COMMUNITY BENEFITS REPORT FOR THE FISCAL YEAR JULY 1, 2012 – JUNE 30, 2013

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

INTRODUCTION AND BACKGROUND:

HSCRC Community Benefit Report:

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

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

PRINCE GEORGE'S HOSPITAL CENTER:

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

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

Leadership: Chairman, Board of Directors – C. Phillip Nichols, Jr.
CEO – Neil J. Moore
President – John A. O'Brien
Chief Nursing Officer – Dolores Marshall

Location: 3001 Hospital Drive, Cheverly, Maryland 20785

Facility type: Acute care teaching hospital and regional referral center

No. of licensed beds: 224 (plus 60 bassinets)

No. of inpatient admissions: 10,400

No. of Employees: 1,748

Specialty services:

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

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

Other specialty services:

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

Facilities:

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

Ownership:

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

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

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

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County	Percentage of Patients who are Medicaid Recipients, by County
224 Beds + 60 Bassinets	10,400	20743 20785 20747 20784 20706 20774 20737 20710 20746 20748 20745	Doctors Community Holy Cross Washington Adventist Southern Maryland Laurel Regional Fort Washington	20.3% (PGHC total patient pop.) PG County: 18.3% DC: 1.3%	37.6% (PGHC total patient pop., includes Medicaid pending) PG County: 32.3% DC: 5.0%

Table I

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

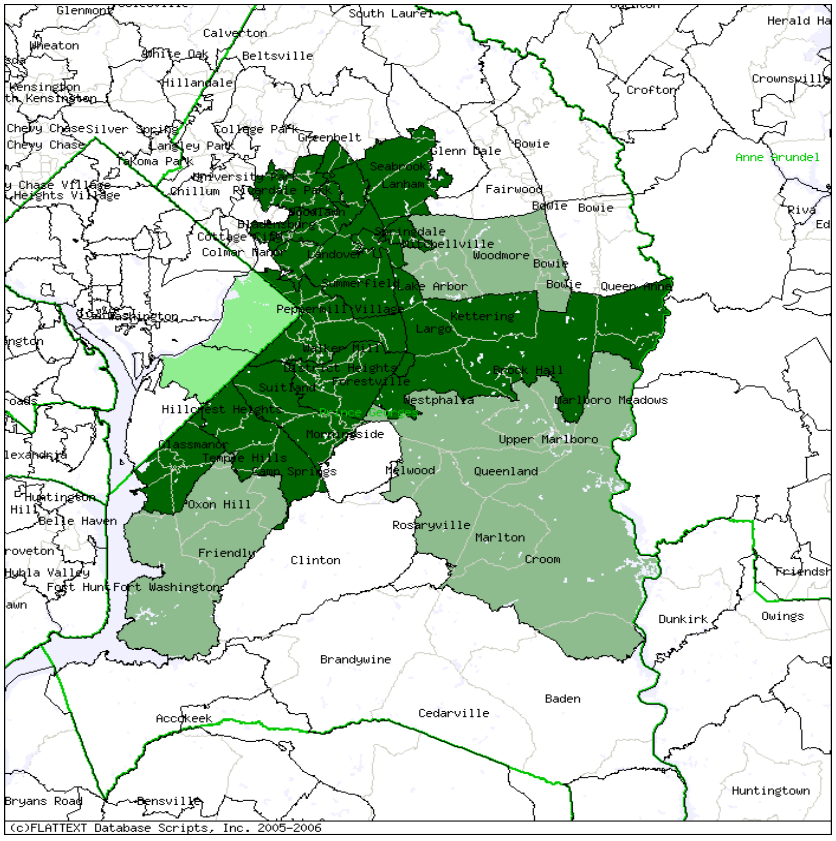
   a. Describe in detail the community or communities the organization serves. (For the purposes of the questions below, this will be considered the hospital's Community Benefit Service Area – "CBSA". This service area may differ from your primary service area on page 1.) This information may be copied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

PRINCE GEORGE'S COUNTY DEMOGRAPHICS:

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

PGHC's Primary Service Area differs from its Community Benefit Service Area (CBSA) in that its CBSA encompasses 14 zip code areas in Western and Central Prince George's County, patients from these zip code areas make up approximately 73% of PGHC's total inpatient and outpatient admissions. The PGHC CBSA also includes two zip code areas in the eastern portion of the District of Columbia (DC) – patients from this area make up 5.5% of PGHC's inpatient and outpatient admissions. An estimated 575,544 people make up the PGHC CBSA. The PGHC Prince George's County and DC CBSA has a population that is 81.4% African-Americans, 5.3% White (non-Hispanic) and reported as 8.8% of Hispanic origin, 2.1% of Asian origin, 2.4% of other ethnic origin.

COMMUNITY BENEFITY SERVICE AREA
FY 2013



COMMUNITY BENEFIT SERVICE AREA (73.3%)	
PG COUNTY REFERRAL AREA (67.8%)	
DC REFERRAL AREA (5.5%)	

(percent of inpatient and outpatient discharges)

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

Some statistics may be accessed from the Maryland State Health Improvement Process, (http://dhmh.maryland.gov/ship/) and its County Health Profiles 2013, (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx), the Maryland Vital Statistics Administration (http://vsa.maryland.gov/html/reports.cfm), The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) (http://www.dhmh.maryland.gov/mhhd/Documents/1stResource_2010.pdf), the Maryland ChartBook of Minority Health and Minority Health Disparities, 2nd Edition (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf)

Table II

Community Benefit Service Area(CBSA) Target Population (target population, by sex, race, and average age)	PGHC Total CBSA Population: 575,544 PG Cty CBSA Population: 471,322 DC CBSA Population: 104,222 Sex M – 46.3% F – 53.7% White (non-Hispanic)– 5.3% African-American – 81.4% Hispanic/Latino –8.8% Asian – 2.1% Other Race – 2.4% *Source: U.S. Census Bureau, 2011 ACS* Prince George's County: % age < 18 years – 23.1% % age 65 and older – 10.3% DC: % age < 18 years – 17.3% % age 65 and older – 11.4% *Source: U.S. Census Bureau, State & County QuickFacts 2012*

Median Household Income within the CBSA (county level)	Prince George's County: $73,447 DC: $61,835 *Source: U.S. Census Bureau, State & County QuickFacts 2012*
Percentage of households with incomes below the federal poverty guidelines within the CBSA	Prince George's County: 8.2% DC: 18.2% *Source: U.S. Census Bureau, State & County QuickFacts 2012*
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links:	Prince George's County: 15.6% DC: 5.9% *Source: U.S. Census Bureau, 2012 ACS*
Percentage of Medicaid recipients by County within the CBSA.	Prince George's County: 15.7% DC: 27.4% *Source: Community Health Status Report, 2009*
Life Expectancy by County within the CBSA.	Prince George's county: All Races: 78.6 years White: 79.6 Black: 77.8 *Source: Maryland Vital Statistics Profile: 2011* DC: 72 years *Source: Community Health Status Report, 2009*
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Prince George's County : 747.8/100,000 *Source: Maryland Vital Statistics Profile: 2011* DC: 812.74/100,000 *Source: CDC Final Data 2009*
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources)	Risk factors for premature death in Prince George's County and DC: -- No exercise PG: 24.6% DC: 22.2% -- Few fruits/vegetables PG: 72.1% DC: 68.1% -- Obesity PG: 34% DC: 21.3%

	-- High blood pressure PG: 26.2% DC: 26.7% -- Smoker PG: 15% DC: 20.4% -- Has diabetes PG: 11% DC: 7.8% -- HIV prevalence rate PG: 636/100,000 DC: 1,107/100,000 -- Violent crime rate PG: 865/100,000 DC: 1,400/100,000 *Source: Community Health Status Report, 2009*
Available detail on race, ethnicity, and language within CBSA.	*Please see charts on pages 10 and 11, which provide detail on race and ethnicity within the CBSA.*
Other Vulnerable populations	Vulnerable populations in Prince George's County: -- Are unemployed Prince George's County: 7.0% DC:10.2% *Source: County Health Rankings, 2013*
Other Access to primary care	Ratio of population to primary care physicians – Prince George's County – 1,077:1 DC: 854.1 Nat'l Benchmark –1067:1 (Prince George's County has substantially lower per capita numbers of primary care physicians when compared to neighboring jurisdictions.) *Source: County Health Rankings, 2013* Number of Safety Net Clinics – Prince George's County: 5 DC: 38 – 40 *Source: Prince George's County Health Improvement Plan 2011 to 2014*

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

	PGHC CBSA Area	% of Total
2011 Total Population	575,544	100.0%
Total Male Population	266,549	46.3%
Total Female Population	308,995	53.7%

Source: U.S. Census Bureau, 2011 ACS

RACE/ETHNICITY

Race/Ethnicity Distribution

Race/Ethnicity	2011 Pop	% of Total	USA % of Total
White Non-Hispanic	30,584	5.3%	63.0%
Black Non-Hispanic	468,564	81.4%	12.4%
Hispanic	50,557	8.8%	16.9%
Asian & Pac. Isl. Non-Hispanic	12,359	2.1%	5.0%
All Others	13,480	2.4%	4.6%
TOTAL	575,544	100.0%	100.0%

Source: U.S. Census Bureau, 2011 ACS

POPULATION DISTRIBUTION

Age Distribution

Age Group	2011 Pop	% of Total	USA % of Total
0 – 17	146,826	25.5%	23.8%
18 - 64	369,827	64.3%	62.6%
65 +	58,891	10.2%	13.5%
TOTAL	575,544	100.0%	100.0%

Source: U.S. Census Bureau, 2011 ACS

UNINSURED
% of Total Population

Race/Ethnicity	Prince George's County	Maryland	USA
Average, All Races	15.6%	10.3%	14.8%
White Non-Hispanic	1.2%	3.3%	6.5%
Black Non-Hispanic	6.6%	3.2%	2.1%
Hispanic	6.9%	2.9%	4.9%
Asian	0.7%	0.8%	0.8%
Some other race alone	4.2%	1.5%	1.5%

Source: U.S. Census Bureau, 2011 ACS

Prince George's Hospital Center
Vital Statistics Data

COMPARATIVE VITAL STATISTICS	PRINCE GEORGE'S COUNTY	MONTGOMERY COUNTY	STATE OF MARYLAND	*PG CTY % VARIANCE TO MONT CTY*	*PG CTY % VARIANCE TO STATE*
Age Adjusted Mortality Rates: 2009 - 2011					
All Causes of Death	**747.8**	**528.4**	**732.5**	***29.3%***	***2.0%***
Disease of the Heart	**203.5**	**124.7**	**181.6**	***38.7%***	***10.8%***
Malignant Neoplasms	**170.3**	**128.5**	**171.4**	***24.5%***	***-0.6%***
Cerebrovascular Disease	**35.7**	**29.2**	**38.7**	***18.2%***	***-8.4%***
Diabetes Mellitus	**28.6**	**12.5**	**20.4**	***56.3%***	***28.7%***
Accidents	**23.6**	**16.8**	**24.7**	***28.8%***	***-4.7%***
Chronic Lower Respiratory Diseases	**25.0**	**19.7**	**35.3**	***21.2%***	***-41.2%***
Septicemia	**17.7**	**11.9**	**15.3**	***32.8%***	***13.6%***
Alzheimer's Disease	**15.7**	**14.6**	**16.1**	***7.0%***	***-2.5%***
Influenza and Pneumonia	**13.7**	**14.6**	**16.6**	***-6.6%***	***-21.2%***
HIV	**6.9**	**1.4**	**4.9**	***79.7%***	***29.0%***
Nephritis, Nephrosis, and Neprotic Syndrome	**15.2**	**9.4**	**13.1**	***38.2%***	***13.8%***
Assault (Homicide)	**11.4**	**2.2**	**7.7**	***80.7%***	***32.5%***
Intentional Harm	**6.1**	**7.3**	**8.9**	***-19.7%***	***-45.9%***

Source: Maryland Vital Statistics Profile: 2011

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

Community Challenges & Health Statistics:

Despite the higher than average median household income, educational attainment, and percentage of individuals in the work force represented by Prince Georgians in comparison with national figures, the County does contain several pockets of low socioeconomic status, particularly including the portions of the County that are inside the Beltway. According to the 2009 RAND Report "Assessing Health and Health Care in Prince George's County", the demographic characteristics in the County Public Use Microdata Areas (PUMAs), including PUMAs 1, 3, 4, and 7 within the Beltway, all report vulnerable populations with lower incomes, majority Black and growing Hispanic populations. The 2009 Community Health Status Report data reveal that medically vulnerable Prince Georgian's (uninsured and Medicaid enrolled individuals) number approximately 297,784 or 35.7% of the total population.

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

As a result, issues such as diabetes mortality, heart disease, hypertension, stroke, deaths from breast, colorectal and prostate cancers, HIV and infant mortality all represent significant health challenges for community members. Furthermore, persistent disparities in mortality and health status for several health indices are seen in various racial and ethnic populations. Among Prince George's residents, relatively high rates of asthma,

obesity, and homicide are additional areas of concern. These are certainly planning considerations in this majority minority community. Additionally, the racial and ethnic minorities are approximately 2/3 of Prince George's County Medicaid beneficiaries. County and Maryland State health statistics are similar to national trends regarding the status of minority health.

IDENTIFICATION OF COMMUNITY HEALTH NEEDS:

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

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

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

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

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

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

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

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

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

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

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

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

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

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

The written document (CHNA) must include the following:

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

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

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

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

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

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

The IMPLEMENTATION STRATEGY must:

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

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

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

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

   __X__Yes

   ____No

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

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

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

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

   _X__Yes

   ___No

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

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

III. COMMUNITY BENEFIT ADMINISTRATION

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

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

_X__Yes

___No

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

i. Senior Leadership

1. __X_CEO
2. __X_CFO
3. __X__Other (please specify – COO, General Counsel)

ii. Clinical Leadership

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

iii. Community Benefit Department/Team

1. __X_Individual (please specify FTE)

1-FTE dedicated to Community Benefit

2. __X_Committee (please list members)

3. ___Other (please describe)

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

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

Spreadsheet ___X__yes _____no

Narrative ___X__yes _____no

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

Spreadsheet __X___yes _____no

Narrative __X___yes _____no

If you answered no to this question, please explain

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

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

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

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

b. Name of Initiative: insert name of initiative.

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

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

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

f. How were the outcomes of the initiative evaluated?

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

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

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

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

- Sexual Assault / Sexual Abuse Program
- Community-Based Care Transition Program
- Prince George's / Wards 7 & 8 Community Breast Health Link

For the fiscal years ending June 30, 2012 and June 30, 2013 PGHC had total community benefit expenditures (as a percent of total operating expenditures) of 26.31% and 24.06%, respectively. Each year, PGHC's total CB expenditures rank as one of the highest for all hospitals in the State of Maryland. PGHC's fiscal year 2013 CB expenditures are

primarily made up of mission-driven physician subsidies at $27,765,216 or 13.2% and charity care at $21,929,900 or 10.4% -- 23.5% total combined for the fiscal year ending June 30, 2013.

PGHC provided $49,695,116 in mission-driven physician subsidies and charity care in the fiscal year ending June 30, 2013. To fund this high level of physician subsidies and charity care, PGHC depends on State and County financial support. In light of PGHC's continued financial challenges and reliance on State and County financial resources, PGHC has limited funds or other resources to earmark for other high-level CB initiatives.

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

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

V. PHYSICIANS

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

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

Department Call; Physician provision of financial assistance to encourage alignment with the hospital financial assistance policies; and Physician recruitment to meet community need.

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

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

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

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

Jurisdiction	Number of uninsured Under Age 65*	Number of Safety Net Clinics	Number of Primary Care Physicians per 100,00 Population (2010)**
Prince George's County	148,038	5	95
Montgomery Count	123,741	11	217
Baltimore County	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)

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

Category 1 – Hospital-Based Physician Subsidies

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

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

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

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

Category 5 – Physician Recruitment to Meet Community Need

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

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

primarily subsidies to cover the compensation of Hospital-based physicians with whom the Hospital has exclusive contracts.

VI. APPENDICES

To Be Attached as Appendices:

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

    For ***example***, state whether the hospital:
    - Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
        - in a culturally sensitive manner,
        - at a reading comprehension level appropriate to the CBSA's population, and
        - in non-English languages that are prevalent in the CBSA.
    - posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
    - provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
    - provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
    - includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills; and/or
    - discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

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

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

1.

a. APPENDIX I -- FINANCIAL ASSISTANCE PROGRAM

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

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

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

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

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

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

c. APPENDIX III – PATIENT INFORMATION SHEET (Attached)

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

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

Description of the PGHC Mission, Vision and Value Statements:

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

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

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

TABLE III

HOSPITAL COMMUNITY BENEFIT PROGRAMS AND INITIATIVES

Identified Need	**Hospital Initiative I**	Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	How were the outcomes evaluated?	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of Initiative for current FY?
To provide support and services to males and females who experience sexual violence. It is estimated that 1 in 4 females and 1 in 6 males will experience some form of sexual violence.	Sexual Assault/ Sexual Abuse Program	To provide crisis counseling and ongoing counseling. To provide forensic medical exams. To provide community education and awareness. To provide victim advocacy.	Multi-Year Initiative The program celebrated its 40th year in September.	MCASA, County and State government, State's Attorney's Office, multiple law enforcement agencies. DV/SAC chairs the Sexual Assault Response Team (SART).	Quarterly reports are submitted to The Governor's Office of Crime Control and Prevention	During the Fiscal Year 2013 – DV/SAC completed over 150 forensic medical exams, served about 2,000 people, plus an additional 1600 people on hotline. Each year over 100 presentations provided on sexual violence and prevention initiatives. Services of over 40 trained volunteers used. Each year, DV/SAC hosts a "Take Back the Night" event. Over 200 gathered to listen to survivor stories and to participate in a candlelight vigil. Traditionally, Prince George's County has the largest number of rapes and forensic exams. This year, it was 2nd.	Yes	Appox. $150,000

Identified Need	**Hospital Initiative II**	Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	How were the outcomes evaluated?	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of Initiative for current FY?
To reduce high readmission rates among chronic disease populations.	Community-based Care Transitions Program – Health Connect	The overall goal of the collaborative initiative is to reduce the negative factors that result in adverse social determinants of health. In order to meet this large goal, the collaborative established the following objectives: -Medication reconciliation -Services • Referral to primary care physicians (PCP) and its effect • Application to Maryland Primary Adult Care (PAC) • Issue of low-cost drug cards • Home visit -Intervention	Multi-year Initiative	Medical Mall Health Services; University of Maryland School of Public Health; Anne Arundel Medical Center; Baltimore Washington Medical Center; Doctors Community Hospital; Fort Washington Medical Center; Howard Community Hospital; Howard University Hospital; Laurel Regional Hospital; Prince George's Hospital Center, Providence Hospital; United	Evaluation provided by Medical Mall based on patient enrollment, distribution of payers and chronic disease, and reduction in readmission rate	In FY 13 October thru November, there were 726 patients enrolled in the program at PGHC. Of those: ▪ 98.2% were referred to a PCP. ▪ 8% completed a PAC application ▪ 8% received low-cost drug cards ▪ 20% received home visits ▪ Comparative analysis from July –Nov 2011 to 2012 saw a 35% reduction rate for 30-day readmission	Based on continued partnership, evaluation and resources	Approx. $25,500

Identified Need	**Hospital Initiative II Cont'd**	Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	How were the outcomes evaluated?	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of Initiative for current FY?
				Medical Center				

Identified Need	**Hospital Initiative III**	Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	How were the outcomes evaluated?	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of Initiative for current FY?
To improve and expedite access to breast cancer screening and treatment for the residents of Prince George's County and Wards 7 & 8 in the District of Columbia.	Prince George's/Wards 7 & 8 Community Breast Health Link	To initiate patient navigation services to expedite access to breast cancer screening and treatment, and to reduce cycle time for breast cancer screening.	Two-year Initiative April 2012-March 2014	Greater Baden Medical Services, Prince George's Hospital Center, Laurel Regional Hospital, Southern Maryland Hospital, Capital Breast Care Center, Family & Medical Counseling, Inc.	Screening results and information provided by providers	FY 2013 Outcomes: 334 African Americans in Prince George's County, which is the target population, were referred for a low-cost mammogram; 149 individuals in the target population completed a low cost mammogram at a stationary mammogram. Of those, approximately 100 were provided at PGHC. 290 individuals in the target population received navigation services.	Based on continued partnership, evaluation and resources	Approx. $110,000

APPENDIX II

FINANCIAL ASSISTANCE PROGRAM POLICY #210-01

FINANCIAL ASSISTANCE PROGRAM

PURPOSE: To identify circumstances when Dimensions Healthcare System (DHS) may provide care without charge or at a discount commensurate with the ability to pay, for a patient whose financial status makes it impractical or impossible to pay for medically necessary services. This policy applies only to facility charges and not physician or other independent company billings. The provision of free and discounted care through our Financial Assistance Program is consistent, appropriate and essential to the execution of our mission, vision and values, and is consistent with our tax-exempt, charitable status.

Resources are limited and it is necessary to set limits and guidelines. These guidelines are not designed to discourage or turn away those in need from seeking treatment. They guidelines are intended to assure that the resources the Hospital can afford to devote to its patients are focused on those who are most in need and least able to pay, rather than those who choose not to pay. Financial assessments and the review of patients' assets and financial information is intended for the purpose of assessing need as well as gaining a holistic view of the patients' circumstances. DHS is committed to:

- Communicating this purpose to the patient so they can more fully and freely participate in providing the needed information without fear of losing basic assets and income;
- Assessing the patients' capacity to pay and reach payment arrangements that do not jeopardize the patients' health and basic living arrangements or undermine their capacity for self-sufficiency;
- Upholding and honoring patients' rights to appeal decisions and seek reconsideration, and to have a self-selected advocate to assist the patient throughout the process;
- Avoiding seeking or demanding payment from or seizing exempt income or assets; and
- Providing options for payment arrangements, without requiring that the patient select higher cost options for repayment.

CANCELLATION: This policy supersedes DHS Policy No. 200-41, "Financial Assistance Program," effective July 26, 2012, which is cancelled.

POLICY: Dimensions Healthcare System has a long tradition of serving the poor, the needy, and all who require health care services. However, our Hospitals alone cannot meet every community need. They can practice effective stewardship of resources in order to continue providing accessible and effective health care services. In keeping with effective stewardship, provision for financial assistance will be budgeted annually. Our Hospitals will continue to play a leadership role in the community by helping to promote community-wide responses to patient needs, in partnership with government and private organizations.

In order to promote the health and well-being of the community served, individuals with limited financial resources who are unable to access entitlement programs shall be eligible for free or discounted health care services based on established criteria. Eligibility criteria will be based upon the Federal Poverty guidelines and will be updated annually in conjunction with the published updates by the United States Department of Health and Human Services. All open self-pay balances may be considered for financial assistance. If a determination is made that the

patient has the ability to pay all or a portion of the bill, such a determination does not prevent a reassessment of the person's ability to pay at a later date. The need for financial assistance is to be re-evaluated at the following times:

- Subsequent rendering of services,
- Income change,
- Family size change,
- When an account that is closed is to be reopened, or
- When the last financial evaluation was completed more than six months before.

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

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

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

DEFINITIONS:

A. *Assets:* Includes immediately available cash and investments such as savings and checking as well as other investments, including retirement or IRA funds, life insurance values, trust accounts, etc. The following are to be considered exempt and shall not be considered in determining whether the uninsured patient qualifies for an uninsured discount:

1. Homestead property
2. $2,000 for the uninsured patient, or $3,000 for the uninsured patient and one dependent residing together.
3. $50 for each additional dependent residing in the same household.
4. Personal effects and household goods that have a total value of less than $2,000.
5. A wedding and engagement ring and items required due to medical or physical condition.
6. One automobile with fair market value of $4,500 or less.
7. Patient must have less than $10,000 in net assets.

B. *Bad Debt Expense:* Uncollectible accounts receivable that were expected to result in cash inflows (i.e. the patient did not meet the facility's Financial Assistance eligibility criteria). They are defined as the provision for actual or expected uncollectible expenses resulting from the extension of credit.

C. *Financial Assistance:* Health care services that were never expected to result in cash inflows, resulting from a provider's policy to provide health care services free or at a discount to individuals who meet the established criteria.

D.

E. *Contractual Adjustments:* Differences between revenue at established rates and amounts realized from third party payers under contractual agreements.

F. *Disposable Income:* Annual family income divided by twelve (12) months, less monthly expenses.

G. *Family:* The patient, his/her spouse (including a legal, common law spouse) and his/her legal dependents according to the Internal Revenue Service rules. Therefore, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of Financial Assistance.

H. *Family Income:* Gross wages, salaries, dividends, interest, Social Security benefits, workers compensation, veterans benefits, training stipends, military allotments, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates and trusts.

I. *Qualified Patient:*

1. *Financially Needy*: A person who is uninsured or underinsured and is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the medical facility's eligibility criteria set forth in this policy.
2. *Medically Needy:* A patient who does not qualify as financially needy, but whose medical or Hospital bills, even after payment by third-party payers, exceed 50% of their gross income. The patient who incurs catastrophic medical expenses is classified as medically needy when payment would require liquidation of assets critical to living or would cause undue financial hardship to the family support system.

J. *Medically Necessary Service:* Any inpatient or outpatient Hospital service that is covered by and considered to be medically necessary under Title XVIII of the federal Social Security Act. Medically necessary services do not include any of the following:

1. Non-medical services such as social, educational, and vocational services
2. Cosmetic surgery

PROCEDURE:

A. Financial Assistance Guidelines and Eligibility Criteria

1. To be eligible for a 100% reduction from the patient portion of billed charges (i.e. full write-off) the patient's household income must be at or below 200% of the

current Federal Poverty Guidelines which represents an individual earning minimum wage.

2. Patients with household income that exceeds 200% but is less than 500% of the Federal Poverty Guidelines will be eligible for a sliding scale discount of the patient portion of billed charges.
3. Medically needy patient accounts will be considered on a case-by-case basis by the Assistant Director of Patient Financial Services. The discounts to be applied will be based on a determination of what the family could reasonably be expected to pay, based on a review of current disposable income and expenses.
4. Individuals who are deemed eligible by the State of Maryland to receive assistance under the Violent Crime Victims Compensation Act or the Sexual Assault Victims Compensation Act shall be deemed eligible for financial assistance at a level to be determined on a case-by-case basis by the Assistant Director of Patient Financial Services.
5. Financial assistance applications will be considered as long as an account is open or when a change in patient financial status is determined.
6. After the financial assistance adjustment has been computed, the remaining balances will be treated in accordance with Patient Financial Services policies regarding self-pay balances. Payment terms will be established on the basis of a reasonable proportion of disposable income negotiated with the patient. No interest charges will accrue to the account balance while payments are being made. This also applies to payments made through a collection agency.

B. Identification of Potentially Eligible Patients

1. Where possible, prior to the admission of the patient, Admitting will conduct a pre-admission interview with the patient, the guarantor, and/or his/her legal representative. If a pre-admission interview is not possible, this interview should be conducted upon admission or as soon as possible thereafter. In the case of an emergency admission, the Hospital's evaluation of payment alternatives should not take place until the required medical care has been provided. At the time of the initial interview, the following information should be gathered:

    a. Routine and comprehensive demographic data.
    b. Complete information regarding all existing third party coverage.

2. Identification of potentially eligible patients can take place at any time during the rendering of services or during the collection process.
3. Those patients who may qualify for financial assistance from a governmental program should be referred to the appropriate program, such as Medicaid, prior to consideration for financial assistance.
4. Prior to an account being authorized for the filing of suit, a final review of the account will be conducted and approved by the Assistant Director of Patient Financial Services to make sure that no application for financial assistance was ever received. The Associate Vice President for Patient Financial Services must authorize a filing of summons. DHS will not request body attachments from the

court system for payment of an outstanding account; however it is recognized that the court system may take this action independently.

C. Determination of Eligibility

1. All patients identified as potential financial assistance recipients should be offered the opportunity to apply for financial assistance. If this evaluation is not conducted until after the patient leaves the facility, or in the case of outpatients or emergency patients, a Patient Financial Services representative will mail a financial assistance application to the patient for completion. In addition, whenever possible, patient billing and collection communications will inform patients of the availability of financial assistance with appropriate contact information. When no representative of the patient is available, the facility should take the required action to have a legal guardian/trustee appointed.
2. Requests for financial assistance may be received from:

    a. The patient or guarantor;
    b. Church-sponsored programs;
    c. Physicians or other caregivers;
    d. Various intake department of the institutions;
    e. Administration;
    f. Other approved programs that provide for primary care of indigent patients.

3. The patient should receive and complete a written *Application for Financial Assistance* (Attachment) and provide all supporting data required to verify eligibility.
4. In the evaluation of an application for financial assistance, a patient's total resources will be taken into account which will include, but not be limited to, analysis of assets (identified as those convertible to cash and unnecessary for the patient's daily living expense), family income and medical expenses. A credit report may be generated for the patient as well as for the purpose of identifying additional expense, obligations, assets and income to assist in developing a full understanding of the patients' financial circumstances.
5. If a patient qualifies as medically needy, then the application should be referred to the Assistant Director of Patient Financial Services for review and determination.
6. Approval for financial assistance for amounts up to $50,000 should be approved by the Associate Vice President of Patient Financial Services.
7. Upon completion of the application and submission of appropriate documentation, the Patient Financial Services representative will complete the Financial Assistance Worksheet (see PFS Department for current form). The information shall be forwarded to the Assistant Director of Patient Financial Services or their designee for determination. Financial assistance approval will be made in accordance with the guidelines and documented on the worksheet (see PFS Department for current form).

8. Accounts where patients are identified as medically needy or accounts where the collector or Director has identified special circumstances that affect the patient's eligibility for financial assistance will be referred to the Assistant Director of Patient Financial Services for consideration and final determination. The Committee's review of accounts that do not clearly meet the criteria and the decisions and rationale for those decisions will be documented and maintained in the account file (see PFS Department for current form).
9. A record, paper or electronic, should be maintained reflecting authorization of financial assistance (see PFS Department for current form). These documents shall be kept for a period of seven (7) years.

D. Notification of Eligibility Determination

1. Clear guidelines as to the length of time required to review the application and provide a decision to the patient should be provided at the time of application.

    a. Probable Eligibility Determination. DHS will make a determination of probable eligibility within two (2) business days following a patient's request for charity care services, application for medical assistance, or both.
    b. Final Determination. DSH will make a final determination, in writing, of eligibility generally within thirty (30) days of receipt of a complete application. Patients who are denied eligibility will be provided a reason(s) for denial, and informed of their appeal rights, and provided contact information to do so.

2. If a patient disagrees with the decision, the patient may request an appeal process in writing within seven (7) days of the denial. The Financial Assistance Committee will review the application. Decisions reached will normally be communicated to the patient within two (2) weeks, and reflect the organization's final and executive review.
3. Collection activity will be suspended during the consideration of a completed financial assistance application or an application for any other healthcare bracket (i.e., Medicare, Medicaid, etc.). A note will be entered into the patient's account to suspend collection activity until the financial assistance process is complete. If the account has been placed with a collection agency, the agency will be notified by telephone to suspend collection efforts until a determination is made. This notification will be documented in the account notes. The patient will also be notified verbally that the collection activity will be suspended during consideration. If a financial assistance determination allows for a percent reduction but leaves the patient with a self-pay balance, payment terms will be established on the basis of disposable income.
4. If the patient complies with a payment plan that has been agreed to by the Hospital, the Hospital shall not otherwise pursue collection action against the patient.
5. If the patient has a change in their financial status, the patient should promptly

notify Patient Financial Services. The patient may request and apply for financial assistance or a change in their payment plan terms.

E. Availability of Policy: Every Hospital, upon request, must provide any member of the public or state governmental entity a copy of its financial assistance policy.

F. Application Forms: Every Hospital must make available, upon request by a member of the public, a copy of the application used by the Hospital to determine a patient's eligibility for financial assistance.

G. Monitoring and Reporting

1. A financial assistance log from which periodic reports can be developed shall be maintained aside from any other required financial statements. Financial assistance logs will be maintained for a period of seven (7) years. At a minimum, the financial assistance logs are to include:

   a. Account number,
   b. Date of service,
   c. Application mailed (Yes/No),
   d. Application returned and complete (Yes/No),
   e. Total charges,
   f. Self-pay balances,
   g. Amount of financial assistance approved, and
   h. Date financial assistance was approved.

2. The cost of financial assistance will be reported annually in the community Benefit Report. Financial will be reported as the cost of care provided (not charges) using the most recently audited Medicare cost report and the associated cost to charge ratio.

ORIGINATOR: Finance /
Patient Financial Services

APPROVAL:

Neil J. Moore
President & Chief Executive Officer

Financial Assistance Program 210-01 (1/23/2008, 7/26/2012, __/__/2013)

ATTACHMENT:

Application for Financial Assistance

Dimensions Healthcare System

APPLICATION FOR FINANCIAL ASSISTANCE

Information About You

Name: _____
First Middle Last

Social Security Number: ___-___-____ Marital Status: Single Married Separated

US Citizen: Yes No Permanent Resident: Yes No
(Citizenship status does not affect your ability to qualify for financial assistance).

Home Address: _____ Phone _____

_____
City State Zip Code Country

Employer Name: _____ Phone _____

Work Address: _____

_____
City State Zip Code

Household Members:

Name Age Relationship

Name Age Relationship

Name Age Relationship

Name Age Relationship

Name Age Relationship

Name Age Relationship

Name Age Relationship

Services for Which You Are Requesting Financial Assistance

Date(s) of service: _____
Total amount of bill: _____
Amount of assistance requested: _____

Have you applied for Medical Assistance? Yes No
If yes, what was the determination? _____

Account Number: _____ Medical Record Number: _____

Family Income

Please list the amount of your monthly income from the following possible sources and include copies of your federal tax return and other documents to show proof if income. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	
Retirement/pensions benefits	
Social Security benefits	
Public Assistance benefits	
Disability benefits	
Unemployment benefits	
Veteran's benefits	
Alimony	
Rental property income	
Strike benefits	
Military allotment	
Farm or self-employment	
Other income source	

Liquid Assets

	Current Balance
Checking accounts	
Savings account	
Stocks, bonds, CD, money market, or other accounts	

Other Assets

If you own any of the following items, please list the type and approximate value.

Home Approximate value

Automobile Make _____ Year _____ Approximate value

Additional vehicle Make _____ Year _____ Approximate value

Additional vehicle Make _____ Year _____ Approximate value

Other property Approximate value

Monthly Expenses

	Amount
Rent or Mortgage	
Utilities	
Car payment(s)	
Credit cards(s)	
Car insurance	
Health insurance	
Other medical expenses	

Other Expenses

Do you have any other unpaid medical bills? Yes No
For what service? _____
If you have arranged a payment plan, what is the monthly payment? _____

If you request that the Hospital extend additional financial assistance, the Hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the Hospital of any changes to the information provided within ten days of the change.

_____ _____
Applicant Signature Date

APPENDIX III

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

- Respect and follow DHS and facility rules and regulations when receiving care/treatment/services to include visiting hours, smoking, noise, and the use of non-hospital medications.
- Respect and be considerate of other patients, visitors and hospital staff
- Respect hospital property, treat such property with reasonable care, and be waste conscious.
- Protect Your Safety

  - *Mark the correct site or side of your body before a procedure.*
  - *Remind staff to check your ID band.*
  - *Remind staff to wash their hands.*
  - *Look for an ID badge on all staff.*
  - *Immediately report to a member of the healthcare team any safety concerns and/or unexpected change(s) in your condition.*

- ***SPEAK UP™:** Be an active member of your healthcare team and help us make your healthcare safer.

  - ***S**peak-up if you have questions or concerns. If you still don't understand, ask again.*
  - ***P**ay attention to your care. Always make sure you're getting the right treatments and medicines by the right healthcare professionals. Don't assume anything.*
  - ***E**ducate yourself about your condition. Learn about the medical tests and your treatment plan.*
  - ***A**sk a trusted family member or friend to be your advocate (advisor or supporter).*
  - ***K**now what medicines you take and why you take them. Medicine errors are the most common healthcare mistakes.*
  - ***U**se a facility, clinic, surgery center or healthcare facility that has been carefully checked out.*
  - ***P**articipate in all decisions about your treatment. You are the center of the healthcare team.*

*Speak Up is a Joint Commission Patient Safety Program Initiative

Health Care Decisions

Dimensions recognizes and respects the rights of patients with decision-making capacity to participate in decisions about their medical treatment. Making health care decisions can be very complex and difficult, especially when the patient does not have the capacity to make their own healthcare decisions. Family members may have difficulty making these health care decisions for the patient.

The Ethics Committee is available to assist patients, families and facility staff in determining the most appropriate plan of care. A family member, physician or a healthcare team member can request an Ethics consultation at Prince George's Hospital Center by calling (301) 618-2740 or at Laurel Regional Hospital by calling (301) 497-7911.

Advance Directives

You have the right to accept or refuse treatment, including forgoing or withdrawing life-sustaining treatment or withholding resuscitative services. These decisions, called advance directives, can include:

- the right to accept or refuse care
- the right to make oral or written declarations
- a living will
- a durable power of attorney for health care decisions
- organ donation wishes

If you would like information about advance directives, ask any member of the healthcare team.

If you have an advance directive, please give a copy to staff so that all members of the healthcare team will be aware of your wishes. You can review, revise or withdraw your advance directive at any time. We will honor your advance directive in accordance with the law.

Other Services

Pastoral Care
Patients and family members often turn to their faith for emotional support in a time of illness or grief. We work with the community faith system to provide support to patients and family who desire pastoral care. Please ask your caregiver if you would like to request a pastoral care visit.

Chapel
There is a chapel available to patients and their families for prayer, meditation and reflection. This room is unattended and provides a quiet place for patients and their families to pray.

Support Groups
We offer a number of support groups. Please ask staff for a list of support groups.

Corporate Compliance

Dimensions Healthcare Systems is committed to excellence. Our services are provided in accordance with applicable laws and regulations. Staff is continuously educated and practice according to legal and ethical standards while providing quality healthcare services to our patients and family members.

If you have any concerns, please contact Corporate Compliance via the Compliance Hotline (877) 631-0015.

Safety and Security

Everyone has a role in making healthcare safe -- staff and you. Every staff member will display picture identification. You must wear your ID band until you are discharged.

You, as the patient, play a vital role in making your care visit safe by becoming an active, involved and informed member of your health care team.

We encourage you to notify us if you have concerns about your safety. To report a concern, please call the Safety Hotline at (301) 618-6400.

Patient Property and Valuables

For your own protection, you should not bring items of value to the facility and we request that you send any personal property home that you may have with you. Dimensions Healthcare System nor any of its facilities will accept responsibility for patient property or valuables.

Smoking

To provide a healthy environment, Dimensions is a smoke-free campus. You must refrain from smoking on all facility property.

To support our employees, family and friends who wish to stop smoking, a free Smoking Cessation Program is offered. The program is 4-weeks in length (one group session per week for 1½ hours). Day and evening sessions are available. To participate, you must be 18 years old and a Maryland resident. For more information, you can call (301) 618-6363.

Follow-up Phone Call

Upon discharge from the hospital/visit, you may receive a follow-up phone call to see how you are doing. It is our goal to be your hospital of choice. Feel free to share your concerns or suggestions with us during this call.

Copy of your Medical Record

If you need a copy of your medical record, you can request a copy by visiting Health Information Management.

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Dimensions Healthcare System

Prince George's Hospital Center
Laurel Regional Hospital
Bowie Health Center
Glenridge Medical Center
Senior Health Center

What You Should Know As A Patient

www.dimensionshealth.org

Access to Care

Each patient has the right to quality care, treatment, service or accommodations that are available or medically necessary without consideration of race, color, religion, sex, national origin, age, handicap or source of payment.

Interpretive Services

A patient and/or his/her companion with hearing, language, speech, vision, or other cognitive impairments, will be offered assistance to ensure effective communication and access to healthcare services at no charge.

If you need assistance or have questions about available accommodations, you may ask any staff member for assistance. If you or a visitor believes you have been unable to use the facility's full array of services, we encourage you to contact the Patient Representative.

Patient Representative

A Patient Representative is available to meet with patients and families who have questions and concerns about their stay, to facilitate problem resolution and to assist with special needs. You may contact the Patient Representative at Prince George's Hospital Center at (301) 618-3857 or at Laurel Regional Hospital at (301) 497-8765.

Visitors

A patient has the right to have a support person he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), family member or a friend present during the visit and/or hospital stay.

Complaints/Grievances

For complaints and grievances contact the Patient Representative ***OR*** you may file directly with one of the following agencies.

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Hospital Center,
Bland Bryant Building
55 Wade Avenue
Catonsville, Maryland 21228
Phone: (410) 402-8000 or (877) 402-8218
Email: ohcq.web@maryland.gov

OR

The Joint Commission
Office of Quality Monitoring
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Phone: (800) 994-6610 / Fax: (630) 792-5636
E-mail: complaint@jointcommission.org

For Medicare discharge and appeal rights:

Delmarva Foundation for Medical Care
6940 Columbia Gateway Drive
Woodlands Two, Suite 240
Columbia, MD 21046
Phone: (800) 492-5811 or TTY (800) 735-2258

For mental and behavioral health services:

Maryland Disability Law Center
1500 Union Avenue, Suite 2000
Baltimore, MD 21211
Phone: (410) 727-6352 or (800) 233-7201
TTY: (410) 235-5387
Fax: (410) 727-6389
Email: feedback@mdlclaw.org

For medication concerns:

Maryland Board of Pharmacy
4201 Patterson Avenue
Baltimore, Maryland 21215
Phone: (410) 764-4755 or (800) 542-4964
TTY: (800) 735-2258
Fax: (410) 358-6207
Email: MDBOP@DHMH.STATE.MD.US

Financial Information

Your insurance information will be verified at each visit in order to bill your insurance company for payment on your behalf. Payment of all known deductibles, co-payments and non-covered services will be required at the time service is rendered.

You may receive a bill from Dimensions for facility fees and from individual physicians for professional fees.

If you need financial assistance, you may qualify for Dimensions' financial assistance program or arrange a payment plan for your facility fees. Financial assistance is not available for professional fees billed to you by individual physicians.

If you have questions regarding your bill, call the Business Office at (301) 618-3100.

For concerns about payment or lack of payment by your health insurance plan, you may file a complaint directly to:

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
Life and Health / Appeals and Grievances
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
Phone: (410) 468-2340 or (800) 492-6116
TTY: (800) 735-2258
Fax: (410) 468-2270 or (410) 468-2260

Patients' Rights and Responsibilities

Healthcare is a cooperative effort between you (the patient) and Dimensions. It is important for you to understand your rights, be well informed and actively participate in decisions about your care.

YOUR RIGHTS ARE:

- To be informed of your rights
- Be treated in a dignified and respectful manner
- To communication in a manner you can understand, this includes the use of a language and/or sign language interpreter
- To have your personal values, religious and other spiritual preferences respected
- To have your privacy respected
- To participate in the management of your pain
- To access, request an amendment to and obtain information on disclosure of your health information
- To participate in decisions about your care, treatment and services. These decisions include:
  - To have your physician notified of your admission to the hospital
  - To refuse care/treatment/services
  - To have a surrogate decision-maker make decisions about your care when you cannot
  - To be informed about outcomes of care, treatment and services, including unanticipated outcomes
- To give or withhold informed consent.
- To give or withhold informed consent to produce or use recordings, films or other images of the patient for purposes other than his/her care.
- To participate or refuse to participate in research, investigation and clinical trials.
- To receive information about the individual(s). responsible for, as well as those providing, his/her care/treatment/service.
- To honor your end of life wishes. This includes:
  - To receive information about advance directives, forgoing or withdrawing life-sustaining treatment and withholding resuscitative services
  - To receive information on the extent to which the hospital is able, unable or unwilling to honor advance directives
  - Honor the your right to formulate or review and revise his/her advance directives
  - Honor your advance directives, in accordance with law and regulation and the hospital's capabilities
  - Honor your wishes concerning organ donation within the limits of the hospital's capability and in accordance with law and regulation
- To be free from neglect, exploitation and verbal, mental, physical and sexual
- To an environment that preserves dignity and contributes your positive self image.
- To have complaints reviewed by the Hospital. This includes:
  - Receive information about the complaint resolution process
  - Receive the phone number and address needed to file a complaint with the relevant state authority
  - Voice complaints and recommend changes freely without being subject to coercion, discrimination, reprisal or unreasonable interruption of care
- To access protective and advocacy services.
- To confidentiality of your medical record.
- To be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.

YOUR RESPONSIBILITIES ARE:

- To provide, to the best of your knowledge, accurate and complete information upon admission/visit that may include information about past hospitalizations, previous and concurrent health problems, medications and treatment (including any vitamins or herbal supplements), insurance data, executed Advance Directives, and all other matters pertaining to your health status.
- To communicate in a direct and honest manner with doctors, nurses, and other hospital staff members about matters or conditions that concern your health
- Inform the staff of your whereabouts and probable return time if you leave the patient unit/ancillary department.
- Accept responsibility for the outcome when you fail to follow the instructions of the physicians and hospital staff.
- Accept responsibility and promptly meet your financial obligations for healthcare provided.

APPENDIX IV

MISSION, VISION, AND VALUES STATEMENT #200-24

MISSION, VISION AND VALUES STATEMENTS

MISSION

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

VISION

To be recognized as a premier regional health care system.

VALUES

Dimensions Healthcare System:

- ***Respects*** the dignity and privacy of each patient who seeks our service.
- Is committed to ***Excellent Service*** which exceeds the expectations of those we serve.
- Accepts and demands ***Personal Accountability*** for the services we provide.
- Consistently strives to provide the highest ***Quality*** work from individual performance.
- Promotes ***Open Communication*** to foster partnership and collaboration.
- Is committed to an ***Innovative Environment***; encouraging new ideas and creativity.
- Is committed to having its hospitals meet the highest standards of ***Safety***.

APPROVAL:

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President & Chief Executive Officer

Mission, Vision, Values and Service Priorities 200-24 (6/6/2006, 4/16/2009, 11/1/2010, 7/14/2011)