Washington site was to be near Berwyn, Maryland, on land depleted by tobacco farming. 12,000 acres (49 km^2) were purchased, and work began in late 1935, using 1000 laborers.[5] Architects and planners were hired in June 1935, site construction began in December 1935, and Roosevelt was briefed on the plans in April 1936. Wallace Richards was the RA regional coordinator, Douglas Ellington was the principal architect, Reginald Wadsworth was associate principal architect, Hale Walker was the town planner, and Harold Bursley was the engineering designer. The design team described areas for group housing, single-family residences, light and heavy industry, businesses, schools and parks. beyond the original town area, planned for 4000 families, two more areas were reserved for 3000 families each, with capacity for 50% growth. Much of the land south of Greenbelt Road that was designated for town expansion has since been transferred to the National Park Service and is now Greenbelt Park, while other areas became the Henry A. Wallace Beltsville Agricultural Research Center.[5]
Within the planned suburban development, 1000 units were designated for white residents, and 250 for African-American residents. A 1,750 acres (710 ha) tract was designated the Rossville Rural Development, and was apparently meant to be an area of 50 farms for African-Americans, based on the old African-American community of Rossville. Both Rossville and the suburban housing for African-Americans were eventually dropped from the plan.[5]

Demographics

Demographics

As of 2010 Greenbelt had a population of 23,068. The racial and ethnic composition of the population was 25.9% non-Hispanic white, 47.0% non-Hispanic black, 0.3% Native American, 2.6% Asian Indian, 7.1% other Asian, 0.1% Pacific Islander, 0.3% non-Hispanic of some other race, 3.3% from two or more races and 14.3% Hispanic or Latino of any race.[11]

As of the census[9] of 2000, there were 21,456 people, 9,368 households, and 4,965 families residing in the city. The population density was 3,586.6 people per square mile (1,385.3/km²). There were 10,180 housing units at an average density of 1,701.7 per square mile (657.3/km²). The racial makeup of the city was 39.74% White, 41.35% African American, 0.23% Native American, 12.05% Asian, 0.05% Pacific Islander, 3.11% from other races, and 3.47% from two or more races. Hispanic or Latino of any race were 6.45% of the population.

There were 9,368 households out of which 26.9% had children under the age of 18 living with them, 33.1% were married couples living together, 15.0% had a female householder with no husband present, and 47.0% were non-families. 35.0% of all households were made up of individuals and 5.8% had someone living alone who was 65 years of age or older. The average household size was 2.29 and the average family size was 3.00.

In the city the population was spread out with 21.9% under the age of 18, 12.5% from 18 to 24, 39.1% from 25 to 44, 19.8% from 45 to 64, and 6.7% who were 65 years of age or older. The median age was 32 years. For every 100 females there were 91.8 males. For every 100 females age 18 and over, there were 88.2 males.

The median income for a household in the city was $46,328, and the median income for a family was $55,671. Males had a median income of $39,133 versus $35,885 for females. The per capita income for the city was $25,236. About 6.0% of families and 10.2% of the population were below the poverty line, including 12.7% of those under age 18 and 7.2% of those age 65 or over.

History of the City

Construction involved the transport of as many a 5000 men by rail to the Branchville railroad halt each day. Roosevelt visited on November 13, 1936. However, politics intervened, and amid criticism of the program, the RA was placed under the U.S. Department of Agriculture. In September 1937 it became the Farm Security Administration. By 1938 the greenbelt town was dissolved. The construction cost for Greenbelt was estimated at $13,394,400.[5]
The government began accepting applications for residence in Greenbelt, basing acceptance on income, health, family size, financial reliability, clean living habits and indications of community

spirit. Prospective tenants were interviewed at their homes. Wives were not permitted to work, and were expected to stay home and take care of children. The average age of the initial tenants was 29 years. Tenants paid $18–25 per month for an apartment, and $28–41 for a semidetached house.[5]

The town was managed as a cooperative, with a citizens committee to run the commercial center. This arrangement was viewed with considerable skepticism, particularly within Congress. Eventually, by the 1950s, several members of Greenbelt's coops appeared before Congressional subcommittees on charges of communism and monopolistic practices as part of the McCarthy investigations.[5]

After several abortive attempts to divest itself of the town, the Federal Government hired Hale Walker, the town's original planner, along with Harold Heller to develop a master plan for expansion of the town. The new plan envisioned a reduction of agricultural use and an increase in single-family housing. In 1947 the Greenbelt Mutual Home Owners Corporation was formed as a vehicle for the sale of the town. Congressional legislation was passed that allowed the government to sell the greenbelt towns to non-profit groups with at least 50% veteran members.

In December 1952 the Greenbelt Veterans Housing Corporation (GVHC) bought 1580 units and 240 acres (0.97 km^2) of developed land for $6,285,450. In 1953 the GVHC bought 709 acres (2.87 km^2) of undeveloped land for $670,219. Other areas were sold to private developers, and in 1956 the GVHC sold the undeveloped land to cover its loan. In 1957 Greenbelt Homes, Inc. was formed from the GVHC to manage the community, and retains title to 1600 units and 280 acres (1.1 km^2) of land. The supermarket remains a co-op.[5]

Greenbelt is laid out as a crescent of "superblocks" containing two rows of frame or concrete block multi-family dwellings. Houses are linked by footpaths and are grouped around central service courts, with the public sides facing the communal "garden" space. A central town common includes the original commercial district, community center and school, linked to the residential areas by pedestrian underpasses. A recreation area, 27 acres (11 ha) lake, and allotment gardens are located beyond the common. The architecture is modernist in style. The historic district includes more than 400 structures, as well as three pre-existing family cemeteries. The original center of Greenbelt has since been surrounded by newer development, causing it to be compared with a medieval fortress town, a walled center surrounded by contemporary neighborhoods.[5]

Greenbelt borrowed techniques pioneered seven years previously at Radburn, New Jersey, which turned housing layouts "inside-out" to keep automobiles and service traffic hidden. The architectural design, while modern in tone, borrows details such as pitched slate roofs, plain walls and steel casement windows from the English garden cities at Letchworth and Welwyn Garden City. International Style influences are visible in the white walls and flat roofs of the concrete block buildings.

Landscaping was integrated into the design, with mature specimen trees saved or transplanted during site development. Each of the group housing units had a plot 30 feet (9.1 m) by 90 feet (27 m) between the house and the parklands, cared for by the tenant. On the service side space was provided for trash storage and clothes drying. Landscaping was used to create privacy, and the finished community was notable for the maturity of the plantings.[

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- ***Capitol Heights, Maryland – Zip Code 20743***

Capitol Heights is a town in Prince George's County, Maryland, United States.[1] The population was 4,337 at the 2010 census.[2] Development around the Capitol Heights Metro station has medical facilities and eateries to support the community. The Washington Redskins football stadium is just to the east of Capitol Heights, near the Capital Beltway (I-95/495) and Hampton Mall shopping center which has a new hotel and eateries. The town borders Washington, D.C.

Demographics

As of the census[4] of 2000, there were 4,138 people, 1,441 households, and 1,014 families residing in the town. The population density was 5,047.3 people per square mile (1,948.4/km²). There were 1,603 housing units at an average density of 1,955.2 per square mile (754.8/km²). The racial makeup of the town was 92.85% Black or African American, 4.81% White, 0.27% Native American, 0.36% Asian, 0.36% from other races, and 1.35% from two or more races. Hispanic or Latino of any race were 0.87% of the population.

There were 1,441 households out of which 37.5% had children under the age of 18 living with them, 35.2% were married couples living together, 28.5% had a female householder with no husband present, and 29.6% were non-families. 25.7% of all households were made up of individuals and 8.0% had someone living alone who was 65 years of age or older. The average household size was 2.87 and the average family size was 3.41.

In the town the population was spread out with 30.8% under the age of 18, 6.9% from 18 to 24, 32.6% from 25 to 44, 21.4% from 45 to 64, and 8.3% who were 65 years of age or older. The median age was 34 years. For every 100 females there were 84.8 males. For every 100 females age 18 and over, there were 78.8 males.

The median income for a household in the town was $46,667, and the median income for a family was $53,826. Males had a median income of $36,950 versus $35,225 for females. The per capita income for the town was $18,932. About 9.3% of families and 11.4% of the population were below the poverty line, including 15.8% of those under age 18 and 9.6% of those age 65 or over.

Notable people include Chad Scott, American football cornerback in the NFL, played for Pittsburgh Steelers and the New England Patriots.[5]

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- ***Kettering, Maryland – Zip Code -20774***

Kettering is an unincorporated area and census-designated place (CDP) in Prince George's County, Maryland, United States.[1] The population was 12,790 at the 2010 census,[2] primarily African-American. The name Kettering was created by a suburban housing developer in the 1960s when development began. Kettering is adjacent to Prince George's Community College, the upscale gated community of Woodmore, Six Flags America, Evangel Temple megachurch, and the community of Largo at the end of the Washington Metro Blue Line. Watkins Regional Park in Kettering offers a large playground, a colorful carousel, miniature golf, a miniature train ride, and various animals.

Kettering is located at 38°53′42″N 76°47′47″W38.895012°N 76.796471°W.[3] According to the United States Census Bureau, the CDP has a total area of 5.5 square miles (14 km^2), all of it land.

Demographics

As of the census[4] of 2000, there were 11,008 people, 3,814 households, and 2,955 families residing in the CDP. The population density was 2,016.5 people per square mile (778.4/km²). There were 3,958 housing units at an average density of 725.0/sq mi (279.9/km²). The racial makeup of the CDP was 5.78% White, 90.62% African American, 0.19% Native American, 1.24% Asian, 0.47% from other races, and 1.71% from two or more races. Hispanic or Latino of any race were 0.95% of the population.

There were 3,814 households out of which 36.3% had children under the age of 18 living with them, 50.0% were married couples living together, 23.3% had a female householder with no husband present, and 22.5% were non-families. 18.4% of all households were made up of individuals and 1.7% had someone living alone who was 65 years of age or older. The average household size was 2.86 and the average family size was 3.24.
In the CDP the population was spread out with 26.6% under the age of 18, 7.1% from 18 to 24, 30.6% from 25 to 44, 29.1% from 45 to 64, and 6.6% who were 65 years of age or older. The median age was 37 years. For every 100 females there were 81.3 males. For every 100 females age 18 and over, there were 75.8 males.

The median income for a household in the CDP was $78,735, and the median income for a family was $82,777. Males had a median income of $47,059 versus $45,243 for females. The per capita income for the CDP was $30,398. About 0.8% of families and 1.9% of the population were below the poverty line, including 1.9% of those under age 18 and 2.0% of those age 65 or over.

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- ***Bowie, Maryland – Zip Code 20721***

Bowie is a city of 54,727 residents, according to the 2010 Census, located in Prince George's County, and convenient to Washington, DC, Annapolis, and Baltimore. The city consists of approximately 18-square miles. There are more than 1,100 acres set aside as parks or as preserved open space, including over 22 miles of paths and trails, and 75 ball fields. Bowie has a nonpartisan city government directed by a mayor and six council members. The City Council meets on the first and third Mondays of most months in sessions that are open to the public.

The following was retrieved from http://en.wikipedia.org/wiki/Bowie,_Maryland.

Bowie is a city in Prince George's County, Maryland, United States.[1] The population was 54,727 at the 2010 census. Bowie has grown from a small railroad stop to the largest municipality in Prince George's County, and the fifth most populous city[2] and third largest city by area in the state of Maryland.

19th century History

The city of Bowie owes its existence to the railway. In 1853, Col. William Duckett Bowie obtained a charter from the Maryland legislature to construct a rail line into Southern Maryland. In 1869, the Baltimore & Potomac Railroad Company began the construction of a railroad from Baltimore to Southern Maryland, terminating in Pope's Creek. The area had already been dotted with small farms and large tobacco plantations in an economy based on agriculture and slavery. In 1870, Ben Plumb, a land speculator and developer, sold building lots around the railroad junction and named the settlement Huntington City. By 1872, the line was completed, together with a "spur" to Washington DC and the entire line through Southern Maryland was completed in 1873.

Huntington City was renamed in honor of the son of William Duckett Bowie and his business partner, Oden Bowie,[3][4][5][6] who was President of the Baltimore & Potomac Railroad at the time,[7] and previously Governor of Maryland.[8] The town was subsequently rechartered as Bowie in 1880. In the early days the land was subdivided by developers into more than 500 residential building lots, to create a large town site at a junction of the Baltimore and Potomac's main line to southern Maryland, and the branch line to Washington, DC.

20th century History

By 1902, the Baltimore & Potomac was purchased by the powerful Pennsylvania Railroad. A second railroad entered the community when the Washington, Baltimore and Annapolis Electric Railway electric trolley line commenced service in 1908. The large interurban cars brought rapid transit to the area, with trains running hourly. Bowie area stations included High Bridge, Hillmeade, and the Race Track.

The convergence of the two rail systems induced the Southern Maryland Agricultural Society to build the Bowie Race Track in 1914. The track enabled the Belair Stud to become one of Maryland's premier areas for thoroughbreds. Also in 1914, a teacher-training college, or normal school as it was referred to then, was built for African-Americans, just outside the town. This now has become Bowie State University. In 1916,the town of Bowie was incorporated.
In 1957, the firm of Levitt and Sons acquired the nearby Belair Estate, the original colonial plantation of the Provincial Governor of Maryland, Samuel Ogle, and developed the residential community of Belair at Bowie. Two years later the town of Bowie annexed the Levitt properties, and then re-incorporated the now-larger area as a city in 1963. The overwhelming majority of Bowie residents today live in this 1960s Levitt planned community, whose street names are arranged in alphabetical sections.[*citation needed*] Levitt & Sons had a long history of prohibiting the sale of houses (including resale by owners) to African Americans which led to civil rights protests in Bowie in 1963.[9]

Bowie enjoys a rich and diverse historic and cultural heritage. The original Belair Estate contains the Belair Mansion (circa 1745), the beautiful five-part Georgian plantation house of Governor Samuel Ogle and his son Governor Benjamin Ogle. It was purchased in 1898 by the wealthy banker James T. Woodward who, on his passing in 1910, left it to his nephew, William Woodward, Sr., who became a famous horseman. Restored to reflect its 250-year-old legacy, the Mansion is listed on the National Register of Historic Places.

Belair Stable, on the Estate, was part of the famous Belair Stud, one of the premier racing stables in the 1930s, '40s, and '50s. Owned and operated by William Woodward, Sr. (1876–1953), it closed in 1957 following the death of his son, Billy Woodward. Belair had been the oldest continually operating thoroughbred horse farm in the country. It is said that the blood of Belair horses flows through the veins of every American race horse of distinction.[*citation needed*]

Bowie today

Honoring the tradition of a rail town, the City of Bowie has preserved this piece of its history in the Huntington Railroad Museum, which includes historic materials displayed in the station's restored railroad buildings. In 2006, the City reopened the Bowie Building Association building as a Welcome Center for all to enjoy and learn about the history of Bowie. This building is a small brick and block structure constructed circa 1930. It originally housed the Bowie Building Association, which helped finance much of the development in the early days of the community. Bowie has grown from a small agricultural and railroad town to one of the largest and fastest growing cities in Maryland. It is a city of 16 square miles (41 km^2) and approximately 50,000 residents. It has nearly 2,000 acres (8.1 km^2) set aside as parks or open space. It has 72 ball fields, three community centers, an ice arena at Allen Pond Park, the Bowie Town Center, the 800-seat Bowie Center for the Performing Arts, a 150-seat theatrical playhouse, a golf course, and three museums. Bowie is home to the Bowie Baysox, a Class AA Eastern League professional baseball team affiliated with the Baltimore Orioles. The Baysox currently play their home games at Prince George's Stadium. The city has recently added a state-of-the-art senior citizens center and a gymnasium for community programs. The city is a family-oriented community whose motto is "Growth, unity and progress".

Despite its low crime rate, Bowie has seen high profile criminal activity. Michael Bray was co-pastor at the Reformation Lutheran Church in Bowie when he conspired to bomb 10 clinics and offices of abortion supporters in three states and the District of Columbia from January 1984 through January 1985. He eventually served almost 4 years in prison for these crimes.[10] On October 7, 2002, a 13-year old boy was critically wounded by a sniper soon after he was dropped off at Benjamin Tasker Middle School in Bowie. This shooting was one in a series of murders and attempted murders referred to collectively as the Beltway sniper attacks.

Bowie State University, located north of Bowie, has been open since 1865.

Bowie is located at 38°57′53″N 76°44′40″W38.96472°N 76.74444°W (38.964727, -76.744531).[12] According to the city's 2009 State of the Environment report, the city has a total area of 18 square miles (47 km^2), of which 0.04 square miles (0.10 km^2), or 0.12%, is water.[13]

Demographics

As of the 2010 Census, Bowie had a population of 54,727. 99.5% of the population lived in households with a total of 19,950 households. The racial and ethnic composition of the population was 38.9% non-Hispanic white, 47.9% non-Hispanic black, 0.3% Native American, 4.1% Asian, 0.1% Pacific Islander, 1.9% from some other race and 3.6% from two or more races. 5.6% of the population was Hispanic or Latino of any race.[14]

As of the census[15] of 2010, there were 54,727 people, 18,188 households, and 13,568 families residing in the city. The population density was 3,121.9 people per square mile (1,205.5/km²). There were 18,718 housing units at an average density of 1,162.5 per square mile (448.9/km²).

The racial makeup of the city was:
41.40% (Non-Hispanic) White
48.70% Black or African American
2.95% Asian
2.92% Hispanic or Latino (of any race)
2.30% from two or more races
0.93% Other races
0.30% Native American
0.03% Pacific Islander

There were 18,188 households out of which 37.7% had children under the age of 18 living with them, 60.0% were married couples living together, 11.0% had a female householder with no husband present, and 25.4% were non-families. 19.7% of all households were made up of individuals and 5.2% had someone living alone who was 65 years of age or older. The average household size was 2.74 and the average family size was 3.16.

In the city the population was spread out with 26.9% under the age of 18, 5.7% from 18 to 24, 34.9% from 25 to 44, 23.0% from 45 to 64, and 9.4% who were 65 years of age or older. The median age was 36 years. For every 100 females there were 91.5 males. For every 100 females age 18 and over, there were 87.3 males.
According to a 2007 estimate, the median income for a household in the city was $99,105, and the median income for a family was $109,157.[16] Males had a median income of $52,284 versus $40,471 for females. The per capita income for the city was $30,703. About 0.7% of families and 1.6% of the population were below the poverty line, including 1.0% of those under age 18 and 1.8% of those age 65 or over.
Rank by Per Capita Income in Prince George's County: 7
Rank by Per Capita Income in Maryland: 65

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- ***Riverdale, Maryland – Zip Code 20737***

Riverdale Park is a town in Prince George's County, Maryland, United States.[1] The population was 6,956 at the 2010 census.[2] Riverdale Park is located at 38°57′46″N 76°55′47″W38.96278°N 76.92972°W (38.962810, -76.929699)[3]. According to the United States Census Bureau, the town has a total area of 1.7 square miles (4.3 km^2), of which 0.03 square miles (0.07 km^2), or 1.50%, is water.[4]

Riverdale Park and the neighboring community of West Riverdale developed in the late nineteenth century as streetcar suburbs in central Prince George's County. The town is located approximately seven miles northeast of Washington, D.C., and is bounded to the north by East-West Highway and bisected by the heavily traveled US Route 1. The City of College Park is located to the north, and the City of Hyattsville is located to the south and southwest.
The area was first developed in 1801 when a Belgian aristocrat, Henri Joseph Stier, purchased 800 acres situated between two tributaries of the Anacostia River known as the Paint and Northwest branches. Stier and his family moved to America several years earlier to escape the French Revolution (1788-1789). He named his holdings Riversdale (PG: 68-04-005) and began constructing his residence that same year. The mansion was modeled after the Stier family's Belgian home, Chateau du Mick, and when completed in 1807, the building stood as a two-story stuccoed-brick dwelling in the late Georgian style.

Just two years after purchasing and improving the property, in 1803, the political tension that had caused Stier to flee his native country subsided and he and his wife, Marie Louise, returned to Belgium. Riversdale was given to their daughter, Rosalie, who married George Calvert, the grandson of the fifth Lord Baltimore, in 1799. After Rosalie Stier Calvert died in 1821 and George Calvert in 1838, their son, Charles Benedict Calvert, took over the plantation. Charles Calvert was a renowned agriculturist and helped establish the Maryland Agricultural College, now the University of Maryland at College Park. In 1861, Calvert was elected to the United States Congress and fought for the establishment of the United States Department of Agriculture. During his life, Charles Calvert conducted a variety of agricultural experiments at Riversdale and expanded the original holdings to 2,200 acres. Calvert died in 1864; however, the property remained in the ownership of the Calvert family for another twenty years.

The 1861 Martenet map depicts the rural setting of Riversdale and identifies Charles B. Calvert as owner. The old Baltimore Turnpike, now known as US Route 1, is located to the west of the mansion house. To the east of the house is the Washington Branch of the Baltimore & Ohio Railway, which opened in 1833. The railway is located inside the boundaries of Riverdale Park, just west of the Paint Branch tributary. The 1878 Hopkins map shows little change and no significant development had occurred.

In 1887, the heirs of Charles Benedict Calvert conveyed 474 acres of land to New York City businessmen John Fox and Alexander Lutz in two separate transactions. The first deed involved the sale of 300 acres including the Riversdale mansion. The remaining 174 acres were transferred to Fox and Lutz shortly thereafter. The cost of the sales to Fox and Lutz totaled $47,000. On March 23, 1889, Fox and Lutz formed the Riverdale Park Company, which was named in honor of the grand Federal-style mansion at the center of the proposed community. The company planned on creating an upper-middle-class residential suburb for residents working in Washington, D.C. and Baltimore.

The land was platted in 1889 by surveyor D.J. Howell and the new development was named Riverdale Park. In an attempt to differentiate the historic plantation known as Riversdale from the subdivision, the "s" was dropped. The new roads were named in honor of United States presidents and were arranged in a grid pattern that surrounded a central ellipse that served as the site of the commuter train station. The first of the stations was constructed in 1890. Laid out as a "villa park," the community featured traffic circles and green space, using the mansion as a central amenity. The three original sections of the suburb utilized relatively uniform lot dimensions and building setbacks, thereby creating a cohesive development of middle- and upper-middle-class housing. The residential housing lots surrounded the high-style Riversdale mansion.

The construction of dwellings in Riverdale Park began in 1890. The buildings reflected popular trends of the time and were of wood-frame construction. Some structures were pyramidal-roof Foursquares, while others had front-gable or cross-gable roofs. Many houses from this period have projecting bays, corner towers, and wrap-around porches. By the turn of the twentieth century, Riverdale Park comprised 60 dwellings, a Presbyterian church, a schoolhouse, and a railroad station. The new community straddled the Washington line of the Baltimore & Ohio Railroad, which provided residents an easy commute to Washington, D.C.

Recognizing the financial potential of the new suburb, builders purchased groups of lots that were soon improved by high-style single-family dwellings. Joseph A. Blundon (ca.1847-1909) was one such late-nineteenth-century builder. Born in Georgetown, Blundon worked as a general contractor in Washington, D.C., before moving to Riverdale Park in 1889. He was instrumental in forming the Riverdale Park Company and served as its first manager. Blundon acted independently of the development company when he purchased several lots each year for the purpose of overseeing the construction of single-family dwellings. Between 1891 and 1909, he was responsible for the erection of roughly 90 buildings in Riverdale Park. Accordingly, he became known as the "Father of Riverdale."

In 1920, a handful of owners in both Riverdale Park and the nearby West Riverdale petitioned the Maryland General Assembly requesting authority to incorporate the two neighborhoods as a municipality. On June 14, 1920, the community was incorporated as the Town of Riverdale. As a result of the transfer of power from the Riverdale Park Company to the municipal government, the importance of the real estate company began to diminish, prompting a financial strain. Within ten years of the town's incorporation, the Riverdale Park Company went bankrupt.

Numerous annexations in the mid-twentieth century have increased Riverdale's overall size. The municipal government continued to grow and change during this period. In 1941, the town changed the name of its roads to conform to the standards of the United States Postal Service and carried a similar pattern as those of Washington, D.C., and nearby College Park. The increasing population and commercial and governmental growth of metropolitan Washington, D.C., most notably during the last twenty years of the twentieth century, has resulted in further development of the town of Riverdale. This late-twentieth-century growth was predominantly commercial and centered along Baltimore Avenue, thereby physically and visually separating West Riverdale from Riverdale Park.

In 1998, the town was officially renamed Riverdale Park. Today, the town is made up of a mix of housing styles including 1960s apartment buildings, pre- and post-World War II era buildings, as well as dwellings from the turn of the twentieth century. The Riversdale mansion, now surrounded by eight acres is owned by The M-NCPPC, which purchased it in 1949. The Riversdale property is bounded roughly by 48th Avenue to the west, Riverdale Road to the north, Taylor Street to the east and Oglethorpe Street to the south.

Demographics

As of the census[5] of 2000, there were 6,690 people, 2,172 households, and 1,437 families residing in the town. The population density was 4,212.7 people per square mile (1,624.5/km²). There were 2,321 housing units at an average density of 1,461.5 per square mile (563.6/km²). The racial makeup of the town was 39.91% White, 38.51% African American, 0.49% Native American, 4.25% Asian, 0.12% Pacific Islander, 12.99% from other races, and 3.74% from two or more races. Hispanic or Latino of any race were 28.27% of the population.

There were 2,172 households out of which 38.4% had children under the age of 18 living with them, 42.0% were married couples living together, 16.4% had a female householder with no husband present, and 33.8% were non-families. 23.9% of all households were made up of individuals and 4.1% had someone living alone who was 65 years of age or older. The average household size was 3.06 and the average family size was 3.60.

In the town the population was spread out with 28.7% under the age of 18, 12.2% from 18 to 24, 38.7% from 25 to 44, 15.6% from 45 to 64, and 4.9% who were 65 years of age or older. The median age was 29 years. For every 100 females there were 110.6 males. For every 100 females age 18 and over, there were 109.3 males.

The median income for a household in the town was $44,041, and the median income for a family was $49,904. Males had a median income of $30,053 versus $30,200 for females. The per capita income for the town was $19,293. About 9.0% of families and 12.0% of the population were below the poverty line, including 16.0% of those under age 18 and 7.2% of those age 65 or over.

References

1. U.S. Geological Survey Geographic Names Information System: Riverdale Park, Maryland
2. "Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data (DP-1): Riverdale Park town, Maryland". U.S. Census Bureau, American Factfinder. http://factfinder2.census.gov. Retrieved December 14, 2011.
3. "US Gazetteer files: 2010, 2000, and 1990". United States Census Bureau. 2011-02-12. http://www.census.gov/geo/www/gazetteer/gazette.html. Retrieved 2011-04-23.
4. "Geographic Identifiers: 2010 Demographic Profile Data (G001): North Brentwood town, Maryland". U.S. Census Bureau, American Factfinder. http://factfinder2.census.gov. Retrieved December 14, 2011.
5. "American FactFinder". United States Census Bureau. http://factfinder.census.gov. Retrieved 2008-01-31.

Sources of Information

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- ***Districts Heights, Maryland – Zip Code 20747***

District Heights is an incorporated city in Prince George's County, Maryland, United States, located near Maryland Route 4.[1] The population was 5,837 at the 2010 census. For more information, see the separate articles on Forestville, Maryland and Suitland.

District Heights was originally farm land owned by Major Leander P. Williams, purchased as four patented Lord Baltimore tracts known as: "Good Luck", "Magruder's Plains Enlarged", "the Levels", and "Offutt's Adventure". Under grants issued to Lord Baltimore by King Charles I of England, the tracts belonged to Colonel Ninian Beall, Benjamin Berry, and Alexander Magruder. District heights evolved from one of the four patents. In 1925 land purchased and formed into District Heights Company by Joseph Tepper, David L. Blanken, Henry Oxenberg, Gilbert Leventhal, Simon Gordon, and Simon Gerber. The land was farmed by Walter and Al Dustin, whose farmhouse stood at 7116 Foster Street. By 1925 streets laid out first three blocks of Halleck Street and Aztec. By 1936, the city had approximately 25 homes built, two businesses, a grocery store and filling station, a pump house and water tower to furnish the water and pressure for the City, a sewage system and a free Model T bus service to 17th and Pennsylvania Avenue, S.E.

District Heights is 9.85 miles (15.85 km) away from central Washington, D.C. District Heights is located at 38°51′34″N 76°53′21″W38.85944°N 76.88917°W (38.859545, −76.889139)[2]. According to the United States Census Bureau, the city has a total area of 0.9 square miles (2.3 km^2), all of it land.

Demographics

As of the 2010 Census the population of District Heights was 5,837. The racial and ethnic composition of the population was 4.25% non-Hispanic white, 89.5% non-Hispanic black, 0.2% Native American, 0.6% Asian, 1.15 from some other race and 1.9% from two or more races. 3.7% of the population was Hispanic or Latino or any race.[3]

As of the census[4] of 2000, there were 5,958 people, 2,070 households, and 1,538 families residing in the city. The population density was 6,649.1 people per square mile (2,556.0/km²). There were 2,170 housing units at an average density of 2,421.7 per square mile (930.9/km²). The racial makeup of the city was 9.20% White, 87.95% African American, 0.12% Native American, 0.86% Asian, 0.20% from other races, and 1.68% from two or more races. Hispanic or Latino of any race were 0.49% of the population.

There were 2,070 households out of which 38.3% had children under the age of 18 living with them, 39.6% were married couples living together, 28.2% had a female householder with no husband present, and 25.7% were non-families. 22.1% of all households were made up of individuals and 5.0% had someone living alone who was 65 years of age or older. The average household size was 2.88 and the average family size was 3.36.

In the city the population was spread out with 30.8% under the age of 18, 8.3% from 18 to 24, 29.3% from 25 to 44, 23.6% from 45 to 64, and 8.0% who were 65 years of age or older. The median age was 34 years. For every 100 females there were 84.9 males. For every 100 females age 18 and over, there were 76.1 males.

The median income for a household in the city was $52,331, and the median income for a family was $61,220. Males had a median income of $37,129 versus $32,443 for females. The per capita income for the city was $21,190. About 4.5% of families and 5.9% of the population were below the poverty line, including 9.0% of those under age 18 and 6.1% of those age 65 or over.

References

U.S. Geological Survey Geographic Names Information System: District Heights, Maryland

"US Gazetteer files: 2010, 2000, and 1990". United States Census Bureau. 2011-02-12. http://www.census.gov/geo/www/gazetteer/gazette.html. Retrieved 2011-04-23.

2010 general profile of population and housing characteristics of District Heights from the US Census

"American FactFinder". United States Census Bureau. http://factfinder.census.gov. Retrieved 2008-01-31.

Demographics

About Us

Sources of Information

Retrieved from http://en.wikipedia.org/wiki/District_Heights,_Maryland.

VII. The Community Benefit Reporting Tool

See Attached PDF

FY 2012 COMMUNITY BENEFIT INVENTORY SPREADSHEET

GENERAL INFORMATION

Hospital Name:	Doctors Community Hospital
HSCRC Hospital ID #:	21-0051
# of Employees:	1,497
Contact Person:	Camille Bash or Mary Dudley
Contact Number:	301-552-8087 301-552-8601
Contact Email:	Cbash @DCHweb.org MDudley@DCHweb.org

	UNREIMBURSED MEDICAID COST	# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST($)	INDIRECT COST($)	OFFSETTING REVENUE($)	NET COMMUNITY BENEFIT
T00	**Medicaid Costs**						
T99	Medicaid Assessments	N/A	N/A	$6,081,983.00	$0.00	$5,200,856.00	$881,127.00

	COMMUNITY BENEFIT ACTIVITES		# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST($)	INDIRECT COST($)	OFFSETTING REVENUE($)	NET COMMUNITY BENEFIT
A00.	**COMMUNITY HEALTH SERVICES**							
A10	Community Health Education		1,364	2,624	$152,256.70	$94,034.87	$18,550.00	$227,741.57
A11	Support Groups		346	2,083	$51,558.00	$31,842.60		$83,400.60
A12	Self-Help					$0.00		$0.00
A20	Community-Based Clinical Services					$0.00		$0.00
A21	Screenings		398	1,972	$26,745.00	$16,517.91		$43,262.91
A22	One-Time/Occasionally Held Clinics					$0.00		$0.00
A23	Free Clinics					$0.00		$0.00
A24	Mobile Units					$0.00		$0.00
A30	Health Care Support Services					$0.00		$0.00
A40						$0.00		$0.00
A41						$0.00		$0.00
A42						$0.00		$0.00
A43						$0.00		$0.00
A44						$0.00		$0.00
A99	**Total Community Health Services**	**TOTAL**	2,108	6,679	230,560	$142,395.38	$18,550.00	$354,405.08

	A	B	C	D	E	F	G	H	I	J	K	L
38						**# OF STAFF HOURS**	**# OF ENCOUNTERS**	**DIRECT COST($)**	**INDIRECT COST($)**	**OFFSETTING REVENUE($)**	**NET COMMUNITY BENEFIT**	
39	**B00**	**HEALTH PROFESSIONS EDUCATION**										
40	**B10**	Physicians/Medical Students							$0.00		$0.00	
41	**B20**	Nurses/Nursing Students				58,991	716	$2,005,694.00	$0.00		$2,005,694.00	
42	**B30**	Other Health Professionals				14,989	2,288	$536,711.00	$0.00		$536,711.00	
43	**B40**	Scholarships/Funding for Professional Education						$30,000.00	$0.00		$30,000.00	
44	**B50**								$0.00		$0.00	
45	**B51**								$0.00		$0.00	
46	**B52**								$0.00		$0.00	
47	**B53**								$0.00		$0.00	
48												
49	**B99**	**Total Health Professions Education**			**TOTAL**	73980	3004	$2,572,405.00	$0.00	$0.00	$2,572,405.00	
50												
51						**# OF STAFF HOURS**	**# OF ENCOUNTERS**	**DIRECT COST($)**	**INDIRECT COST($)**	**OFFSETTING REVENUE($)**	**NET COMMUNITY BENEFIT**	
52	**C00**	**MISSION DRIVEN HEALTH SERVICES (please list)**										
53	**C10**	PG County Continuum of Breast Care						$31,315.00	$0.00		$31,315.00	
54	**C20**	Transitional Care Program						$62,501.15	$0.00		$62,501.15	
55	**C30**	Joslin Diabetes Awarenwss Program associated with Harvard Medical School						$134,000.00	$0.00		$134,000.00	
56	**C40**								$0.00		$0.00	
57	**C50**								$0.00		$0.00	
58	**C60**								$0.00		$0.00	
59	**C70**								$0.00		$0.00	
60	**C80**								$0.00		$0.00	
61	**C90**								$0.00		$0.00	
62	**C91**								$0.00		$0.00	
63												
64	**C99**	**Total Mission Driven Health Services**			**TOTAL**	0	0	$227,816.15	$0.00	$0.00	$227,816.15	
65												
66						**# OF STAFF HOURS**	**# OF ENCOUNTERS**	**DIRECT COST($)**	**INDIRECT COST($)**	**OFFSETTING REVENUE($)**	**NET COMMUNITY BENEFIT**	
67	**D00**	**RESEARCH**										
68	**D10**	Clinical Research							$0.00		$0.00	
69	**D20**	Community Health Research							$0.00		$0.00	
70	**D30**								$0.00		$0.00	
71	**D31**								$0.00		$0.00	
72	**D32**								$0.00		$0.00	
73												
74	**D99**	**Total Research**			**TOTAL**	0	0	0	$0.00	0	$0.00	

	A	B	C	D	E	F	G	H	I	J	K	L
75						# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST($)	INDIRECT COST($)	OFFSETTING REVENUE($)	NET COMMUNITY BENEFIT	
76	**E00**	**Cash and In-Kind Contributions**										
77	**E10**	Cash Donations						$24,138.00	$0.00		$24,138.00	
78	**E20**	Grants							$0.00		$0.00	
79	**E30**	In-Kind Donations				1,738	9,810	$242,783.00	$0.00		$242,783.00	
80	**E40**	Cost of Fund Raising for Community Programs							$0.00		$0.00	
81												
82	**E99**	**Total Cash and In-Kind Contributions**			**TOTAL**	1738	9810	$266,921.00	$0.00	$0.00	$266,921.00	
83												
84						# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST($)	INDIRECT COST($)	OFFSETTING REVENUE($)	NET COMMUNITY BENEFIT	
85	**F00**	**COMMUNITY BUILDING ACTIVITIES**										
86	**F10**	Physical Improvements and Housing							$0.00		$0.00	
87	**F20**	Economic Development				46	869	$40,750.00	$25,167.50		$65,917.50	
88	**F30**	Community Support				12,100	3,161	$385,000.00	$237,778.86		$622,778.86	
89	**F40**	Environmental Improvements							$0.00		$0.00	
90	**F50**	Leadership Development/Training for Community Members							$0.00		$0.00	
91	**F60**	Coalition Building				40		$12,000.00	$7,411.29		$19,411.29	
92	**F70**	Advocacy for Community Health Improvements							$0.00		$0.00	
93	**F80**	Workforce Development				26	550	$1,069.00	$660.22		$1,729.22	
94	**F90**								$0.00		$0.00	
95	**F91**								$0.00		$0.00	
96	**F92**								$0.00		$0.00	
97												
98	**F99**	**Total Community Building Activities**			**TOTAL**	12,212	4,580	438,819	271,018	0	709,837	
99												
100						# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST($)	INDIRECT COST($)	OFFSETTING REVENUE($)	NET COMMUNITY BENEFIT	
101	**G00**	**COMMUNITY BENEFIT OPERATIONS**										
102	**G10**	Assigned Staff				700		$27,300.00	$16,860.68		$44,160.68	
103	**G20**	Community health/health assets assessments							$0.00		$0.00	
104	**G30**								$0.00		$0.00	
105	**G31**								$0.00		$0.00	
106	**G32**								$0.00		$0.00	
107												
108	**G99**	**Total Community Benefit Operations**			**TOTAL**	700	0	$27,300.00	$16,860.68	$0.00	$44,160.68	
109												

	A	B	C	D	E	F	G	H	I	J	K	L
110	**H00**	**CHARITY CARE (report total only)**										
111	**H99**	**Total Charity Care**			**TOTAL**	$2,949,975.00						
112												
113		**FINANCIAL DATA**										
114	**I10**	INDIRECT COST RATIO				61.76%						
115												
116	**I00**	**OPERATING REVENUE**										
117	**I20**	Net Patient Service Revenue				$186,290,140.00						
118	**I30**	Other Revenue				$4,488,880.00						
119	**I40**	**Total Revenue**				$190,779,020.00						
120												
121	**S99**	**TOTAL OPERATING EXPENSES**				$191,007,547.00						
122												
123	**I50**	**NET REVENUE (LOSS) FROM OPERATIONS**				-$228,527.00						
124												
125	**I60**	**NON-OPERATING GAINS (LOSSES)**				$2,706,815.00						
126												
127	**I70**	**NET REVENUE (LOSS)**				$2,478,288.00						
128												
129						**# OF STAFF HOURS**	**# OF ENCOUNTERS**	**DIRECT COST($)**	**INDIRECT COST($)**	**OFFSETTING REVENUE($)**	**NET COMMUNITY BENEFIT**	
130	**J00**	**FOUNDATION COMMUNITY BENEFIT**										
131	**J10**	Community Services							$0.00		$0.00	
132	**J20**	Community Building							$0.00		$0.00	
133	**J30**								$0.00		$0.00	
134	**J31**								$0.00		$0.00	
135	**J32**								$0.00		$0.00	
136												
137	**J99**	**TOTAL FOUNDATION COMMUNITY BENEFIT**				0	0	$0.00	$0.00	$0.00	$0.00	
138												

	A	B	C	D	E	F	G	H	I	J	K	L
139						# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST($)	INDIRECT COST($)	OFFSETTING REVENUE($)	NET COMMUNITY BENEFIT	
140	**K00**	**TOTAL HOSPITAL COMMUNITY BENEFIT**										
141	**A99**	**Community Health Services**				2,108	6,679	230,560	142,395	18,550	354,405	
142	**B99**	**Health Professions Education**				73,980	3,004	2,572,405	0	0	2,572,405	
143	**C99**	**Mission Driven Health Care Services**				0	0	227,816	0	0	227,816	
144	**D99**	**Research**				0	0	0	0	0	0	
145	**E99**	**Financial Contributions**				1,738	9,810	266,921	0	0	266,921	
146	**F99**	**Community Building Activities**				12,212	4,580	438,819	271,018	0	709,837	
147	**G99**	**Community Benefit Operations**				700	0	27,300	16,861	0	44,161	
148	**H99**	**Charity Care**				N/A	N/A	N/A	N/A	N/A	$2,949,975.00	
149	**J99**	**Foundation Funded Community Benefit**				0	0	0	0	0	0	
150	**T99**	**Medicaid Assesments**				N/A	N/A	6,081,983	0	5,200,856	881,127	
151												
152	**K99**	**TOTAL HOSPITAL COMMUNITY BENEFIT**				90,738	24,073	9,845,804	430,274	5,219,406	8,006,647	
153												
154	**U99**	**% OF OPERATING EXPENSES**				4.19%						
155	**V99**	**% of NET REVENUE**				323.07%						
156												

VIII. Table III – Initiatives

Initiative 1. Continuum of Breast Care

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY? (See Instructions)
High Breast Cancer incident with low results in Breast Cancer Screening	Collaboration with Susan G. Komen Foundation for a grant titled: "The Prince George's County Continuum of Breast Care	1) To reduce disparities in breast health care in Prince George's County residents. 2) To offer free screenings 3) To navigate those patients with abnormal findings 4) To assist residents in the screening process, up to an including medical or surgical treatment 5) To provide high quality outreach using existing community organizations. 6) To ensure early detection of breast disease and early treatment.	4 Year Period: CY 2012-CY 2015	Dr Regina Hampton Capital Breast Care Center (CBCC) African Women's Cancer Awareness Association (AWCAA)	Every 6 months starting June 30, 2012 through December 31, 2016	See next page for Objectives and Results	Yes	$31,315 out of pocket plus forfeiture of revenue and inkind expenses estimated to be $905,000 over 4 years of grant

Exert from Komen Report on Outcomes

By the end of the project, we will create a community-based continuum that will increase utilization of breast screening by uninsured and underserved women.		
Objective 1: Establish staffing and infrastructure to support the community-based continuum of breast care. o Examine % of staff positions filled every 6 months. o Confirm navigator program launched.		o Staffing/Infrastructure includes: 100% filled. *1) Program Coordinator* 2) *Treatment Navigator* (In-kind) 3) The navigator program has been designed and launched using Priority Consult Software which was recently upgraded to a web based system allowing easier access. 4) Offer has been extended to the *Imaging Navigator* with a potential start date in early December.
Objective 2: By the end of the first project year, a breast care navigation network will be established with the community providers. o Ensure personnel in place o Evaluate staff every six months o Review and revise MOU with community partners o Track referrals		o All personnel will be in place by Dec.31, 2012. Memorandum's Of Understandings have been established with community partners to offer free screening mammograms and follow-up exams through outreach and transportations efforts. Our community partners include: 1) African Women's Cancer Awareness Assoc (Oct.) Outreach activities are conducted at churches and health fairs. Referrals to date: 35 patients 2) All Shades of Pink, Inc.(October) 3) Zaida Morris – (August) Conduct outreach with two partners in the Latino Community: The Community Clinic and Casa of Maryland located in Langley Park, Maryland. Other outreach activities are conducted at grocery stores, churches and health fairs.

		Referrals to date: 95 patients 4) First Baptist Church of Glenarden – Shabbach! Ministries (November) This partnership will provide transportation two times per month to and from the partner centers in Langley Park. 5) The Mary's Center Clinic (November) Collaborated to begin screening the MC patients with a start date of December 4, 2012, every other Tuesday from 8am – 12 noon for the uninsured, underinsured, and insured; up to 13 patients. We will consider expanding to an additional day based on volume. 6) Prince George's Breast & Cervical Program: We partnered with PGBCC Program to offer free screening mammograms, bra fittings, and clinical breast exams to the women age 40 – 65 years of age. We saw over 100 patients and performed 55 screening mammograms; 46 Clinical Breast Exams and 47 Bra fittings. 24 of the patients screened for mammograms were underinsured Komen Grant patients. We created a flyer to be used in advertising the Susan G. Komen/DCH Grant Free Mammogram Screening opportunity. The Flyer was created in both English and Spanish. They are distributed to our community partners, churches, government agencies, and grocery stores. A patient packet was developed that includes forms such as: patient registration, patient consent to release information, and the mammography history questionnaire. The registration form is also used to track community navigators' referrals. Patients can call and make their appointments or they may elect to come on the Tuesday screening day that is offered twice per month.

Objective 3: Through the utilization of a community navigator, 1200 uninsured women per year will receive access to breast care screening through the collaborative network of community-base partners coordinated by DCH.
 	
○ Track number of women referred for services
○ % of women screened :
• 100% of the women referred for screening were screened
○ % of women needing further evaluation and navigator services.
    • 5% needed navigation services.
    • 10 % needed further evaluation
		July - October 2012
		
		Total # of Komen Grant patients referred: 205
		
		Screening mammograms = 205
		
		Follow-up : Diagnostic mammogram = 6
		
		Breast Ultrasound = 28
		
		Stereotactic Bx = 2
		
		Ultrasound Bx = 8

Initiative 2. Reduction of Readmissions

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY? (See Instructions)
Prince George's County had 4 hospitals in the top quartile of readmission s in the state per CMS. The state has 9 hospitals in this quartile.	Reduce unnecessary readmissions	Initiation of a new department: Transitional Care. This new department looked at the high readmitting patients and contacted them to understand the reasons for the returns within 30 days of discharge. The department makes outpatient appointments for the patients, to ensure compliance with discharging goals. The department contacts patients to ensure they are taking their medications or attending appointments, such as dialysis treatments.	Multi-years	CMS Readmisson study DCH Physicians DCH Utilization Review Committee DCH Finance Department KPMG Consultant BRG Consultans	Annually with HSCRC readmissio n reduction formulas	Per BRG consultants, the results forFY2012 were 179 fewer readmissions within 30 days of the initial admission.	Yes	$200,000 for salaries, patient scales, ambulance rides, taxi rides, and cost of telephone service.

Initiative 3. Diabetes Program Expansion

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY? (See Instructions)
Prince George's County has 11% of its population with Diabetes, while the state is only 9%. Diabetes is the 4th leading cause of death	Joslin Diabetes Awareness Program associated with Harvard Medical School	This program is designed to make physicians and their patients aware of diabetes, the risks, the preventions, and the medical treatments. Typical program: This 8 ½-hour program provides a complete overview of how to effectively manage your diabetes. It is offered through two half-day interactive sessions followed by an individual follow-up appointment. This program is geared to the participant who has been diagnosed with diabetes within the last 6 months, or has never met with a diabetes educator. Participants will learn basic diabetes self-management skills for medication, nutrition, meal planning, physical activity, and blood glucose monitoring.	Multi-year and has been in operation since early 2000s.	Dr. Madhu K. Mohan, Endocrinologist, Riverdale, Maryland DCH Physicians DCH Diabetes Program Joslin Services of Harvard Medical School	FY 2012	In FY12 the program saw: 305 new medical patient appointments 2390 follow up medical patient appointments 160 new education patients Billed for 386 1:1 individual hours Billed for 1653 group education hours	Yes	$84,000 for franchise fee and $50,000 for marketing materials

Region		All Causes	Heart Disease	Cancer	Cerebro-vascular Disease	Diabetes	Chronic Lower Respiratory Disease	Other Causes	Total Population, Age 65+
Prince George's County		4380.7	1418.0	1005.0	213.4	174.8	155.6	1413.9	72,637
Inside Beltway	North PUMA 1	4361.2	1453.7	985.3	129.2	242.3	145.4	1405.3	6,191
Inside Beltway	North Central PUMA 3	4154.8	1446.0	916.5	173.1	152.8	142.6	1323.8	9,820
Inside Beltway	South Central PUMA 4	4743.6	1570.5	1121.8	170.9	267.1	160.3	1453.0	9,360
Inside Beltway	South PUMA 7	4429.4	1503.7	1119.0	221.5	244.8	128.2	1212.2	8,579
Outside Beltway	North PUMA 2	3854.1	1023.7	808.7	301.1	103.2	189.3	1428.1	11,624
Outside Beltway	Central PUMA 5	4160.4	1215.2	1072.3	214.5	150.1	135.8	1372.5	13,989
Outside Beltway	South PUMA 6	4948.8	1759.2	1024.9	229.5	137.7	175.9	1621.6	13,074
Total number of deaths in county, Age 65+		3182	1030	730	155	127	113	1027	

SOURCE: Deaths--Maryland Department of Health and Hygiene Vital Statistics Administration, *http://www.vsa.state.md.us/html/reports.html*; Population denominator for mortality rate calculation—2006 American Community Survey.

Green	Light yellow	White	Orange	Red
PUMA rate ≥ 50% below County rate	PUMA rate 25% to 50% below County rate	PUMA rate 25% above or below County rate	PUMA rate 25% to 50% above County rate	PUMA rate ≥ 50% above County rate

Age-Adjusted Death Rate per 100,000 due to Diabetes

Doctors Community Hospital

Financial Assistance Policy

SUBJECT: Financial Assistance Policy

Policy Number 050

Prepared by: Patient Financial Services

Date: May 5, 2003

Revised: December 17, 2007
January 2008, May 2009,
Oct 2009, Feb 2010,
April 2010, May 2010, Aug 2010,
Nov 2010

Philip B. Down, President

Approved by

PURPOSE

To provide general information and guidelines to identify indigent persons who have no means of paying for medical services or treatments.

POLICY

General Statement:

The Patient Financial Services Department of the hospital is responsible for determining the eligibility for Financial Assistance patients. Referral for Financial Assistance is made by Registration, Billing, and Financial Counseling Staff within the department or by other departments such as, Nursing, Quality Assurance, Social Services, Physician Offices or the patient or a patient's family member with legal authority to act on behalf of the patient. Referral for Financial Assistance is also made by Medicaid Advocates and Collection Agents. The hospital will consider all medical debts for services provided within the hospital excluding purely cosmetic services.

1. Patient Education

Doctors Community Hospital recognizes its charitable mission to provide reasonable care to those patients who cannot afford healthcare and has provided the following methods to communicate the Financial Assistance Program.

a. Published notices of available Financial Assistance are printed in local newspapers annually,
b. Signs are posted at emergency registration, outpatient registration and the hospital's business office in patient waiting areas,
c. Financial policy brochures written in English and Spanish, specifying who to call for Financial Assistance, medical assistance and billing questions, is available in patient lobby waiting areas of the hospital,
d. Financial policy brochures are provided to every inpatient at time of admission. The information is a hand-out as part of the Hospital's admission package,
e. Financial policy is provided to every patient with their initial summary bill,

f. Financial policy is provided to every patient upon patient request by the business office,
g. An overview of Financial Assistance is provided to all hospital employees as part of the annual employee orientation in order to provide direction or assistance to patients.

2. Eligibility Criteria

Patients will be considered for Financial Assistance regardless of race, sex, national origin or creed. To qualify for Financial Assistance, the following areas of eligibility must apply:

a. Free Care will be given to patients whose gross income is at or below 200 percent of the Federal Poverty Guidelines when considering number of family members in the household.

b. Reduced Cost Program is available with a 25% balance bill reduction when the family unit income is between 200 to 300 percent of the Federal Poverty Guidelines. Reduced cost program includes patient liability after third party payment such as deductible, coinsurance and co-payment amounts.

c. Medical Hardship is available for patients whose gross family income is between 200 and 500 percent of the Federal Poverty Guidelines, when hospital debt exceeds 25% of the family gross income for the family unit. and such eligibility will remain active during a 12 month period beginning on the date which the reduced cost medically necessary care was initiated. All immediate family members within the family household who have medical debts at Doctors Community Hospital will be considered. However, debts for other providers or account balances for patient deductible, coinsurance or copayments will be excluded under the Medical Hardship Program.

3. Other Eligibility Consideration:

a. Self-pay patients enrolled in certain means-tested programs will qualify as presumptive Financial Assistance eligibility for free care by submitting proof of enrollment in a social service program within 30 days of request for free care. If the patient fails to summit the means-tested documentation within 30 days, upon patient request an additional 30 days will be granted for documentation. Programs that should be considered for presumptive assistance are as follows:

   1. Household with children in the free or reduced lunch program,
   2. Supplemental Nutritional Assistance Program (SNAP),
   3. Low income household energy assistance program,
   4. Primary Adult Care Program,
   5. Womens, Infants and Children program (WIC),

b. In addition to programs listed in means-test for presumptive charity, the hospital will consider all accounts as free care without patient application or further proof when such patients' insurance eligibility through the hospital eligibility verification system indicate that the patient qualifies for a program such as pharmacy only or physician only coverage. Other state programs not mentioned where the patient is eligibility for assistance programs where there is no medical insurance coverage will also be considered.

c. The hospital may apply discretion and approve patients beyond the 12 month medical bill period when the patient's health status is severe or other financial circumstances prevent payment from the patient.

4. Ineligible Patients

The following is a list of situations where patients will not qualify for Financial Assistance.

a. Patients who have health insurance and services are payable by other third-party insurance,
b. Patients who refuse to complete the hospital's Financial Screening Application, when presumptive free care is not warranted,
c. A non U S citizen who traveled to the US primarily for the purpose of receiving medical services at no cost,
d. Patients whose credit bureau report validates the patient's application was false or misleading,
e. Patients who fail to provide supporting information to validate information contained on the Financial Assistance Application,
f. Patients whose monetary assets exceed $10,000 excluding up to $150,000 in a primary residence and retirement benefits where the IRS has granted preferential treatment.

5. Application Requests

Self pay patients, who do not meet the presumption means-test, are requested to complete an application when they apply for Financial Assistance. A Financial Screening Application (see Exhibit A) is given to the patient when one of the following situations occurs:

a. Patient requests Financial Assistance,
b. Patients or family member expresses inability to pay for medical debts,
c. Other hospital departments staff request Financial Assistance for the patient,
d. Medicaid Advocates or Collection Agents request Financial Assistance Application.

6. Application Process

Applicants are requested to complete the Financial Screening form and a cover letter listing documents to support program eligibility will be attached (see Exhibit B). Listed below is the required information, which must be received and verified prior to consideration for Financial Assistance, when presumptive meant test programs do not apply

a. All gross income for all family members of the household unit,
b. Other income such as, Alimony, Child support and stipends,
c. Assets as listed in Section Item 4, "Ineligible Patients" under section F of this document,
d. Monthly expenses for immediate family members of the household,
e. List of outstanding debtors,
f. List of medical debts owed or paid for the past 12 months for services at Doctors Community Hospital.

7. Approval Process

Excluding presumption programs, prior to approving patient applications, information is reviewed and additional verification of eligibility may be made by obtaining a credit bureau application. The patient generally is notified by letter, (see Exhibit C) unless the patient calls the office or makes a visit to the business office to determine eligibility. Patients are advised of the amount of eligibility and if there is any patient liability and who to call to make payment arrangements. Approval for write-off for Financial Services is made by the Director of Patient Financial Services with additional approval of the Vice President of Finance for account balances greater than $5,000.

8. Denial Process

Upon final review of the application and patient income and expense documents, patient's who do not qualify for the program are notified by letter indicating the reason for denial and how to request reconsideration if the patient disagrees with the hospital decision (see Exhibit D).

Exhibit A (1)

DOCTORS COMMUNITY HOSPITAL

[illegible] sion for caring.

DOCTOR'S COMMUNITY HOSPITAL
8118 Good Luck Road
Lanham, Maryland 20706-3596

Financial Screening Form

Please Print Legibly

Patient Name ______________________ SS # _____ - _____ - _____

Patient Address ______________________

City ______________________ State __________ Zip Code __________

Birth Date ____ / ____ / ____ Home Phone No. (   ) _____ - _____ Work Phone No. (   ) _____ - _____

Spouse Name *(if applicable)* ______________________ SS # _____ - _____ - _____

Spouse Address *(if different from Patient)* ______________________

City ______________________ State __________ Zip Code __________

Birth Date ____ / ____ / ____ Home Phone No. (   ) _____ - _____ Work Phone No. (   ) _____ - _____

LIST ALL CHILDREN UNDER 21 YEARS OF AGE

Child's Name ______________________ Birth Date ____ / ____ / ____

Child's Name ______________________ Birth Date ____ / ____ / ____

Child's Name ______________________ Birth Date ____ / ____ / ____

Child's Name ______________________ Birth Date ____ / ____ / ____

Child's Name ______________________ Birth Date ____ / ____ / ____

RESPONSIBLE PARTY INFORMATION *(Do NOT Complete if Patient is Responsible Party)*

Responsible Party Name ______________________ SS # _____ - _____ - _____

Address ______________________

City ______________________ State __________ Zip Code __________

Birth Date ____ / ____ / ____ Home Phone No. (   ) _____ - _____ Work Phone No. (   ) _____ - _____

EMPLOYMENT INFORMATION

Place of Employment ______________________

Address ______________________

City ______________________ State __________ Zip Code __________

Telephone No. (   ) _____ - _____ Extension __________ Supervisor Name ______________________

INSURANCE INFORMATION

Do you have health insurance? .... ☐ Yes ☐ No

If YES, Name of Company ______________________ Policy # __________

Have you ever applied to a State Medical Assistance Program? .... ☐ Yes ☐ No

If YES, Name of State ______________________ Birth Date ____ / ____ / ____

Did you receive assistance from the state? .... ☐ Yes ☐ No

Exhibit A (2)

Please provide proof of income and expenses with this application:

Such as: Last 2 pay stubs, W-2 Forms, Bank Statements, Utility Bills, Mortgage Statements

MONTHLY INCOME

	GROSS	NET
Patient Salary	______	______
Spouse / Other	______	______
Soc. Sec. Income	______	______
Disab. Income	______	______
Pension Income	______	______
Interest Income	______	______
Unemployment	______	______
TOTAL	______	______

OTHER MONEY RECEIVED

Alimony	______	______
Child Support	______	______
Other	______	______
TOTAL	______	______

OTHER ASSETS

Name of Bank (Checking) ______________

Account # ______________

Name of Bank (Savings) ______________

Account # ______________

Name of Bank (Checking) ______________

Account # ______________

Name of Credit Union ______________

Account # ______________

Other Bank Account(s) ______________

____

Do you own stocks? .... ☐ Yes ☐ No

Do you own bonds? .... ☐ Yes ☐ No

Do you own property? .... ☐ Yes ☐ No

I have answered the questions in this application correctly to the best of my recollection and based on my records. I understand that the Account Review Committee of Doctors Community Hospital may request additional information from credit reporting agencies, employers and other third parties.

Applicant Signature ______________

Date of Application ______________

MONTHLY EXPENSES

Rent / Mortgage ______________

To Whom Paid ______________

Telephone No. ( ) ____ - ______ Ext. ______

Auto Payment ______________

Year ______ Make ______ Model ______

Financed By ______________

Phone No. ( ) ____ - ______ Ext. ______

Electricity ______________

Gas Utility ______________

Telephone ______________

Alimony ______________

Child Support ______________

Credit Cards *(See Below)* ______________

Medical / Dental *(See Below)* ______________

TOTAL ______________

DOCUMENT CREDIT CARDS & MEDICAL / DENTAL

List Credit Cards

Account # ______________

Account # ______________

Account # ______________

List Medical / Dental

______________ ______________

______________ ______________

______________ ______________

Other Expenses

____

____

____

____

____

____

____

____

 Exhibit B

Dear Patient:

It is believed that you may qualify for the hospital's Financial Assistance Program. Hospital Financial Assistance is only considered when there are no other financial assistance programs, which pay medical debts or insurance coverage.

Financial Assistance help is limited to medical expenses for services at Doctors Community Hospital. The program does not cover services elsewhere or physician bills. If you qualify for the program, all or part of your medical expenses may be considered.

If you quality for one of the following programs, please complete the attached application form and only provide with your application proof of eligibility in any one of the social service programs such as;

Children with reduced or free lunch program,
Supplemental Nutritional Assistance Program (SNAP),
Low-income household energy assistance program,
Primary Adult Care Program (PAC),
Women, Infants and Children (WIC).

If you do not qualify for one of the social service programs as listed above, you must complete the attached application screening form and provide with your application sufficient documents to prove your total income and expenses. In addition, the hospital may perform a credit check at the hospital's expense, validating your eligibility for the program. Documents required to be considered for Financial Assistance are as follows:

Wage statements for all household members such as pay stubs,
Other income such as, alimony, child support and stipends,
Your W-2 forms for current and prior year,
Bank statements, which show income and expenses,
Statement of any other income received in your household,
Copies of monthly statements and expenses paid to creditors,
List of outstanding medical expenses, owed or paid to Doctors Community Hospital for the past 12 months.

Please provide documents supporting assets excluding retirement programs where benefits are listed as exclusions under the IRS.

If you are unemployed and receive help or other support for daily living, you may provide a letter from another source indicating what kind of help you are receiving such as free room and board, utilities payments etc.

Failure to provide information to support your need for Financial Assistance may disqualify your eligibility. Please send all information within 30 days of this letter to:

Leslie Meade, Lead Patient Accounts Coordinator
Doctors Community Hospital
8118 Good Luck Road
Lanham, MD 20706-3596
(301) 552-8186

MNEMONIC: CHARITY1 **ACTIVE:** Y **NAME:** FINANCIAL APPLICATION APPROVED
PAGE SIZE: 66 **LINE LENGTH:** 75 **LEFT MARGIN:** 20
AUTO SPOOL: **AUTO SORT:**

Exhibit C

DOCTORS COMMUNITY HOSPITAL
8118 GOODLUCK ROAD
LANHAM, MARYLAND 20706

[DATE]

[GUARANTOR NAME]
[GUARANTOR ADDRESS LINE]
[GUARANTOR CITY,STATE ZIP]

RE: [ACCOUNT #]
[PATIENT NAME]

Dear [GUARANTOR NAME]:

Your application has been approved for financial assistance for the following account(s):

ACCOUNT #	AMOUNT APPROVED	REMAINING BALANCE PAYABLE BY PATIENT
________________	_____________	_____________
________________	_____________	_____________
________________	_____________	_____________
________________	_____________	_____________

If there is a remaining balance on your account(s), please call the hospital's Business Office at 301-552-8092 to establish a payment plan.

Yours truly,

Leslie Meade
Collections Team Leader

 Exhibit D

Dear Patient:

We regret to inform you that your application for financial assistance has been denied for the following reason (s).

______ Your application was missing sufficient documentation to prove income and expenses,

______ Your income exceeds eligibility criteria under the Federal Poverty Guidelines. Please contact our office at (301) 552-8092 to establish a payment plan,

______ There is a conflict in the Credit Report and data reported with your application,

______ Our records indicate that you have third-party insurance or you may qualify for a state program for Medical Assistance.

______ Other reason (s) ________________________________

____

____

____

If you disagree with this decision, please provide missing information or contact me to provide reasons why your debts should be reconsidered for Financial Assistance by calling (301) 552-8186 within the next fifteen day (15) from the date of this letter to reopen your case.

Thank you,

Leslie Meade, Team Leader
Patient Accounts Coordinator

Paying Your Bill

Bills for services rendered are to be paid upon receipt. **Co-payments are set by your insurance provider and are due at the time of service.**

Services Not Billed by Doctors Community Hospital

Your treatment at Doctors Community Hospital may require services of healthcare professionals who will bill your insurance provider separately. However, if for some reason the insurance company does not pay for the services, you may receive the bill. If you have questions about such bills, contact those professionals directly. Below is the contact information for some of these services.

Professional Services

- Clinical Laboratory Associates
- Diagnostic Imaging Associates
- Doctors Emergency Physicians
- Elliott & Wargotz Pathology

Contact Meridian Financial Management at 301-498-2922

- Joslin Diabetes Center
- Center for Wound Healing and Hyperbaric Medicine

Contact Universal Health Network at 888-846-5527

- Southern Maryland Anesthesia & Associates, LLC

Contact Southern Maryland Anesthesia & Associates at 800-583-1360

Your private physician may also bill you. Please contact him/her directly to discuss those bills.

What If My Visit Is Due To A Motor Vehicle Accident?

We will ask for your automobile and health insurance information. Your automobile insurance will be billed first. If your automobile insurance does not pay the bill, your medical insurance will be billed next. We will bill you for any non-covered balances.

What If I Am Injured On The Job?

We will bill the workers' compensation insurance provider of your employer. If payment is not received from this provider, you are responsible for the bill.

What Does Medicare Cover?

Medicare Part A covers inpatient charges, and Medicare Part B covers outpatient charges that are considered "medically necessary."

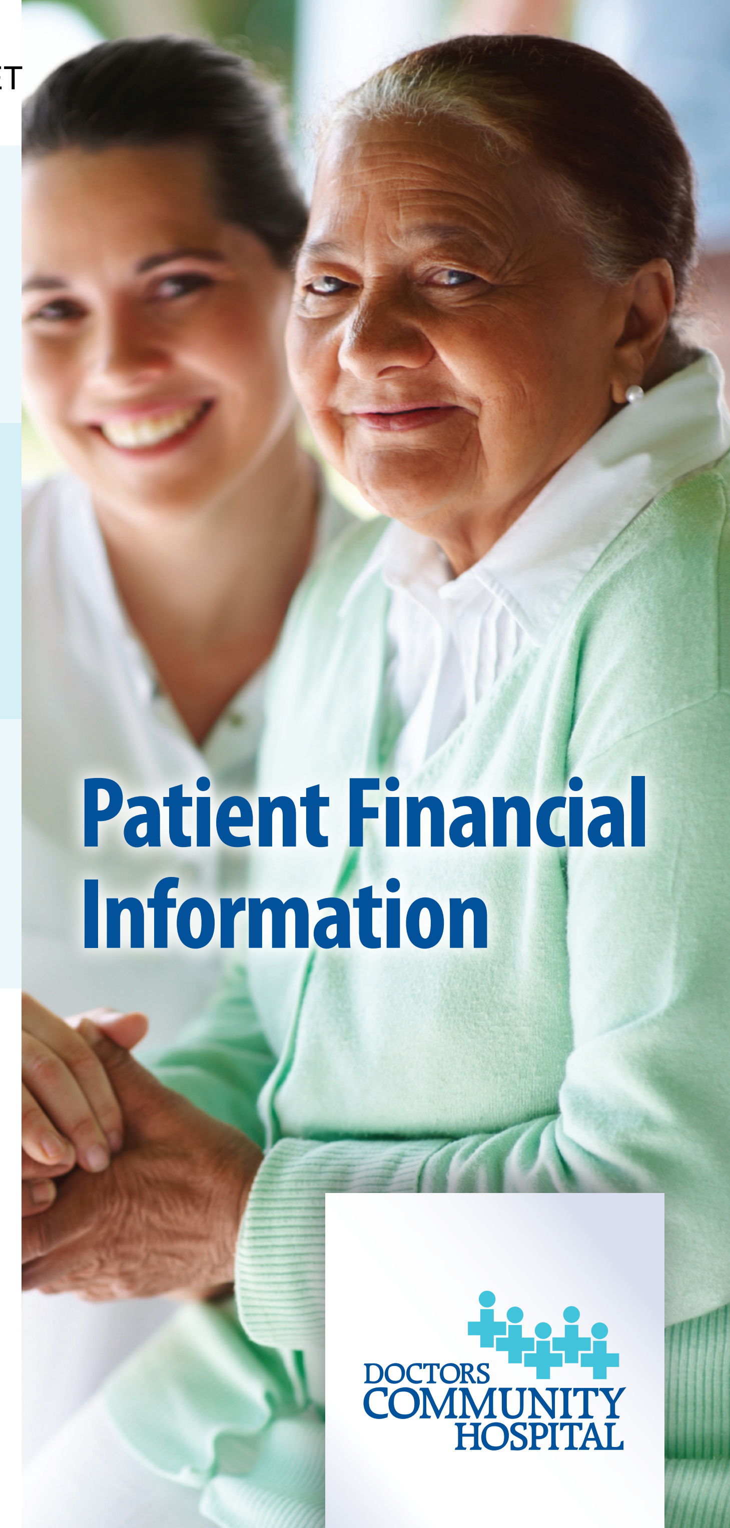
If your doctor orders a service that is not considered "medically necessary" by Medicare, you will be asked to sign an Advance Beneficiary Notice (ABN). The ABN is Medicare's way of informing you of the possibility that it might not pay for the service ordered. By signing the ABN, you agree to accept responsibility for payment if Medicare does not pay.

You can sign the ABN and agree to pay for service, or you can refuse the service. If you refuse, we encourage you to talk with your doctor about alternative options that would be covered by Medicare.

DOCTORS COMMUNITY HOSPITAL

8118 Good Luck Road
Lanham, Maryland 20706

PHONE 301-552-8118



Patient Financial Information

DOCTORS COMMUNITY HOSPITAL

General Billing Information

About four days after receiving medical services, you will receive a Summary Bill in the mail. To request an itemized bill or if you have any questions, contact the Business Office:

7404 Executive Place, Suite 300 A
Seabrook, MD 20706
301-552-8093

While you are still at the hospital, you may pose your questions to the following:

+ **Outpatient Registration Department**
  Main Hospital, 2nd Floor
  Monday to Friday, 8:00 a.m. to 4:30 p.m.
+ **Emergency Department Registration Office**
  Main Hospital, 1st Floor
  24 hours a day

Patient Obligation

+ Pay your bills timely
+ Provide your correct insurance information
+ Notify the Business Office if your financial status changes and will impact your ability to pay the bill

Patient Rights

+ Doctors Community Hospital or Medicaid may provide assistance to patients who meet the financial assistance criteria
+ Patients who believe they were wrongly referred to a collections agency have the right to contact the Business Office to discuss this matter

How Does Health Insurance Billing Work?

After receiving services, we will bill your health insurance. To ensure that the claim was properly submitted, we will make a copy of your current identification and insurance cards.

Insurance companies require that we supply them with complete information on the person who carries the coverage. This information includes name, address, telephone number, date of birth, employment and social security number.

Incomplete information could cause a denial by your insurance provider, and you could be responsible for the balance.

If you are unable to provide complete insurance and subscriber information, we will not be able to bill your insurance.

Financial Assistance

Financial assistance is available for patients who receive services at Doctors Community Hospital. Patients may qualify for free care or partial care based on their family's gross income as applied to the Federal Poverty Guideline.

Applications for financial assistance may be obtained at emergency registration or outpatient registration at the hospital. **You can also call the Business Office at 301-552-8186 to have an application mailed to you.**

Mail the completed application as well as proof of family income and expenses to the following:

Doctors Community Hospital
Patient Financial Services
8118 Good Luck Road
Lanham, MD 20706

Maryland Medical Assistance

Doctors Community Hospital provides case workers to assist patients who received inpatient or emergency outpatient care with Maryland Medical Assistance applications. Patients who received inpatient care, and do not have insurance, may contact one of the telephone numbers listed below.

LAST NAME BEGINNING WITH:

A-J	DECO	301-552-8116
K-Z	MEDLAW	301-552-8682

Additional Assistance

Emergency Outpatient Services

Contact DECO at 301-552-8116

Medical Medicaid Applications for Other Outpatient Services

Contact the Maryland Department of Social Services at 800-332-6347, TTY 800-925-4434

Prince George's County Maryland
Rushern L. Baker, III
County Executive

HEALTH DEPARTMENT
Prince George's County

Prince George's County Health Action Plan 2012

Pamela B. Creekmur, Acting Health Officer
301-883-7834 | pbcreekmur@co.pg.md.us

Fran Preneta, Consultant
301-883-3153 | fpreneta@co.pg.md.us

Table of Contents

Prince George's County Health Action Plan 2012

1. Local Health Planning Coalition Description

The Local Health Planning Coalition Description, provided previously to Maryland Department of Health and Mental Hygiene (DHMH), can be viewed online at:

Overview:
http://www.princegeorgescountymd.gov/Government/AgencyIndex/Health/pdf/PGHAC_Overview_1-12.pdf

Coalition Members:
http://www.princegeorgescountymd.gov/Government/AgencyIndex/Health/pdf/membership.pdf

Adjunct Coalitions, Organizations and Committees:
http://www.princegeorgescountymd.gov/Government/AgencyIndex/Health/pdf/PGHAC_Adj%20Coals%20Orgs%20Ctees_1-12.pdf

2. Local Health Data Profile

Selection of the Priorities, Objectives, and Strategies included in Prince George's County's Health Improvement Plan (PGCHIP) took into consideration:

- The Health Department's federal, state, and local mandates for provision of services and programs and its available resources (funding and personnel) to implement strategies.
- The capacity of existing and potential community partners to share responsibility for meeting our health objectives
- The commitment of local political leaders (i.e. Board of Health) to monitor progress towards meeting our objectives and to consider health implications when making policy decisions and adopting legislation.
- Evidence-based best practices that address our objectives.
- National and statewide public health strategies for reducing HIV infection.

The first six Priorities with their corresponding Objectives and Strategies are in alignment with the Maryland State SHIP Vision Areas 1-6; however, we have re-arranged the Priorities in descending order of importance according to the extent to which the health concerns they address impact the population as a whole, demonstrate major disparities, and/or pose longstanding, complex challenges to their prevention and control in Prince George's County. Consequently, Access to Care is listed as our first priority, followed by Chronic Diseases, Infant Mortality/Reproductive Health, Infectious Diseases (HIV/AIDS, Sexually Transmitted Infections and TB), Safe Physical Environments, and Safe Social Environments.

The “County-Specific Health Priorities” address broader issues related to health care infrastructure, workforce, and systems issues of particular concern to County stakeholders.

For the purposes of the 2012 Local Health Action Plan, the Prince George’s Health Action Coalition selected strategies within four of our six Priority Areas - Access to Care, Chronic Diseases, Infant Mortality, and HIV/AIDS and Sexually Transmitted Diseases - as the priorities for Coalition and partner activity during calendar year 2012, as outlined in Section 4 (Local Health Improvement Priorities 2011- 2014) of this document.

A. SHIP Measures – Regional/County Profile (provided by DHMH)

The online County Profile can be viewed at:
http://eh.dhmh.md.gov/ship/SHIP_Profile_Prince_Georges.pdf

B. Additional Data Collected through Local Assessments, Surveys, and Other Methods

Additional data used to make decisions about the County’s priority health concerns was collected from a variety of sources, including input from local political and community leaders, key health care stakeholders, and County residents. This included:

- A review of **County-specific statistics** from the Maryland Department of Health and Mental Hygiene Vital Statistics Administration (DHMH VSA) reports, Behavioral Risk Factor Surveillance System (BRFSS) data, U.S. Census Bureau information, and other commonly used data sources. A summary of the County’s greatest health concerns based on this data is provided in the PGCHIP (Section entitled “The Health of Our Population and Health Care System - Where We Stand”).

- A review of the **2009 RAND Report**, a comprehensive study sponsored by the Prince George’s County Council of the health needs of County residents and the capacity of the County’s health care system to respond. A **summary** of the RAND data is provided in the online Prince George’s County Health Improvement Plan, and can be viewed at:
http://www.princegeorgescountymd.gov/Government/AgencyIndex/Health/pdf/LocalhealthPlanPrefinal.pdf

- A **comprehensive and detailed presentation** of the health data and study conclusions by the RAND researchers can be viewed in the RAND report entitled “Assessing Health and Health Care in Prince George’s County” located on the Prince George’s County Government’s Web site, and can be viewed at:

http://www.princegeorgescountymd.gov/pgcha/PDFS/rand-assessing-health-care.pdf

- A review of the "**Baker 2010 Transition Team Transition Report**, March 11, 2011". A Transition team was assembled by County Executive Rushern Baker to study the workings of all County Government agencies in order to seek ways to streamline operations and improve service delivery. The full online report is can be viewed at: http://www.princegeorgescountymd.gov/Government/ExecutiveBranch/PDF/Baker2010TransitionTeamTransitionReport.pdf

- Summary information from **nine "town hall" style forums** held by the Prince George's County Health Officer in July and August of 2009.

- A **consensus report** from a meeting of major State and local health officials and health care stakeholders, political and community leaders, health experts and community advocates in December 2010, sponsored by the Prince George's County Executive. The findings and recommendations of this group are published in a report entitled "Conversation on Building an Integrated Community-oriented Healthcare System in Prince George's County, Executive Summary, Prince George's Community College, December 14, 2010".

- Input from **meetings with the Prince George's County Council/Board of Health** between May and September 2011 that included a presentation by the Maryland Secretary of Health on the State Health Improvement Process (SHIP). In addition, the County Health Improvement Plan was presented between October-December 2011 at separate meetings with the County stakeholders for additional input and feedback.

- Results of a **survey of 126 County residents** attending an annual "Holiday Food and Fitness Expo" in November 2009, sponsored by Prince George's County Health Department (PGCHD), Maryland-National Capital Park and Planning Commission (M-NCPPC), and Prince George's County Public Schools (PGCPS).

- Input from **key County coalitions and community groups** at a meeting held on September 9, 2011, sponsored by the Maryland Department of Health and Mental Hygiene (DHMH) and PGCHD.

- Comments from participants at a **symposium entitled "Health √ (Check)**, The Prognosis for Prince George's County", held at Prince George's Community College on October 1, 2011 and sponsored by the National Harbor Chapter of Jack and Jill of America, Inc., Prince George's County Council Chair Ingrid M. Turner, and M-NCPPC Parks and Recreation.

- **Feedback from the community** during the public comment period when the draft Plan was posted on PGCHD Web site in October and November 2011.

In addition, between November 2011 and January 2012, the Prince George's County Health Department contracted with Abt SRBI to conduct a Behavioral Risk Factor Surveillance System (BRFSS) telephone survey in Prince George's County. Altogether, 1,125 households throughout the County were interviewed, with an additional 375 households "oversampled" in four Port Town communities, which have a large percentage of minority residents (predominantly African American/Black and Hispanics). The results of this survey will be available in March 2012.

Finally, a map of the County entitled "Number of Elevated Indicators by Zip Code, Prince George's County", provided by Maryland Department of Health and Mental Hygiene, will be used by the PGHAC to identify areas of the County where strategies and action steps outlined in this document (Section 4) will specifically be targeted (primarily inside the Capital Beltway 495/95). The online map can be viewed at:
http://www.princegeorgescountymd.gov/Government/AgencyIndex/Health/pdf/Elev+Hlth+Indic+by+Zip_11-11.pdf

3. Local Health Context

In addition to the formation of the Prince George's Health Action Coalition (PGHAC), a number of existing Coalitions have been included as partners in developing, implementing, and evaluating the Prince George's County Health Improvement Plan (PGCHIP) and Health Action Plan 2012. These Coalitions, listed in Section 1 (Local Health Planning Coalition Description) of this document, are considered to be Adjunct PGHAC members. As such, they will continue to independently meet according to their established meeting schedules as well as attend meetings of the PGHAC Coalition and its Workgroups in order to inform the health planning process.

4. Local Health Improvement Priorities 2012 (See Attachment A)

5. Local Health Planning Resources and Sustainability Plan

In a future meeting of the PGHAC, the Coalition will conduct an inventory of all the existing and anticipated assets and resources available among Coalition members, Coalition Workgroup members, Coalition Adjunct members and other key stakeholders to support implementation of the specific strategies outlined in the Health Action Plan 2012. These resources, both in-kind and direct funding, may include:

- Personnel (i.e. professional, administrative, clerical)
- Services (i.e. medical, social, educational, lab, language and deaf interpreter, other agency-specific)

- Training, meeting, and office space
- Equipment and Supplies (i.e. office, medical, lab, educational)
- Communication methods (websites, television, radio, publications, newsletters, other)
- Printing, reproduction, and postage
- Subscriptions to professional publications, grant directories, other sources that support research into best practices, funding
- Computers and computer software
- Training/conference funds and stipends for trainers
- Mileage reimbursement funds
- Agency mini-grants and other available direct funds

Each Coalition Workgroup and their designated Research Intern will also have an on-going responsibility to identify potential funding sources that can support the Prince George's County Health Action Plan 2012 and PGCHIP. If needed, a special Funding Workgroup will be established to oversee fund seeking activities. Administrative support staff will assist the Workgroups in responding to Requests for Proposals.

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Attachment A

Prince George's County Health Action Plan 2012: Action Plan for Priority 1

Implementation Period: **January 1 – December 31, 2012**

Name and Title of Person Completing Action Plan: **Gloria Brown, Co-Chair; Ben Ijomah, Co-Chair**

PGHAC Workgroup: **Access to Care Workgroup (Priority 1)**

Priority 1: Ensure that Prince George's County Residents Receive the Health Care They Need, Particularly Low Income, Uninsured/Underinsured Individuals

County Outcome Objective	Current County Baseline Data	2014 County Goal
Increase the proportion of persons with health insurance	82.2% (percentage of civilian non-institutionalized ages 18-64 with any type of health insurance, BRFSS 2008-2010)	91.1% using midpoint to Healthy People (HP) 2020
Reduce the proportion of individuals who are unable to obtain, or delay obtaining, necessary medical care, dental care, or prescription medications	15.8% (percentage of people who reported that there was a time in the past 12 months when they **could not** afford to see a doctor, BRFSS 2008-2010)	15% using 5% decrease
Increase the proportion of low income children and adolescents who receive dental care	57.8% (percentage of low income children ages 4-20 enrolled in Medicaid that received a dental service in the past year, Medicaid Calendar Year 2009)	60.7% using 5% increase

Increasing Enrollment of Adults and Children in Medicaid, HealthChoice/MCHP, Other Health Programs

Strategy (What?)	Responsible Agencies (Who?)	Target Date for Completion (When?)	Action Steps (How?)	Performance Indicators
#6: Place Medical Assistance eligibility/enrollment workers at strategic clinic sites (i.e. FQHCs).	Prince George's County Department of Social Services Maryland Department of Human Resources Maryland Department of Health and Mental	June 2012	1. Develop Medical Assistance (MA) Co Pay Contracts to place DSS Eligibility Workers at 3 FQHCs to process MA applications.	Eligibility Workers (3) placed at 3 FQHC sites Number of MA applications submitted for processing by Eligibility Workers and number actually approved. Percent increase over previous reporting period in the total

	Hygiene HealthChoice Program Community Clinic, Inc. (FQHC) Greater Baden Medical Services (FQHC) Mary's Center (FQHC)			number of MA applications processed by responsible agencies Percent increase from previous reporting period in the total number of County women and children enrolled in MA

Increasing Linkage to Care				
Strategy (What?)	**Responsible Agencies (Who?)**	**Target Date for Completion (When?)**	**Action Steps (How?)**	**Performance Indicators**
#6: Work with the Medical Society, Board of Physicians, Board of Pharmacy, and other medical associations to identify ways to increase access to dental, vision, and medical care (including specialty care), and to low cost prescriptions medication.	Prince George's County Health Department Medical Society Board of Physicians Board of Pharmacy Other medical professional associations (i.e. for Physician Assistants, Nurses, Nurse Practitioners, Dentists, Dental Hygienists, Opthalmologists and Optometrists) Greater Baden Medical Services (FQHC) Mary's Center (FQHC)	Throughout 2012	1. Designate at least 2 Prince George's Health Action Coalition (PGHAC) meetings to include representatives of identified medical professional associations for the purpose of identifying areas of the County and populations with access to care issues, the specific services that are needed to fill service gaps, and ways to increase access to care. 2. Convene monthly meetings of the PGHAC Access to Care Workgroup to follow-up on actions identified in the above-mentioned meetings. 3. Continue promoting existing services to the public on the part of all partners,	Meetings held; number and types of professional associations participating Geographic areas and populations with access to care issues identified Needed services identified Recommendations on ways to increase access to care identified, along with resources needed to implement recommendations Workgroup meetings held; actions undertaken and barriers to implementing actions identified Outreach and public information activities implemented; number

	Community Clinic, Inc. (FQHC) PGHAC members		using established and non-traditional outreach and public information methods/materials. Focus efforts on specifically reaching hard-to-reach, minority, non-English-speaking, and uninsured or underinsured County residents.	and types of materials distributed Percent increase over previous reporting period in the number of calls to the Health Department's Health*line* Program, a widely publicized free telephone information and referral service, from individuals seeking care Percent increase over the previous reporting period in the number of calls to other agency customer service or information desks from individuals seeking care Percent increase over the previous reporting period in the number of individuals served (by all partners)
#8: Provide up-to-date information to the public about the services available through existing providers including FQHCs and other safety net clinics.	Prince George's County Department of Family Services Prince George's County Department of Social Services Prince George's County Health Department Greater Baden Medical Services FQHC)	June 2012	1. Develop and/or revise safety net providers' informational flyers, brochures, and other materials describing their services and service locations for distribution to the public through established outreach activities, including website postings, health fairs, community events, etc. 2. Identify and use non-traditional outreach methods, materials and outlets to broaden distribution of safety net provider informational materials to	Informational materials updated and translated into relevant languages Number and types of materials distributed Number and types of distribution sources used Number, types, and locations of non-traditional outreach methods/outlets identified and used to distribute information to

	Community Clinic, inc. (FQHC) Mary's Center (FQHC) Pregnancy Aid Center Forestville Pregnancy Center Mobile vans (Governor's Wellmobile, Deamonte Driver Dental van, Mary's Center van, Children's Hospital van) Other community safety net providers Dimensions Healthcare and other hospitals serving County residents PGHAC members and other partners Prince George's County Memorial Library System Local churches, businesses, low income housing complexes and other non-traditional sites for distributing informational materials		the public, especially to hard-to-reach, non-English-speaking, low income, and uninsured/underinsured individuals. 3. Revise the widely used Health Department "Community Services Guide-at-a-Glance", a resource directory, for distribution to and use by all partners and provider agencies in referring individuals to needed care. Create an on-line version of the Guide-at-a-Glance that can be updated regularly and downloaded.	the public; number of materials distributed Community Services Guide-at-a-Glance revised and available on-line. Number of Guides distributed Number of partners using Guides for referring clients in need of services Percent increase over previous reporting period in the number of calls to the Health Department's Health*line* Program from individuals seeking care Percent increase over previous reporting period in the number of calls to other partner agencies' customer service or public information desks from individuals seeking care Percent increase over the previous reporting period in the number of individuals served (by all partners)

Prince George's County Health Action Plan 2012: Action Plan for Priority 2

Implementation Period: **January 1 – December 31, 2012**

Name and Title of Person Completing Action Plan: **John O'Brien, Chair; Karen Bates, Co-Chair; James Chesley, Co-Chair**

PGHAC Workgroup: **Chronic Diseases Workgroup (Priority 2)**

Priority 2: Prevent and Control Chronic Disease in Prince George's County, Particularly Among Minorities.

County Outcome Objective	Current County Baseline Data	2014 County Goal
Increase the proportion of adults who are at a healthy weight	28.6% (percentage of adults at a healthy weight {not overweight or obese}, BRFSS 2008-2010) White Non-Hispanic – 39.6% Black – 13.0% Hispanic – 23.0% Asian – Not Available	30% using 5% increase White Non-Hispanic – 41.6% using 5% increase Black – 13.7% Hispanic – 24.2% Asian – Not Available
Reduce the proportion of children and adolescents who are considered obese	16.1% (percentage of youth ages 12-19 who are obese, MYTS 2008)	15.3% using 5% decrease

Increasing Access to Healthier Foods

Strategy (What?)	Responsible Agencies (Who?)	Target Date for Completion (When?)	Action Steps (How?)	Performance Indicators
#1: Adopt local policies requiring chain restaurants to provide menu labeling that gives consumers information on nutritional values of in-store menu selections.	Prince George's County Health Department PGHAC members Prince George's County Office of the County Executive Prince George's County Council/Board of	April 2012 (Bills to be heard April 2013)	1. Research the strategies that neighboring jurisdictions used to successfully established menu labeling in their restaurants. Identify strategies that can be replicated in Prince George's County. 2. Prepare an educational packet and presentation that will be used to educate the County Council/Board of Health, County Executive's Office	Research completed; strategies identified for implementation in the County Educational packet and presentation prepared and presented to County Council/Board of Health,

	Health/County Executive's Office Restaurant owners and other menu labeling supporters		about the importance of menu labeling. 3. Using other jurisdictions' legislation as models, develop a draft of proposed legislation for presentation to the Prince George's County Council/ Board of Health and County Executive's Office. 4. Solicit owners of restaurants that have already adopted menu labeling in their stores, as well as other advocates of menu labeling, to provide support for the menu labeling proposed legislation.	County Executive's Office Proposed legislation drafted and presented to County Council/Board of Health, County Executive's Office Restaurant owners and other advocates identified and involved in educating County Council/Board of Health, County Executive's Office, about menu labeling Menu labeling legislation adopted Chain restaurants providing menu labeling in compliance with the legislation requirements (per Health Department restaurant inspections)
#2: Educate local leaders, restaurant owners, and the public about menu labeling and its impact on selection of healthy food choices, using media outlets, community events, educational materials, and	Prince George's County Health Department PGHAC members Restaurant owners and other menu labeling supported Local political, religious, academic, and other community leaders	Throughout 2012	1. Research the strategies that neighboring jurisdictions used to successfully established menu labeling in their restaurants. Identify strategies that can be replicated in Prince George's County. 2. Prepare an educational packet and presentation that will be used to educate local leaders, restaurant owners, the media, and the public about the importance of menu labeling. Include educational materials and	Research completed; strategies identified for implementation in the County Educational packet and presentation prepared Number and types of educational programs conducted; number of

other venues/methods.	Media		venues that reach minorities, non-English-speaking populations. 3. Identify the food deserts and high-risk geographic areas of the County with a concentration of fast-food chain restaurants to target educational efforts. 4. Solicit owners of restaurants that have already adopted menu labeling in their stores, as well as other advocates of menu labeling, to provide assistance in educating local leaders, restaurant owners, the media, and the public.	participants Number and types of venues (including media outlets) used to impart menu labeling information to leaders, restaurant owners, the public; number of individuals reached Number and locations of food deserts and high risk areas identified; number of educational programs presented in these areas; number of participants Restaurant owners and other advocates identified and involved in educating local leaders, restaurant owners, the media, and the public about menu labeling Menu labeling legislation adopted Chain restaurants providing menu labeling in compliance with the legislation requirements (per Health Department restaurant inspections)

#3: Increase public demand for healthier food choices at restaurants and food markets through education and advocacy; partner with the Food Supplemental Nutrition Education Program to assist with community education to low income and other at-risk communities.	Prince George's County Health and Human Services Agencies Food Supplemental Nutrition Education Program PGHAC members Restaurant owners Grocery store managers and owners Local farmers and farmers' markets Community sites where health fairs, community events, educational programs can be conducted (i.e Park and Planning Recreation Centers, schools, churches, local businesses, County government agencies, low income apartment complexes)	Throughout 2012	1. Prepare a public education program in conjunction with the Food Supplemental Nutrition Education Program that specifically reaches low income, minority, non-English-speaking, and other populations at risk for chronic diseases. 2. Identify the food deserts and high-risk geographic areas of the County where populations at greatest risk for chronic diseases reside, for targeted education, advocacy for farmers' markets, and implementation of other strategies that promote purchase of healthier foods 3. Explore with Verizon the possibility of offering free texting services to partners for the purpose of sending text messages to County residents regarding healthier food choices. 4. Identify free media, Website and internet internet outlets that can be used to educate the public about healthier food choices, including County government agency Websites. 5. Identify and implement strategies to promote greater consumer participation in local farmers' markets, greater consumer support for additional farmers' markets, and increased purchasing of locally grown foods.	Educational program prepared Number of educational programs presented; number of participants Number and locations of food deserts and high risk areas identified Number of educational programs presented in these areas; number of participants Number and types of activities that promote the purchase of healthier foods implemented Verizon contacted; if successful, text messages prepared and sent to County residents; number of text messages Verizon receives in response Media, Website, and internet outlets identified and used to deliver messages about healthier food choices; number of page views or visits to sites Strategies identified and implemented Number of new farmers' markets established Number of individuals using

				farmers' markets (estimates) Number of WIC food vouchers used at farmers' markets (or number of women on WIC using food vouchers at farmers' markets)
			6. Identify grocery stores willing to offer healthier food choices and incentives for consumers to purchase healthier foods. Develop a plan to implement healthier food selection strategies in these locations.	Grocery stores identified Plan developed; strategies and incentives that promote consumer purchase of healthier foods offered (i.e. increased use of locally grown food products, larger choice of fresh fruits and vegetables, in-store signage identifying healthier foods) Grocery store data on healthier food purchases
#5. Increase marketing of healthier foods, using the Get Fresh Baltimore model.	Prince George's County Health Department (WIC Farmers' Market Nutrition Program) Kaiser Permanente Get Fresh Baltimore Program Prince George's County Public Schools Maryland-National Capital Park and Planning Commission (Planning Department and Parks and	December 2012	1. Meet with Get Fresh Baltimore Program staff to identify elements of the Program that can be replicated in Prince George's County, i(i.e. establishment of a Get Fresh Prince George's Website, a virtual supermarket, community gardens) 2. Identify specific partners to be involved in establishing the Get Fresh Prince George's County Program. 3. Develop a plan for implementing the Get Fresh Program in the County, including strategies that reach minorities, non-English-speakers, low income, and other populations at	Meeting(s) held; strategies to be replicated in the County identified Partners identified Plan developed

	Recreation) Maryland Department of Agriculture University of Maryland Extension Grocery stores Farmers and farmers' markets Food Supplemental Nutrition Education Program Media Supplemental Nutrition Assistance Program (SNAP) Local municipalities with community gardens		risk for chronic diseases. 4. Identify geographic areas of the County and populations at greatest risk for poor eating habits and chronic diseases, for targeted 5. Identify funding and other resources needed to support the implementation of the Get Fresh Prince George's County Program.	Target areas and populations identified Funding and other resources identified and procured Get Fresh Prince George's Program phased in as funding permits (fully operational by March 2013)
Promoting Physical and Recreational Activity				
Strategy (What?)	**Responsible Agencies (Who?)**	**Target Date for Completion (When?)**	**Action Steps (How?)**	**Performance Indicators**
#1: Support the implementation of the PGCPS new Fitness-Gram Program in grades K-12. (FitnessGram includes an	Prince George's County Public Schools PGHAC members	Throughout the 2012 school year	1. Provide ongoing school staff training to ensure the program is being uniformly implemented. 2. Review data collected from the assessment tools and compare with	Fitness-Gram Program implemented in grades k-12 Number of students participating in Program Student level of fitness (associated with being healthy)

assessment tool that obtains personal data to determine a student's fitness level).			previous yea's data to determine program effectiveness.	measured by data collected in assessment tools
#2: Work with the PGCPS including the School Wellness Councils to sustain the Healthy Schools Program and ensure compliance with the school system Wellness Policy that identifies increased physical activity for students, promotes healthier food and beverage choices in schools, and contributes to a healthier school environment in general.	Prince George's County Public Schools (School Wellness Councils) Kaiser Permanente PGHAC members	Throughout the 2012 school year	1. Secure grant funding to support/sustain the Healthy Schools Program. 2. Initiate the development of a strategic plan with interested partners to expand the Healthy Schools Program. 3. Increase the number of healthy food selections on the school menus. 4. Collect and analyzing BMI data from the Healthy Schools Program on an on-going basis.	Funding procured Plan developed Partners have a written agreement indicating support of the Healthy Schools Program Number of schools actively participating in the HSP (as evidenced by completion of the annual school health inventory); number of students participating Number and types of new menu items that meet new dietary guidelines Data on student purchases of healthy food items from school menus BMI data collected and analyzed
#3: Seek funding to pilot the implementation of the M-NCPPC and PGCHD's	Maryland-National Capital Park and Planning Commission Prince George's County	January 2013	1. Identify funding to support implementation of the Prescription-REC Program as a pilot project.	Funding identified Prescription-REC Program implemented

Prescription-REC Program for County residents with high blood pressure and/or high cholesterol who have a "prescription" from their health care provider to start an exercise regimen.	Health Department Local health care providers PGHAC members		2. Identify at least 3 physicians that will make 5 or more client referrals to the Prescription-REC Program and participate in the pilot to measure the Program's effectiveness in reducing high blood pressure and high cholesterol among clients. 3. Advertise the Prescription –REC Program, targeting geographic areas and populations at greatest risk for high blood pressure and/or high cholesterol.	Physicians identified and making referrals Number of clients referred, enrolled, and completing the Prescription-REC Program Number, types, and locations of advertising venues/formats used to promote the Prescription-REC Program Improvements in selected client health indicators (i.e. BMI, weight reduction, BP, Hemoglobin A1c, blood glucose) Client satisfaction surveys

Prince George's County Health Action Plan 2012: Action Plan for Priority 3

Implementation Period: **January 1 – December 31, 2012**

Name and Title of Person Completing Action Plan: **Elliot Segal, Co-Chair; Evelyn Reed, Co-Chair**

PGHAC Workgroup: **Infant Mortality Workgroup (Priority 3)**

Priority 3: Improve Reproductive Health Care and Birth Outcomes for Women in Prince George's County, Particularly Among African American Women.

County Outcome Objective	Current County Baseline Data	2014 County Goal
Reduce infant deaths	Overall rate - 10.4 (number of infant deaths/1,000 live births, VSA 2007- 2009) White/Non-Hispanic rate - 10.6 Black rate - 13.3 Hispanic rate - 4.6 Asian rate - 2.7	Overall rate - 8.2 using midpoint to HP 2020 White/Non-Hispanic rate - 10.1 using 5% decrease Black rate - 12.6 using 5% decrease Hispanic rate - 4.4 using 5% decrease Asian rate - 2.6 using 5% decrease By 2012 reduce to 9.6/1,000 By 2013 reduce to 9.0/1,000 By 2014 reduce to 8.2/1,000
Reduce low birth weights (LBW) and very low birth weights	Overall - 10.6% (percentage of births that are LBW, VSA 2007-2009) White/Non-Hispanic - 7.6% Black - 12.5% Hispanic - 7.5% Asian - 7.7%	Overall - 9.2% using midpoint to HP 2020 White - 7.2% using 5% decrease Black - 11.9% using 5% decrease Hispanic - 7.1% using 5% decrease Asian - 7.3% using 5% decrease
Increase the proportion of pregnant women who receive prenatal care beginning in the first trimester	Overall - 67% (percentage of births where mother received first trimester prenatal care, VSA 2007-2009) White/Non-Hispanic - 82.3%	Overall - 70.4 % using 5% increase White - 86.4% using 5% increase Black - 72.9% using 5% increase

	Black - 69.4% Hispanic - 52.7% Asian - 66.6%	Hispanic - 55.3% using 5% increase Asian - 69.9% using 5% increase

Linking Women to Prenatal Care and Women's Wellness Services

Strategy (What?)	**Responsible Agencies (Who?)**	**Target Date for Completion (When?)**	**Action Steps (How?)**	**Performance Indicators**
#1: Expand existing prenatal care and women's health services to include screening and counseling for diabetes prevention and management (including gestational diabetes), weight management and nutrition counseling, substance abuse and smoking cessation services, referral to dental health services, mental health services and domestic violence prevention, and screenings and referrals for Medicaid.	MD Dept. of Health and Mental Hygiene – FIMR and SIDS data Fetal and Infant Mortality Review Team Greater Baden Medical Services (FQHC) Mary's Center (FQHC) Community Clinic, Inc. (FQHC) Mobile Vans (Governor's Wellmobile, Mary's Center van, March of Dimes) Dimensions Healthcare System Doctor's Community Hospital Southern Maryland Hospital Other hospitals serving County women	April 2012 December 2012	1. Identify all areas with high infant mortality (i.e. 20785, 20743, 20706) at the level of neighborhood/zipcode. a. Use IPO/FIMR and SIDS death certificate data to identify addresses and race/ethnicity. b. Use addresses and zipcodes to identify neighborhoods for more specificity in determining target areas for outreach purposes (see Action Step #10). 2. Work with providers of prenatal, preconception, inter-conception, and women's wellness services to inventory services currently provided (including family planning, patient navigator, and other services listed in the strategy statement) and to determine service gaps. 3. Identify barriers that may prevent women from seeking early and continual access to care and potential solutions. 4. Create referral mechanisms with new	Zipcodes and neighborhoods identified Addresses and racial/ethnic data identified Number of fetal and infant deaths by zipcode/neighborhood ascertained Inventory of existing services completed; gaps in service identified Barriers identified Short-term solutions identified and implemented Long-term solutions identified Referral mechanisms in place

	Pregnancy Aid Center Forestville Pregnancy Center Prince George's County Medical Society Improved Pregnancy Outcome Committee Local FIMR Team Prince George's County Department of Social Services TMAN (Treatment of Mothers of Addicted Newborns) Program Prince George's County Health Department (Maternity and Family Planning, Children and Parents, Dental Health, Healthline, School Health, and Infants At Risk Programs) Prince George County Department of Family Services Healthy Families Prince George's Program Prince George's County Public Schools	December 2012 March 2013	providers/partners and streamline the referral processes among existing providers/partner agencies to facilitate access to early and on-going care by pregnant women and women of childbearing age. 5. Work with providers and partners to develop a plan to expand/improve existing services and add new services in future years. 6. Work with partners to increase the proportion of women delivering a live birth who received preconception or inter-conception care services and practiced key CDC-recommended preconception and inter-conception health behaviors: a. Develop a form to be used by all county OB-GYN providers to collect needed information. b. Enlist all county OB/GYNs to use the new form to collect information regarding woman's wellness or preconception/inter-conception health visits at the first prenatal care visit for all pregnant women.	Preliminary plan developed that identifies new services that need to be created, existing services that need to be expanded (i.e. increased number of appointment slots, increased number of service locations and hours, added bi-lingual capacity) Services that can be created or expanded/improved right away and without additional resources in place; number of women served Form developed and in use by providers; data tabulated and analyzed Number of women who deliver an infant at term and of normal birth weight and who have received woman's wellness and preconception or interconception care services.

	Access to Wholisitc and Productive Living Institute (community-based organization that provides perinatal navigator, home visiting services to predominantly minority pregnant women) Domestic Violence Task Force PGHAC members		c. Forms will be submitted to the Health Department or other designated agency for tabulation and analysis.	Forms submitted; data tabulated and analyzed
		December 2012	7. Develop/update Resources and Referral List for OB/GYNS that identifies available services for treatment and monitoring of hypertension, diabetes, obesity, dental, smoking cessation and substance abuse; update the Health Department's "Community Services Guide-at-a-Glace" to include these services, for distribution to and use by all partner agencies in linking pregnant women and women of childbearing age to care.	Resource list developed and distributed
		September 2012	8. Conduct outreach (seminar) to OB/GYN practitioner community at Prince George's Hospital Center (PGHC) regarding the importance of:	Number and types of outreach activities conducted; number of providers participating; number of providers who make positive evaluation comments after the seminar
			a. Universal drug testing for all prenatal patients (schedule meeting with PGHC physicians and nurse-midwives, the representative from SSA/DHR and representatives from the TMAN Committee.	Number of pregnant women tested for drugs
			b. Increasing the number of family planning and preconception /interconception care referrals from the practitioners to community providers.	Number of referrals from Prince George's Hospital Center to community providers for family planning and preconception /interconception care

		December 2012	c. Expand wrap-around services to pregnant women such as housing, counseling, employment , assistance with domestic violence issues, that also reach women seeking care at private physician offices. Provide written information regarding these services at the time they renew their driver's license.	Types and numbers of wrap-around services provided; number of women who received these services Number of written materials distributed to women at Motor Vehicle Administration sites
		February 2013	9. Once a year, convene a symposium to educate public and private providers and community health centers on the importance of preconception/interconception care to establish wellness before pregnancy for improvement of pregnancy outcomes, to share information on best practices, strengthen collaborations, etc.	Symposium conducted; number of participants
		December 2014	10. Create a central data base for all pregnant women for the purposes of offering home visitation services and linking them and their families to a medical home and family planning services.	Number of pregnant women entered into data base. Number of pregnant women who received home visits and who were linked to a medical home and family planning
		Throughout 2012	11. Continue providing outreach on the part of all partners to at-risk pregnant women and women of childbearing age, particularly those who reside in zipcodes and neighborhoods identified in Action Step #1, to inform them of the importance of early and on-going prenatal,	Number, types, and locations of outreach activities undertaken by all agencies; number and types of materials distributed through outreach (including materials in Spanish and other languages)

			preconception/inter-conception, and women's wellness services. Focus on using strategies, outlets, and materials that reach minorities, non-English-speaking, and low income uninsured and underinsured women.	

Prince George's County Health Action Plan 2012: Action Plan for Priority 4

Implementation Period: January 1 - December 31, 2012

Name and Title of Person Completing Action Plan: Reverend Tony Lee, Chair; Charlene Dukes

PGHAC Workgroup: HIV/STIs Workgroup (Priority 4)

Priority 4: Prevent and Control Infectious Disease in Prince George's County, Particularly Among African Americans and Other Minorities.

County Outcome Objective	Current County Baseline Data	2014 County Goal
Reduce new HIV infections among adults and adolescents	Overall rate - 56.4 (rate of new {incident} cases of HIV in persons age 13 and older per 100,000 population, IDEHA 2009) In progress for race specific data	Overall rate - 53.6 using 5% decrease
Reduce chlamydia trachomatis infections among young people	Overall rate - 631 (rate of chlamydia infections for all ages per 100,000 population, IDEHA 2009) White rate - 32.4 Black rate - 206.4 Hispanic rate - 74.8 Asian rate - Not Available (all ages)	Overall rate - 599.5 using 5% decrease White rate - 30.8 using 5% decrease Black rate - 196.1 using 5% decrease Hispanic rate - 71.1 using 5% decrease Asian rate - Not Available

Addressing HIV/AIDS

Strategy (What?)	Responsible Agencies (Who?)	Target Date for Completion (When?)	Action Steps (How?)	Performance Indicators
#8: Expand outreach and prevention education efforts to include the use of innovative media and information	Prince George's County Public Schools Prince George's County Health Department Heart-to-Hand	December 2012	1. Identify target populations in zip codes identified by DHMH with increased incidence of Sexually Transmitted Infections. 2. Contact partnering agencies and identify new partners within target zip	Target populations identified New and existing partners identified; capacity to provide

technology methods such as online and social network services (i.e. Web sites, blogs, Facebook, Twitter, YouTube and Internet-Based Partner Services).	(community-based organization serving predominantly minority populations) Dimensions Healthcare System Prince George's County Department of Corrections University of Maryland (College Park) School of Public Health Bowie State University (HBCU - Historically Black University) Prince George's Community College Other academic institutions Faith-Based Organizations, particularly those serving minority and non-English speaking populations Apartment Management Companies, particularly those in target zip codes and serving low-income populations		codes defined above and assess their capacity to provide education and outreach (particularly to minority and non-English-speaking communities) to stem transmission rates. 3. Institute capacity-building opportunities for responsible agencies. 4. Develop and carry out coordinated outreach strategies with responsible agencies. 5. Develop partnerships with academic institutions to develop and undertake new media projects and a social media campaign.	education and outreach, particularly to minority and non-English-speaking communities, assessed Number and types of capacity building activities undertaken; number of participants Number and types of outreach strategies implemented; number of individuals reached Partnerships established Media campaign implemented; number of individuals reached Percent increase over previous reporting period in number of visits to Be STD Free Website: BeSTDfree.com Number and types of online and social media outlets used; number of page views to internet sites Percent increase over previous reporting period in the number of contacts made by the Health Department's STD Program (via Internet Partner Services) with anonymous sex partners of HIV/STI positive individuals who they met on social media sites/internet; percent increase over previous reporting period in

	Sexually Transmitted Infections Community Coalition PGHAC members Local and regional radio, newspaper, and television media outlets, particularly those reaching minority and non-English-speaking audiences On-line social media outlets, particularly those reaching minority and non-English-speaking audiences			the number of these individuals who are tested for HIV/STIs. Percent increase over previous reporting period in the overall number of individuals tested for HIV Number of new testing sites established and percent increase over previous reporting period in the number of first-time tested.

Rushern L. Baker, III
County Executive

HEALTH
DEPARTMENT
Prince George's County

Prince George's County
Health Improvement Plan 2011 to 2014

Blueprint For A Healthier County

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HEALTH DEPARTMENT
Prince George's County

Office of the Health Officer

Dear Fellow County Residents,

The arrival of 2012 marks an exciting time for Prince George's County. With the anticipated launching of nationwide health care reform in the near future and the elevation of health care as a priority under the leadership of County Executive Rushern L. Baker, III, we now have an unprecedented opportunity, unlike any time in the past, to make significant improvements in the health of all citizens and residents of our County.

To this end, I am pleased to announce the release of the Prince George's County Health Improvement Plan for 2012-2014 and beyond. This Plan provides a blueprint for creating new and innovative health programs, enhancing existing services, and making health systems changes at the local level that will help us to address our County's most pressing health concerns such as infant mortality, chronic conditions like diabetes and heart disease, HIV and other infectious diseases, access to care, substance abuse and domestic violence.

With support from our local hospitals, the public schools and other academic institutions, County agencies, the Maryland-National Capital Park and Planning Commission, and numerous other key health care providers and stakeholders, we are poised and ready to accept the challenge of transforming Prince George's County from one whose history of poor health outcomes overshadowed our many strengths to a County whose communities and residents serve as models for achieving health and well-being through partnerships, strategic planning, and effective resource management. In addition, our Plan includes strategies that are designed to help individuals adopt behaviors that lead to healthier lifestyles and greater quality of life for themselves, their families, and their neighbors.

As we embark on this new initiative, I invite you to join us in making Prince George's County one of the healthiest places in the world to live, work, and play. Health for all by the year 2020 need not be just a dream – together, and in collaboration with our many partners, we can make it happen!

Sincerely,

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Rushern L. Baker, III
County Executive

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Introduction

At the heart of any community's success and prosperity is the health of its residents. When people have affordable health care, safe neighborhoods, a clean environment, and access to physical activity, recreation, nutritious foods, and other resources that contribute to a healthy lifestyle, they are more equipped to excel in school, thrive in the workforce, and fulfill their civic responsibilities.

This County Health Improvement Plan was prepared by the Prince George's County Health Department with the assistance of numerous stakeholders. These include the County Council serving as the Board of Health, the Maryland Department of Health and Mental Hygiene, existing community coalitions, and key stakeholders concerned about the health status and health needs of our County's population.

The Plan addresses our County's most pressing and immediate health needs as well as overarching concerns of the health stakeholder community as a whole. Collectively, the priorities, objectives, and strategies are ambitious and cover a broad array of health issues. Included are initiatives and programs specific to individual agencies as well as strategies that address policy and systems changes and that reflect social determinants of health. We also considered the key concepts that underscore the "Place Matters Initiative" launched by the Joint Center for Political and Economic Studies Health Policy Institute.

The County Health Improvement Plan has a ten-year timeframe (through 2020); however, the year 2014 was selected as the initial target year for reviewing most of our objectives for three reasons: 1) to be in alignment with the Maryland State Health Improvement Process (SHIP) target dates, 2) to allow us the opportunity to evaluate progress towards reaching our health objectives and make adjustments to the Plan at the halfway point towards meeting Healthy People 2020 goals and 3) to enable us to assess our priorities as they relate to planned health care reform for the nation.

Since no organization alone can perform all of the activities listed, the Plan relies extensively on existing partnerships and the forging of new alliances among many community groups and agencies. In addition, a robust and on-going search for funding and other resources will be required.

There is already tremendous enthusiasm, optimism and resolve among our key health stakeholders and local political leaders to make this Plan succeed in creating a healthier Prince George's County. While the work will be challenging, the benefits will be great.

Purpose of the County Health Improvement Plan

The County Health Improvement Plan for Prince George's County is a statement of policy and strategies which provide a planning framework for improving the health status of County residents.

The intent of the Plan is to promote a high level of communication among a diverse constituency involved in health-related activities and to serves as a central focal point for all health planning activities in the County.

In addition, it is intended to serve as a guide to decision makers for the effective allocation of health resources in that it contains specific priorities, health outcome objectives, and strategies that will be addressed over the next four to ten years.

Prince George's County–Who We Are

Prince George's County, Maryland, is located immediately north, east, and south of Washington, D.C and 18 miles south of the City of Baltimore. Our County has 485 square miles and 863,420 residents, which makes us the second most populous jurisdiction in the State of Maryland. Prince George's County has a number of unique characteristics which factored significantly into the development of our County Health Improvement Plan:

- **We are one of the most culturally diverse counties in Maryland**. Our residents include individuals from 149 countries who collectively speak 165 languages and dialects.

- **The majority of our residents are people of color**. Over 79% of the population are minorities - African Americans represent 65% of the total population followed by Hispanics/Latinos (15%), Asian-American/Pacific Islanders (4%), and Native American Indians (less than 1%). White Caucasians comprise 19% of the population.

- **Our County is comprised of a mix of urban, suburban, and rural communities**. However, the majority of our residents live inside the Capital Beltway adjacent to the District of Columbia.

- **The educational attainment of our population is comparable to that of the nation.** 85% percent of our population versus 84% for the U.S. as a whole have a high school degree or higher. U.S. Census Bureau figures for 2008 show that 27% of County residents over age 25 have a bachelor's degree or higher.

- **Our population is relatively affluent**. The U.S. Census Bureau Community Survey for 2010 shows that the median household income of County residents was $69,545, considerably higher than the U.S. average of $50,740. However, the County has a substantial number of low income "working poor" who reside primarily in densely populated communities located inside the Capital Beltway. Almost 10% of the County's children live in poverty.

- **Unlike neighboring jurisdictions, our County's ability to generate revenue to provide public services is severely restricted** because of a 1978 amendment to the County Charter called TRIM (Tax Reform Initiative by Marylanders) that places a cap on the collection of real property taxes. Our current assessable tax base, especially with regard to commercial properties, is insufficient to address all of the County's needs.

- **A large percent of our population is in the workforce, more than the national average.** 74% of our population ages 16 and over are gainfully employed versus 65% for the nation; however, this is lower than the Maryland average.

- **We have a significant number of uninsured County residents**. Estimates vary among data sources, ranging from 80,000 (RAND Report) to 150,000 uninsured, with possibly another 150,000 to 200,000 who are underinsured. The 2006 Small Area Health Insurance Estimate reveals that the County has the highest percentage and absolute number of uninsured persons in Maryland. The 2008 Behavioral Risk Factor Surveillance System self-reported data reveals that 19% of the County's population is uninsured (16% of African Americans versus 12% of White adults).

- **Despite our shortage of primary care physicians and inadequate primary care safety net,** our County has only one Medically Underserved Area (MUA) designation and only one federally qualified health center (FQHC) whose headquarters are located in the County.

- **The County-owned Prince George's Hospital Center operated by Dimensions Healthcare System provides a substantial amount of uncompensated care to our County's sizeable uninsured/underinsured population, and essentially serves as the primary safety net provider for the indigent.** This has contributed to serious financial challenges for the Hospital system, which is now in the process of being restructured. Dimensions also operates the Laurel Regional Hospital and the Bowie Health Center.

- **Other hospitals in the County provide a variety of premier services relevant to our health priorities**. Southern Maryland Hospital Center operates two women's health centers and recently opened a newly expanded Women and Newborns Center. Doctor's Community Hospital houses the Joslin Diabetes Center and the Center for Women's Wellness. Ft. Washington Medical Center is a small facility that provides a range of services and Malcolm Grow Medical Center serves the Andrews Air Force Base community.

- **Our County has an extensive array of park and recreation facilities operated by the Maryland-National Capital Park and Planning Commission (M-NCPPC)** that includes over 40 miles of trails, over 27,000 acres of park land, 43 community recreation centers, 10 aquatic facilities, and a state-of-the-art sports complex offering programs that promote healthy lifestyles**.**

- **Our County is home to the University of Maryland School of Public Health (UMDSPH), Bowie State University School of Nursing, and Prince George's Community College Center for Health Studies and Academy of Health Sciences,** and is in close proximity to other academic and medical institutions that can lend resources to address our health needs.

Assessing Our Health Needs

To determine our County's priority health needs, we reviewed data from a variety of sources and sought input from local political and community leaders, key health care stakeholders, and County residents. This included:

- **A review of County-specific statistics** from the Maryland Department of Health and Mental Hygiene Vital Statistics Administration (DHMH VSA) reports, Behavioral Risk Factor Surveillance System (BRFSS) data, U.S. Census Bureau information, and other commonly used data sources.

- **A review of the 2009 RAND Report**, a comprehensive study sponsored by the Prince George's County Council, of the health needs of County residents and the capacity of the County's health care system to respond. The RAND Report concluded that…

  "The County's capacity to provide safety-net care beyond hospital and emergency care appears severely limited"… and that … "strengthening the Prince George's ambulatory care safety net is an urgent concern".

  Key findings of the RAND Report are presented in this Plan; however, a more comprehensive and detailed presentation of the health data and study conclusions by the RAND researchers can be viewed in the RAND report entitled "Assessing Health and Health Care in Prince George's County" located on the Prince George's County Government's Web site at:

  http://www.princegeorgescountymd.gov/pgcha/PDFS/rand-assessing-health-care.pdf

- **A review of the "Baker 2010 Transition Team Transition Report, March 11, 2011".** A Transition team was assembled by County Executive Rushern Baker to study the workings of all County Government agencies in order to seek ways to streamline operations and improve service delivery. Among the various subcommittees' recommendations were the following: making improvements to the County's health information technology infrastructure, establishing a health care system that is more patient-centered and community-based, and making improvements in the Prince George's County Health Department's (PGCHD) leadership and organizational structure. The full report is available at:

  http://www.princegeorgescountymd.gov/Government/ExecutiveBranch/PDF/Baker2010TransitionTeamTransitionReport.pdf

- **Summary information from nine "town hall" style forums** held by the Prince George's County Health Officer in July and August of 2009. In open discussions and small groups, over 200 participants expressed the need for safer neighborhoods, clean water, healthier food choices in their communities, more open spaces and walking/bike trails to promote physical activity, and greater access to health information, screenings, and primary health care, especially for the uninsured.

- **A consensus report from a meeting of major State and local health officials and health care stakeholders, political and community leaders, health experts and community advocates** in December 2010, sponsored by the Prince George's County Executive. Using the findings of the RAND Report and the Washington AIDS Partnership Profiles Report as a backdrop, the participants concluded that there is a need for further dialogue and action leading to the establishment of a more comprehensive, inter-connected and community-oriented system of health care for Prince George's County. The strategies included in the "County-Specific Health Priorities" section of this health plan reflect the findings and recommendations of this group, which are published in a report entitled "Conversation on Building an Integrated Community-oriented Healthcare System in Prince George's County, Executive Summary, Prince George's Community College, December 14, 2010".

- **Input from meetings with the Prince George's County Council/Board of Health** between May and September 2011 that included a presentation by the Maryland Secretary of Health on the State Health Improvement Process (SHIP). Access to care, reducing infant mortality, decreasing the burden of HIV, and meeting the health needs of County women were specifically named as areas of greatest concern. In addition, the County Health Improvement Plan was presented between October-December 2011 at separate **meetings with the County Executive and his staff as well as the Directors of the County Government's Health and Human Services agencies** for additional input and feedback.

- **Results of a survey of 126 County residents attending an annual "Holiday Food and Fitness Expo**" in November 2009, sponsored by Prince George's County Health Department (PGCHD), Maryland-National Capital Park and Planning Commission (M-NCPPC), and Prince George's County Public Schools (PGCPC). Top health concerns identified by respondents included healthy eating, low cost health care, diabetes, high cholesterol, exercise, asthma, and overweight/obesity.

- **Input from key County coalitions and community groups** at a meeting held on September 9, 2011, sponsored by the Maryland Department of Health and Mental Hygiene (DHMH) and PGCHD. This meeting produced a substantial number of the strategies listed in this Plan and helped to solidify critical partnerships among agencies, providers, and community groups. Participants included:

- **Community Health Transformation Coalition and Leadership Team**, assembled in June 2011 to apply for a Centers for Disease Control (CDC) and Prevention Community Transformation Grant.

- **Health Action Forum**, a community advocacy group that promotes health systems changes to improve access to care.

- **Health Disparities Coalition**, originally assembled as a Tobacco Coalition when Cigarette Restitution grant funds were first awarded to the County.

- **Improved Pregnancy Outcome Coalition (IPOC)**, established in 2008 as part of a Minority Infant Mortality Reduction Project.

- **Minority Outreach and Technical Assistance (MOTA)** Group at Bowie State University, formed when the Cigarette Restitution Funds were first awarded to the County and dedicated to meeting the needs of minority populations.

- **Port Towns Community Health Partnership**, formed as part of a new initiative funded by Kaiser Permanente to improve the health of residents living in four historic port communities in the County.

- **Sexually Transmitted Infections Community Coalition (STICC of Metropolitan Washington, DC)**, a partnership of over thirty public and private stakeholders with a common interest to reduce the impact of HIV and other sexually transmitted infections (STIs) in the community.

- **Comments from participants at a symposium entitled "Health √ (Check), The Prognosis for Prince George's County",** held at Prince George's Community College on October 1, 2011 and sponsored by the National Harbor Chapter of Jack and Jill of America, Inc., Prince George's County Council Chair Ingrid M. Turner, and M-NCPPC Parks and Recreation. Over 100 people attended the symposium, where a draft of the County Health Improvement Plan was presented for public comment.

- **Feedback from the public** during the period when this Plan was posted on PGCHD Web site in October and November 2011.

The Health of Our Population and Health Care System–Where We Stand

A review of available County-specific health statistics shows that Prince George's County faces many challenges across a broad spectrum of health issues. Two significant themes are evident from the data analysis: disparities between minority and non-minority populations for many health conditions, and huge challenges related to access to care.

Key RAND REPORT Findings

Demographic

- Prince George's County is relatively affluent and highly diverse. The County has a large number of upper income Black residents and, compared to neighboring jurisdictions, the largest proportion of Hispanic and non-English speaking residents (second to Montgomery County).

- Many County residents commute outside the County (three in five work outside the County and one in five commutes more than 60 minutes to work). Compared to neighboring jurisdictions, County residents are least likely to live and work in the same county and most likely to work outside the state.
- In 2006, Prince George's County had a higher unemployment rate than any other neighboring jurisdiction except the District of Columbia.

- Among the County's seven Public Use Microdata Areas, communities varied widely for a number of socio-demographic characteristics; however, communities inside the Capital Beltway are more likely to be majority Black or Hispanic and lower income.

Health

- Compared to residents of the State and neighboring jurisdictions (except Baltimore City), Prince George's County residents were more likely to die from all reported causes of death combined, from five of the ten leading causes of death (heart disease, diabetes, accidents, septicemia, and kidney diseases), and from homicides and HIV/AIDS.

- County residents were significantly more likely to report that a health care provider told them they had a chronic condition than residents of Howard and Montgomery Counties and Maryland State.

- County residents were more likely to be overweight or obese than those in the District, Maryland State, and Baltimore, Montgomery and Howard Counties.

- Site specific (i.e. pancreas, ovaries, lungs) mortality rates from cancer are relatively high for Blacks in the County, while incidence rates are relatively low. This may indicate possible poor screening and detection rates for, and poor quality treatment of, identified cancers for Blacks as compared to Whites.

- The County has relatively high rates of asthma, obesity, HIV/AIDS, and homicide.

- Compared to surrounding jurisdictions, Prince George's County and the District of Columbia had the highest rates of infant mortality and low birth weight babies between the years 2000-2005.

Health Behaviors

- Compared to residents of neighboring jurisdictions, Prince George's County residents are less likely to drink heavily, less likely to exercise, more likely to smoke, and more likely to be overweight or obese. Within the County, however, those who are poor and less educated are more likely to drink heavily, smoke, not exercise, and not use seatbelts.

- In general, residents with more than a high school education reported more favorable health status on every measure except hypertension and overweight/obesity.

- Black County residents are less likely than Whites to report being vaccinated against flu and pneumonia, but more likely to report being tested for HIV, having received a mammogram within the last two years, and having had a cholesterol test within the past five years.

- Uninsured County residents use preventive care at sharply lower rates than insured residents.

Capacity and Access to Care

- An estimated 80,000 Prince George's County adult residents are uninsured, more than twice that of neighboring Howard County and approximately one-third more than in Montgomery County.

- Residents who lack health insurance are more likely than those with insurance to have no regular source of care, to miss care because of cost, and to have gone more than five years since their last dental exam (especially among Blacks).

- There is a shortage of primary care physicians (PCPs) in the County. Relatively few pediatricians practice in poor areas of the County, and adult PCPs and specialists are concentrated in more affluent areas of the County located outside the Capital Beltway and near hospitals.

- Prince George's County appears to have an adequate hospital capacity relative to population growth; however, the County has a lower per capita supply of medical/surgical, obstetric, pediatric, and psychiatric beds as well as a lower per capita supply of emergency department (ED) treatment slots as compared to other jurisdictions.

- County residents use ED capacity more intensively than residents of other jurisdictions.

- The County lacks an adequate and comprehensive primary care safety net. Only one federally qualified health center (Greater Baden Medical Services) is headquartered in the County.

Patterns of Hospital and Emergency Department Use

- The County has higher rates of ambulatory care-sensitive hospitalizations and ED visits than surrounding jurisdictions.

- Prince George's County residents are more likely to leave the County for hospital and emergency care than are residents of Montgomery County and the District of Columbia.
- Prince George's Hospital Center discharges a disproportionate share of Medicaid patients, suggesting that it serves as a de facto safety net provider.

Other Pertinent Health Statistics (Highlights)*

- **Overall Health Ranking and Health Disparities:** Data from the County Health Rankings Report ranks Prince George's County 17 out of 24 among Maryland counties (24 being the lowest score). The 2010 report gives the County an overall comparative poor health ranking for the following:

    - death rates before the age of 75
    - the percentage of people who reported being in fair or poor health
    - the number of days people reported being in poor physical health
    - smoking, obesity, and binge drinking
    - receipt of clinical care
    - violent crime and liquor store density
    - unemployment rates and the number of children living in poverty
    - air pollution levels and access to healthy foods.

According to the *Maryland Department of Health and Mental Hygiene (DHMH) Vital Statistics Administration (VSA) Report*, the leading causes of death in 2009 for Prince George's County included:

Cause of Death	Ranking (Leading Causes of Death)
Diseases of the Heart	1st
Malignant Neoplasms	2nd
Cerebrovascular Diseases	3rd
Diabetes Mellitus	4th
Accidents	5th
Assaults (Homicides)	8th
Influenza and Pneumonia	11th
HIV	12th
Essential Primary Hypertension and Hypertensive Renal Disease	15th

The *2009 Maryland Chartbook of Minority Health and Minority Health Disparities* combined 2002-2006 data showed that Blacks or African Americans in Prince George's County had higher mortality rates than Whites for all-cause mortality and for six of the top eight causes of death (exceptions were chronic lung disease and liver disease). The mortality ratio disparity was greatest for HIV and kidney disease where Blacks or African Americans had 4.3 times the HIV death rate and 2.4 times the kidney disease death rate of Whites.

- **Chronic Diseases and Related Conditions**:

***Overweight/Obesity**:* The percentage of overweight or obese County residents is among the highest in the State of Maryland and nation and has steadily increased since 1995 for both adults and children. From 1995-2007, the number of County residents that were obese increased by 13%. Prince George's County and one other county had the highest obesity rates in the state (69%) in 2007, and *Behavioral Risk Factor Surveillance System (BRFSS)* data for 2010 shows this to have slightly increased to 70%. Among children up to age 18, 48% are at risk for obesity and are currently overweight. African Americans are disproportionately affected by obesity. The 2008 BRFSS data shows that 76% of Africans Americans were either overweight or obese, as compared to 62% of Whites.

Diabetes: According to the *Maryland VSA Reports*, 12% of County residents are diabetic. Significant disparities exist in the County regarding death rates due to diabetes. The age-adjusted death rate for diabetes in County African Americans is 47.1 per 100,000 versus 21.9 per 100,000 for Whites. This is significantly higher than the Maryland age-adjusted diabetes death rates of 34.3 per 100,000 for African Americans and 21.7 per 100,000 for Whites. The 2009 Vital Statistics report indicates that Prince George's County had the highest number of diabetes deaths in the State (197), followed by Baltimore City (196) and Baltimore County (192).

According to the *2009 Maryland Pregnancy Risk Assessment Monitoring System Report*, 10% of women self-reported that diabetes was a complication during pregnancy. Within the Prince George's County Health Department maternity clinics, in 2010, 100 clients (17%) were diagnosed with gestational diabetes. Women who have had gestational diabetes have a 35 to 60 percent chance of developing diabetes in the next 10 to 20 years, and 5 to 10% of women with gestational diabetes are found to have Type 2 diabetes immediately after pregnancy.

Cardiovascular Disease and Related Risk Factors: Cardiovascular disease is the leading cause of death in Prince George's County and a key contributor to the County's racial gap in life expectancy. Twenty-eight percent of County residents have cardiovascular disease. According to DHMH's Vital Statistics Administration and Family Health Administration, the County's 2008 age-adjusted death rate from heart disease was disproportionately higher than the Maryland rate (280.4 versus 252.8 per 100,000). For African Americans, the age-adjusted death rate was 338.4 per 100,000 compared to 228.7 per 100,000 for Whites.

A comparison of BRFSS data from 2009 and 2010 shows that rates for selected chronic disease risk factors had an increasing trend in the County:

Risk Factor	2009	2010
Ever told you had a stroke?	1.2%	1.6%
Ever told you had diabetes?	10.9%	11.9%
Did not meet the Healthy People 2010 objective for moderate or vigorous physical activity.	56.5%	62.0%

Cancer: Malignant neoplasms (cancers) are the second leading cause of death among County residents. The County's 2008 age-adjusted mortality rate for all malignant neoplasms was 175.9/100,000 population, with disparities again appearing among African Americans. Their age-adjusted mortality rate was 202.2/100,000 compared to 151.6 deaths/100,000 for non-Hispanic Whites. African American women also have higher breast cancer mortality than White women – 38.3 deaths/100,000 versus 17.3/100,000. The prostate cancer death rate for African American men was higher (43.2/100,000) than that for White men (23.7/100,000). Disparities also exist for African Americans with regard to colorectal cancer, pancreatic cancer, and liver and biliary cancer.

The 2010 BRFSS survey shows that 22.7% of County residents ages 50+ have not had a sigmoidoscopy or colonoscopy, 25% of males ages 50+ have not had a Prostate Specific Antigen (PSA) test or digital rectal exam, 49.8% of people have never use sunscreen lotion with sun protection factor (SPF) 15 or higher when outdoors, and 15.4% of women ages 40+ have not had a mammogram or breast exam.

Tobacco Use: In Prince George's County, 12% of youth ages 18 and younger smoke, as do 16% of adults ages 19 and older according to the 2010 County Health Rankings Report. The percentage of African Americans in the County who currently report smoking cigarettes daily is 4% compared to 16% of Whites.

Asthma: The *September 2009 DHMH Asthma Profile* indicates that between the years 2004-2006, approximately 15% of County adults had been diagnosed with asthma and approximately 8% reported currently having asthma. In 2006, over 6,000 asthma-related ED visits and over 1,300 hospitalizations occurred among County residents. The asthma ED visit rate was four times higher among Black residents than among White residents and the hospitalization rate was approximately three times higher among Blacks than Whites.

- **Infant Mortality**: The current infant mortality rates for the County demonstrate that racial disparities still exist. The 2009 infant mortality rate for Blacks in the County was 11.1 per 1,000 live births, twice that for Whites (6.0) and Hispanics (6.0). Of note, the Hispanic infant mortality rate of 6.0 increased from 3.3 in year 2008. The County's overall infant mortality rate significantly declined between 2000-2004 and 2005-2009, and the infant mortality rate for Blacks significantly declined between 2008-2009; however, the infant mortality rate for Blacks has remained consistently higher than for Whites for a number of years.

- **Low Birth Weights:** Between the years 2000-2005, Blacks had the highest percentage of low birth weight babies in the County. In 2009, Blacks continued to have more low birth weight infants as compared to Whites and Hispanics: 8.0% for non-Hispanic Whites, 12.3% for Blacks, and 7.3% for Hispanics.

- **Late or No Prenatal Care:** In 2009 Prince George's County had the highest percent in Maryland of women of all ethnic backgrounds who received late or no prenatal care, and again, the data shows disparities: 7.7% of non-Hispanic Whites, 11.2% of Blacks, and 11.7% of Hispanics.

- **Substance Abuse**: It is estimated that 8% of the County's population has a chronic alcohol or other drug use problem. The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that roughly 7% of County residents used an illicit drug in the past month. Year 2009 BRFSS data indicates that over 45% of residents used alcohol within the past 30 days, with 6% reporting binge drinking. Among youth, substance abuse is a cause for concern. The Center for Substance Abuse Research (CESAR) 2008 data shows that 3.5% of County crashes and 5% of County fatal crashes involved alcohol or drug impaired drivers ages 16-20, and over 12% of youth ages 12-20 reported binge drinking in the past month. Between July 2008 and June 2009, over 3,700 County residents were enrolled in substance abuse treatment.

- **Domestic Violence:** In 2009, 1,073 domestic violence cases were reported in Prince George's County, the fifth highest number among all Maryland counties. While the number of domestic violence related deaths in the County have steadily declined every year since July 2006, between July 1, 2007-June 30, 2010, 21 individuals died as a result of domestic violence. In a four year period of time, the Domestic Violence Advocate Unit at the Prince George's County Sheriff's Department saw a significant increase in the number of domestic violence victims referred to them for services, from 274 in 2007 to 3,675 in 2010.

- **HIV/AIDS**: According to data from the Infectious Diseases Environmental Health Administration (IDEHA) of DHMH, Prince George's County Maryland is ranked second in the State for the number of AIDS and HIV cases. As of December 31, 2009, there were 5,463 total living HIV and AIDS cases in the County. The County's 2008 HIV prevalence rate was 666 per 100,000 as compared to compared to 515 per 100,000 for the State of Maryland. At the end of 2009, Prince George's County accounted for approximately 65% of all AIDS cases in Suburban Maryland.

  African Americans and other minorities in Prince George's County are disproportionately affected by HIV infection. Data through December 31, 2009 indicates that African Americans account for almost 88% of total living HIV cases, Hispanics account for 4.7% of total living HIV cases, and Whites represent 6.6% of total living HIV cases. The majority of the HIV cases occur in communities (zip codes) adjacent to the District of Columbia inside the Capital Beltway.

- **Other Sexually Transmitted Infections (STIs):** IDEHA data shows that in 2010, Prince George's consistently reported the highest number of cases in Maryland (excluding Baltimore City) of chlamydia, gonorrhea, and primary and secondary syphilis. Rates for these diseases were reportedly almost twice that of rates for the State of Maryland. Chlamydia and gonorrhea cases in the County were highest for those in age group 15-19 in 2008 (DHMH). This data has implications for HIV prevention based on the fact that persons infected with an STI are up to five (5) times more likely to get infected with HIV, if exposed. Conversely, those infected with HIV can transmit HIV more easily when having an STI.

- **Tuberculosis (TB):** According to the *2009 Maryland VSA Report*, there were 7 deaths in the State due to tuberculosis, 3 of whom were among Prince George's County residents. In 2010, Prince George's County was second in the state of

Maryland for TB Cases behind Montgomery County. Seventy-two percent (72%) of TB cases in Prince George's County occur in foreign-born clients. The TB Control Program exceeds the State of Maryland TB control objective of providing Directly Observed Therapy (DOT) services to at least 90% of TB cases.

- **Immunizations and Seasonal Flu Shots:** From 2007 to 2009, Prince George's County's vaccine coverage estimates among children 19-35 months of age were generally higher than those for the rest of the State of Maryland and Baltimore City in the National Immunization Survey. The County's vaccine coverage rates also increased in the most recent survey of the last two years, with over 95% of children ages 19-35 months being protected against diphtheria, tetanus, pertussis, haemophilus influenzae, hepatitis B, varicella and pneumococcal diseases. Prince George's County Health Department (PGCHD) Immunization Clinics serve approximately 5,000 children each year.

  Reliable PGCHD data on the administration of seasonal/H1N1 flu shots is not available due to problems with establishing an electronic data base in the 2009-2010 County-wide flu campaigns and subsequent loss of some data; however, the BRFSS data for 2009 shows that only 33.5% of County residents stated they had received a flu shot in the past year. This number only slightly improved in 2010 to 36.6%. Neighboring counties and the State of Maryland had markedly higher percents of their populations stating they had received a flu shot in the 2010 BRFSS survey - Montgomery County (48.6%), Howard County (47.7%), Anne Arundel County (43.3%) and the State of Maryland (43.0%). In sampling 58 out of 200 schools and 3 public clinics where flu shots were administered in Prince George's County during the 2009-2010 campaign, (a total of 1533 vaccinations given), the demographic data showed that 42.5% of vaccinations given were to African Americans, followed by 35% to Hispanics, 11% to Whites, 4% to Asians, and 1.6% to Native Americans in the County.

- **Motor Vehicle Accidents, Assaults (Homicides), and Intentional Self-Harm (Suicides):** The *2009 Maryland VSA Report* shows that Prince George's County had the highest number of deaths due to motor vehicle accidents in the State (94) and the second highest number of deaths (behind Baltimore City) due to homicides (99). Thirteen deaths by accident were among adolescents ages 10-19, ten of whom were Black adolescents and three were White. Twelve of the homicides were among adolescents ages 10-19, and ten of these deaths were among Black adolescents. The County also had the third highest number of suicides (57), after Baltimore County (88) and Montgomery County (66). Of the deaths by intentional self-harm, 2 were among adolescents ages 10-19, and both were White. Between 2000-2004, 374 young people committed suicide in Maryland, 51 of whom were Prince George's County residents (approximately 6/100,000).

- **Fall-Related Injuries and Drownings:** According to the 2008 statistical report on injuries in Maryland, Prince George's County ranked 3rd in the State for the number of injury-related emergency department visits (over 60,000), of which 12,501 were fall-related, and 5th in the State for the number of hospitalizations (1,728 fall-related). There were 55 fall-related deaths in 2008, 51 of which were among individuals ages 45 and over. According to the 2010 BRFSS Survey, 5.4% of County residents ages 45 and over fell once, and 2.1% fell twice in the past three months; of these falls, 27% of respondents said one fall caused an injury and 1.1% said two falls caused an injury. There were 14 drownings in 2008, four among individuals ages 0-24 and ten among individuals ages 35 and over.

- **Alzheimer's Disease:** According to the Maryland VSA 2007-2009 data, the County's age-adjusted death rate due to Alzheimer's disease was 19.2/100,000 population, higher than the State's death rate of 16.9/100,000, and 6th highest in the State. In 2009, there were 87 deaths due to Alzheimer's disease.

- **Dental Health:** 2010 BRFSS Survey data shows that 14.1% of County residents went two years or more since last visiting a dentist for any reason. Over 65% of County residents indicated they had never had a test or exam for oral cancer or mouth cancer and over 14% of County residents went two years or more since their last teeth cleaning.

- **Access to Care – Health Care Resources:** Only one federally qualified health center (FQHC), Greater Baden Medical Services (GBMS), has its headquarters in the County. It provides comprehensive primary care medical services at five locations. One of these sites, Suitland Health and Wellness Center, represents a partnership between PGCHD and GBMS. In 2007, GBMS provided care to approximately 5,200 uninsured patients.

  In recent years, Community Clinics, Inc. (CCI), a federally qualified health center based in Montgomery County, established a Women, Infants, and Children (WIC) distribution center and a family planning clinic at its Greenbelt location in Prince George's County. In addition, Mary's Center, Unity Health Clinics, and several non-FQHC safety net clinics located in neighboring jurisdictions provide care to County residents. However, 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 are federally designated as medically underserved areas or underserved populations. When comparing Prince George's County's health resources to those of neighboring jurisdictions, the differences are remarkable:

Jurisdiction	Number of Uninsured Under Age 65*	Number of Safety Net Clinics	Number of Primary Care Physicians per 100,000 Population (2010)**
Prince George's County	149,038	5	95
Montgomery County	123,741	11	217
Baltimore City	77,570	44 ***	191
Washington, D.C.	61,680	38 - 40	241.6****

* Small Area Health Insurance Estimates for Counties, 2007
** County Health Rankings Report, 2010
*** Mid-Atlantic Community Health Center Association (1/2009)
**** RAND Report (Area Resource File 2005 and U.S. Census Bureau)

- **Individuals with Special Needs**: A substantial number of Prince George's County residents are individuals with special health needs. This includes individuals with intellectual and developmental disabilities (i.e. autism, cerebral palsy, Down Syndrome), individuals who develop or acquire disabilities after the age of 21 (i.e. multiple sclerosis, traumatic brain injury), individuals with mental illnesses, veterans with health conditions acquired as a result of their service in Iraq, Afghanistan, the Persian Gulf War and other wars/conflicts), blind/visually impaired individuals, deaf/hearing impaired individuals, and the homeless.

  Currently there are approximately 1,850 Prince George's County residents with intellectual and developmental disabilities who are receiving State funded services from the Developmental Disabilities Administration (DDA). As of October 2011, there were 1,104 individuals on the waiting list for services from DDA. In fiscal year 2010, 835 families in Prince George's County applied for services from the Low Intensity Support Services Program, which provides up to $3,000 during a fiscal year to assist families with smaller needs; between these two programs, Prince George's County was able to serve 522 individuals and families.

  In fiscal year 2011, PGCHD's Infants and Toddlers Program served 1656 children ages 0-4 with developmental disabilities, and the PGCPS' September 30, 2010 enrollment data indicated that 14,381 students, or 11.4% of the student population, were children with disabilities (Maryland State Department of Education [MSDE], Maryland Special Education/Early Intervention Services Census Data and Related Tables, October 29, 2010). In school year 2009-10, there were 1,192 placements of students with disabilities in non-public school settings.

  The number of County residents with mental illnesses and the number of homeless individuals in Prince George's County are both difficult to quantify. However, according to the SAMHSA 2008-2009 data, 16.71% of Marylanders ages 18+ reported a diagnosed mental illness in the past year; this translates to 144,277 Prince George's County residents with mental illnesses. The Prince George's County Department of Family Services (PGCDFS) Mental Health and Disabilities Administration reported that 10,792 individuals in Prince George's County were served in the Public Mental Health System in fiscal year 2011.

A "Point-in-Time" survey (one-day street count) of sheltered and unsheltered homeless individuals and families completed in partnership with the Council of Governments and eight other counties and cities in the Washington Metropolitan area indicated that in fiscal year 2011, 773 individuals in the County were homeless. Data from the Canadian Post-M.D. Education Registry shows that in fiscal year 2011, 6008 individuals and families in Prince George's County requested shelter assistance, and 1932 received shelter. The County currently funds three emergency shelters and one hypothermia overnight shelter for homeless people.

According to the Columbia Lighthouse for the Blind and Visually Impaired, there are approximately 11,000 County residents who are blind or visually impaired. This data reflects the number of individuals with self-declared eye issues related to all the leading causes of blindness and visual impairment. The National Institutes of Health and Johns Hopkins University estimate that between one in five and one in seven individuals in the U.S. are deaf or hearing impaired; these estimates translate to 123,346-172,684 deaf or hearing impaired Prince George's County residents.

According to the *U.S. Census Bureau State and County QuickFacts* for 2005-2009, there were 66,256 veterans residing in Prince George's County. The number of these veterans with special health care needs related to their service is unknown; however, the physical, mental, and emotional injuries and disabilities among veterans, particularly those who served in the Vietnam and Persian Gulf wars, Iraq, and Afghanistan, are well documented. Homelessness among veterans is also a problem; in fiscal year 2011, the County served 82 homeless veterans.

- Additional County-specific health data can be found at the DHMH Web site (see State Health Improvement Process [SHIP]) at:

  http://dhmh.maryland.gov/ship/measures.html .

Plan Development, Monitoring, and Evaluation

Selection of the Priorities, Objectives, and Strategies included in this Plan took into consideration:

- PGCHD's federal, state, and local mandates for provision of services and programs and its available resources (funding and personnel) to implement strategies.
- The capacity of existing and potential community partners to share responsibility for meeting our health objectives
- The commitment of local political leaders (i.e. Board of Health) to monitor progress towards meeting our objectives and to consider health implications when making policy decisions and adopting legislation.
- Evidence-based best practices that address our objectives.
- National and statewide public health strategies for reducing HIV infection.

The first six Priorities with their corresponding Objectives and Strategies are in alignment with the Maryland State SHIP Vision Areas 1-6; however, we have re-arranged the Priorities in descending order according to the extent to which the health concerns they address impact the broader community, demonstrate major disparities, and/or pose longstanding, complex challenges to their prevention and control in our County. The "County-Specific Health Priorities" address broader issues related to health care infrastructure, workforce, and systems issues of particular concern to County stakeholders. In no way do the Strategy statements reflect the totality of work that the Health Department and stakeholders listed in this Plan perform; rather, they represent substantive efforts, collaborative arrangements, and new approaches. It is important to note that for a number of Strategies to be implemented, a considerable infusion of new funding will be required, as well as the establishment of new and non-traditional partnerships.

To ensure that the County Health Improvement Plan is implemented and evaluated in terms of progress towards meeting the Plan's Health Objectives, the Health Department will establish a Prince George's Healthcare Action Coalition (PGHAC) lead by the Health Officer and comprised of critical stakeholders and consumers representing all major segments of the health care delivery system. Existing coalitions will be invited to serve as adjunct members of the PGHAC, lending their "content expertise" as it relates to each Priority.

The purpose of the PGHAC will be to assist the Health Officer as follows:

- developing an action plan for carrying our and evaluating the County Health Improvement Plan that includes a timeline, responsible agencies/individuals, and success measures

- developing a framework (methods, materials, and timeframe) for gathering pertinent data from each partner involved in implementing the Plan's strategies, for evaluation and reporting purposes

- monitoring all activities related to the County Health Improvement Plan to ensure that all aspects of the Plan are carried out in a coordinated fashion among the responsible agencies and individuals

- maintaining communications among partner agencies, adjunct coalitions, and individuals regarding all matters related to the County Health Improvement Plan and the local health planning process

- identifying when new partnerships are needed to carry out the Plan and assisting in establishing those partnerships

- advising the Health Officer when barriers to the Plan's implementation and evaluation arise and resolutions are needed, or when new health issues emerge that may impact the Plan.

- preparing information for the media, local political and community leaders, researchers, and the public regarding progress made towards improving the health status of the County

- coordinating public meetings or forums when needed to obtain input from County residents and health care consumers into the Plan and the health planning process

- coordinating the adoption of health information technology among all partners to enhance provider communication and improve the delivery of care to County residents.

Priority 1: **Ensure that Prince George's County Residents Receive the Health Care They Need, Particularly Low Income, Uninsured/Underinsured Adults and Children.**

(Corresponds with SHIP Vision Area 6: Ensure that Marylanders Receive the Health Care They Need)

County Outcome Objective	Current Baseline	2014 Target
Increase life expectancy in Prince George's County	77.5 years (life expectancy at birth, VSA 2009)	81.4 years using 5% increase
Increase the proportion of persons with health insurance	82.2% (percentage of civilian non-institutionalized ages 18-64 with any type of health insurance, BRFSS 2008-2010)	91.1% using midpoint to Healthy People (HP) 2020
Reduce the proportion of individuals who are unable to obtain, or delay obtaining, necessary medical care, dental care, or prescription medications	15.8% (percentage of people who reported that there was a time in the past 12 months when they **could not** afford to see a doctor, BRFSS 2008-2010)	15% using 5% decrease
Increase the proportion of low income children and adolescents who receive dental care	57.8% (percentage of low income children ages 4-20 enrolled in Medicaid that received a dental service in the past year, Medicaid Calendar Year 2009)	60.7% using 5% increase
Increase the percentage of adults who visited a dentist within the past year	70.7% (percentage who visited a dentist for any reason in the past year, BRFSS 2010)	74.2% using 5% increase
Reduce the proportion of preventable hospitalizations related to Alzheimer's disease and other dementias	11.5 (rate of hospital admissions [inpatient + outpatient] related to dementia/Alzheimer's per 100,000 population, Health Services Cost Review Commission [HSCRC] 2010)	10.9 - rate using 5% decrease

Note: A number of these strategies also address Priority 3.

Increasing Enrollment of Adults and Children in Medicaid, HealthChoice/Maryland Children's Health Program (MCHP), and Other Health Programs

Strategy 1: Improve the timely processing of HealthChoice/MCHP applications for pregnant women and children, enhance customer service to clients at the PGCHD's Regional Access Center, and continue to follow up on incomplete applications.

Strategy 2: Establish quick screening and prequalification processes that expedite eligible clients' enrollment in HealthChoice/MCHP and other government-sponsored health programs.

Strategy 3: Educate the public and providers about the eligibility requirements for the HealthChoice/MCHP, Medicaid Families and Children, Primary Adult Care, and Maryland Family Planning Programs, using methods and venues that target hard-to-reach women and children.

Strategy 4: Continue collaboration among the PGCHD's MCHP Program and other programs serving women and children (Healthy Start, Health*line*, Healthy Women/Healthy Lives, etc.) to identify potentially eligible clients and streamline their entry into HealthChoice/MCHP.

Strategy 5: Maintain communications between the PGCHD's MCHP Eligibility unit and the Prince George's County Department of Social Services (PGCDSS) to ensure that pregnant women and children receive a timely determination of eligibility.

Strategy 6: Place Medical Assistance eligibility/enrollment workers at strategic clinic sites (i.e. FQHCs).

Strategy 7: Increase awareness among the public and agencies serving children about the Kaiser Care for Kids Program that serves children ages 0-18 who are ineligible for MCHP; focus on reaching the Spanish-speaking community and families with undocumented children.

Strategy 8: Identify funding to adequately staff the Kaiser Bridge Program, and increase public awareness of the Program through widespread dissemination of informational materials and expansion of outreach efforts into non-traditional settings (i.e. unemployment offices, churches, non-profit organizations) where potentially eligible and hard-to-reach individuals seek services.

Increasing Linkage to Care

Strategy 1: Continue widespread dissemination of informational materials promoting the Health*line* Program that links pregnant women and children into care and expansion of outreach efforts into non-traditional settings (i.e. thrift stores, pawn shops, small strip mall businesses) to identify hard-to-reach individuals needing Health*line* services.

Strategy 2: Seek additional funding to enhance Health*line*'s capacity to assist clients having problems with their HealthChoice/MCHP providers and difficulty complying with appointment keeping, and to maintain communications with providers to improve the provision of health services and resolve barriers to care for enrollees.

Strategy 3: Work towards establishing a single-point-of-entry health and human services center that provides "one-stop shopping" (per the 2013 Capital Improvement Plan) for individuals needing primary health care and other services.

Strategy 4: Seek funding to create community patient navigators who facilitate access to a medical home and specialty care for individuals facing barriers to care.

Strategy 5: Explore funding to support the addition of public health nurses and/or social workers at low-income housing complexes to expedite residents' access to services.

Strategy 6: Work with the Medical Society, Board of Physicians, Board of Pharmacy and other medical associations to identify ways to increase access to dental, vision, and medical care (including specialty care), and to low cost prescription medication.

Strategy 7: Explore ways to increase the number of urgent care centers in the County to reduce inappropriate used of hospital emergency departments.

Strategy 8: Provide up-to-date information to the public about the services available through existing FQHCs and other safety net clinics.

Increasing Health Literacy

Strategy 1: Educate health care providers and the public about available health literacy tools that enable individuals to access and understand health information, navigate the health care delivery system, and participate in decision-making about their own health care.

Strategy 2: Expand the use of modern technology such as social media outlets and mobile phones to communicate health information to the public and clients, particularly to individuals without internet access.

Strategy 3: Partner with the University of Maryland School of Public Health (UMDSPH) to conduct research on ways to advance the health literacy of County residents.

Enhancing School-Based Health Care and Dental Health Services

Strategy 1: Assess all students seen at the County's four School-Based Wellness Centers (SBWCs) funded through Prince George's County Department of Family

Services (PGCDFS) for their health insurance status and history of annual physical exams; provide students who lack a primary care provider/insurance with an annual physical exam (and risk assessment), and refer them to MCHP, Kaiser Care for Kids Program, and dental providers willing to accept uninsured children.

Strategy 2: Seek funding to establish dental case management services in the four SBWCs and in existing community dental health programs to ensure that children and adults without a dental provider are linked to dental care.

Strategy 3: Work with Kaiser Permanente to pilot a project to provide on-site dental care to the students attending Bladensburg High School and its three feeder elementary and middle schools.

Strategy 4: Continue educating parents, the public, school officials, and others about the importance of early intervention in preventing dental problems and the low cost dental services available in the community, including the Deamonte Driver Dental Project (mobile van) and the dental care pilot project at Bladensburg High School.

Strategy 5: Develop and disseminate oral health messages for adults that stress the link between chronic diseases, infant mortality and oral health.

Strategy 6: Work with community partners to enhance the network of dental providers willing to treat Medicaid insured and uninsured children and adults in the County.

Strategy 7: Seek funding for existing safety net clinics to provide dental services to uninsured/underinsured adults and children.

Strategy 8: Continue serving on the Maryland Dental Action Coalition to advocate for increased Medicaid reimbursements for dental services, and to identify ways to improve the oral health of County residents through increased prevention, education, advocacy, and access to oral health care.

Addressing Alzheimer’s Disease

Strategy 1: Partner with the National Capital Area Chapter of the Alzheimer’s Association to provide widespread public information about the ten warning signs of Alzheimer’s, the importance of early detection and intervention, and the steps individuals with Alzheimer’s and their families/caretakers can take to enhance the quality of their care and safety of their environment.

Strategy 2: Work with the PGCDFS Aging Services Division to identify additional strategies for providing seniors who have Alzheimer’s or other dementias with information and services that enable them to better manage their disease and maintain maximum independence.

*Improving Health Care for Individuals with Special Needs**

* Also see Priority 2, Enhancing Access to Mental Health Services

Strategy 1: Continue collaboration between the PGCHD's Infants and Toddlers Program, The Arc, the PGCDFS, the Prince George's County Public Schools (PGCPS) Special Education Program, the Family Service Foundation, and other agencies serving County residents with intellectual and developmental disabilities to develop a consolidated multi-agency plan that outlines strategies and partnerships needed to address gaps in the delivery of health care to individuals with special needs.

Strategy 2: Continue assisting families of children enrolled in the Infants and Toddlers Program to ensure that children ages birth to three with special needs have updated immunizations and a medical home.

Strategy 3: Work with partner agencies serving individuals with disabilities to educate the public about the challenges they face in receiving health care, to increase public acceptance and support of persons with disabilities, and to eliminate the stigma associated with disabilities; enlist the faith community, local businesses that employ persons with disabilities, and other traditional and non-traditional partners in this effort.

Strategy 4: Identify a cadre of health care professionals (i.e. OB-GYNs and other physicians, nurses, dentists, physical therapists, nutritionists, social workers) willing to participate in training to increase their understanding of the unique needs of individuals with disabilities and to adapt their medical practices to better serve this population.

Strategy 5: Train health care providers to look for signs and symptoms of stress among their patients who are family members and caregivers of persons with special needs and to refer them to appropriate support services.

Strategy 6: Work with residential care providers to identify ways to make the environment healthier for and more supportive of the adoption of healthy lifestyles among individuals with special needs; offer educational programs that address the health care needs of direct care staff.

Strategy 7: Update the PGCHD's Community Services Guide-at-a-Glance to include agencies and programs that serve individuals with special needs; disseminate the Guide to community providers and agencies for use as a tool in linking clients with special needs and their families to available resources; ensure that these resources are made known to families by posting the information on agency Web sites and in their publications.

Strategy 8: Ensure that the Prince George's Healthcare Action Coalition (PGHAC) includes providers that serve populations with special needs and community advocates; establish a work group that focuses on improving care to individuals with special needs to reduce their risk for chronic diseases, dental problems, unintended pregnancy, sexually transmitted and other communicable diseases, sexual abuse, and substance abuse.

Strategy 9: Partner with PGCDFS Commission for Veterans, PGCDSS, the Homeless Services Partnership, the Salvation Army, and other organizations and agencies serving veterans and the homeless to identify ways to improve health service delivery to these populations.

Strategy 10: Increase public awareness of the County's Homeless Hotline which links individuals who are homeless or at risk of homelessness to needed services, as well as the 211 (Homelessness Prevention) Hotline, which assists individuals before they become homeless by providing mortgage/rental assistance and referral to other support services.

Strategy 11: Partner with the Columbia Lighthouse for the Blind and Visually Impaired, the Family Service Foundation, Gallaudet University, and other organizations serving blind/visually impaired and deaf/hearing impaired individuals to identify ways to improve health service delivery to these populations.

Strategy 12: Continue supporting the PGCDFS Mental Health and Disabilities Division's programs that serve individuals with mental illnesses and individuals in psychiatric crisis, particularly where collaborative agreements among community service providers are essential.

Strategy 13: Partner with PGCDFS, the Mental Health Association of Prince George's County, the National Alliance for the Mentally Ill, On Our Own, and other organizations serving individuals with mental illnesses to identify ways to improve health service delivery to this population.

Key Partners: The Arc, Board of Pharmacy, Board of Physicians, Columbia Lighthouse for the Blind and Visually Impaired, Community Clinics, Inc., community medical and dental providers, Deamonte Driver Dental Project, Dimensions Healthcare System, Doctors Community Hospital, Family Service Foundation, Forestville Pregnancy Center, Gallaudet University, Greater Baden Medical Services, Homeless Services Partnership, Improved Pregnancy Outcome Coalition, Kaiser Permanente, low-income housing complexes, managed care organizations, Maryland Dental Action Coalition, Mary's Center, Medical Society, Mental Health Association of Prince George's County, National Alliance for the Mentally Il, National Capital Area Chapter of the Alzheimer's Association, On Our Own, Pregnancy Aid Center, Prince George's County Commission for Persons with Disabilities, Prince George's County Department of Family Services, Prince George's County Department of Social Services, Prince George's County Health Department, Prince George's County Public Schools, residential care providers, Salvation Army, Southern Maryland Hospital Center, University of Maryland School of Public Health.

Priority 2: **Prevent and Control Chronic Disease in Prince George's County, Particularly Among Minorities.**

(Corresponds with SHIP Vision Area 5: Prevent and Control Chronic Disease)

County Outcome Objective	Current Baseline	2014 Target
Reduce deaths from heart disease	Overall rate - 224.2 (rate of heart disease deaths per 100,000 population (age-adjusted), VSA 2007-2009) White rate - 195.5 Black rate - 221.0 Hispanic rate - 66.4 Asian rate - 96.0	Overall rate - 188.5 using midpoint to HP 2020 White rate - 174.1 using midpoint to HP 2020 Black rate - 186.9 using midpoint to HP 2020 Hispanic rate - 63.1 using 5% decrease Asian rate - 91.2 using 5% decrease
Reduce the overall cancer death rate	Overall rate - 173.8 (rate of cancer deaths per 100,000 population [age-adjusted], VSA 2009) White rate - 199.0 Black rate - 181.9 Hispanic rate - 70.9 Asian rate - 87.0	Overall rate -167.2 using midpoint to HP 2020 White rate - 179.8 using midpoint to HP 2020 Black rate - 171.3 using midpoint to HP 2020 Hispanic rate - 67.4 using 5% decrease Asian rate - 82.7 using 5% decrease
Increase the proportion of adults who are at a healthy weight	28.6% (percentage of adults at a healthy weight [not overweight or obese], BRFSS 2008-2010) White Non-Hispanic - 39.6% Black - 13.0% Hispanic - 23.0% Asian - Not Available	30% using 5% increase White Non-Hispanic - 41.6% using 5% increase Black - 13.7% Hispanic - 24.2%
Reduce the proportion of children and	16.1% (percentage of youth ages 12-19 who are obese, MYTS 2008)	15.3% using 5% decrease

adolescents who are considered obese		
Reduce hypertension-related emergency department visits	Overall rate - 257.7 (rate of ED visits for hypertension [inpatient + outpatient] per 100,000 population, HSCRC 2010) White rate - 101.8 Black rate - 341.7 Hispanic rate - 54.3 Asian rate - 67.6	Overall rate - 244.8 using 5% decrease White rate - 96.7 using 5% decrease Black rate - 324.6 using 5% decrease Hispanic rate - 51.6 using 5% decrease Asian rate - 64.2 using 5% decrease
Reduce diabetes-related emergency department visits	Overall rate - 308.4 (rate of ED visits for diabetes [inpatient + outpatient] per 100,000 population, HSCRC 2010) White rate - 179.5 Black rate - 388.2 Hispanic rate - 101.6 Asian rate - Not Available	Overall rate - 293 using 5% decrease White rate - 170.5 using 5% decrease Black rate - 368.8 using 5% decrease Hispanic rate - 96.5 using 5% decrease Asian rate - Not Available
Reduce drug induced deaths	6.1 (rate of drug-induced deaths per 100,000 population, VSA 2007-2009)	5.8 - rate using 5% decrease
Reduce tobacco use by adults	13.3% (percentage of adults who currently smoke, BRFSS 2008-2010) White Non-Hispanic - 16.8% Black - 17.8% Hispanic - 5.7% Asian - Not Available	12.7% using midpoint to HP 2020 White Non-Hispanic - 14.4% using midpoint to HP 2020 Black - 14.9% using midpoint to HP 2020 Hispanic - 5.4% using 5%

		decrease Asian - Not Available
Reduce the proportion of youth who use any kind of tobacco product	23.3% (percentage of high school students grades 9-12 that have used any tobacco product in the past 30 days, Maryland Youth Tobacco Survey 2010)	22.2% using midpoint to HP 2020
Reduce the number of ED visits related to behavioral health conditions	713.1 (rate of ED visits for behavioral health conditions [inpatient + outpatient] per 100,000 population, HSCRC 2010) White rate - 740.7 Black rate - 778.3 Hispanic rate - 2243.9 Asian rate - 151.4	677.4- rate using 5% decrease White rate - 703.7 using 5% decrease Black rate - 739.4 using 5% decrease Hispanic rate - 2131.7 using 5% decrease Asian rate - 143.8 using 5 % decrease

Increasing Access to Healthier Foods *

* Also see Improving Our Environment under Priority #5

Strategy 1: Adopt local policies requiring chain restaurants to provide menu labeling that gives consumers information on nutritional values of in-store menu selections.

Strategy 2: Educate local leaders, restaurant owners, and the public about menu labeling and its impact on selection of healthy food choices, using media outlets, community events, educational materials, and other venues/methods.

Strategy 3: Increase public demand for healthier food choices at restaurants and food markets through education and advocacy; partner with the Food Supplement Nutrition Education Program to assist with community education to low income and other at-risk communities.

Strategy 4: Seek funding for educational programs that link healthy nutrition to other desirable outcomes (i.e. healthy pregnancy, reduced incidence of chronic disease).

Strategy 5: Increase marketing of healthier foods, using the Get Fresh Baltimore model.

Strategy 6: Develop and disseminate culturally and linguistically appropriate informational materials to educate the public about healthy nutrition and its impact on the body, healthy food selection and preparation; enlist the support of local chefs and restaurateurs in this effort.

Strategy 7: Adopt local policies providing incentives (tax credits, grants, loan programs, etc.) to supermarkets that lower prices on healthier food products and to attract new supermarkets to underserved areas.

Strategy 8: Identify funding to provide incentives to stores that offer healthier food choices at low cost, and advertise these incentives to the public; help connect local farmers with food outlets so that locally grown foods can be offered everywhere.

Strategy 9: Collaborate with supermarket corporate offices and local store managers to explore ways to provide incentives to customers that encourage the purchase of healthier foods.

Strategy 10: Adopt local policies to discourage consumption of calorie dense, nutrient poor foods through the use of incentives, land use and zoning regulations that place restrictions on the number and location of fast food restaurants, particularly in high-risk communities.

Strategy 11: Promote local farmers' markets and seek to add farmers' markets in food desert areas; appeal to local farmers to come to inner-Beltway locations by promoting their safety and the ability to accept food stamps and Women, Infants, and Children (WIC) Program vouchers for payment.

Strategy 12: Increase the number of needy families that participate in federal, state, and local government nutrition programs such as WIC, the Food Stamps Program, School Breakfast and Lunch Programs, the Child and Adult Care Food Program, the Senior Nutrition Program, the Afterschool Snacks and Supper Program, and the Summer Food Service Program.

Strategy 13: Enlist the faith-based community in providing education about healthy eating and chronic disease prevention, and explore funding to install computers in local churches where parishioners can access health information from Web sites.

Strategy 14: Encourage County residents to eat locally grown foods and educate them on methods for growing their own food, including gardening techniques (i.e. composting) and establishing community gardens; involve schools, local farmers, and municipalities in this effort.

Strategy 15: Encourage prenatal care providers to include nutrition education that teaches pregnant women how to purchase and prepare healthier foods to improve their health and that of their families.

Promoting Physical and Recreational Activity

Strategy 1: Support the implementation of the PGCPS new Fitness-Gram Program in grades K-12, which provides an individualized physical fitness plan for each participating student.

Strategy 2: Work with the PGCPS School Wellness Councils and the Healthy Schools Program to advocate for the adoption of school policies that increase physical activity for students, promote healthier food and beverage choices in schools, and contribute to a healthier school environment in general.

Strategy 3: Seek funding to pilot the implementation of the M-NCPPC and PGCHD's Prescription-REC Program for County residents with high blood pressure and/or high cholesterol who have a "prescription" from their health care provider to start an exercise regimen.

Strategy 4: Explore innovative ways to increase opportunities for physical and recreational activity in communities, schools, workplaces including:

- offering incentives to developers to build safe, attractive parks, playgrounds and recreation centers
- establishing joint use of school and community facility agreements allowing playing fields, playgrounds, and recreation centers to be used by the public when schools are closed
- promoting youth athletic leagues and worksite walking and other physical activity programs
- adopting a policing strategy to improve safety and security at parks
- promoting a culture of "everyday" physical activity (i.e. taking stairs, walking during breaks and lunchtime)
- offering discounts to consumers as incentives to use existing public and private health clubs and recreational facilities.

Promoting Clinical, Self-Management, and Other Services That Address Chronic Conditions

Strategy 1: Promote innovative community programs that address chronic diseases such as the Gaston and Porter Health Improvement Center's Women's Health Institute and Prime Time Sister Circles Program, the Children's National Medical Center's Obesity Institute, Southern Maryland Hospital Center's Fit 'N Fun Program, Cardiac Risk Reduction Center, and the Diabetes Self-Management Education Program, and the Doctor's Community Hospital's Joslin Diabetes Center; establish a mechanism for community providers to refer their at-risk clients.

Strategy 2: Identify best practices for diagnosis and management of high blood pressure and encourage physicians to incorporate them into their practices, including the use of electronic health record (EHR) prompts (i.e. Veteran's Administration model).

Strategy 3: Identify funding for a public education campaign to reinforce the risks of high blood pressure and to promote measures to reduce/control high blood pressure, including diet, physical activity, and medical management.

Strategy 4: Seek partnerships with hospitals, physician groups, and interested community groups to provide diabetes self-management education to those who are uninsured/underinsured; utilize services of diabetes educators.

Strategy 5: Seek funding to establish diabetes case management services that link uninsured/underinsured individuals to medical care, education, and supplies; include a hotline for those who have short-term needs.

Strategy 6: Offer diabetes prevention programs in non-clinical settings (i.e. M-NCPPC programs, schools).

Strategy 7: Work with physician groups to identify those at risk for diabetes and provide prevention education, including use of EHR prompts.

Strategy 8: Work with the American Association of Diabetes Educators to seek funding to recruit and train more minority diabetes educators; develop culturally and linguistically appropriate diabetes educational materials for our diverse population.

Strategy 9: Provide an assessment and physical exam to all students seen at the four SBWCs that include screening for obesity/overweight, and referral for further clinical and/or self-management programs as needed.

Strategy 10: Update the PGCHD's *Community Services Guide At-A-Glance* to feature providers and programs that address obesity, diabetes, hypertension, smoking cessation, weight management, and physical activity; disseminate the Guide (via Web sites and mailings) to community providers and agencies (including libraries) for use as a tool in linking individuals with chronic conditions to needed clinical care and self-management programs.

Strategy 11: Explore with PGCDFS and Prince George's Community College expanding their joint Living Well Chronic Disease Self-Management Program (from Stanford University) to serve a greater number of County residents diagnosed with chronic diseases.

Strategy 12: Partner with holistic health practitioners and other complementary and alternative medicine (CAM) providers to identify ways to integrate CAM into conventional health care practices and to promote chronic disease prevention and wellness models that will assist County residents adopt positive lifestyle changes and increase their level of personal responsibility for improving their health status.

Enhancing Health Care Providers' Skills in Treating and Preventing Chronic Diseases

Strategy 1: Seek funding to expand the PGCHD's Center for Healthy Lifestyles Initiative (CHLI) and to establish a Healthy Futures Training Institute (HFTI) through the UMDSPH. CHLI and HFTI will provide training and technical assistance to health care institutions, organizations, and providers to incorporate into their routine patient care practices evidence-based interventions for the following: reducing/managing overweight and obesity through physical activity and nutrition; controlling hypertension, diabetes, and high cholesterol; reducing cardiovascular disease; and preventing/reducing tobacco use.

Strategy 2: Expand the PGHAC to include members representing communities experiencing high rates of heart disease and other chronic conditions; establish work groups within the Coalition to continually research best practices and ways to incorporate them into standards of care for high blood pressure, high cholesterol, cardiovascular disease, etc.

Preventing and Treating Cancer

Strategy 1: Continue providing breast and cervical cancer screening (and referral for treatment) to women ages 40 and over who are uninsured/underinsured and whose incomes are at or below the 250% poverty level through the PGCHD's Breast and Cervical Cancer Screening Program (BCCP); fully implement the Expanded BCCP Program which will also serve men.

Strategy 2: Continue providing colorectal cancer screening and referral to appropriate entitlement programs for follow-up treatment to individuals ages 50 and over and who are uninsured/underinsured through the PGCHD's Colorectal Cancer Prevention, Education, Screening, and Treatment Program (CPEST).

Strategy 3: Partner with the American Cancer Society, Susan G. Komen For the Cure, and other agencies addressing cancer to provide public education on cancer prevention and to encourage individuals to get recommended screenings (i.e. mammograms, colonoscopies, PSA tests); focus efforts on reaching African Americans and other minorities.

Strategy 4: Use the Maryland Comprehensive Cancer Control Plan as a guide for developing additional strategies to address cancer prevention, early detection and treatment, and disparities.

Strategy 5: Continue offering in the PGCHD's Immunization Clinics the Gardasil vaccine to males and females starting at age 11 to prevent genital warts caused by the human papilloma virus (HPV) and HPV-associated cancers (cancer of the cervix, vulva, vagina, penis, anus as well as head and neck cancer); continue educating the public about Gardasil's role in preventing genital warts and cancer.

Strategy 6: Seek funding to hire patient navigators who facilitate access to resources, financial assistance, transportation, and other needed services for individuals with breast and other cancers.

Increasing Public Awareness

Strategy 1: Work with community partners, the American Diabetes Association, American Heart Association, American Lung Association and other organizations to implement special initiatives that increase public awareness of measures to prevent chronic diseases and encourage adoption of healthier lifestyles.

Strategy 2: Develop and disseminate culturally and linguistically appropriate materials and messages about chronic disease prevention targeting the County's diverse populations, minorities and non-English speaking individuals.

Strategy 3: Place information on County agency and partner Web sites and in publications that provides tips for achieving a healthier lifestyle.

Creating Breastfeeding-Friendly Communities

Strategy 1: Establish a network of local hospitals interested in adopting practices to become baby-friendly; establish a network of OB/GYNs, family practice practitioners, and midwives who are supportive of breastfeeding and willing to promote it among clients and the community.
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Strategy 2: Encourage local employers, health care institutions, and child care settings to establish policies and programs that support worksite breastfeeding.

Strategy 3: Identify funds to conduct a multi-media campaign to improve public attitudes towards breastfeeding.

Strategy 4: Identify new venues where mothers seeking health and other services can be educated about the health benefits of breastfeeding for their infants and children and breastfeeding as a potential obesity prevention strategy.

Strategy 5: Establish a work group within the PGHAC that continually researches best practices for promoting breastfeeding in maternal health care settings (i.e. WIC, Family Planning, Nutrition, Early, Periodic, Screening, Diagnosis, and Treatment Programs) and the community.

Enhancing Access to Substance Abuse Treatment

Strategy 1: Continue implementing the Safety NET (Network for Entry into Treatment) Project that provides substance abuse treatment and education to adults and youth. This Program addresses substance abuse as a factor in criminal justice system entry and recidivism, and youth violence prevention.

Strategy 2: Continue implementing PLAN (Partnership for Learning Among Neighbors), an intensive assessment and re-integration program for detainees with co-occurring mental health and substance use disorders that place them at high risk for recidivism and poor health outcomes.

Strategy 3: Update agreements with the extensive network of public and private substance abuse treatment providers to ensure multiple pathways to care and to facilitate the seamless provision of screening, intake, referral, assessment, and treatment services for County residents.

Strategy 4: Increase the number of individuals in substance abuse treatment who belong to priority (highest risk, highest cost) populations that put other members of the general population at risk, including:

- parenting women and women of childbearing age, to reduce the risk for infant mortality, fetal alcohol syndrome, failure to thrive, and early initiation of alcohol, tobacco and other drug use (ATOD)
- injection drug users, to reduce the spread of HIV and hepatitis
- first-time marijuana users and DUI/DWI offenders, to reduce crash and non-crash injuries (i.e. falls and domestic violence) and ATOD-related deaths.

Strategy 5: Increase the number of individuals in substance abuse treatment who are at greatest risk for ATOD use by demographics or health status, including:

- Latinos, by offering more English-Spanish addiction treatment capability

- youth ages 12–16, who are retained in treatment 90 days or more, to enable parents/guardians to participate in the treatment process

- individuals with co-occurring disorders, to reduce jail recidivism.

Strategy 6: Sustain jail-based substance abuse treatment, and Juvenile and Adult Drug Court interventions to increase the number of other individuals at high risk who are enrolled in treatment.

Strategy 7: Increase the number of individuals connected to substance abuse treatment through Screening, Brief Intervention and Referral to Treatment (SBIRT) efforts at local hospitals, to reduce repeat emergency room use by individuals addicted to ATOD.

Strategy 8: Increase advertisement of the wide range of substance abuse prevention, treatment, and community support services available to County residents through a radio campaign and outreach to schools, communities, businesses, and faith-based organizations.

Promoting Smoke-Free Communities

Strategy 1: Support M-NCPPC's plan to expand its smoking ban to include the outdoor (open) spaces at all of its facilities.

Strategy 2: Work with partners to increase the number of smoke-free multi-unit housing properties in the County, particularly in areas most at risk for tobacco-related disease and disability (based on disease burden, socioeconomic status of residents, and size of the housing complex).

Strategy 3: Educate building managers, tenants, and tenant associations about the hazards of tobacco use and the steps to implement a smoke-free policy at their dwellings.

Strategy 4: Work toward the establishment of a smoke-free County by adopting legislation that bans smoking at all County and municipal government-owned properties (including outdoor spaces).

Strategy 5: Work with the University of Maryland Legal Resource Center for Tobacco Regulation, Litigation, and Advocacy to identify additional strategies leading to a smoke-free County.

Strategy 6: Work with partners to promote smoke-free college campuses.

Strategy 7: Work with partners to identify funds to conduct a County-wide campaign to educate at-risk adults and adolescents about the hazards of tobacco use and resources available for tobacco use cessation, using mass and social media outlets that appeal especially to youth; focus efforts on reaching County residents in the southern part of the County where tobacco use is more prevalent.

Strategy 8: Collaborate with existing school-based tobacco prevention programs to promote additional anti-tobacco messages to students.

Strategy 9: Explore with partners ways to train physicians, dentists, nurses, and other health care providers to deliver brief messages on the dangers of tobacco use and to refer their clients to available cessation programs.

Enhancing Access to Mental Health Services

Strategy 1: Support the implementation of PGCDFS Mental Health and Disabilities Administration, Fiscal Year 2012 Annual Plan* to develop and maintain a comprehensive, efficient, and cost effective system of community-based mental health care in Prince George's County, particularly as it relates to collaborative agreements among community service providers.

* A complete description of this Plan is available in the *Prince George's County Department of Family Services, Mental Health and Disabilities Administration, Fiscal Year 2010 Annual Report and Fiscal Year 2012 Annual Plan Update*.

Strategy 2: Continue to provide behavioral health condition screenings to County residents at various points of service entry where potentially at-risk individuals may be identified (i.e. women's wellness centers, SBWCs, Prince George's County Department of Corrections (PGCDOC), Youth Service Bureaus, PGCDFS, PGCDSS, and Adam's House).

Key Partners: Affiliated Santé, Alcohol and Drug Abuse Administration, American Association of Diabetes Educators, American Cancer Society, American Diabetes Association, American Heart Association, American Lung Association, Children's National Medical Center, community substance abuse treatment providers, complementary and alternative medicine and holistic health providers, Dimensions Healthcare System, Doctors Community Hospital, faith-based and non-profit community-based organizations, Food Supplement Nutrition Education (University of Maryland), Gaston and Porter Health Improvement Center, local businesses, local chefs, restaurateurs, farmers, and farmers' markets, Maryland-National Capital Park and Planning Commission multi-unit housing managers and tenant associations, Prince George's County Council/Board of Health, Prince George's County Executive, Prince George's County Courts, Prince George's County Criminal Justice Coordinating Council and Drug and Alcohol Advisory Committee, Prince George's County Department of Corrections, Prince George's County Department of Family Services, Prince George's County Department of Juvenile Services, Prince George's County Department of Social Services, Prince George's County Health Department, Prince George's County Memorial Library System, Prince George's County Parole and Probation Office, Prince George's County Police Department, Prince George's County Public Schools, Prince George's County State's Attorney's Office, private sector health care providers, Southern Maryland Hospital Center, supermarket corporate offices and grocery stores, Susan G. Komen For the Cure, University of Maryland Legal Resource Center for Tobacco Regulation, Litigation, and Advocacy, Youth Service Bureaus, University of Maryland School of Public Health.

Priority 3: Improve Reproductive Health Care and Birth Outcomes for Women in Prince George's County, Particularly Among African American Women.

(Corresponds with SHIP Vision Area 1: Improve Reproductive Health Care and Birth Outcomes)

County Outcome Objective	Current Baseline	2014 Target
Reduce infant deaths	Overall rate - 10.4 (number of infant deaths/1,000 live births, VSA 2007- 2009) White/Non-Hispanic rate - 10.6 Black rate - 13.3 Hispanic rate - 4.6 Asian rate - 2.7	Overall rate - 8.2 using midpoint to HP 2020 White/Non-Hispanic rate - 10.1 using 5% decrease Black rate - 12.6 using 5% decrease Hispanic rate - 4.4 using 5% decrease Asian rate - 2.6 using 5% decrease
Reduce low birth weights (LBW) and very low birth weights	Overall - 10.6% (percentage of births that are LBW, VSA 2007-2009) White/Non-Hispanic - 7.6% Black - 12.5% Hispanic - 7.5% Asian - 7.7%	Overall - 9.2% using midpoint to HP 2020 White - 7.2% using 5% decrease Black - 11.9% using 5% decrease Hispanic - 7.1% using 5% decrease Asian - 7.3% using 5% decrease
Increase the proportion of pregnant women who receive prenatal care beginning in the first trimester	Overall - 67% (percentage of births where mother received first trimester prenatal care, VSA 2007-2009) White/Non-Hispanic - 82.3% Black - 69.4% Hispanic - 52.7% Asian - 66.6%	Overall - 70.4 % using 5% increase White - 86.4% using 5% increase Black - 72.9% using 5% increase Hispanic - 55.3% using 5%

		increase Asian - 69.9% using 5% increase

Note – A number of these strategies also address Priority 1.

Linking Women to Prenatal Care and Women's Wellness Services

Strategy 1: Expand existing prenatal care and women's health services to include screening and counseling for diabetes prevention and management (including gestational diabetes), weight management and nutrition counseling, substance abuse and smoking cessation services, referral to dental health services, mental health services and domestic violence prevention, and screenings and referrals for Medicaid.

Strategy 2: Continue working with key partners to secure funding for existing County prenatal care programs that serve high risk and very high risk uninsured pregnant women needing specialty perinatology, midwifery and other services.

Strategy 3: Work with the PGCDOC to ensure that incarcerated pregnant women receive prenatal care and are linked to community services upon release.

Strategy 4: Continue working with the PGCPS to ensure that pregnant adolescents receive prenatal care and are referred to family planning services after delivery.

Strategy 5: Identify resources to expand existing Healthy Start and perinatal navigator services that provide home visits and intensive follow-up for high risk pregnant women.

Strategy 6: Continue collaboration between PGCHD, PGCDFS, PGCDSS, and the Healthy Families Prince George's County Program to ensure that pregnant women receive needed prenatal, pediatric, mental health, health education, and other support services in a coordinated manner.

Strategy 7: Identify funding for and implement an advertising campaign to promote all of the women's wellness and prenatal care services available in the County and to encourage pregnant women to get into care early, focusing on reaching minority women.

Strategy 8: Work with local hospitals to identify ways to increase access to perinatology and fetology services for high risk pregnant women, as well as tubal ligation and vaginal births after c-section (VBACs).

Strategy 9: Increase availability of post-abortion counseling services.

Identifying Innovative Strategies to Address Infant Mortality

Strategy 1: Continue convening meetings of the Prince George's County Improved Pregnancy Outcome Coalition (IPOC) to identify best practices and seek resources for reducing infant mortality, and to advocate for policy, legislative, and systems changes that have an impact on infant mortality reduction; follow-up with providers to ensure they are initiating IPOC recommendations.

Strategy 2: Continue convening meetings of the Fetal and Infant Mortality Review (FIMR) Team to review infant mortality cases and to make recommendations to the Health Department regarding strategies to address the Team's specific findings.

Strategy 3: Recruit more hospital providers and primary care physicians to join the IPOC and FIMR.

Strategy 4: Provide information to pregnant women and women of childbearing age (including women with health insurance and higher incomes) about the risk factors that affect birth outcomes, especially focusing on African American women.

Promoting Family Planning Services

Strategy 1: Identify funding to implement an advertising campaign promoting existing community family planning services; focus on reaching minority women and adolescents through novel approaches.

Strategy 2: Continue partnerships between family planning providers in the County to ensure that available family planning appointment slots are filled through appropriate referral arrangements.

Strategy 3: Ensure that students seen at the four SBWCs are linked to family planning services in the community.

Strategy 4: Explore ways to engage male partners of sexually active women in seeking family planning services and supporting partner compliance with family planning methods.

Strategy 5: Ensure that obstetrics patients are provided with family planning education during prenatal care and referred to family planning services after delivery.

Strategy 6: Ensure that women who are ineligible for Title X family planning services, are uninsured/underinsured, have aged out or are over income limits, have access to women's wellness services.

Key Partners: Access to Wholistic and Productive Living Institute, Inc., Community Clinics, Inc., Dimensions Healthcare System, Doctors Community Hospital, Greater Baden Medical Services, Healthy Families Prince George's Program, FIMR Team, Forestville Pregnancy Center, Improved Pregnancy Outcome Coalition, Maryland Community Health Resources Commission, Maryland Department of Health and Mental Hygiene [DHMH] Family Health Administration and Office of Minority Health and Health Disparities, Mary's Center, Pregnancy Aid Center, Prince George's County Department of Corrections, Prince George's County Department of Family Services, Prince George's County Department of Social Services, Prince George's County Health Department, Prince George's County Public Schools, Southern Maryland Hospital Center, University of Maryland School of Medicine.

Priority 4: Prevent and Control Infectious Disease in Prince George's County, Particularly Among African Americans and Other Minorities.

(Corresponds with SHIP Vision Area 4: Prevent and Control Infectious Disease)

County Outcome Objective	Current Baseline	2014 Target
Reduce new HIV infections among adults and adolescents	Overall rate - 56.4 (rate of new [incident] cases of HIV in persons age 13 and older per 100,000 population, IDEHA 2009) In progress for race specific data	Overall rate - 53.6 using 5% decrease
Reduce chlamydia trachomatis infections among young people	Overall rate - 631 (rate of chlamydia infections for all ages per 100,000 population, IDEHA 2009) White rate - 32.4 Black rate - 206.4 Hispanic rate - 74.8 Asian rate - Not Available (all ages)	Overall rate - 599.5 using 5% decrease White rate - 30.8 using 5% decrease Black rate - 196.1 using 5% decrease Hispanic rate - 71.1 using 5% decrease Asian rate - Not Available
For patients with newly diagnosed TB for whom 12 months or less of treatment is indicated, increase the proportion of patients who complete treatment within 12 months	91.7% of new TB cases have completed treatment (National TB Indicators Project, Centers for Disease Control and Prevention [CDC])	93.0% by 2015 to meet National TB Indicators Project goal
Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among young children	Varies according to specific vaccine administered - refer to National Immunization Survey for vaccine-specific data	Maintain high coverage levels

Increase the seasonal flu vaccine rates	33.9% (percentage of adults who have had a flu shot in the last year, BRFSS 2008-2010) White Non-Hispanic - 43.8% Black - 32.5% Hispanic - 24.9%	57% using midpoint to HP 2020 White Non-Hispanic - 61.9% using midpoint to HP 2020 Black - 56.3% using midpoint to HP 2020 Hispanic - 52.3% using midpoint to HP 2020

Addressing HIV/AIDS

Strategy 1: Increase routine HIV screening in clinical settings and targeted screening in non-clinical settings, including the PGCDOC, public substance abuse treatment programs, and the SBWCs (all located in areas with the highest morbidity rates); link HIV positives immediately to care, and high risk HIV negatives to other medical care and HIV prevention programs.

Strategy 2: Provide behavioral risk screening and evidence-based risk reduction education to persons living with HIV (PLWH) and HIV negative persons at highest risk, including men who have sex with men, high risk heterosexuals, at-risk youth, PGCDOC detainees, etc.

Strategy 3: Implement prevention education and outreach strategies that specifically target heterosexual women, especially minority women.

Strategy 4: Explore ways to integrate evidence-based risk reduction education into the curriculum at the schools where the four SBWCs are located.

Strategy 5: Continue to provide on-going partner services for PLWH, including newly infected and their partners and PLWH diagnosed with a new sexually transmitted infection (STI).

Strategy 6: Continue to refer or link PLWH identified through partner services to medical care and support, and assign Linkage to Care workers to assist PLWH not currently in care.

Strategy 7: Work with a behavioral specialist to develop criteria for providing on-going behavioral counseling to at-risk persons; provide behavioral counseling to PLWH who engage in high risk behaviors, high risk negatives with repeat STIs, high risk men who have sex with men, and high risk heterosexuals.

Strategy 8: Expand outreach and prevention education efforts to include the use of innovative media and information technology methods such as online and social network services (i.e. Web sites, blogs, Facebook, Twitter, YouTube and Internet-Based Partner Services).

Strategy 9: Increase awareness among medical providers of the HIV medical care and support services available to HIV infected residents, and encourage providers to make HIV testing a routine part of care.

Strategy 10: Use case finding activities and partner surveillance data to identify the most effective settings and geographic areas to conduct targeted outreach and education.

Strategy 11: Train the medical community to be more comfortable and proficient in discussing substance use, sexual history and sexual habits with their patients, and in addressing cultural and linguistic barriers to their care.

Strategy 12: Increase the involvement of the faith-based community and churches in providing culturally sensitive HIV/STI prevention education and in serving as sites for free HIV testing; explore funding to establish a position within the PGCHD dedicated to working with the faith-based community.

Strategy 13: Work with medical associations, pharmaceutical representatives, and local academic institutions to provide continuing education to medical providers to ensure that their clinical skills in treating HIV/AIDS patients are up-to-date.

Addressing Other Sexually Transmitted and Communicable Diseases

Strategy 1: Identify funding to support a new chlamydia initiative including its prevention, expanded treatment capabilities, and partner services to identify individuals in need of treatment.

Strategy 2: Work with the Sexually Transmitted Infections Community Coalition (STICC) and other community partners to explore the development of a regional plan to address HIV and other STIs.

Strategy 3: Develop and disseminate, through media outlets and innovative outreach approaches, culturally and linguistically appropriate educational materials and messages on the most common STIs and their prevention.

Strategy 4: Continue to work with the medical community in managing and co-managing all active tuberculosis (TB) cases to ensure appropriate treatment of all TB cases.

Strategy 5: Continue to provide directly observed therapy (DOT) services to all TB cases in order that treatment is completed for the prevention of spread of TB.

Ensuring that Children Receive Recommended Immunizations

Strategy 1: Continue collaborating with the PGCPS nurses to ensure that all enrolled children are in compliance with required immunizations; provide updates about immunization requirements and available services to public school system nurses during the yearly health services orientation.

Strategy 2: Continue to provide outreach to private and non-public schools regarding immunization requirements and review their student immunization records.

Strategy 3: Continue collaborating with WIC offices, PGCDFS, the Healthy Families Prince George's County Program, and other programs that serve County children to ensure that these children receive recommended immunizations.

Strategy 4: Expand outreach efforts through community health fairs, Web site listings, and other venues to increase public awareness of the importance of childhood vaccines and the availability of County immunization clinics for uninsured/underinsured children; develop educational materials and messages that specifically target immigrants and new refugees.

Strategy 5: Maintain high vaccination coverage levels of County children by continuing to provide free immunizations to children at PGCHD Immunization Clinics and the SBWCs.

Increasing Community Acceptance of Seasonal Flu Shots

Strategy 1: Carry out an aggressive public information campaign about the importance of getting a seasonal flu shot; include messages and media outlets targeting minority and non-English speaking populations.

Strategy 2: Continue providing free flu shots in existing PGCHD clinics (Maternity, Family Planning, Sexually Transmitted Disease (STD), TB, HIV Clinics, etc.).

Strategy 3: Collaborate with school officials, mayors of municipalities, public officials representing local councilmanic districts, community clinics, PGCDFS and other County agencies to identify venues accessible to the public where free flu shots can be provided, especially for elderly and other at-risk populations; partner with community groups and businesses to provide low cost flu shots.

Strategy 4: Use the County's Medical Reserve Corps and Citizen Emergency Response Team volunteers to help staff public flu clinics.

Strategy 5: Collaborate with community medical providers interested in providing flu shots to ensure they have sufficient vaccine and other resources to provide flu shots to the public.

Strategy 6: Promote universal acceptance of flu vaccinations among all healthcare workers.

Key Partners: Academic institutions, Citizen Emergency Response Teams and Medical Reserve Corps, Community Clinics, Inc., councilmanic district public officials, Dimensions Healthcare System, Greater Baden Medical Service, Healthy Families Prince George's County Program, Heart-to-Hand and other HIV/STD community partners, faith-based community and local churches, local businesses and community-based organizations, Mary's Center, mayors of local municipalities, medical associations and pharmaceutical representatives, Prince George's County Courts, Prince George's County Department of Corrections, Prince George's County Department of Family Services, Prince George's County Department of Social Services, Prince George's County Health Department, Prince George's County Public Schools, private medical providers, private and non-public schools, Reality House and Salvation Army Rehabilitation Program (community substance abuse treatment centers), Sexually Transmitted Infection Community Coalition.

Priority 5: Ensure that Prince George's County Physical Environments are Safe and Support Health, Particularly in At-Risk Communities.

(Corresponds with SHIP Vision Area 3: Ensure that Maryland Physical Environments are Safe and Support Health)

County Outcome Objective	Current Baseline	2014 Target
Reduce the rate of fall-related deaths	4.6 (rate of deaths associated with falls per 100,000 population, VSA 2007-2009)	4.37 - rate using 5% decrease
Reduce pedestrian injuries on public roads	47.8 (rate of pedestrian injuries, State Highway Administration 2007-2009)	34.1 - rate using midpoint to HP 2020
Reduce the number of drownings among children and adults	14 (count only, VSA 2008)	7 count only using 50% decrease
Reduce blood lead levels in children	74.6 (rate of new [incident] cases of elevated blood lead level in children under 6 per 100,000, Maryland State Department of Education [MSDE] 2009)	37.3 - rate using 50% decrease
Reduce the number of infant deaths from sudden unexpected infant deaths (SUIDs), including Sudden Infant Death Syndrome (SIDS), unknown cause, accidental suffocation and strangulation in bed	.9 (rate of SUIDs (including deaths attributed to SIDS, accidental suffocation and strangulation in bed [ASSB], and deaths of unknown cause per 1,000 live births, VSA 2005-2009)	.85 - rate using midpoint to HP 2020
Reduce salmonella infections transmitted through food	11.7 (rate of salmonella infections per 100,000 population, IDEHA 2010)	7.96 - rate using 32% decrease
Reduce hospital emergency department (ED) visits from asthma	Overall rate - 71.7 (rate of ED visits for asthma [inpatient and outpatient] per 10,000 population, HSCRC 2010) White rate - 25.8	Overall rate - 57.4 using 20% decrease White rate - 20.6 using 20% decrease

	Black rate - 90.9 Hispanic rate - 30.5 Asian rate - 17.7	Black rate - 72.7 using 20% decrease Hispanic rate - 24.4 using 25% decrease Asian rate - 14.2 using 20% decrease
Increase access to healthy food and venues for physical and recreational activity	13.6% (percentage of census tracts with food deserts, U.S, Department of Agriculture [USDA] 2000)	12.9% using 5% decrease

Preventing Fall-Related Deaths and Pedestrian Injuries*

* Note: See Addressing Alzheimer's Disease under Priority # 1 for additional strategies.

Strategy 1: Collaborate with Prince George's County's Interagency Committee to obtain a mini-grant to pilot test Safe Steps: A Falls Prevention Program for Seniors with an at-risk senior population.

Strategy 2: Support the Prince George's County Department of Public Works and Transportation and the PGCPS to implement a Safe Routes to Schools Program to increase the number of children safely walking and biking to school.

Strategy 3: Support the PGCDFS Aging Services Division's Health Promotion and Disease Prevention Program that educates senior citizens about healthy lifestyles, including falls prevention.

Strategy 4: Support more widespread enforcement of pedestrian and driving laws by the County and municipal Police Departments.

Strategy 5: Support implementation of the Maryland State Highway Administration's highway and traffic safety programs like the Click It or Ticket Program that promotes the proper use of child safety seats and seat belts and the Smooth Operator Program that addresses aggressive driving.

Strategy 6: Increase public education about pedestrian safety through use of multi-media venues and development and dissemination of culturally and linguistically appropriate educational materials.

Preventing Deaths from Drownings

Strategy 1: Partner with M-NCPPC to increase the number of free or low-cost swimming lessons available to low-income County residents.

Strategy 2: Provide written information on pool and water safety to apartment complex managers during PGCHD pool inspection visits for distribution to their residents.

Strategy 3: Post seasonal pool and water safety tips (including the role of alcohol as a risk factor) on County Web sites as well as tips for remaining safe during periods of flooding.

Eliminating Lead Poisoning

Strategy 1: Use Geographic Information System (GIS) technology to pinpoint where children with elevated blood lead levels live in the County in order to identify at-risk families and communities in need of intervention.

Strategy 2: Expand efforts to educate the public about sources of environmental lead, using novel outreach approaches and culturally and linguistically appropriate materials to specifically reach non-English speaking residents, immigrants, and other at-risk populations.

Strategy 3: Provide the medical community and organizations serving vulnerable populations with periodic lead poisoning prevention updates, including Web site listings, e-mail notices, and workshops.

Strategy 4: Expand collaboration with County medical providers to assure their awareness of current protocols for medical intervention/case management of children with elevated blood lead levels.

Strategy 5: Work with local remodeling contractors and their professional associations to enhance their understanding of ways to prevent lead-containing materials from contaminating the environment during renovations of older homes and buildings.

Strategy 6: Continue providing aggressive intervention and case management to children with elevated blood lead levels, education to their families to further reduce their environmental exposure to lead, and collaboration with their medical providers to assure healthy outcomes.

Strategy 7: Maintain County lead testing for uninsured and underinsured children who live in high risk areas and assure any needed medical follow-up.

Promoting Safe Sleep Practices for Infants

Strategy 1: Continue to provide parents of newborns who are at risk for having an unsafe sleeping environment education about safe sleep practices and a Pac n' Play crib.

Strategy 2: Explore ways to continue funding the PGCHD's Tomorrow's Children Initiative and seek other grants (from local businesses, community organizations, other sources) for providing safe cribs to needy County infants.

Strategy 3: Identify and train new IPOC members and other appropriate providers to be distributors of safe sleep education and cribs to families in need.

Strategy 4: Work with local hospitals to ensure infants being discharged at birth have access to a safe sleep environment and that all educational messages about safe sleep are consistent among providers of SIDS and safe sleep education.

Strategy 5: Collaborate with the PGCDFS and the Healthy Families Prince George's County Program to identify additional ways to educate parents about SIDS prevention.

Ensuring the Safety of Our Food

Strategy 1: Increase the number of high priority food service facility inspections and conduct intensive education and follow-up inspections targeting facilities that chronically fail to comply with critical item (food safety) standards.

Strategy 2: Provide handouts and educational materials for non-English speaking food facility owners and their employees, and enhance information pertinent to food service facilities on the PGCHD's Web site.

Strategy 3: Publish a list of chronic or egregious violators of food safety standards in the newspaper and on the PGCHD's Web site.

Reducing Asthma-Related Incidents

Strategy 1: Institute a Healthy Homes Program that assists families with asthmatic children to reduce or manage environmental triggers; explore ways to expand the program to include provision of asthma medications and supplies (and education on their proper use) for families in need.

Strategy 2: Use GIS and hospital data to identify zip codes with the highest number of asthma-related incidents among children, and develop and implement an educational program targeting families in these areas that focuses on helping them reduce or eliminate asthma triggers.

Strategy 3: Conduct home visits to families with asthmatic children to help them identify potential asthma triggers and to educate them about preventing or reducing future asthma incidents among their children.

*Improving Our Environment**

*Also see Increasing Access to Healthier Foods under Priority #2

Strategy 1: Adopt local policies that incorporate principles of smart growth and population health determinants to evaluate and issue permits for new land use, housing development, transportation, and urban renovation/revitalization projects for the purposes of improving the built environment (access to walking/biking trails, crosswalks, etc.).

Strategy 2: Identify geographic health priority areas in the County, using GIS mapping and a scoring system that includes health-related factors such as presence of full-service grocery stores, sidewalks, bike trails, etc., where greatest need exists for improved community design.

Strategy 3: Work with the Port Towns Healthy Eating/Active Living (HEAL) Partnership to promote the HEAL Project as a model for other communities to replicate that demonstrates the use of smart growth principles in community design.

Strategy 4: Educate local political and community leaders (i.e. Prince George's County Council/Board of Health), developers, building managers, tenant associations and the public about smart growth principles, population health determinants, and built environment best practices.

Strategy 5: Collaborate with M-NCPPC to implement their ACHIEVE Project that focuses on policies, systems, and environmental change to promote healthier lifestyles through improved community design.

Strategy 6: Explore ways to offer incentives to developers for creating remote parking and drop-off zones near schools, public facilities, and shopping malls, and for making improvements in stairway access in new construction and renovations.

Strategy 7: Use GIS technology to identify areas of the County that are food deserts and that are disproportionately affected by unhealthy food vending to determine communities at risk for unhealthy dietary behaviors and in greatest need of more healthy food sources.

Strategy 8: Educate community residents in identified high-risk areas about the impact of unhealthy food choices and the need to advocate for more accessible, healthy food sources.

Strategy 9: Work with the PGCPS and M-NCPPC to explore ways to establish community gardens at public schools in at-risk communities in order to increase access to fruits and vegetables by students and their families.

Strategy 10: Work with the PGCPS to explore ways to develop and implement a Healthier School Environment Action Plan in selected schools that promotes physical activity and healthy eating among students and staff.

Strategy 11: Encourage after-school programs, licensed child care facilities and family child care providers to adopt policies and practices that promote safe and healthy child care environments, to include healthy eating and physical activity.

Strategy 12: Continue monitoring public mental health services for compliance with Americans with Disabilities Act requirements through the PGCDFS Mental Health and Disabilities Division, to ensure a safe environment for individuals with mental illnesses.

Key Partners: Building managers, Care First Blue Cross/Blue Shield, community medical providers, contractors and their professional associations, Dimensions Healthcare System, Doctors Community Hospital, Food Supplement Nutrition Education (University of Maryland) Program, Healthy Families Prince George's County, Improved Pregnancy Outcome Coalition, licensed child care facilities and family child care providers, local businesses, Maryland-National Capital Park and Planning Commission (Planning Department), Maryland State Highway Administration, Port Town Healthy Eating/Active Living community leaders, Prince George's County Council/Board of Health, Prince George's County Department of Family Services, Prince George's County Department of Public Works and Transportation, Prince George's County Executive, Prince George's County Health Department, Prince George's County Interagency Committee, Prince George's County Police Department and municipal police departments, Prince George's County Public Schools, Prince George's County Transportation Planning Board, SIDS MidAtlantic, Southern Maryland Hospital Center, tenant associations.

Priority 6: Ensure that Prince George's County Social Environments are Safe and Support Health.

(Corresponds with SHIP Vision Area 2: Ensure that Maryland Social Environments are Safe and Support Health)

County Outcome Objective	Current Baseline	2014 Target
Decrease the rate of alcohol-impaired driving (.08+ blood-alcohol content [BAC] fatalities	0.3 (rate of deaths associated with fatal crashes where driver had alcohol involvement per 100 million Vehicle Miles of Travel, State Highway Administration 2009)	.29 - rate using 5% decrease
Reduce the suicide rate	6.3 (rate of suicides per 100,000 population, VSA 2007-2009)	5.99 - rate using 5% decrease
Increase the proportion of students who graduate with a regular diploma 4 years after starting 9th grade	73.3% (percentage of students who graduate high school four years after entering 9th grade, MSDE 2010)	77% using 5% increase
Reduce fatal and non-fatal child maltreatment	3.6 (rate of non-fatal maltreatment cases reported to social services per 1,000 children under age 18, Department of Human Resources, FY 2010)	3.4 - rate using 5% decrease
Reduce domestic violence or reduce non-fatal physical assault injuries	62.7 (rate of ED visits related to domestic violence/abuse related per 100,000 population, HSCRC 2010)	59.6 - rate using 5% decrease

Addressing Underage and Adult Alcohol Use

Strategy 1: Work with partners to continue implementing the Communities Mobilizing Change on Alcohol (CMCA) Program, a project that involves a broad range of community support to discourage underage alcohol use by changing conditions in the physical, social, and cultural environment.

Strategy 2: Expand to other communities the Strategic Community Services, Inc. Communities That Care model, a program that addresses under-age drinking through the establishment of Prevention Councils that implement evidence-based strategies to educate and engage parents.

Strategy 3: Implement with partners other nationally recognized evidence-based substance abuse prevention programs at selected community sites, such as All Stars, Strengthening Families Adolescent Program, and Dare to Be You.

Strategy 4: Support the establishment of formal and informal neighborhood watch programs that enlist local residents to assist County and municipal Police Departments by identifying and reporting incidents of underage drinking, alcohol-impaired driving and other community hazards.

Strategy 5: Work with County and municipal Police Departments to develop strategies that encourage County residents to seek recreation opportunities that are safer alternatives to after-hour clubs.

Strategy 6: Promote the use of designated drivers, especially during holiday seasons and special events where alcohol use may increase.

Preventing Suicides

Strategy 1: Partner with Community Crisis Services, Inc. (which runs the Youth Suicide Prevention Hotline), the Prince George's County Response System, PGCDFS, and other health and human service providers about the availability of 24/7 counseling, support, and other services for individuals at risk of suicide, suicide attempters, their families and friends, and loss survivors.

Strategy 2: Partner with Community Crisis Services, Inc, to recruit and train lay individuals, professionals and other interested community residents in suicide prevention and intervention methods, using evidence-based programs such as the Substance Abuse and Mental Health Services Administration's (SAMHSA) SafeTALK (Suicide Alertness For Everyone), QPR (Quality Persuade and Refer), and ASIST (Applied Suicide Intervention Skills Training).

Strategy 3: Educate the public and health and human service providers about how to refer individuals in imminent danger of suicide to crisis services such as the Suicide Hotline or, when appropriate, to a crisis intervention team or the emergency room.

Strategy 4: Continue to provide a suicide risk assessment on every young person who presents for substance abuse services; refer cases to a crisis intervention service for follow-up or to the PGCDSS Child Protective Services (CPS) when cases meet criteria for medical neglect on the part of the parents or legal guardian.

Strategy 5: Work with the PGCPS to ensure that faculty and staff are trained on adolescent suicide risk factors and warning signs, and to help the school system develop a safety plan that includes clear protocols, lines of communication, and a crisis team to be activated when risk of a suicide is identified or when a suicide attempt or completion by a student occurs.

Strategy 6: Ensure that every student at risk of suspension or expulsion for violent or illegal behavior receives immediate counseling for him/herself and family.

Strategy 7: Educate parents, adolescents, community leaders, faith leaders, and others about the risk factors that make adults and young people vulnerable to suicide (including the role of alcohol, other drugs, and handguns) and the services available to individuals at risk of suicide.

Increasing the High School Graduation Rate

Strategy 1: Continue to link students at risk of suspension or expulsion to needed community services and resources, including alternative educational programs (i.e. General Equivalency Diploma [GED]).

Strategy 2: Provide social work counseling and other appropriate interventions to every student seen at the County's four SBWCs who is truant or at risk for dropping out.

Strategy 3: Increase awareness among community providers and the public of the PGCDFS Gang and Truancy Prevention Initiatives, After-School Programs, Youth Service Bureau programs, and other programs that serve vulnerable and at-risk youth.

Addressing Child Maltreatment and Domestic Violence

Strategy 1: Assess students seen at the four SBWCs who self-identify or are identified by school personnel as being at risk for an unsafe school, home, or community environment and make referrals for further intervention, including referral to CPS.

Strategy 2: Encourage schools and parent groups to establish formal and informal school and neighborhood "watch" programs that specifically monitor and report incidents of bullying, and to form intervention teams to address the problem.

Strategy 3: Assess every student seen by a Social Worker at the four SBWCs for his/her risk for child abuse, sexual abuse, or maltreatment; refer suspicious cases to CPS for follow-up.

Strategy 4: Continue convening meetings of the Prince George's County Child Fatality Review Team (CFRT) to review child fatality cases and to make recommendations for preventing child abuse and neglect to the local partner agencies and DHMH.

Strategy 5: Conduct outreach to medical providers to ensure they are aware of their responsibility and have the necessary information to report cases of child abuse and neglect.

Strategy 6: Continue providing domestic violence and healthy relationship counseling to clients of the PGCHD, Shepherd's Cove Shelter, and the PGCDOC who self-identify or are identified by a health provider as a victim or potential victim of domestic violence.

Strategy 7: Continue convening meetings of the Domestic Violence Coordinating Council for the purpose of reviewing domestic violence cases, sharing information, and building resources to address domestic violence.

Strategy 8: Collaborate with the Maryland Network Against Domestic Violence (MNADV) for professional training of County health care workers who serve at-risk clients.

Strategy 9: Continue convening meetings of the Domestic Violence Fatality Review Team to review records of domestic violence related fatalities and to make recommendations to the MNADV for future interventions.

Strategy 10: Continue providing relationship counseling, anger management and effective communications training, and parenting classes through the County's Adam's House Program to individuals at risk for domestic violence who are identified by the State's Attorney's Office, Parole and Probation Office, Family and Child Support Courts, PGCDSS, and other agencies.

Strategy 11: Enlist the faith-based community and other groups to establish support groups for victims and potential perpetrators of domestic violence.

Strategy 12: Collaborate with key stakeholders serving on the Prince George's County Justice Center Task Force to establish a model center where victims of domestic violence can obtain a multitude of services in one location such as restraining orders, substance abuse treatment, videotaped testimony for court (in lieu of personal appearance), child care, etc.

Strategy 13: Work with local law enforcement agencies to educate the public about firearms safety practices.

<u>Key Partners</u>: Community-based organizations, Community Crisis Services, Inc., community liquor stores, Dimensions Healthcare System, Doctors Community Hospital, Family Crisis Center, insurance companies, local communities and municipalities, local driver education schools, Maryland Department of Health and Mental Hygiene Alcohol and Drug Abuse Administration, Maryland 4-H Program, Maryland-National Capital Park and Planning Commission, Maryland Network Against Domestic Violence, Maryland State Liquor Board, Prince George's County Alcohol and Other Drugs Coalition and Youth Councils, Prince George's County Child Fatality Review Team, Prince George's County Courts, Prince George's County Crisis Response System, Prince George's County Department of Corrections, Prince George's County

Department of Family Services, Prince George's County Department of Social Services, Prince George's County Domestic Violence Coordinating Council and Domestic Violence Fatality Review Team, Prince George's County Fire Department and Emergency Services, Prince George's County Health Department, Prince George's County Highway Safety Task Force, Prince George's County Justice Center Task Force, Prince George's County Parole and Probation Office, Prince George's County Police Department and municipal police departments, Prince George's County Public Schools, Prince George's County Sheriff's Department, Prince George's County State's Attorney's Office, Shepherd's Cove homeless shelter, Southern Management, Southern Maryland Hospital Center, Strategic Community Services, Inc.

County-Specific Health Priorities*

*Note: Specific partners are not listed in this section because it is assumed that all partners identified previously under Priorities 1-6 will work collectively with the LHAPC to address the County-Specific Health Priorities.

Priority 1: By 2015, enhance the health information technology infrastructure of Prince George's County in order to increase reimbursements for health services provided, improve patient care, and address disparities.

Strategy 1: Establish an agency-wide third party electronic billing system in the PGCHD that meets federal and state Health Information Portability and Accountability Act (HIPAA) and other requirements.

Strategy 2: Work with the Chesapeake Health Information System for our Patients (CRISP - Maryland Statewide Health Information Exchange [HIE]) and the Management Service Organization to adopt Meaningful Use of Electronic Health Record (EHR) technology. The benefits of EHR, called eHealth for Prince George's County, will include:

- improvements in the quality and coordination of care delivered
- decreased health care costs and greater provider accountability
- reductions in the provision of unnecessary services
- engagement of health care consumers in the decision-making process and self-care management
- improvements in the overall management of population health.

Strategy 3: Work with DHMH to develop strategies for collecting health statistics at the sub-County level (i.e. census tracts, zip codes) in order to target health initiatives in areas of the County with greatest need.

Strategy 4: Fully integrate the County Stat data reporting system into PGCHD and other County agency operations for the purpose of evaluating progress towards meeting County Health Improvement Plan health objectives, identifying deficiencies in service delivery and possible remedies, and providing reports on the health status of the County to the public.

Priority 2: By 2020, obtain public health national accreditation of the Prince George's County Health Department.

Strategy 1: Work with DHMH to determine the requirements, steps and a timeline for seeking public health national accreditation.

Priority 3: By 2020, build a comprehensive integrated community-oriented health care system that meets the needs of all County residents.

Strategy 1: Forge long-lasting public and private partnerships with critical community stakeholders for the purposes of conducting joint long and short-term strategic health planning, increasing addressing existing and emerging health issues of mutual concern, and managing resources to support essential services and new initiatives.

Strategy 2: Complete the process outlined in the Memorandum of Understanding (MOU) between the County, State of Maryland, University of Maryland Medical System, University System of Maryland and Dimensions Health Corporation to have the Prince George's County hospital system join the University of Maryland Medical System. This process includes the construction of a new regional medical center (RMC) in Prince George's County supported by a comprehensive ambulatory care network and a University of Maryland Baltimore health sciences presence within the County. The RMC would serve Prince George's County and southern Maryland.

The MOU also calls for:

- Physician/Provider Needs: Development of a strategy to address physician and other allied health care provider needs

- Strategic Plan for Discharging Liabilities: Development of a feasible plan and timeline for satisfaction of the Dimensions' liabilities

- Public Funding: The County and State shall execute a Letter of Intent that reflects their commitment to provide a total of $30 million of funding ($15 million each) through FY 2015 to support the Dimensions' operations and discharge of liabilities

- Reducing and Eliminating Operating Losses: Development of a plan and timeline for implementing cost-containment, quality enhancement, and clinical integration measures necessary to reduce and ultimately eliminate the Dimensions' operating losses.

  *Note: See "Prince George's County Hospital Authority Final Report and Recommendations, May 21, 2010" for a complete description of findings and recommendations.

Strategy 3: Move forward with implementing recommendations of the Prince George's County Executive's 2010 Transition Team to improve service delivery by Prince George's County health and human service agencies and other County agencies providing services that impact the health of County residents.

Strategy 4: Work with federal and state authorities to explore ways to achieve additional Medically Underserved Area (MUA), Medically Underserved Population (MUP) and Governor Exceptional MUP designations for the County, in an effort to increase the number of FQHCs and other safety net clinics in areas of the County where health resources are scarce.

Strategy 5: Leverage the existing resources of GBMC, CCI, Mary's Center, Dimensions Healthcare System, Children's National Medical Center, and other community providers to address the immediate need for additional well child, women's wellness, immunization, sick care, prenatal care, family planning, health education, dental, and other primary care services.

Strategy 6: Work towards the establishment of a primary care coalition that focuses on improving the quality and provision of primary care in the County through adoption of best practices, technology, and systems changes.

Strategy 7: Establish a Health Care Coordinating Council comprised of key health stakeholders that will inform the Prince George's County Council on issues requiring health policy and financing decisions, advise the Council in its role as the Board of Health, and participate in designing a comprehensive and integrated healthcare system for the County.

Strategy 8: Develop the County's grantsmanship capacity by establishing a unit within County government dedicated to the pursuit of federal, state, local, and private foundation resources.

Strategy 9: Explore opportunities to provide additional funding to community-based non-profit organizations and to critical programs that serve vulnerable populations but are severely underfunded and/or understaffed, such as the SBWCs and Health*line*.

Strategy 10: Partner with UMDSPH, Bowie State University, other academic institutions, private and non-profit organizations to determine opportunities for collaboration in the following areas: seeking funding for existing and new health initiatives, conducting community needs assessments and program evaluations, and carrying out research and demonstration projects that help to determine best practices needed to address our critical health concerns and to eliminate disparities.

Strategy 11: Tap the expertise and resources of the National Institutes of Health, Food and Drug Administration, other federal health agencies in the Washington Metropolitan area, Kaiser Permanente, other managed care organizations, health insurance companies, local businesses, faith-based organizations, and pharmaceutical and biomedical technology companies to identify ways to collaborate on special initiatives that enhance access to care.

Strategy 12: Partner with community groups such as Health Action Forum, the River Jordan Project, and Progressive Cheverly to identify ways to increase public input into long and short-range health planning for the County that reflects the concerns of all of the County's diverse populations.

Strategy 13: Develop and implement an educational campaign to significantly increase awareness among community providers, key stakeholders, partners, and the public about the comprehensive array of services available to vulnerable, at-risk, and special needs populations through the County Government's Health and Human Services agencies.

Strategy 14: Increase awareness among community providers, key stakeholders, partners, and the public about the various County agency programs that serve as expedited or single points of entry into care for specific populations, including PGCHD's Health*line* Program for pregnant women and children, PGCDFS's Local Access Mechanism for families seeking youth services, and PGCDFS's Maryland Access Point for family caregivers and persons with disabilities seeking services.

<u>Priority 4</u>: Throughout 2011 - 2015, work with partners to implement strategies that attract more licensed medical professionals and other health care workers to the County in order to address the severe health care workforce shortage.

Strategy 1: Explore ways to offer sign-on bonuses and/or other incentives to licensed health professionals considering positions in County Government.

Strategy 2: Partner with the UMDSPH, Bowie State University and Prince George's Community College to promote careers in public health among their students and to create student internships, preceptorships, and other programs that address the staffing needs of community health providers.

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- Community Health Transformation Coalition and Leadership Team
- Domestic Violence Coordinating Council
- Domestic Violence Fatality Review Team
- Fetal and Infant Mortality Review Team
- The Gaston and Porter Health Improvement Center
- Health Action Forum
- Health Disparities Coalition
- Improved Pregnancy Outcome Coalition
- Jack and Jill of America, Inc., National Harbor Chapter
- MICAW Insurance Agency
- Minority Outreach and Technical Assistance Group at Bowie State University
- Port Towns Community Health Partnership
- Prince George's County Justice Center Task Force
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Document Abbreviations

ACHIEVE	Action Communities for Health, Innovation, and Environmental Change
ASIST	Applied Suicide Intervention Skills Training
ATOD	Alcohol, Tobacco, and Other Drugs
BCCP	Breast and Cervical Cancer Program
BRFSS	Behavioral Risk Factor Surveillance System
CAM	Complementary and Alternative Medicine
CCI	Community Clinics, Inc.
CDC	Centers for Disease Control (and Prevention)
CESAR	Center for Substance Abuse Research
CHLI	Center for Healthy Lifestyle Initiatives
CMCA	Communities Mobilizing Change on Alcohol
CPEST	(Colorectal) Cancer Prevention, Education, Screening, and Treatment
CPS	Child Protective Services
DDA	Developmental Disabilities Administration
DHMH	(Maryland) Department of Health and Mental Hygiene
DOT	Directly Observed Therapy
DUI/DWI	Driving Under the Influence/Driving While Intoxicated
ED	Emergency Department
EHR	Electronic Health Record
FIMR	Fetal and Infant Mortality Review
FQHC	Federally Qualified Health Center
GBMS	Greater Baden Medical Services
GED	General Equivalency Diploma
GIS	Geographic Information Systems
HEAL	Healthy Eating/Active Living
HFTI	Healthy Futures Training Institute
HIE	Health Information Exchange
HIPAA	Health Information Portability and Accountability Act
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HP	Health People
HSCRC	Health Services Cost Review Commission
IDEHA	Infectious Diseases and Environmental Health Administration
IPOC	Improved Pregnancy Outcome Coalition
LBW	Low Birth Weight

MCHP	Maryland Children's Health Program
MCO	Managed Care Organization
MNADV	Maryland Network Against Domestic Violence
M-NCPPC	Maryland-National Capital Park and Planning Commission
MOU	Memorandum of Understanding
MSDE	Maryland State Department of Education
MUA	Medically Underserved Area
MUP	Medically Underserved Population
OB/GYN	Obstetrician/Gynecologist
PCP	Primary Care Physician
PGCDFS	Prince George's County Department of Family Services
PGCDOC	Prince George's County Department of Corrections
PGCDSS	Prince George's County Department of Social Services
PGCHD	Prince George's County Health Department
PGCPS	Prince George's County Public Schools
PGHAC	Prince George's Healthcare Action Coalition
PLAN	Partnership for Learning Among Neighbors
PLWH	Persons Living With HIV/AIDS
PSA	Prostate Specific Antigen
QPR	Quality Persuade and Refer
SafeTALK	Suicide Alertness for Everyone TALK
SafetyNET	Safety Network for Entry into Treatment
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention and Referral to Treatment
SBWCs	School-Based Wellness Centers
SIDS	Sudden Infant Death Syndrome
SIDS/MA	Sudden Infant Death Syndrome/MidAtlantic
SPF	Sun Protection Factor
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
STICC	Sexually Transmitted Infections Community Coalition
SUID	Sudden Unexpected Infant Death
TB	Tuberculosis
UMDSPH	University of Maryland School of Public Health
USDA	United States Department of Agriculture
VBAC	Vaginal Birth After C-Section
WIC	Women, Infants, and Children

For More Information

Electronic copies of this document are available at www.princegeorgescountymd.gov/health.

If you wish to become a partner in carrying out the County Health Improvement Plan, or if you have questions or comments about this Plan, please call 301-883-7834.