Dimensions Healthcare System

Laurel Regional Hospital

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

Laurel Regional Hospital

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

INTRODUCTION AND BACKGROUND:

HSCRC Community Benefit Report:

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

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

LAUREL REGIONAL HOSPITAL:

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

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

DHS President & CEO – Neil Moore

DHS, Interim Chief Operating Officer & President, LRH – John Spearman

Chief Nursing Officer – Michelle Epps (Interim)

Location: 7300 Van Dusen Road, Laurel, Maryland 20707

Facility type: Full-service community hospital

Licensed Bed Designation: 152 (plus 9 bassinets)

Included are: 78 - Inpatient Acute
28 - Inpatient Medical Rehabilitation
46 - Special Hospital (Chronic)

Inpatient Admissions for FY 2013: 5,365

No. of employees: 743

Services:

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

- Behavioral Health Services (with an inpatient psychiatric unit for adults and outpatient partial hospitalization program)
- Cardiac Catheterization (diagnostic peripheral vascular studies, cardioversions, TEE's, pacemaker insertions)
- Cardiopulmonary Services (Echo, EKG, Stress tests, EEG, PFT)
- Critical Care Services (includes coronary care and 10-bed intensive care unit)
- Diabetes Services (inpatient and outpatient services)
- Emergency Services (24-hour emergency care)
- Infusion Services (outpatient intravenous infusion services)
- Maternal and Child Health (obstetrics, anesthesia, and nursery services)
- Medical / Surgical Services (virtually all adult specialties performed)
- Physical Rehabilitation (only hospital-based accredited inpatient rehabilitation unit in Prince George's County)
- Pulmonary Rehabilitation (outpatient pulmonary rehabilitation program)
- Sleep Wellness Center (sleep medicine services)
- Specialty Care Unit (chronic care specialty unit providing comprehensive nursing care in a full-service hospital environment)
- Wound Care & Hyperbaric Medicine Center (wound treatment and healing services)

Facilities:

- The emergency department includes 14 acute rooms; 10 intermediate rooms; 6 fast track rooms (ambulatory care) and one resuscitation/trauma room; 4 isolation rooms and 3 more that can be converted to negative pressure isolation rooms; POC (Point of Care) lab, and blood bank located in the main lab.
- In-house Infusion Center includes 5 rooms and 2 beds.
- In-house Specialty Care Unit includes 46 beds.

- Surgical services houses 7 operating suites, a 10-bed intensive care unit, cardiac catheterization lab and 2 endoscopy suites.

Ownership:

Laurel Regional Hospital is a member of Dimensions Healthcare System, the largest provider of healthcare services in Prince George's County. Dimensions Healthcare System also includes Prince George's Hospital Center, Cheverly, Maryland, and Bowie Health Center, Bowie, Maryland.

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

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

Table I

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:
1521 + 9 Bassinets	**5,365**	**20707** **20708** **20705** **20706** **20723** **20724** **20737** **20740** **20743** **20747** **20904** **20770** **20785**	**Washington Adventist** **Howard County General** **Montgomery General** **Doctors Community** **Holy Cross** **Prince George's Hospital Center**	LRH total patient population: 7.68% Prince George's: 16% Anne Arundel: 9% Howard: 8% Montgomery: 13%	LRH total patient population: 21.23% Prince George's: 16.9% Anne Arundel: 6.5% Howard: 2.9% Montgomery: 12.8%

PRIMARY SERVICE AREA DEMOGRAPHICS:

Laurel Regional Hospital's (LRH) Primary Service Area (PSA) is made up of 13 zip code areas within northern Prince George's County and portions of Anne Arundel, Howard and Montgomery counties.

The counties within the LRH PSA are affluent, Howard County being the wealthiest with a median household income of $107,821. Montgomery County has the largest population with an estimated 1,016,677 residents. In Prince George's County more than half the population, 65.1%, is African American compared to the other counties, with predominantly White populations, making it one of the few majority-minority counties in Maryland. Much like other counties throughout Maryland and the nation, each of these counties has challenges concerning the administration of health services. The bulk of those challenges are due to lack of access to health care, especially primary care, a high uninsured population, and disparate health among ethnic groups.

Smoking, obesity, high blood pressure and diabetes are health risk factors within all of the counties however Prince George's, Montgomery and Anne Arundel counties appear to have higher percentages for risk for premature death in those areas. This is most likely due to the inability to access healthy foods and primary care services. Prince George's County represents the largest portion of the PSA and faces the greatest health challenges when compared to neighboring counties. Data provided in this report will show that socioeconomic status and healthcare access affect health outcomes and contribute to disproportionate care within the populations served in the service areas.

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.

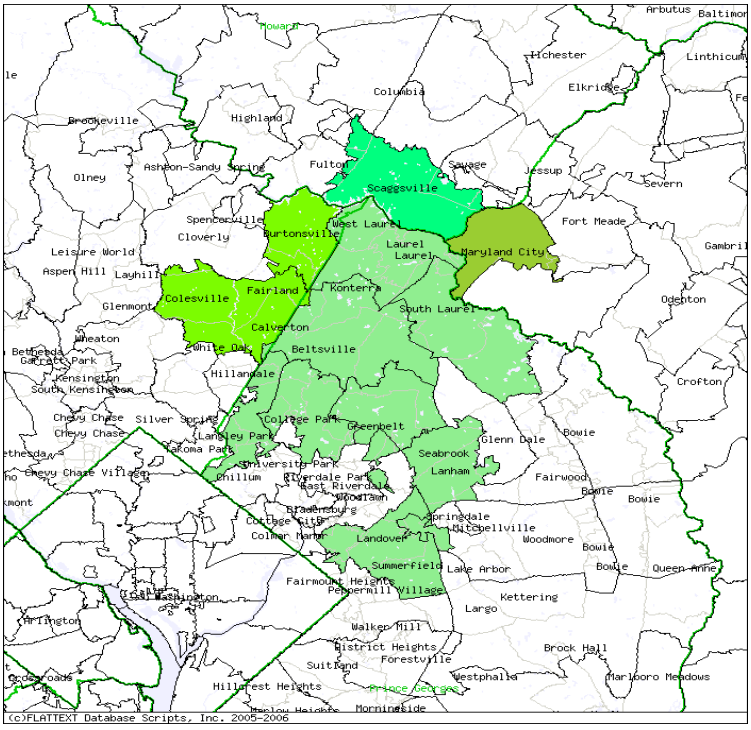
Much like the LRH PSA, the LRH Community Benefit Service Area (CBSA) is unique due to the fact that it covers portions of four different counties. However LRH's CBSA differs from its PSA in that it encompasses only eight of the zip code areas found in the PSA. The zip code areas in the LRH CBSA are: 20705, 20706, 20707, 20708, 20723, 20724, 20866, and 20904. Four of these zip codes are in Prince George's County, one in Anne Arundel County, one in Howard County and two in Montgomery County.

Patients from these zip code areas make up approximately 60% of LRH's total inpatient and outpatient admissions. Patients from Prince George's County represent about 51.8%

of these admissions while patients from Anne Arundel, Montgomery, and Howard counties represent 6.9%, 28.8%, and 12.5% respectively. More than 245,000 people make up the LRH CBSA. The LRH CBSA has a population that is 45.5% African-American, 26% White (non-Hispanic), 15.4% of Hispanic origin, 10.1% of Asian origin, and 2.6% of other ethnic origin.

In terms of identified need, once again, it should be noted that zip code areas in Prince George's County have been identified to have the greatest need for health services to improve health status and disparities. At 8.7%, Prince George's County has the highest percentage of households with incomes below the federal poverty line as well as higher percentages of uninsured (15.6%), Medicaid recipients (15.7%) and the highest mortality rate (747.8/100,000 people). As discussed later in the report, it has been the focal point of a number of studies to improve access to care and health outcomes.

LRH COMMMUNITY BENEFIT SERVICE AREA FY 2013



CBSA Zip Codes	City	Population	County
20705	Laurel	26,336	Prince George's
20706	Lanham	42,095	Prince George's
20707	Laurel	32,706	Prince George's
20708	Laurel	25,908	Prince George's
20723	Laurel	30,543	Howard
20724	Laurel	16,879	Anne Arundel
20866	Burtonsville	13,956	Montgomery
20904	Silver Spring	56,683	Montgomery

(Percent of total 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.)

Table II

Community Benefit Service Area(CBSA) Target Population (target population, by sex, race, and average age)	CBSA Population: 245,106 Sex M – 47.5% F – 52.5% White (non-Hispanic)– 26% African-American – 45.5% Hispanic/Latino –15.4% Asian –10.1% Multiple Race – 3.7% Other Race –7.1% Median Age: ***Source:***
Median Household Income within the CBSA (county level)	Prince George's County: $73,568 Anne Arundel County : $86,987 Howard County: $107,821 Montgomery County: $96,985 ***Source: US Census Bureau, 2013 QuickFacts***
Percentage of households with incomes below the federal poverty guidelines within the CBSA	**County level**

	Prince George's County: 8.7% Anne Arundel County : 5.9% Howard County: 4.4% Montgomery County: 6.5% ***Source: US Census Bureau, 2013QuickFacts***
Please estimate the percentage of uninsured people by County within the CBSA.	Prince George's County: 15.5% Anne Arundel County : 6.6% Howard County: 7.6% Montgomery County: 11.1% ***Source: U.S. Census Bureau, 2013 ACS***
Percentage of Medicaid recipients by County within the CBSA.	Prince George's County: 15.7% Anne Arundel County : 9% Howard County: 7% Montgomery County: 9% ***Source: US Dept. of Health & Human Services,2009 Community Health Status Indicator (CHSI)***
Life Expectancy by County within the CBSA.	**All races (White & Black)** Prince George's County: 79.2 years Anne Arundel County : 79.8 years Howard County: 82.3 years Montgomery County: 84.1 years ***Source: Maryland Vital Statistics Annual Report, 2012***
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Prince George's County : 570.7/100,000 Anne Arundel County : 701.9/100,000 Howard County: 487.9/100,000 Montgomery County: 573.2/100,000 ***Source: Maryland Vital Statistics Profile: 2012***

<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)

PG – Prince George’s

AA – Anne Arundel

H- Howard

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

<table>
<tr><th></th><th>PG</th><th>AA</th><th>H</th><th>M</th></tr>
<tr><td>No exercise</td><td>23.8%</td><td>22.5%</td><td>18.4%</td><td>17.4%</td></tr>
<tr><td>Limited access to healthy foods</td><td>4%</td><td>3%</td><td>2%</td><td>1%</td></tr>
<tr><td>Obesity</td><td>33.9%</td><td>28%</td><td>24.6%</td><td>18.4%</td></tr>
<tr><td>High blood pressure</td><td>26.2%</td><td>28.2%</td><td>19.8%</td><td>22.4%</td></tr>
<tr><td>Smoker</td><td>13.9%</td><td>15.6%</td><td>8.4%</td><td>7.9%</td></tr>
<tr><td>Diabetes</td><td>8.3%</td><td>7.5%</td><td>4.5%</td><td>5.2%</td></tr>
</table>
Source: County Health Rankings, Maryland Data, 2014 and US Dept. of Health & Human Services,2009 Community Health Status Indicator (CHSI)</td>
</tr>
<tr>
<td>Other

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

Prince George’s County: 6.8%

Anne Arundel County : 6.1%

Howard County: 5.0%

Montgomery County: 5.1%

Source: County Health Rankings 2014</td>
</tr>
<tr>
<td>Other

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

Prince George’s County – 1,804:1

Anne Arundel County - 1,452:1

Howard County- 540:1

Montgomery County – 729:1

Nat’l Benchmark – 1,051:1

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

Source: County Health Rankings 2014</td>
</tr>
</table>

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

Gender	**CBSA Area**	**% of Total**
2014* Total Population	245,106	100%
Total Male Population	116,495	47.5%
Total Female Population	128,612	52.5%

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

Race/Ethnicity	**2014 Population**	**% of Total**	**USA % of Total**
White (Non-Hispanic)	63,801	26%	63.3 %
Black (Non-Hispanic)	111,611	45.5%	12.6%
Hispanic	37,846	15.4%	16.6%
Asian (Non-Hispanic)	24,830	10.1%	4.9%
All Others	7,022	2.9%	4.7%
Total	245,106	100%	100%

Source: U.S. Census Bureau, 2013 ACS

Age Distribution	**2014 Population**	**% of Total**	**USA % of Total**
Ages 0-17	58,643	24%	23.3%
Ages 18-64	158,495	64.7%	62.9%
Ages 65 and over	27,962	11.4%	13.5%
Total	245,106	100%	100%

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

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

Uninsured by County	**Prince George's**	**Anne Arundel**	**Howard**	**Montgomery**	**Maryland**	**USA % of Total**
Average, All Races	15.5%	7.2%	7.2%	11.5%	10.2%	14.5%
White (Non-Hispanic)	1.2%	5.4%	1.6%	1.9%	3.3%	9.8%
Black (Non-Hispanic)	6.6%	7.7%	1.1%	2.7%	3.2%	2.1%
Hispanic	6.9%	2.1%	1.3%	5.5%	2.9%	4.9%
Asian	0.7%	0.6%	1.1%	1.7%	0.8%	0.8%
Some other race alone	4.2%	1.4%	1.2%	3.0%	1.5%	1.5%

Source: U.S. Census Bureau, 2013 ACS

Comparative Vital Statistics	**Prince George's County**	**Anne Arundel County**	**Howard County**	**Montgomery County**	**Maryland**
Age Adjusted Mortality Rates: 2009 - 2012					
All Causes of Death	718.5	714.2	594.2	514.7	714.5
Disease of the Heart	191.2	171.5	137.4	119.7	174.9
Malignant Neoplasms	165.2	164.1	140.4	126.7	166.8
Cerebrovascular Disease	35.2	39.9	33.8	27.5	37.4
Diabetes Mellitus	27.6	21.5	13.7	13.2	19.9
Accidents	24.0	22.4	19.6	16.7	25.7
Chronic Lower Respiratory Diseases	22.7	38.9	23.8	18.2	33.7
Septicemia	16.3	14.0	9.9	10.6	14.1
Alzheimer's Disease	15.0	12.4	20.6	14.4	15.4
Influenza and Pneumonia	13.5	17.8	15.3	13.1	16.1
HIV	5.6	1.5	***	1.6	4.3
Nephritis, Nephrosis, and Neprotic Syndrome	14.6	10.9	8.8	8.6	12.1
Assault (Homicide)	10.4	3.4	2.7	2.4	7.5
Intentional Harm	5.7	9.3	9.2	7.0	8.8

Source: Maryland Vital Statistics Profile: 2012

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

Community Challenges & Health Statistics:

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

Despite the higher than average median household income, educational attainment, and percentage of individuals in the work force represented by Prince Georgians on 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 NEEDS:

LRH is improving and adapting current health programs into sustainable community-based programs to impact the overall health and wellness of the community in a positive way. This service expansion and adaptation is being achieved through collaborative partnerships with community organizations as well as state and local health agencies. LRH management actively solicits information from community stakeholders and other community-based organizations to assess the health needs in our community. LRH

representatives serve as members of a variety of healthcare focused community organizations and provide staff expertise and other resources, including hosting meetings at our facility, and participating in events, by providing health screening services. Some of these organizations include:

- Prince George's County Health Department
-
- 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 Mental Health and Hygiene, Integrity Health Partners and the City of Seat Pleasant, among others.

LRH continues to build more community partnerships to improve community benefit. LRH is developing more health initiatives to promote awareness of risk and prevention associated with health conditions such as asthma, diabetes, and mental health.

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

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

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

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

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

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

- "Prince George's County Health Department – Health Report 2014", completed by the Prince George's Health Department (retrieved

http://www.princegeorgescountymd.gov/sites/Health/ContactUs/Publications/Documents/2014%20health%20report%20v4-08-14%20no%20blank%20pages.pdf (November 2014)

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-LRH-CHNA-REPORT.2013.pdf

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

_X__Yes

___No

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

http://www.dimensionshealth.org/wp-content/uploads/2013/11/LRH-ISP-10-22-13.pdf

III. COMMUNITY BENEFIT ADMINISTRATION

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

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

_X__Yes

___No

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

i. Senior Leadership

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

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.

Laurel Regional Hospital participates in a number of community benefit initiatives and programs (see attached Table III). The current initiatives and programs are as follows:

- Prince George's/Wards 7 & 8 Community Breast Health Link
- Community Health Education Program
- Blood Pressure Screening & Education Program

For the fiscal years ending June 30, 2013and June 30, 2014 LRH had total community benefit expenditures (as a percent of total operating expenditures) of 16.91%, and 15.02%

respectively. Each year, LRH's total CB expenditures rank as one of the highest for all hospitals in the State of Maryland. LRH's fiscal year 2014 CB expenditures are primarily made up of mission-driven physician subsidies at $10,430,506 or 10% and charity care at $4,507,400 or 4.32% -- 14.32% total combined for the fiscal year ending June 30, 2014.

LRH provided $14,937,906 in mission-driven physician subsidies and charity care in the fiscal year ending June 30, 2014. To fund this high level of subsidies and charity care, LRH depends on State and County financial support. In light of LRH's continued financial challenges and reliance on State and County financial resources, LRH 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, LRH is not currently focusing on top health concerns identified by the CHNA such as heart and kidney failure due to lack of 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. Though these needs are not presently being addressed by LRH 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.

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

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

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

In addition, three of the Prince George's County zip code areas in the LRH CBSA are considered Health Enterprise Zones (HEZs). They are zip code areas 20705, 20707 and 20708. HEZs, defined as geographically designated areas with high rates of disparities, are the result of the Health Disparities and Reduction Act of 2012 which was enacted by Maryland Governor Martin O'Malley.

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, LRH had a patient and third party payer mix that included 38.7% Medicaid and uninsured self-pay patients.

Category 1 – Hospital-Based Physician Subsidies

LRH's emergency department, 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 caused by LRH'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, LRH 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 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 LRH physician subsidies also include expenses incurred for ongoing physician recruitment.

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

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

LRH has a long tradition of serving the poor, the needy, and all who require health care services. However, the Hospital alone cannot meet every community need. We practice effective stewardship of resources in order to continue providing accessible and effective health care services. In keeping with effective stewardship, the provision for financial

assistance is budgeted annually. LRH continues to play a leadership role in the community by helping to promote community-wide responses to patient needs, in partnership with government and private organizations.

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

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

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

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

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 LRH Mission, Vision and Value Statements:

- The mission of LRH 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 LRH is to be recognized as a premier regional health care system.

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

TABLE III

HOSPITAL COMMUNITY BENEFIT PROGRAMS AND INITIATIVES

Table III – LAUREL REGIONAL HOSPITAL
FY14

Initiative 1.

Identified Need	Hospital Initiative	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	A. Cost of initiative for current FY?	B. Amount of Direct Offsetting Revenue from Restricted Grants
Health education and awareness	Community Health Education Program	Engage and partner with community phsycians to increase awareness of diabetes services and education availability	Ongoing Initiative	Laurel Regional Hospital (LRH) Healthways, Inc. LRH Pulmonary Dept. LRH Physical Medicine Dept. Dimensions Healthcare System Diabetes Center Dimensions Healthcare System Smoking Cessation Program Laurel Beltsville Senior Activity Center	Tracked number of individuals accessing health education programs and health screenings	From July. 2013 thru June. 2014 about 68 individuals participated in more than 20 program sessions. There were approximately 180 encounters. Sessions included: Education programs on health disease, sleep medicine, COPD, Diabetes self-management Hosted the annual "Take a Loved One to the Doctor Day" event which included screening related to diabetes heart disease, pulmonary conditions, breast health, etc. more than 200 individuals registered at the event with approximately 480 encounters	Based on continued partnership, evaluation and resources	$59,500	

Table III – LAUREL REGIONAL HOSPITAL
FY14

Initiative 2

Identified Need	Hospital Initiative	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	A. Cost of initiative for current FY?	B. Amount of Direct Offsetting Revenue from Restricted Grants
Access to health services	Improve physician services to the community	Improve the availability of diabetes self-management education and services to the community Promote diabetes literacy – particularly focusing on prevention of diabetes. Number of Patients served. Blood sugar levels	Multi-year	Dimensions Healthcare Associates City of Laurel LRH Pulmonary Dept. Dimensions Healthcare System Smoking Cessation Program Laurel Beltsville Senior Activity Center	EMR & Clinical documentation Patient surveys	Outreach by DHA Laurel Physician Practice and integration of diabetes education and management by PCPs Healthways Diabetes Self-management – (Program - PGHC & LRH) Total of 818 inpatient visits 148 Inpatient appts 76 patients in outpatient classes Measures of Diabetes Self-Management Education outpatient program success: Data from primary MD offices – LRH and PGHC combined August 2013	Ongoing	$56,342	

Table III – LAUREL REGIONAL HOSPITAL
FY14

						A1C – 9.54 July 2014 A1C – 7.85 LRH Satisfaction results Physican 95.2% Nursing – 96.7% Outpatient – 100%			

Table III – LAUREL REGIONAL HOSPITAL
FY14

Identified Need	Hospital Initiative	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	A. Cost of initiative for current FY)	B. Amount of Direct Offsetting Revenue from Restricted Grants
Access to health services;	Respiratory Health/Wellness	To provide health/wellness education information/services in community based settings to promote improved health awareness/knowledge about diabetes, asthma, COPD, physical rehabilitation and smoking cessation. Improve quality of life of patients with COPD and Asthma in the Greater Laurel community. Metric: New ambulatory service(s) in Laurel, Maryland	Multi-year	Laurel Regional Hospital Dimensions Healthcare Associates	New provider services	Established Pulmonary practice in Laurel Maryland Sleep Medicine Program expanded	Ongoing	$161,271	

APPENDIX II

FINANCIAL ASSISTANCE PROGRAM POLICY #210-01

DIMENSIONS HEALTHCARE CORPORATION
FINANCIAL ASSISTANCE PROGRAM

Sliding Fee Scale - 2014

% Of Write Off	100%	100%	70%	60%	50%	25%
Family Size	**Income**	**Income**	**Income**	**Income**	**Income**	**Income**
1	$11,670	$23,340	$26,258	$29,175	$35,010	$58,350
2	$15,730	$31,460	$35,393	$39,325	$47,190	$78,650
3	$19,790	$39,580	$44,528	$49,475	$59,370	$98,950
4	$23,850	$47,700	$53,663	$59,625	$71,550	$119,250
5	$27,910	$55,820	$62,798	$69,775	$83,730	$139,550
6	$31,970	$63,940	$71,933	$79,925	$95,910	$159,850
7	$36,030	$72,060	$81,068	$90,075	$108,090	$180,150
8	$40,090	$80,180	$90,203	$100,225	$120,270	$200,450
For families/households with more than 8 persons, add $ 4,060 for each additional person.						
% of Income at or above 2014 Poverty Guidelines	**100%**	**200%**	**225%**	**250%**	**300%**	**500%**

Effective: January 22, 2014

Current Status: *Active* **PolicyStat ID:** *1177729*

Dimensions Healthcare System

Effective:	*04/2013*
Approved:	*07/2014*
Last Revised:	*07/2014*
Expiration:	*07/2017*
Owner:	*Lisa Goodlett*
Policy Area:	*Finance*
References:	

Financial Assistance Program, 210-01

PURPOSE:

To identify circumstances when the Hospital 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 are not designed to turn away or discourage those in need from seeking treatment. They 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. Dimensions Healthcare System 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 is a new corporate policy. It supersedes all policies on this subject at the facility level.

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.

SPECIAL INSTRUCTIONS/FORMS TO BE USED:

DEFINITIONS:

A.

1. *Assets:* Assets include 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:
    a. Homestead property
    b. $2,000 for the uninsured patient, or $3,000 for the uninsured patient and one dependent residing together.
    c. $50 for each additional dependent residing in the same household.
    d. Personal effects and household goods that have a total value of less than $2,000.
    e. A wedding and engagement ring and items required due to medical or physical condition.
    f. One automobile with fair market value of $4,500 or less.
    g. Patient must have less than $10,000 in net assets.
2. *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 resulting from the extension of credit.
3. *Financial Assistance:* Health care services that were never expected to result in cash inflows. Financial Assistance results from a provider's policy to provide health care services free or at a discount to individuals who meet the established criteria.
4. *Financial Assistance Committee:* A committee consisting of the Chief Financial Officer, the Corporate Director of Patient Financial Services, the Risk Manager, the Director of Case/Care Management, and the Director of Patient Relations, or a similar mix of individuals.
5. *Contractual Adjustments:* Differences between revenue at established rates and amounts realized from third party payers under contractual agreements.
6. *Disposable Income:* Annual family income divided by 12 months, less monthly expenses as requested on the application in Attachment II.

7. *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.
8. *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.
9. *Qualified Patient:*
    a. *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.
    b. *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.
10. *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:
    a. Non-medical services such as social, educational, and vocational services.
    b. Cosmetic surgery.

B. **Financial Assistance Guidelines and Eligibility Criteria (see PFS Department)**

a. To be eligible for a 100 percent (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 percent of the current Federal Poverty Guidelines. 200 percent (200%) of the Federal Poverty Guidelines represents an individual earning minimum wage.

b. Patients with household income that exceeds 200 percent (200%) but is less than 500 percent (500%) of the Federal Poverty Guidelines will be eligible for a sliding scale discount of the patient portion of billed charges.

c. Medically needy patient accounts will be considered on a case-by-case basis by the Financial Assistance Committee. 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.

d. 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 Financial Assistance Committee.

e. Financial assistance applications will be considered as long as an account is open or when a change in patient financial status is determined.

f. 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.

g. Effective October 1, 2010, if the hospital has collected more than $25 from a patient or patient's guarantor and the patient was found to be eligible for free care on the date of service within a two-year period, the hospital must refund the patient or guarantor any amount collected above $25. If a judgment or adverse credit report has been entered on a patient who was later found to be eligible for free care on the date of service, the hospital must vacate the judgment or strike the adverse information. The hospital may reduce the two-year period to not less than 30 days after relevant information needed to determine eligibility for financial assistance is requested from the patient as long as it is documented that the patient or guarantor did not cooperate in providing the requested information.

PROCEDURE:

A. **Identification of Potentially Eligible Patients:**

Admitting

1. Where possible, prior to the admission of the patient, the Hospital 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.

Dir., PFS

4. All self pay accounts will be run through a Charity Care eligibility software program used by vendors to determine if the patient meets eligibility for the federal poverty guideline up to 500%. Any patient with a self pay balance will be sent through this program when they are in a self pay status or in a bad debt status. Once it has been determined that the patient falls into this category, the account(s) will be written off to the Financial Assistance Program (FAP) with or without a completed FAP application.
5. Prior to an account being authorized for the filing of suit, a final review of the account will be conducted and approved by the Corporate Director of Patient Financial Services to make sure that no application for financial assistance was ever received. Prior to a summons being filed, the CFO's approval is required. Dimensions Healthcare System Facilities 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.

B. **Determination of Eligibility:**

PFS

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 (Attachment II) 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 Financial Assistance Committee for review and determination.

   Dir., PFS or Asst Dir PFS

6. Approval for financial assistance for amounts up to $50,000 should be approved by the Director of Patient Financial Services or the Assistant Director of Patient Financial Services.

   PFS

7. Upon completion of the application and submission of appropriate documentation, the Patient Financial Services representative will complete the Financial Assistance Worksheet (Attachment III). The information shall be forwarded to the Assistant Director or the 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 (Attachment III).
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 for consideration and final determination. The 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 Attachment III).
9. A record, paper or electronic, should be maintained reflecting authorization of financial assistance (Attachment III). These documents shall be kept for a period of seven (7) years.

C. **Notification of Eligibility Determination:**

   PFS

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 prompt turnaround and a written decision, which provides a reason(s) for denial will be provided, generally within thirty (30) days of receipt of a complete application. Patients will be notified in the denial letter that they may appeal this decision and will be provided

contact information to do so.

FAC

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.

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.

D. **Availability of Policy:**

PFS

1. Every hospital, upon request, must provide any member of the public or state governmental entity a copy of its financial assistance policy.

E. **Application Forms:**

PFS

1. 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.

F. **Monitoring and Reporting:**

PFS

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 (y/n),
d. application returned and complete (y/n),
e. total charges,
f. self-pay balances,
g. amount of financial assistance approved,
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

ATTACHMENT:

Release from Responsibility for Discharge Against Medical Advice, 1-107
Financial Assistance Program Sliding Fee Scale – 2013

Attachments:

Dimensions Healthcare Corporation
Financial Assistance Program

Discharge against Medical Advice

APPENDIX III

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

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 a 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. To contact the patient representative at Prince George's Hospital Center, call 301-618-3857. To contact the patient representative at Laurel Regional Hospital, call 301-497-8765.

Visitors / Patient Guests

Patients and families are welcomed as essential members of the healthcare team, helping to ensure quality and safety. All guests designated by the patient or their "partner in care", when appropriate, will have full and equal visitation privileges that are no more restrictive than those that immediate family members enjoy. Your guests' visitation privileges will be consistent with your preferences and will not be denied on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity or disability.

A patient has the right to withdraw or deny visitation at any time and there may be times that it is necessary to restrict patient visitors, such as in the case of a justified clinical restriction. The decision to restrict or limit the presence of visitors, as well as the reason for the decision, will be explained to the patient and/or their partner in care. Dimensions Healthcare System's visitation policies are aimed at protecting the health and safety of all patients.

Complaints / Grievances

Dimensions Healthcare System endeavors to meet its patients' expectations for care and services in a timely, reasonable and consistent manner. Patients, their immediate family members and/or their representatives have the right to submit a complaint or grievance regarding their experience. Should you have a complaint about your care, please ask to speak with the manager/supervisor of the department or area involved. Our healthcare staff will seek to resolve your issues to your satisfaction as soon as possible. Please note that resolution is defined by the patient/family member and may include a meeting with all involved parties.

If you have a complaint pertaining to the following Dimensions Healthcare System facilities: **Bowie Health Center; Dimensions Surgery Center; Family Health and Wellness Center; Glenridge Medical Center; Prince George's Hospital Center;** and/or **Rachel H. Pemberton Senior Health Center** that has not been resolved by the healthcare staff at the time of your complaint and you wish to file a grievance, you may do so by telephone, letter or e-mail, at the following:

Dimensions Healthcare System / Prince George's Hospital Center
Attn: Patient Relations
3001 Hospital Drive
Cheverly, MD 20785
Phone: 301-618-3857
E-mail: complaints@dimensionshealth.org

If you have a complaint pertaining to **Laurel Regional Hospital** that has not been resolved by the healthcare staff at the time of your complaint and you wish to file a grievance, you may do so by telephone, letter or in person, at the following:

Laurel Regional Hospital
Attn: Patient Relations Department
7300 Van Dusen Road
Laurel, MD 20707
Phone: 301-497-8765
(Business Hours: Monday – Friday: 9:30 a.m. – 6:00 p.m.)

Laurel Regional Hospital's complaint/grievance process is as follows:

STEP 1: If, in your judgment as a patient/family member, the issue has not been resolved by the manager or supervisor to your satisfaction, please ask to speak with a patient relations coordinator. During business hours, the patient relations coordinator can be reached at 301-497-8765. After hours, and on weekends and holidays, dial the hospital operator, at "0," and ask to speak with the nursing administrative supervisor, who will seek resolution of your issues. Filing a grievance will not subject you to any form of adverse action or jeopardize your future access to care at any Dimensions Healthcare System facility. Your grievance will be reviewed and investigated, and you will receive a written response within two (2) days of receipt of the grievance. Due to the nature and complexity of your grievance, it may take longer in some instances to make a written response. The written response will include steps taken on your behalf to investigate the grievance, results of the grievance process, the date of completion and the appropriate hospital contact person.

Note: Resolution is defined by the patient/family member and may include a meeting with all involved parties.

STEP 2: If you, the patient/family member, remain dissatisfied with the hospital's resolution, the matter will be referred to the hospital's Vice President of Medical Affairs (VPMA), Chief Nursing Officer (CNO) or administrative designee. The VPMA, CNO or designee will further investigate the issue and provide results to you in writing within seven (7) days. If the investigation requires more than seven (7) days, you will be notified for the reason of the delay and when you can expect a response.

If you are dissatisfied with any facility's report or outcome at the conclusion of your complaint/grievance investigation, you may contact one of the following agencies directly:

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Hospital Center
Bland Bryant Building
55 Wade Avenue
Catonsville, MD 21228
Phone: 410-402-8000 or 877-402-8218
E-mail: 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, MD 21215
Phone: 410-764-4755 or 800-542-4964
TTY: 800-735-2258
Fax: 410-358-6207
Email: MDBOP@DHMH.STATE.MD.US

Note: This patient grievance process excludes account and billing issues. These issues should be referred to Patient Financial Services at 301-618-3100.

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 Healthcare System 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, MD 21202
Phone: 410-468-2340 or 800-492-6116
TTY: 800-735-2258
Fax: 410-468-2270 or 410-468-2260

Patient Rights and Responsibilities

As a patient at any Dimensions Healthcare System facility, we encourage you to speak openly with your healthcare team, to take part in your treatment choices and to assist in the safety of your care by being well informed and involved. Since we believe that you are a partner in your care, we want you to know your rights, as well as your responsibilities, during your stay at any of our facilities. We invite you and your family to join us as active members of your care team.

You Have the Right to:

- Receive considerate, respectful and compassionate care in a safe setting regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity or disabilities.
- Receive care in a safe environment free from all forms of abuse, neglect or mistreatment.
- Be called by your proper name and to be in an environment that maintains dignity and adds to a positive self-image.
- Know the names of your doctors, nurses and all healthcare team members directing and/or providing your care.
- Have a family member or person of your choice, as well as your own doctor, notified promptly of your admission to the hospital.
- Have someone remain with you for emotional support during your hospital stay, unless your visitor's presence compromises your or others' rights, safety or health.
- Deny visitation at any time (see Visitors/Patient Guests section for additional information).
- Have your doctor inform you about your diagnosis and possible prognosis, the benefits and risks of treatment, and the expected and unexpected outcomes of treatment. You have the right to give written informed consent before any non-emergency procedure begins.
- Have your pain assessed and to be involved in decisions about treating your pain.
- Be free from restraints and seclusion in any form that is not medically required.
- Expect full consideration of your privacy and confidentiality in care discussions, exams and treatments. You may ask for an escort during any type of exam.
- Access protective and advocacy services in cases of abuse or neglect. The hospital will provide a list of these resources.
- Be free from neglect, exploitation and abuse that could occur while the patient is receiving care, treatment and services.
- Have your family and friends, with your permission, participate in decisions about your care, your treatment and services, including the right to refuse treatment to the extent permitted by law.
- Give or withhold informed consent for care.
- Have your end of life wishes honored to include forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services, in accordance with the law and regulations.
- Agree or refuse to take part in medical research studies. You may withdraw from a study at any time without impacting your quality of care.
- Communication that you can understand. The hospital will provide, at no cost to you, sign language and foreign language interpreters as needed.

Information given will be appropriate to your age, understanding and language. If you have vision, speech, hearing and/or other impairments, you will receive additional aids to ensure your care needs are met.

- Make an advance directive and appoint someone to make healthcare decisions for you, if you are unable. If you do not have an advance directive, we can provide you with information and help you complete one.
- Be involved in your discharge plan. You can expect to be told in a timely manner of your discharge, transfer to another facility or transfer to another level of care. Before your discharge, you can expect to receive information about follow-up care that you may need.
- Receive detailed information about your hospital and physician charges.
- Expect that all communication and records about your care are confidential, unless disclosure is permitted by law.
- See or get a copy of your medical records, request an amendment to your medical record and/or request a list of people to whom your personal health information was disclosed by contacting the medical records department.
- Give or refuse consent for recordings, photographs, films or other images to be produced or used for internal or external purposes other than identification, diagnosis or treatment. You have the right to withdraw consent up until a reasonable time before the item is used.
- Discuss an ethical issue related to your care (see Healthcare Decisions section).
- Spiritual services (see Pastoral Care section).
- Voice your concerns about the care you receive. If you have a problem or complaint, you may talk with your doctor, nurse manager or a department manager (see Complaints/Grievances section).

Your Responsibilities Are to:

- Provide complete and accurate information, including your full name, address, home telephone number, date of birth, Social Security number, insurance carrier and employer when it is required.
- Provide the hospital or your doctor with a copy of your advance directive if you have one.
- Provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products and any other matters that pertain to your health, such as perceived safety risks.
- Communicate in a direct and honest manner with doctors, nurses and other hospital staff members about matters or conditions that concern your health.
- Follow instructions regarding your care and treatment. If you leave the hospital against the advice of your doctor, the hospital and doctors will not be responsible for any medical consequences that may occur.
- Inform the staff of your whereabouts and probable return time if you leave the patient unit/ancillary department.
- Ask questions when you do not understand information or instructions. If you believe you cannot follow through with your treatment plan, you are responsible for telling your doctor. You are responsible for outcomes, if you do not follow the care, treatment and service plan.
- Actively participate in your pain management plan and to keep your doctors and nurses informed of the effectiveness of your treatment.
- Leave valuables at home and bring only necessary items for your hospital stay.
- Treat all hospital staff, other patients and visitors with courtesy and respect; abide by all hospital rules and safety regulations; and be mindful of noise levels, privacy and number of visitors/guests.
- Accept accountability for your financial obligations for health care provided and to pay your bills in a timely manner.
- Keep appointments and be on time, and to call your healthcare provider if you are unable to do so.
- ***SPEAK UP™**: Be an active member of your healthcare team and help us make your health care safer.
- Speak-up if you have questions or concerns. If you still don't understand, ask again.
- Pay attention to your care. Always make sure you're getting the right treatments and medicines by the right healthcare professionals. Don't assume anything.
- Educate yourself about your condition. Learn about the medical tests and your treatment plan.
- Ask a trusted family member or friend to be your advocate (advisor or supporter).
- Know what medicines you take and why you take them. Medicine errors are the most common healthcare mistakes.
- Use a facility, clinic, surgery center or healthcare facility that has been carefully checked out.
- Participate in all decisions about your treatment. You are the center of the healthcare team.

*Speak Up is a Joint Commission Patient Safety Program Initiative

Healthcare Decisions

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

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

Advance directive decisions 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 healthcare decisions, and/or
- 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. Your advance directive will be honored in accordance with the law.

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/Meditation Room

At Laurel Regional Hospital, there is a chapel available to patients and their families for prayer, meditation and reflection. Prince George's Hospital Center has a meditation room for this same purpose. These rooms are unattended and provide a quiet place for patients and their families to pray.

Support Groups

We offer a number of support groups. Please visit www.dimensionshealth.org for additional information.

Corporate Compliance

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

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

Safety and Security

Everyone has a role in making health care safe. Therefore, every staff member will display picture identification and every patient must wear their ID band until they are discharged.

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

We encourage you to notify us if you have concerns about your safety. To report a concern at Laurel Regional Hospital, please call Safety & Security at 301-497-8752. To report a concern at any other Dimensions Healthcare System facility, 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. Neither Dimensions Healthcare System nor any of its facilities will accept responsibility for patient property or valuables.

Smoking

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

If you wish to stop smoking, a free smoking cessation program is offered. The program is four 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 leaving the hospital, you may receive a follow-up phone call to see how you are doing. It is our goal to be your healthcare provider 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 the medical records department.

WHAT YOU SHOULD KNOW **AS A PATIENT**

Dimensions Healthcare System

Bowie Health Center
Dimensions Surgery Center
Family Health and Wellness Center
Glenridge Medical Center
Laurel Regional Hospital
Prince George's Hospital Center
Rachel H. Pemberton Senior Health Center

DimensionsHealth.org

ALL *we* DO IS *care*℠

APPENDIX IV

MISSION, VISION, AND VALUES STATEMENT
#200-24

- Changes by

Current Status: *Active* **PolicyStat ID:** *1177597*

Dimensions Healthcare System

Effective: *06/2006*
Approved: *05/2014*
Last Revised: *05/2014*
Expiration: *05/2017*
Owner: *Al Campbell: Executive Adminstrator*
Policy Area: *Corporate - General*
References:

Mission, Vision and Values Statements, 200-24

MISSION

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

VISION

To be recognized as a premier regional health care system.

VALUES

Dimensions Healthcare System:

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

Attachments: