FORT WASHINGTON MEDICAL CENTER

Community Benefit Report

Fiscal Year 2015

Submitted to:

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

BACKGROUND

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

The Commission's response to its mandate to oversee the legislation was to establish a reporting system for hospitals to report their community benefits activities. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulated environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, (3) hospital community benefit administration, and (4) community benefit external collaboration to develop and implement community benefit initiatives.

On January 10, 2014, the Center for Medicare and Medicaid Innovation (CMMI) announced its approval of Maryland's historic and groundbreaking proposal to modernize Maryland's all-payer hospital payment system. The model shifts from traditional fee-for-service (FFS) payment towards global budgets and ties growth in per capita hospital spending to growth in the state's overall economy. In addition to hitting aggressive quality targets, this model must save at least $330 million in Medicare spending over the next five years. The HSCRC will monitor progress overtime by measuring quality, patient experience, and cost. In addition, measures of overall population health from the State Health Improvement Process (SHIP) measures will also be monitored (see Attachment A).

To succeed, hospital organizations will need to work in collaboration with other hospital and community based organizations to increase the impact of their efforts in the communities they serve. It is essential that hospital organizations work with community partners to identify and agree upon the top priority areas, and establish common outcome measures to evaluate the impact of these collaborative initiatives. Alignment of the community benefit reporting with these larger delivery reform efforts such as the Maryland all-payer model will support the overall efforts to improve population health and lower cost throughout the system.

For the purposes of this report, and as provided in the Patient Protection and Affordable Care Act ("ACA"), 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), as provided in the ACA, 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 obtains input from persons who represent the broad interests of the community served by the hospital facility, (including working with private and public health organizations, such as: the local health officers, local health improvement coalitions ("LHIC's)[see: http://dhmh.maryland.gov/healthenterprisezones/Documents/Local_Population_Health Improvement_Contacts_4-26-12.pdf] schools, behavioral health organizations, faith based community, social service organizations, and consumers) including a description of when and how the hospital consulted with these persons. 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.

Examples of sources of data available to develop a CHNA include, but are not limited to:

(1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP)(http://dhmh.maryland.gov/ship/);
(2) SHIP's CountyHealth Profiles 2012 (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx);
(3) the Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(4) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(5) Local Health Departments;
(6) County Health Rankings (http://www.countyhealthrankings.org);
(7) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(8) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(9) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(10) Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(11) Youth Risk Behavior Survey (http://phpa.dhmh.maryland.gov/cdp/SitePages/youth-risk-survey.aspx)

(12) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(13) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNA involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(14) Survey of community residents; and
(15) Use of data or statistics compiled by county, state, or federal governments.

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, as provided in the ACA, 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, such as how they will collaborate with other hospitals with common or shared CBSAs and other community organizations and groups (including how roles and responsibilities are defined within the collaborations); and
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.

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 acute care 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:
Licensed for 34 beds; 30 Beds – Acute Care 4 Beds – CCU	2,285	• 20744 • 20745 • 20748	None	10.8%	7.1%

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. Based on findings from the CHNA, provide a list of the Community Benefit Service Area (CBSA) zip codes. These CBSA zip codes should reflect the geographic areas where the most vulnerable populations reside. Describe how the CBSA was determined, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, i.e. individuals with > 3 hospitalizations in the past year). This information may be copied directly from the section of the CHNA that refers to the description of the Hospital's Community Benefit Community.

Fort Washington Medical Center is the newest hospital in the Maryland system. Licensed for 34 beds, it admits more than 2,285 patients through its medical-surgical unit and sees nearly 42,000 patients through its Emergency Room annually.

The hospital provides inpatient and outpatient care, diagnostic laboratory and radiology services, inpatient pharmacy, rehabilitation, and ambulatory surgical services. Fort Washington Medical Center maintains its ties with area residents through community wellness programs, dedicated services, and responsive staff.

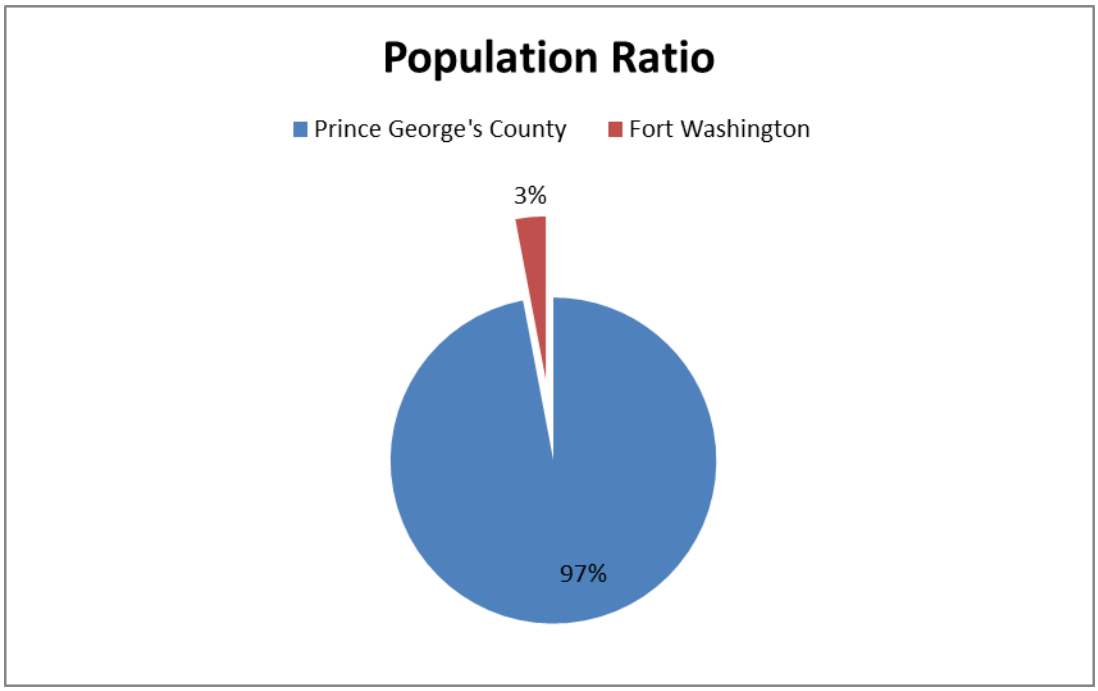
The hospital primarily serves residents of Fort Washington, Maryland where the facility is based. However, it also serves residents of Oxon Hill and Temple Hills. Collectively, these three areas of Prince George's County constitute more than 60 percent of the hospital's entire patient base.

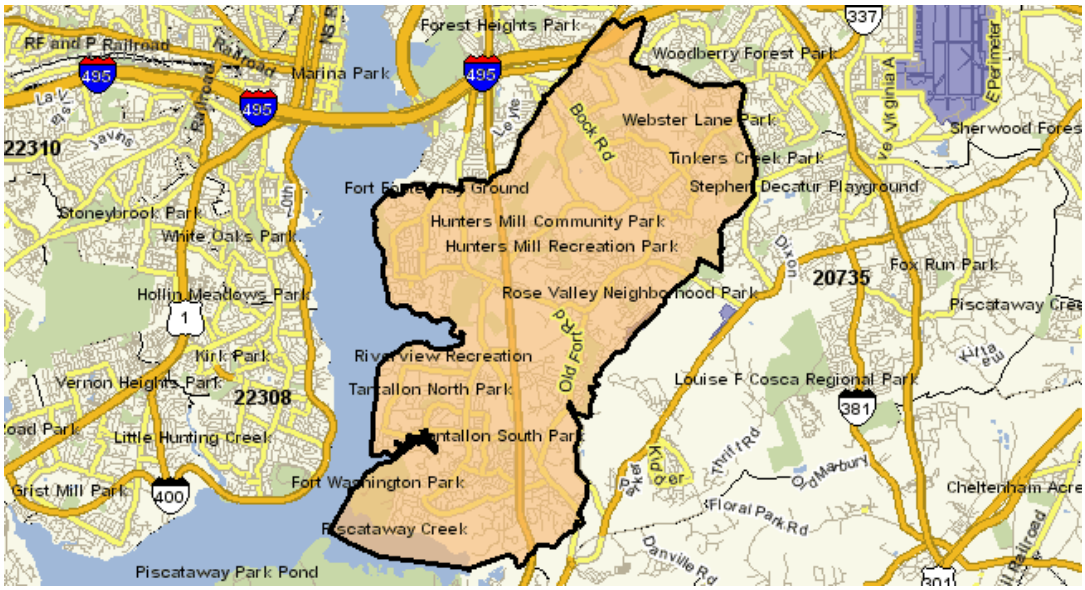
Prince George's County, Maryland, is located immediately north, east, and south of Washington, D.C and 18 miles south of the City of Baltimore. The county has 485 square miles and 881,876 residents, which 48% are males and 52% are females who make up the population. In addition, the county race population consists of: 19% White, 63% Black, and 0.5% American Indian and Alaska Native races. Prince George's County is considered the second most populous jurisdiction in the State of Maryland.

Fort Washington (20744), Oxon Hill (20745) and Temple Hills (20748) comprise Fort Washington Medical Center's Community Based Service Area (CBSA) and are located in Prince George's County. The suburban cities are within a short distance from the Washington, D.C./Maryland line. African Americans make-up the majority of the population FWMC serves.

Fort Washington, 20744

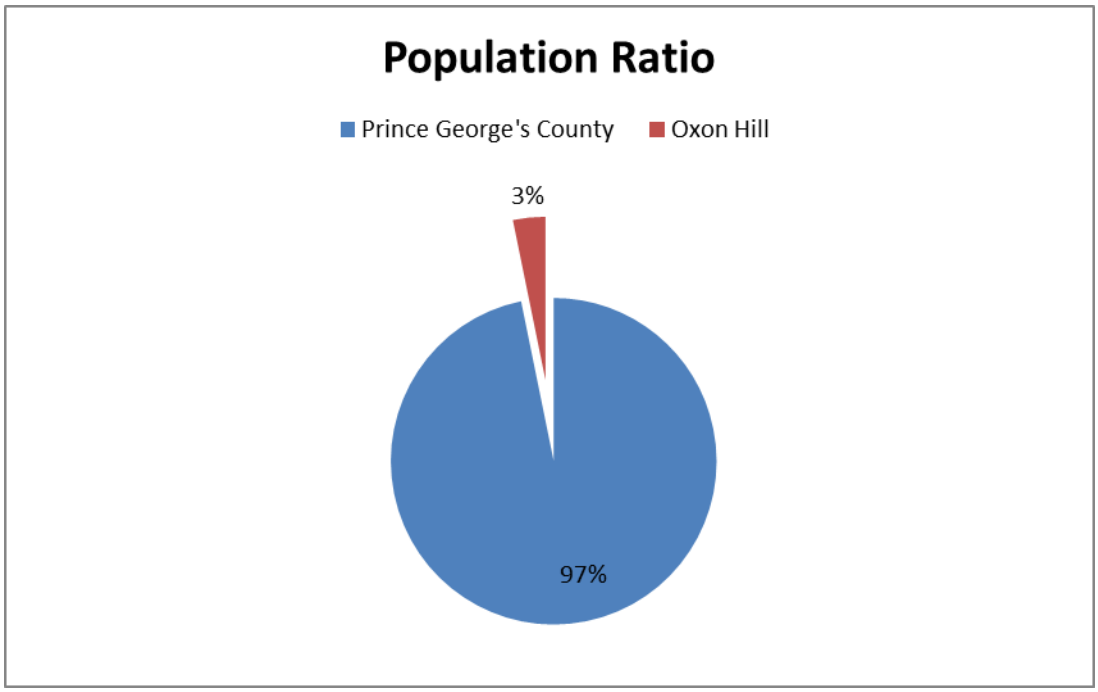
Fort Washington encompasses a 14-square mile radius and. According to pghealthzone.org, Fort Washington has a population of 54,163 people, which represents roughly 3% of Prince George's County population. The racial dynamic of Fort Washington is primarily African–American with 74.3% residents; 10.5% White residents; 0.2% Asian, and the remainder of other races are, Native Hawaiian, American Indian, and Pacific Islander.



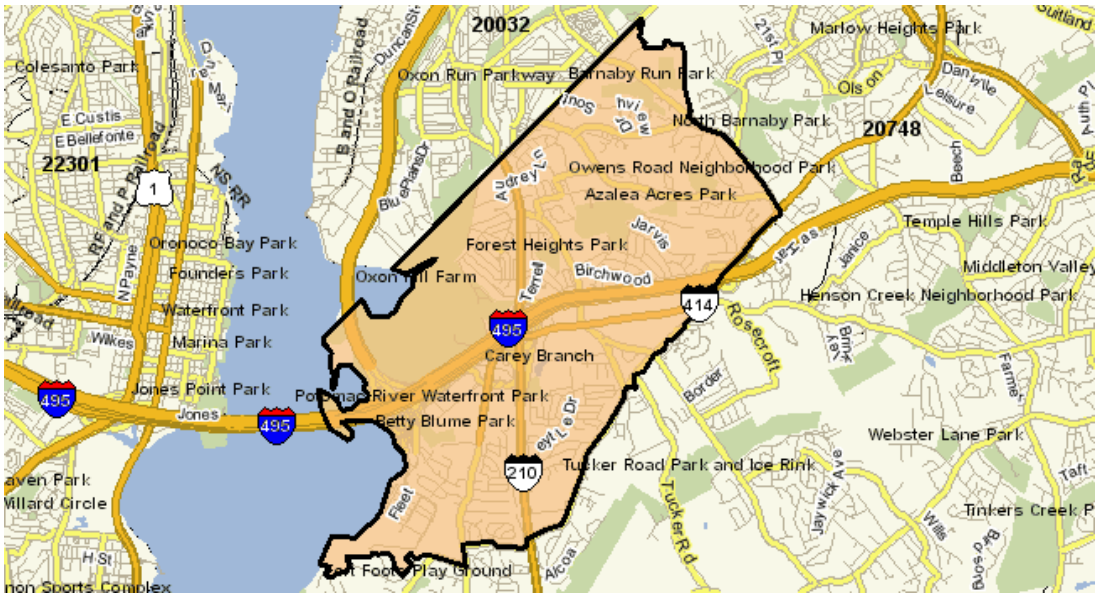


Oxon Hill, 20745

Surrounding portions of Fort Washington is 9-square miles of land in Oxon Hill, Maryland. It extends along the 210 North corridors and along Southern Avenue, which separates it from Washington, D.C. According to the pghealthzone.org, its population is 29,660 residents and represents roughly 3% of Prince George's County population.

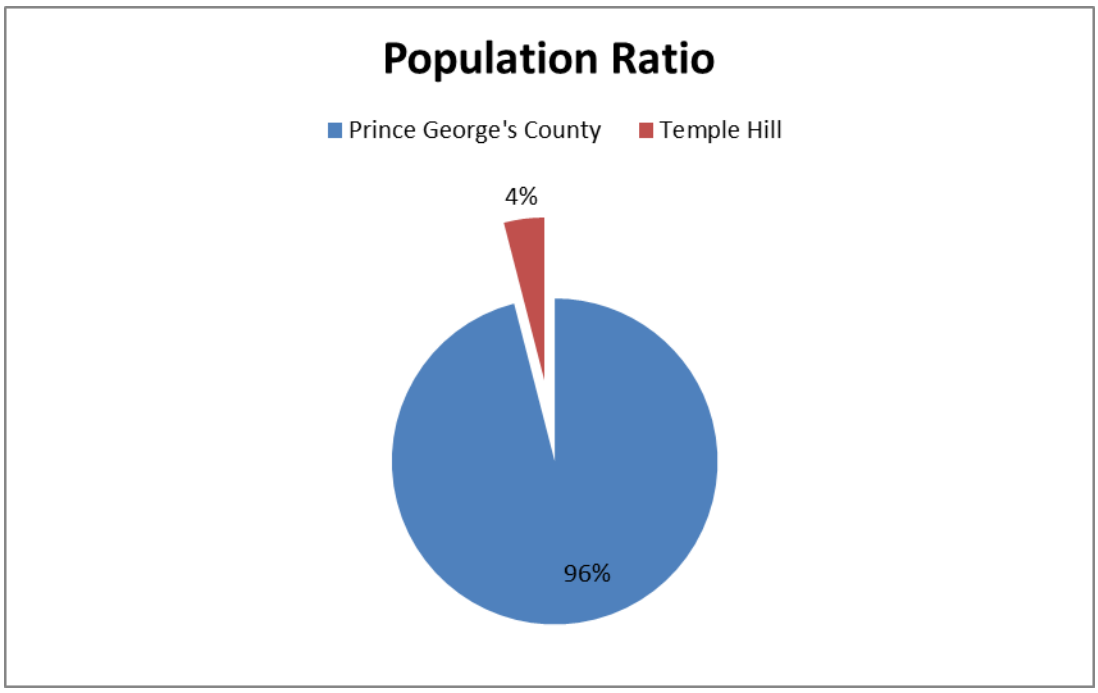


The racial make-up of Oxon Hill is 78.9% African–Americans; 4.6% White residents and 9.8% Asian residents.

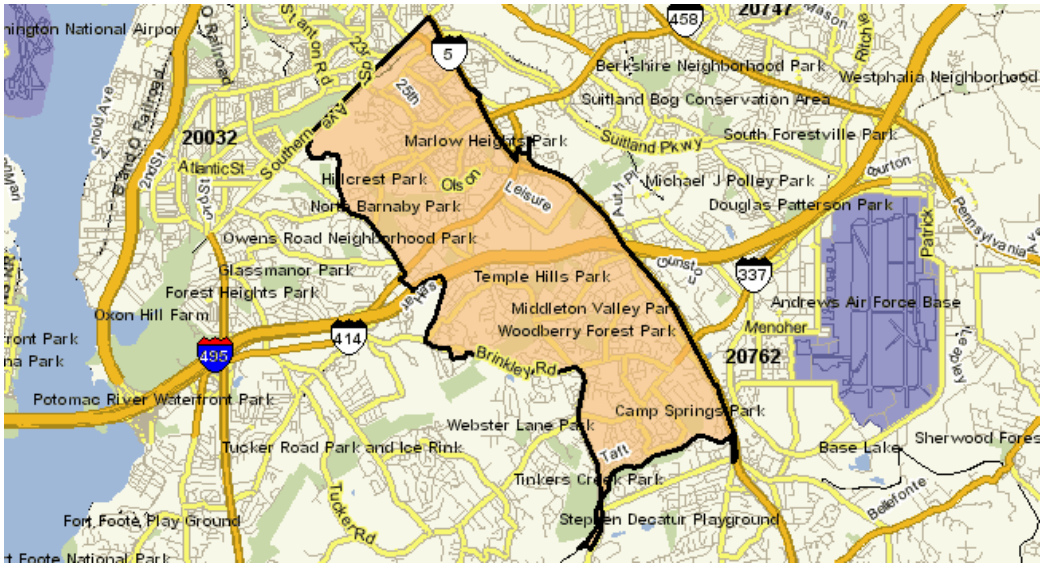


Temple Hills, 20748

Another component of the FWMC service area is Temple Hills, which is 1.4 square miles, and is west of Oxon Hill and southeast of Washington, D.C. According to pghealthzone.org, Temple Hills has a population of 36,496 people and represents 4% of Prince George's County population.



African-Americans comprise the majority of the population with 85.4% residents, 11.0% White residents and 1.9% Hispanic residents. There is a small population of Native Hawaiian, American Indian and Pacific Islanders.



b. In Table II, describe the population within the CBSA, including 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, transportation, education and healthy environment, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary).

TABLE II

DEMOGRAPHIC CHARACTERISTICS	INFORMATION	DATA SOURCE
Community Benefit Service Areas (CBSA) Target Population (target population, by sex, race, ethnicity, and average age)	20744 20745 20748	HSCRC
Target Population	Total Population of 20744: 53,701 Total Population of 20745: 29,282 Total Population of 20748: 36,957 Total Population: 121,319 Total Male Population: Zip Code 20744: 47.02% Zip Code 20745: 46.79%, Zip Code 20748: 46.30% Total Female Population: Zip Code 20744: 52.98% Zip Code 20745: 53.21% Zip Code 20748: 53.70%	http://www.pgchealthzone.org/index.php?module=DemographicData&type=user&func=ddview&varset=1&ve=text&pct=2&levels=1&topic1=County http://www.pgchealthzone.org/index.php?module=DemographicData&type=user&func=ddview&varset=1&ve=text&pct=2&levels=1&topic1=County http://www.pgchealthzone.org/index.php?module=DemographicData&type=user&func=ddview&varset=1&ve=text&pct=2&levels=1 http://www.pgchealthzone.org/index.php?module=DemographicData&type=user&func=ddview&varset=1&ve=tab&pct=2&levels=-1&topic1=Zip Code&varid=1487&topic2=20745&vl=tb&sregcomp=1

Race/Ethnicity	20744 Race Breakdown Black (non-Hispanic): 74.38% White (non-Hispanic): 10.52% Hispanic: 7.50% Asian: 0.20% Other: 0.20% 20745 Race Breakdown Black (non-Hispanic: 78.90% White (non-Hispanic): 4.60% Hispanic: 9.80% Asian: 0.20% Other: 0.20% 20748 Race Breakdown Black (non-Hispanic): 86.08% White (non-Hispanic): 6.45% Hispanic: 5.99% Asian: 1.47% Other: 3.05%	*http://www.pgchealthzone.org/index.php?module=DemographicData&type=user&func=ddview&varset=1&ve=text&pct=2&levels=1&topic1=County* *http://www.zipdatamaps.com/20745* *http://www.pgchealthzone.org/index.php?module=DemographicData&type=user&func=ddview&varset=1&ve=text&pct=2&levels=1*
Average Age	Median age of residents in Prince George's County: 36 years old (Males: 34 years old, Females: 38 years old) (Median age for: White residents: 39 years old, Black residents: 36 years old, American Indian residents: 30 years old, Asian residents: 34 years old, Hispanic or Latino residents: 27 years old, Other race residents: 27 years old)	*http://www.pgchealthzone.org/index.php?module=DemographicData&type=user&func=ddview&varset=1&ve=text&pct=2&levels=1&topic1=County*
Median Household Income	20744: $87,657 20745: $58,842 20748: $54,478 Median Income for Prince George's County is $73,192	*http://www.pgchealthzone.org/index.php?module=DemographicData&type=user&func=ddview&varset=1&ve=text&pct=2&levels=1&topic1=County* *http://www.pgchealthzone.org/index.php?module=DemographicData&type=user&func=ddview&varset=1&ve=text&pct=2&levels=1*
Individuals/Households below the federal poverty	20744: 5.26%	*20744:* *http://www.pgchealthzone.org/index.php?mod*

line	20745: 9.98% 20748: 8.64% Prince George's County Families Below Poverty Level: 7.02%	*ule=DemographicData&type=user&func=ddview&varset=1&ve=text&pct=2&levels=1&topic1=County* *20745: http://www.pgchealthzone.org/index.php?module=DemographicData&type=user&func=ddview&varset=1&ve=text&pct=2&levels=1&topic1=County* *20748: http://www.pgchealthzone.org/index.php?module=DemographicData&type=user&func=ddview&varset=1&ve=text&pct=2&levels=1&topic1=County* *http://www.princegeorgescountymd.gov/sites/Health/ContactUs/Publications/Documents/2014%20health%20report%20v4-08-14%20no%20blank%20pages.pdf*
Percentage of uninsured people by County within the CBSA	Prince George's County: 15.4% 20744: 9.1% 20745: 14.8% 20748: 11.1%	*http://factfinder2.census.gov/*
Percentage of Medicaid recipients by County within the CBSA	Prince George's County: 24.4% 20744: 24.6% 20745: 25.3% 20748: 28.4%	*http://factfinder2.census.gov/*
Life Expectancy by County within the CBSA (including race and ethnicity where data is available).	All Races Prince George's County: 77.8 years Black: 75.9 years White: 80.2 years	*http://eh.dhmh.md.gov/ship/SHIP_Profile_Prince_Georges.pdf* *Source: Maryland Vital Statistics Annual Report, 2012*
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	All Races, Total: 5,029 White: 1,405 Black: 3,303 American Indian: 3 Asian/Pacific Islander: 105 Hispanic: 209	*Data Source: Maryland Vital Statistics Annual Report, Division of Health Statistics, DHMH* *http://www.princegeorgescountymd.gov/sites/Health/ContactUs/Publications/Documents/2014%20health%20report%20v4-08-14%20no%20blank%20pages.pdf*
Food Stamp/SNAP benefits in the past 12 months (2013)	Prince George's County: 27,683 20744- 401	*http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?fpt=table*

	20745- 825 20748- 462	
Access to Healthy Food	Access to Healthy Food: According to John Hopkins' Center for a Livable Future, 43 percent of county residents live in "food deserts," or low-income census tracts where residents are more than .5 miles (urban) or 10 miles (rural) from the nearest supermarket. The average for the state of Maryland is only 27 percent, according to the Prince George's County Food Systems Profile. Readily available are "food swamps" through a densely populated network of fast food chain restaurants, which make up 71 percent of the county's restaurants.	*Access to Healthy Food* *Source: Institute for Public Health Innovation* *http://www.institutephi.org/* *http://www.institutephi.org/prince-georges-county-food-equity-forum-addresses-county-health-healthy-foods/*
Access to Transportation	Metrobus, Metrotrail, TheBus, Call-A-Bus, Park and Ride, Commuter Connection, Central Maryland Regional Transit, Call-A-Cab, MARC and County Roads. Metrorail Subway- Serves 86 stations throughout the area along 106 miles of track, much of it underground. The Bus-Provides 27 routes, covering over 10,000 miles. Seniors (60+) and persons with disabilities and Medicare card holders with a valid photo ID ride FREE-of-charge during normal operational hours from 6 AM – 7 PM, Monday - Friday. In addition, persons with disabilities with a MetroAccess ID may bring one personal companion with them on board at no charge. "Kids Ride Free" is available to students after school dismissal on regularly scheduled school days, Monday – Friday (holidays and vacations excluded), from 2:00 – 7:00 PM. Commuter Connection- Program to help promote transportation alternatives and connect commuters to jobs, education, shopping, healthcare, and other important destinations. Call-A-Bus- is a demand response curb-to-curb service. Service is available to all residents of Prince George's County who are not served by or cannot use existing bus or rail services. However, priority is given to senior and disabled persons. Call-A-Cab- A transportation assistance program that provides mobility at a reduced cost for County seniors (age 60+) and/or County persons with disabilities.	*http://www.ridesmartsolutions.com/bus/thebus* *http://mta.maryland.gov/local-and-statewide-transit-info* *http://thearcofpgc.org/resources_transportation_arc_prince_georges_maryland.html*

	This program allows eligible residents to purchase coupon books that can be used to pay for rides with participating cab companies when Metrobus, Metrorail, and/or Call-A-Bus are not available. Metro Bus/Rail-Operates over 70 routes in Prince George's County. Serves most major population centers and travel corridors in the County, providing more than 2,600 trips daily.	
Available detail on race, ethnicity, and language within CBSA.	Race Detail: White alone, 26.9% Black or African American 64.7% American Indian and Alaska Native alone, 1.0% Asian 4.6% Native Hawaiian and Other Pacific Islander 0.2% Two or More Races 2.6% Hispanic or Latino 16.9% White alone, not Hispanic or Latino, 14.2% Language: Percent of population ages 5+ who speak a language other than English at home: 20.8%	*Source: The U.S. Census Bureau State and County Quickfacts -* *http://quickfacts.census.gov/qfd/states/24/24033.html* *Language:* *http://quickfacts.census.gov/qfd/states/24/24033.html*
Environmental factors	Prince George's has less access to care than its neighbors, with low numbers of physicians and high numbers of uninsured residents. A barrier to accessing care is a lack of providers: there are 1,837 residents to every primary care physician in the County which is much higher compared to Maryland. 99% of the county experiences access restrictions to exercise opportunities. 21% of the population experience severe housing problems.	*www.marylandnonprofits.org* *http://www.princegeorgescountymd.gov/sites/Health/ContactUs/Publications/Documents/2014%20health%20report%20v4-08-14%20no%20blank%20pages.pdf* *http://www.countyhealthrankings.org/app/maryland/2015/rankings/prince-georges/county/outcomes/overall/snapshot*

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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. 3 /1 /2013
If you answered yes to this question, provide a link to the document here.
https://fortwashingtonmc.org/services/community_health/community_benefits.aspx

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

_X_ Yes 8/30/2013
___ No

Reference attachment.

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? (Please note: these are no longer check the blank questions only. A narrative portion is now required for each section of question b,)

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

_X_ Yes
___ No

If yes, please provide a description of how the CB planning fits into the hospital's strategic plan, and provide the section of the strategic plan that applies to CB.

Community wellness, outreach and collaborations are included in the hospital's strategic plan to increase awareness of health care conditions facing FWMC's population and to provide educational programming regarding chronic diseases and healthy lifestyle choices. To extend our reach, the hospital enhanced its participation in community related activities, to work collaboratively with community and faith-based organizations to cultivate partnerships to achieve the hospital's vision to be recognized as a superior, innovative health care system exhibiting excellence in patient care and safety, illness prevention and the wellness needs of our communities.

Excerpts from FWMC Strategic Plan

Perspective: Internal Systems and Processes – Increasing Awareness	
2.3 Heighten awareness	
Action Plan	Benchmarks
2.Expand community outreach programs with faith-based community organizations and government agencies	▪ Implement ongoing community educational programming
5.Increase participation / sponsorship in community health fairs / events	▪ Assess participation ▪ Evaluate output needed to exceed annual participation ▪ Begin (CB) related activities

Perspective: Partnerships	
3.5 Cultivate partnerships that support the vision of the organization Outcome Measures: Increase the number of partnerships by 100% to achieve the vision of illness prevention and wellness needs Strategy: Seek to engage community partners that embrace our vision; Establish partnerships to support the vision of the organization	
Action Plan	Benchmarks
1.Identify potential community partners	▪ Create list of partners ▪ Develop illness prevention and wellness concepts ▪ Pitch concepts to potential partners ▪ Collaborate on projects that support the vision

a. 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 describe the role each plays in the planning process (additional positions may be added as necessary)

i. Senior Leadership

1. CEO – Leads the strategic direction of the organization and ensures the mission, vision and values align with the company's goals and objectives. Additionally, embrace the tenets of the State's Triple Aim objectives, to reduce costs, improve the health of communities and the experience of care for patients. To also expand collaborations, community partnerships and extend the hospital's reach throughout its service area.
2. Chief Financial Officer – Oversees the financial components of the organization and ensures that all policies and procedures are adhered to as it relates to charity, Medicare and Medicaid spending, budget and reimbursements to ensure the company maintains its 501(c)(3) responsibility thereby maintaining its eligibility.
3. Chief Medical Officer – Works with medical executive team and physicians, assesses gaps in the availability of specialist providers and works to reduce such gaps.
4. Vice President of Patient Services/Chief Nursing Officer – Participates on collaborative hospital initiatives, writes grants for outreach activities, ensures participation with key partners on health care related projects, programs and activities. Works on population health initiatives and emergency preparedness. Collaborates with the County's Emergency Planner and Region 5 to ensure hospital emergency preparedness.

5. Vice President of Performance Improvement & Patient Safety – Assess and implement quality improvements, ensures patient safety and regulatory and infectious control guidelines are met for the health and safety of employees and the public.
6. Corporate Director of Communications & Marketing – Executes several community outreach programs, activities, and partnerships, collects and synthesizes the hospital's Community Benefit-related information for the annual Community Benefit report.
7. Corporate Controller – Collects and appropriate cost of programs and activities associated with Community Benefits and ensures alignment with year-end financials and IRS Schedule H 990 Reporting.
8. Patient Accounts Director – Provides information regarding Financial Assistance Program, policies and procedures, patient rights and responsibilities.
9. Hospital Educator – Educate and train staff, track continuing education, monitors changes in regulations, certifications, and evaluates training programs. Maintains data on nursing student program.

ii. Clinical Leadership

1. Physicians – Some physicians volunteer at community events to provide free medical advice to residents at major fairs and community events. Some physicians also volunteer to serve as the official Medical Team of a local marathon.
2. Nurses – Registered nurses conduct health screenings on behalf of the hospital during fairs and community events.

iii. Community Benefit Operations

1. Community Benefit Team
   - Corporate Communications & Marketing Director
   - Corporate Communications & Marketing Specialist
   - Corporate Controller

b. 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

The Community Benefits Report is reviewed by members of the Community Benefits team, which includes the Communications senior leader, Controller and CFO.

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

Spreadsheet	__X__ yes	_____no
Narrative	__X__ yes	_____no

The Community Benefits Report is submitted to the Board of Trustees for review and approval.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

Yes Other hospital organizations
Yes Local Health Department
Yes Local health improvement coalitions (LHICs)
Yes Schools
Yes Behavioral health organizations
Yes Faith based community organizations
No Social service organizations

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

Organization	Name of Key Collaborator	Title	Collaboration Description
Southern Maryland Regional Coalition for Care Transitions (TLC-MD)	50 partners, non-governmental organizations in Prince George's County	Collaborative	Regional coalition established to Improve clinical outcomes, care transition and coordination and reduce total cost of healthcare for Medicare beneficiaries
American Diabetes Association	Cheryl Smith	Associate Director Step Out Walk to Stop Diabetes	Partnered with ADA on Alert Day activities to increase awareness regarding risk associated with diabetes; Supported the National American Diabetes Walk as a designated Mega Team
Integrated Public Health and Medical Preparedness Forum	Department of Health and Mental Hygiene		Review best practices for emergency management and planning for public health in the county
Prince George's County Healthy	Prince George's Department of	Pamela Creekmur	Serves on committee to

Community Coalition	Health	Health Officer	assess and address community health needs in Prince George's County
Friendly High School	Academy of Health and Biosciences (AHBS)	Counselor	FWMC supports students participating in the AHBS medical career track
College of Southern Maryland	Laura Polk	Dean of Nursing	CNO works with College of Nursing administrator and meets quarterly to collaborate regarding ways to improve nursing education and preparedness
Prince George's Community College Harris Business School College of Southern Maryland	Nursing Depts.	Representatives	Serve as a clinical training site to compliment the didactic training of the community colleges for the Registered Nursing Program
Behavioral Health	Bernice Griffin	H.E.A.L. Program	Lifestyle modification program that enables participants to develop lifelong healthy eating and physical activity behaviors
Southern Regional Technology & Recreation Complex LG Total Fitness	Mary Fitzsimmons Lynda Grymes	South Rec Tech Asst. Dir. L.G. Total Fitness Owner / Consultant	Community partners support hospital Walking Program initiative held at the County's recreational complex. The consultant leads the walkers in the program and provides instruction on technique, benefits, etc.
Prince George's Chamber of Commerce	Tonya Jackson	Chair Healthcare Committee	Collaboration with other hospitals and businesses who serve the Prince George's County area to provide programs and opportunities for the community
Prince George's County District 8 Health	Obie Patterson	County Councilman	Hospital partners to provide health screenings, outreach and prevention for residents the hospitals serves
River Jordan Project	Rev. Dr. Robert Screen	Executive Director	FWMC supports various initiatives in this Community outreach organization, which is located in the hospitals primary service area. The organization addresses health issues, health education and preventive medical measures.

Woodrow Wilson Bridge Half-Marathon	Steve Nearman	Founder and Director	FWMC physicians and nurses volunteered to serve as the official medical team of the Woodrow Wilson Bridge Half-Marathon to provide medical assistance to participants

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

_____yes ___X__no

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

_____yes ___X__no

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

This Information should come from the implementation strategy developed through the CHNA process.

1. Please use Table III, to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each evidence based initiative and how the results will be measured (what are the short-term, mid-term and long-term measures? Are they aligned with measures such as SHIP and all-payer model monitoring measures?), 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 example of how to report.

Fort Washington Medical Center (FWMC) conducted a Community Health Needs Assessment (CHNA) in March 2013 to identify the needs of the communities it serves in Fort Washington, Oxon Hill, and Temple Hills, Maryland. This community health needs assessment was conducted to evaluate the study area (by zip code) and understand the region's health needs.

The CHNA, conducted by CHNA Consultant Tripp Umbach, identified specific community health needs and evaluated how those needs are being met in order to better connect health and human services with the needs of residents in the region. Fort Washington Medical Center connected with a wide range of organizations, health-related professionals, local government officials, human service organizations, and faith-based organizations to evaluate the community's health and social needs. The assessment included primary data collection via electronic and hand-distributed surveys and phone interviews with the following:

<u>Community Stakeholders Interviewed via Phone</u>

- YMCA Potomac Overlook: Allison Jones, Vice President Operations
- Prince George's County Health Department: Dr. Ernest Carter, Deputy Health Officer
- Prince George's County Councilman /State Legislator: Prince George's County Councilman Obie Patterson; D-8 Maryland State Delegate Kriselda Valderrama
- Fort Foote Baptist Church: Rev. Norman Robinson, Pastor
- River Jordan Project Community Organization and FWMC Advisory Council Members: Rev. Dr. Robert Screen; Rev. Tierney Screen

Community Population Surveys

Fort Washington Medical Center attended health fairs, and distributed the hand survey to end-users in the study area. An online survey also was employed. The hand survey was distributed to the community through the YMCA, FWMC hospital, local school, library and local group events, health fairs, strip malls, barbershops, and senior homes.

A total of 339 surveys were collected:

- 299 via in-person, hand-survey collection; 88.2%
- 40 via online collection; 11.8%

Tripp Umbach's independent data analysis, in concert with community forums and prioritization of the community health assessment findings, resulted in the identification of key community health needs, which includes high blood pressure, weight and diabetes. The community health needs were prioritized and an implementation strategy was developed and executed to address overall healthy lifestyles through diet, exercise and health education.

To ensure that all health needs were met, FWMC identified at least one and often multiple resources available to meet each identified community health need through the CHNA Asset Community Inventory Assessment. (See attached Table) and through its partnerships with the Prince George's County Healthcare Action Coalition who is focusing on Access to Care, Chronic Disease, Infant Mortality, HIV, Domestic Violence and Pedestrian Safety.

In addition, FWMC continues to use multiple mechanisms to gauge the pulse of the population's health using our own internal data by assessing our patients' top presenting conditions, engaging medical staff regarding needed services; and evaluations and tracking reasons for transfers from our facility.

Reference Table III below for further details regarding FWMC community benefits.

TABLE III

Initiative 1: Healthy Eating Active Living (H.E.A.L.)

1. Identified Need 2. Was this identified through the CHNA process?	Obesity Yes. The FWMC CHNA revealed that weight obesity has doubled in Maryland in the past 20 years. Prince George's County resident are 32.% obese.	
Hospital Initiative	Healthy Eating Active Living (H.E.A.L.) Program	
Total Number of People Reached by the Initiative Within the Target Population	90	
Primary Objective of the Initiative	To assist individuals in modifying their lifestyle to reduce their risk of developing chronic diseases, such as high blood pressure, heart disease and diabetes. To encourage participants to become more active through a program of regular exercise and physical fitness by adopting better eating habits to include healthier food choices.	
Single or Multi-Year Initiative –Time Period	Jan. 1, 2014 – Sept. 30, 2014	
Key Collaborators in Delivery of the Initiative	Behavioral Health Navigators (BHNC) and the YMCA Potomac Overlook.	
Impact/Outcome of Hospital Initiative?	The YMCA provided a weekly trainer to conduct exercise classes. Nutrition education classes were held to assist individuals in making healthy food choices and preparing foods with specific health benefits. BHNC provided program and peer support.	
Evaluation of Outcomes:	Blood pressure, glucose levels and body weight measurement; change in eating habits	
Continuation of Initiative?	Not at this time. Grant funding ended Sept. 30, 2014.	
Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	Total Cost of Initiative $26,378.04	Direct Offsetting Revenue from Restricted Grants $16,026.38

1. Identified Need 2. Was this identified through the CHNA process?	High Blood Pressure According to FWMC's CHNA, overall more than one-half of the population (50.7%) reported having high blood pressure.	
Hospital Initiative	Hypertension Education Program (Community Based Clinical Services)	
Total Number of People Reached by the Initiative Within the Target Population	780	
Primary Objective of the Initiative	To provide blood pressure screenings within the communities we serve to assess and educate residents on the dangers of undiagnosed hypertension, offer recommendations for immediate treatment, physician follow-up and/or provide educational materials for prevention.	
Single or Multi-Year Initiative –Time Period	Multi-Year	
Key Collaborators in Delivery of the Initiative	Faith and community based organizations and schools	
Impact/Outcome of Hospital Initiative?	Monitor, treat hypertension to maintain a healthy blood pressure and minimize Identify potential risks, education and prevention opportunities	
Evaluation of Outcomes:	Provide blood pressure screenings to assess risk of hypertension	
Continuation of Initiative?	Yes.	
Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	Total Cost of Initiative $19,448.15	Direct Offsetting Revenue from Restricted Grants

1. Identified Need 2. Was this identified through the CHNA process?	Diabetes Yes.	
Hospital Initiative	Diabetes Self-Management Education Program	
Total Number of People Reached by the Initiative Within the Target Population	30	
Primary Objective of the Initiative	Educate and assist individuals with diabetes to maintain glycemic control through proper goal setting, meal planning and exercise	
Single or Multi-Year Initiative –Time Period	Multi-Year	
Key Collaborators in Delivery of the Initiative	Community and Faith-based organizations	
Impact/Outcome of Hospital Initiative?	Appropriate glycemic control, hypertension and cholesterol levels and reduction in participating patients diabetes-related hospital re-admissions	
Evaluation of Outcomes:	Periodic assessments of glucose levels,, blood pressure, cholesterol and the number of re-admissions to the hospital.	
Continuation of Initiative?	Yes.	
Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	Total Cost of Initiative $10,651.50	Direct Offsetting Revenue from Restricted Grants $8,500

1. Identified Need 2. Was this identified through the CHNA process?	Healthy Lifestyles and Health and Education Prevention To assist in meeting the needs of those in the Fort Washington Medical Center community, it was recommended through the CHNA to address these health priorities.	
Hospital Initiative	Community Walking & Education Program	
Total Number of People Reached by the Initiative Within the Target Population	50	
Primary Objective of the Initiative	To reduce the occurrence of preventable chronic diseases, particularly, those associated with being overweight, such as hypertension and diabetes by walking 3-5 times a week.	
Single or Multi-Year Initiative –Time Period	Multi-Year	
Key Collaborators in Delivery of the Initiative	Prince George's County Southern Regional Recreation & Technology Complex and LG Total Fitness Consultants.	
Impact/Outcome of Hospital Initiative?	To increase residential participation to exercise and maintain a healthy lifestyle. In addition, to provide educational information on various health-related topics, such as Walking 101, Diabetes, Hypertension, Proper Nutrition, etc.	
Evaluation of Outcomes:	Assess weight loss, blood pressure, glucose of participants. Number of participants enrolled in program whose body mass index decreased. We believe that this demonstrated a success.	
Continuation of Initiative?	Yes.	
Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	Total Cost of Initiative $2,635	Direct Offsetting Revenue from Restricted Grants

2. Were there any primary community health needs 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.

   To ensure that all health needs were met, FWMC identified at least one and often multiple resources available to meet each identified community health need through the CHNA Asset Community Inventory Assessment. (See attached Table) and through its partnerships with the Prince George's County Healthcare Action Coalition who is focusing on Access to Care, Chronic Disease, Infant Mortality, HIV, Domestic Violence and Pedestrian Safety.

3. How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health?

   Fort Washington Medical Center provides programs that are directed towards reducing health disparities and identifying health needs of the community, increasing community engagement, and building partnerships that address access to care, resources and preventative care.

   The hospitals Community Benefit initiatives align with population health by ensuring access to care for all patients, regardless of their ability to pay or the need for financial assistance and uncompensated care. All patients are treated equally and are provided the right venue of care and access to medical services and educational programs.

   Programs such as Healthy Eating Active Living (H.E.A.L.), Hypertension Program, Healthy Lifestyles and Health and Education Prevention, and the Diabetes Self-Management Program, are initiatives that target FWMC's population health priorities identified in our service areas. The programs include components such as health screenings, education, residential participation, modifying lifestyles, and prevention and working with key collaborators in the delivery of the initiatives.

   In addition, cost reduction, quality care, efficiency and population health, are focus areas for the hospital. FWMC is utilizing opportunities and addressing improvement processes, such as: providing prevention and modification of chronic disease initiatives to address the patients' health needs, while reducing hospital readmissions. FWMC is also implementing areas to improve productivity, value vs. volume system, accountability and cost reduction, and utilizing a global budget system.

VI. PHYSICIANS

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

Gaps in the availability of specialist providers:

a) Mental Health care is a major need in the community as reflected by the lack of resources when patients are seen in the emergency department. There are at least 10% of transfers are mental health related conditions. There is only one psychiatrist on the medical staff. This limits FWMC's ability to provide 24-hour mental health in patient consultations. According to FWMC CHNA survey, only 30% of family members are able to "find and use" mental health services. (CHNA, pg. 52, 6/13) Currently, outpatient services simply do not meet the needs of the community, including the uninsured.
b) Surgical subspecialty services – Ear, Nose and Throat specialist are unavailable to both the community and FWMC. This severally limits the hospital's ability to care for the demands of our community as it relates to emergency or elective surgical ENT surgical procedures. In addition, ENT outpatient serves adolescent and pediatrics, which is not available in the local community.
c) Pain Specialist – The hospital sees a large proportion of patients with chronic pain related conditions, including sickle cell disease. No specialists are available in or out patient to manage the more complex patients, thereby avoiding unnecessary and wasteful admissions. According to BRG Healthcare "Southern Maryland Regional Coalition for Heath System Transformation", chronic abdominal pain, pain in limbs, headache and unspecified chest pain diagnoses were ER high utilizers defined as >4 ER visits in a calendar year. (5/1/15).
d) Neurology Services are limited. Neurology on-call is available just ten days of each month. Outpatient follow-up services limited access for appointments. Limited services to provide uninsured for the management of seizures, sleep disorders, and migraines.
e) Breast Surgical Specialist – unavailable services because surgeons must be board certified or have completed fellowships in breast surgery. Difficult to recruit, and yet there is a demand for its services in the area. Amongst African-American woman breast cancer is the most common, 33%. Despite this, there are no local services.
f) Oncology services are limited in the area, and FWMC is unable to provide this service. African Americans have the highest cancer death rate and shortest survival of any racial or ethnic group. Patients may receive care at tertiary centers which is a considerable burden to the patient and family members requiring to commute long distances.
g) Geriatric Specialist – Fort Washington population is rapidly aging with a growing medicare population, yet Geriatric trained specialist are lacking on staff at FWMC and in the community. These patients require special attention and skills to manage multiple complex medical conditions.
h) FWMC has a 4 bed ICU that supports only 1.0 FTE Intensivist. Continual on-site 24 hour coverage of urgent management of ICU patients is limited with hospitalist providing this back-up service. Tele-ICU enables frontline staff including hospitalist to have immediate critical care specialist consultants and advice. In addition, the consultant can safely manage these patients remotely with availability for IT platforms that enable them to see monitors, EKGs and lab work, as well ordering remotely through the EMRs. Basic ICU care and monitoring is an essential community need to drive down unnecessary transfers to DC or neighboring facilities. It allows families to see their love-ones in the close proximity of their community and homes.

VII. APPENDICES

APPENDIX I:

FORT WASHINGTON MEDICAL CENTER'S CHARITABLE CARE POLICY

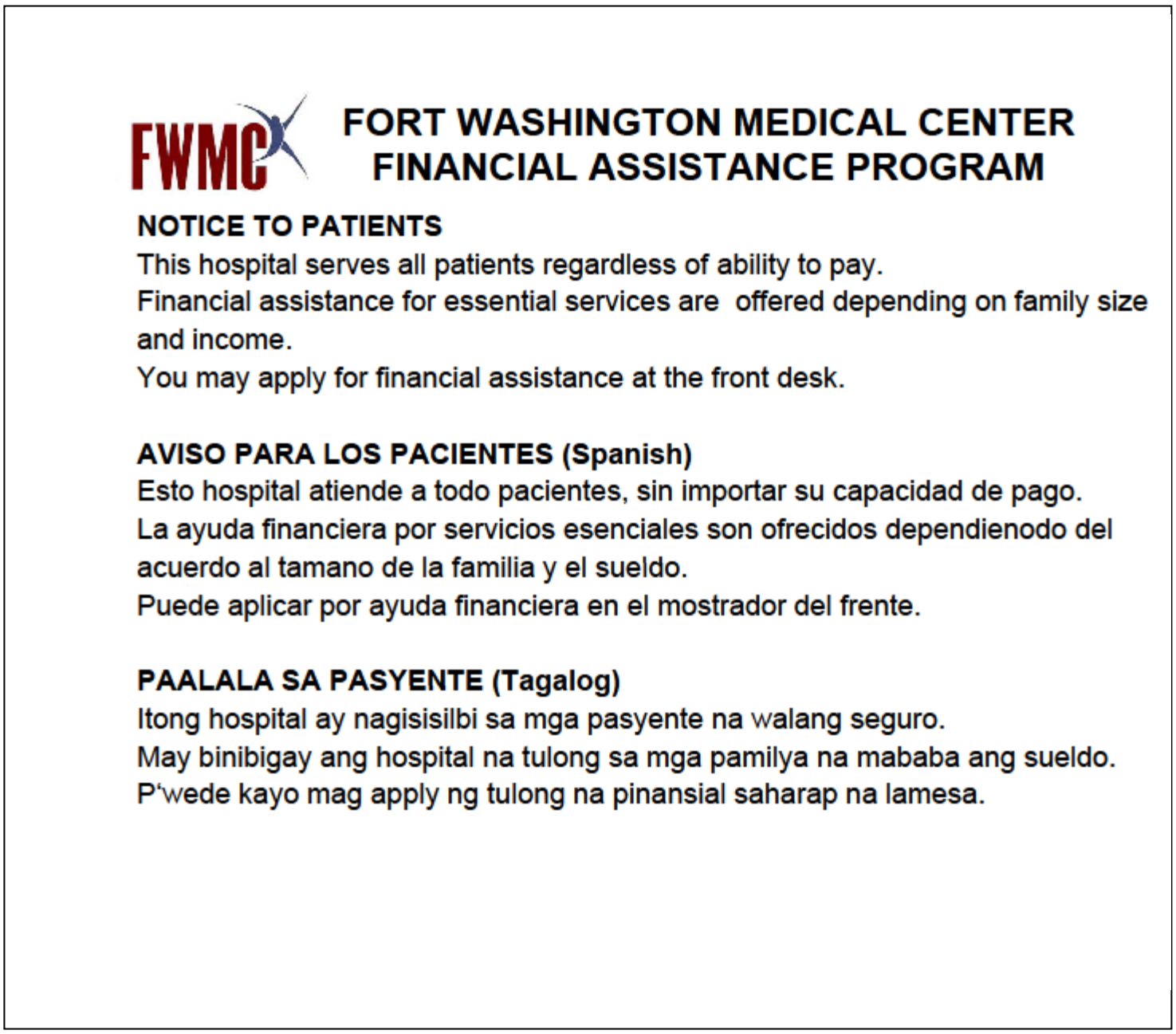
Fort Washington Medical Center provides Financial Assistance for uninsured and under insured patients. The hospital provides charitable care to those in need regardless of an individual's ability to pay for services. Care can be provided without charge, or at a reduced charge to those who do not have insurance, with Medicare/Medical Assistance coverage and are without the means to pay. An individual's eligibility to receive care without charge, at a reduced charge or to pay for their care over time is determined on a case-by-case basis.

FWMC provides financial assistance information as part of the intake process to patients and/or their families. The hospital shares the cost of a State of Maryland Medicaid Case Worker to assist our patients that may qualify for state or federal assistance. Patients are referred to the case worker by the Hospital's Financial Counselor, who is available Monday through Friday to assist patients with medical bills, financial assistance application, with a MD Medicaid application or a MD PAT application, as appropriate or to provide information regarding outpatient medical clinics.

Hospital personnel issues patients pamphlets upon registration with information regarding financial assistance, the process for applying for assistance and the appropriate contact information. Information on the availability of financial assistance also is noted on the hospital's billing statements with a contact phone number.

Patients are also informed of the assistance available via financial materials, such as a patient information brochure, posters posted in the admitting/registration area, the Emergency Department and at the receptionist's desk in the main lobby. These posters are written in English, Spanish and Tagalog (most common languages of the community).

The hospital also issues a copy of the hospital's patient handbook, which also contains financial assistance information.



APPENDIX II:

b. Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014 (label appendix II).

The parameters regarding Fort Washington Medical Center's Financial Assistance Program has not changed since the ACA's Health Care Coverage Expansion Option was instituted. However, the hospital has seen fewer applicants for financial assistance.

APPENDIX III:

FWMC Financial Assistance Policy

FORT WASHINGTON MEDICAL CENTER
Policy and Procedure Manual
Patient Rights

TITLE: FINANCIAL ASSISTANCE PLAN

Policy No. RI 240

PURPOSE:

The purpose of this policy is to document the Fort Washington Medical Center (FWMC) process for granting financial assistance where patients are unable to meet their obligations to the organization due to lack of insurance or other financial resources or other conditions of financial hardship.

POLICY:

Fort Washington Medical Center provides care to all patients regardless of ability to pay.

It is the policy of Fort Washington Medical Center to provide Financial Assistance based on inability to pay or high medical expenses for patients who meet specified financial criteria and request such assistance.

The determination of probable eligibility for Financial Assistance (or charity care services) will be made within two business days following a patient's request for such services, application for medical assistance or both.

FWMC will communicate the availability of financial assistance on the hospital website and in hospital publications.

A notice of FWMC's Financial Assistance Plan will be posted in the Admitting & Registration (Admissions) Department, Patient Accounts (Business Office), in the Emergency Department, and Administration.

Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

PROCEDURE:

1. Patient's will be informed of the following upon admission through the Financial Assistance Brochure/Information Sheet:
    a. Description of the Financial Assistance Policy;
    b. Patient's rights and obligations with regard to hospital billing and collection under the law;

c. Contact information at the hospital that is available to assist the patient, the patient's family/significant other, or the patient's authorized representative in order to understand:

i. The patient's hospital bill;

ii. The patient's rights and obligations with regard to the hospital bill;

iii. How to apply for free and reduced cost care in the billing office;

iv. How to apply for the Maryland Medical Assistance Program and any other programs that may help pay the bill.

d. Contact information for the Maryland Medical Assistance Program;

e. Physician charges are not included in the hospital bill and are billed separately.

2. The patient's initial bill will include reference on whom to contact for Financial Assistance Information.

3. The Financial Assistance Brochure/Information sheet will be distributed to each patient.

4. An evaluation for Financial Assistance can be commenced in a number of ways:
   a. A patient with a self-pay balance due notifies the self-pay collector that he/she cannot afford to pay the bill and requests assistance.
   b. A patient presents at a clinical area without insurance and states that he/she cannot afford to pay the medical expenses associated with their current or previous medical services.
   c. A physician or other clinician refers a patient for financial assistance evaluation for potential admission.

5. The Insurance Verification Representative/Financial Counselor (located in the Admitting office), Admitting and Patient Accounts personnel will be responsible for taking Financial Assistance applications.

6. When a patient requests Financial Assistance, the staff member who receives the request will:

   a. AFTERHOURS/WEEKEND: Give the patient a Financial Assistance Program and Practices brochure and application (attached) and refer the patient to contact the Insurance Verification Representative/Financial Counselor. Patients may drop off applications with anyone in the Admitting area.

   b. DURING THE WORKWEEK NORMAL BUSINESS HOURS: Refer the patient to the Insurance Verification Representative/Financial Counselor.

7. To make a determination of probable eligibility for Financial Assistance, the applicant must complete the Maryland State Uniform Application for Financial Assistance.

    a. The Insurance Verification Representative/Financial Counselor will perform an assessment to determine if the patient meets preliminary criteria based on the family size/income as defined by Medicaid regulations (See Attached Poverty Level Guidelines Table).

    b. A Letter of Conditional Approval for probable eligibility (see attached) will be sent to the patient within two business days.

    c. The person seeking financial assistance may contact Insurance Verification at the end of the second business day to learn of the determination.

    d. Applications received and preliminary determinations made by the Insurance Verification Representative/Financial Counselor will be sent daily to Patient Accounts for review

8. In order to make the final determination for Financial Assistance as provided for in the letter of conditional approval, following documents must be provided to any personnel in Admitting or Patient Accounts.
    a. A copy of the conditional approval letter (attached).
    b. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations).
    c. A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.
    d. A Medical Assistance Notice of Determination (if applicable).
    e. Proof of disability income (if applicable).
    f. Reasonable proof of other declared expenses.

9. The following must be met in order for a review for a final determination for a Financial Assistance adjustment:
    a. The patient must apply for Medical Assistance unless the financial representative can readily determine that the patient would fail to meet the disability requirement. In cases where the patient has active Medicare Prescription Drug Program or Qualified Medicare Beneficiary (QMB) coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.
    b. Review viability of offering a payment plan agreement.
    c. All insurance benefits have been exhausted.

10. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. If the patient's application for Financial Assistance is determined to be complete and appropriate:
    a. the Insurance Verification Representative/Financial Counselor will forward all documents and recommended patient's level of eligibility to the Director, Patient Accounts;
    b. the Director of Patient Accounts has the authority to approve/reject charity amounts less than $5,000; and
    c. The Chief Financial Officer has the authority to approve/reject charity amounts estimated to exceed $5,000.

11. A Letter of Final Determination (see attached) will be sent to the patient within 30 days to inform him/her eligibility for:
    a. Financial Assistance (Full or partial)
    b. Payment Plan

12. FWMC has the option to designate certain elective procedures for which no Financial Assistance options will be given.

13. Once a patient is approved for Financial Assistance, it is expected that the patient will continue to meet his/her required financial commitments to Fort Washington Medical Center. If a patient is approved for a percentage allowance due to financial hardship and the patient does not make the required initial payment within 60 days towards their part of the bill, the Financial Assistance allowance will be reversed and the patient will owe the entire amount. It is recommended that the patient make a good faith payment at the beginning of the Financial Assistance period.

14. Any payment schedule developed through this policy will ordinarily not exceed two years in duration. In extraordinary circumstances, a payment schedule may extend to three years in duration, with the approval of the Chief Financial Officer.

15. The Director of Patient Accounts will advise ineligible patients of other alternatives available to them including Medical Assistance or bank loans.

16. Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing (including any accounts having gone to bad debt within 3 months of application date) and any projected medical expenses.

17. A determination of Financial Assistance will be re-evaluated every six (6) months as necessary.

GLOSSARY

TERM	DEFINITION
Catastrophic circumstances	A situation in which the self-pay portion of the FWMC medical bill is greater than the patient/guarantor's ability to repay with current income and liquid assets in 24 months or less.
Current Medical Debt	Self-responsible portion of current inpatient and outpatient affiliate account(s). Depending on circumstances, accounts related to the same spell of illness may be combined for evaluation. Collection agency accounts are considered.
Liquid Assets	Cash/Bank Accounts, Certificates of Deposit, bonds, stocks, Cash Value life insurance policies, pension benefits.
Living Expenses	Per person allowance based on the Federal Poverty Guidelines times a factor of 3. Allowance will be updated annually when guidelines are published in the Federal Register.
Permanent Resident	Holder of a United States Permanent Resident Card, also known as a "green card," which is an identification process card attesting the permanent resident status of alien in the United States of America. The green card serves as proof that its holder, a Lawful Permanent Resident (LPR), has been officially granted immigration benefits, which include permission to conditionally reside and take employment in the USA. The holder must maintain his permanent resident status, and can be removed if certain conditions of such status are not met.
Projected Medical Expenses	Patient's significant, ongoing annual medical expenses, which are reasonably estimated, to remain as not covered by insurance carriers (i.e. drugs, co-pays, deductibles and durable medical equipment.)
Qualified Medicare Beneficiary (QMB)	The QMB program is for persons with limited resources whose incomes are at or below the national poverty level. It covers the cost of the Medicare premiums, coinsurance and deductibles that Medicare beneficiaries normally pay out of their own pockets.
Spell of Illness	Medical encounters/admissions for treatment of condition, disease, or illness in the same diagnosis-related group or closely related diagnostic-related group (DRG)

	occurring within a 120-day period.
Supporting Documentation	Pay stubs; W-2s; 1099s; workers' compensation, social security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments; and, credit bureau reports.
Take Home Pay	Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, net rental income before depreciation, retirement/pension income, social security benefits, and other income as defined by the Internal Revenue Service, after taxes and other deductions.

TRAINING:

All staff will be informed of the Financial Assistance Plan and their specific responsibilities related to this plan.

Training will be provided at orientation, annual professional update and periodically as indicated.

DOCUMENTATION:

Registrars will document that they provided the newly admitted patient with the Financial Assistance Brochure/Information Sheet in the information system by placing a check in the HIPAA box. This check indicates that HIPAA, Patient's Rights Brochure and the Financial Assistance Brochure was given to the patient.

ANNUAL EVALUATION:

FWMC Trends of Annual Percent of Financial Benefit

Update Poverty Table

Review of literature for national, state and local legislative review to maintain current compliance.

APPROVAL PROCESS/COMMITTEE FLOW:

Finance Committee

Patient Safety/Performance Improvement Committee (for information)

President and CEO

REFERENCE (S):

Federal Register (Poverty Level Guidelines)

Maryland legislation §19-214.1

Maryland State Uniform Financial Assistance Application located at www.hscrc.state.md.us/consumers_uniform.cfm

FWMC Patient Rights and Responsibilities brochure

HB 1069 HSCRC Financial Assistance and Debt Collection Policy (Effective 6/1/2009)

ATTACHMENT(S):

Financial Assistance Program and Practices brochure

Letter of Conditional Approval

Letter of Determination

Financial Assistance Notice for lobby

2012 Poverty Level Guidelines (January 2012 Federal Register)

Maryland State Uniform Financial Assistance Application

DATE REVIEWED:	SIGNATURE:	DATE REVIEWED:	SIGNATURE:
APPROVED: Verna S. Meacham, President/CEO	DATE ISSUED: 11/1998	DATE REVISED: 12/21/07, 6/2009, 4/2012, 3/2013, 11/2014	

ASK QUESTIONS

- Cooperate with all hospital personnel caring for you and ask questions if you do not understand the directions given to you;
- The hospital has a Patient Representative to answer questions about patient's responsibilities and patient rights, provide information, investigate complaints and act as your advocate. To reach the Patient Representative, please call (301) 203-2230.

FOLLOW TREATMENT INSTRUCTIONS

- Help your doctors, nurses and other medical personnel in their efforts to care for you by following their instructions;
- Follow the treatment recommended by your doctor and notify him or her of any changes.

SHOW RESPECT AND CONSIDERATION

- Respect the privacy of your roommate;
- Be considerate of other patients and Hospital personnel and see that your visitors are considerate as well, particularly in regard to noise and number of visitors;
- Be respectful of others, their property and the Hospital's property.

ACCEPT CONSEQUENCES

Assume the consequences of refusal of treatment and for outcomes if you do not follow the care, service or treatment plan.

FOLLOW RULES AND REGULATIONS

Abide by Hospital rules and regulations and see that your visitors do likewise.

MEETING FINANCIAL COMMITMENTS

- Promptly provide information for insurance processing, ask questions concerning medical costs and accept financial obligations associated with your care.
- Physician charges are not included in the hospital bill.
- Financial Assistance or reduced cost may be available for low-income patients. For application contact Admitting at 301-203-2154 or Billing 301-203-7890, 301-203-3456.

COMPLAINT OR GRIEVANCE

If a patient or legal representative would like to make a complaint, they may do so by:

1. Sending his or her written grievance to:
   Administration
   Fort Washington Medical Center
   11711 Livingston Road
   Fort Washington, MD 20774
2. Calling the Patient Representative at 301-203-2230 to file a grievance to the Grievance Committee.
3. Contacting the Maryland Department of Health and Mental Hygiene/Office of Healthcare Quality at 410/402-8016 or 201 West Preston Street
   Baltimore, Maryland 21201.
4. Contacting the Maryland Board of Pharmacy 410-764-4755 4201 Patterson Ave. Baltimore, MD 21215
5. Contacting the Joint Commission at 1-800-994-6610 or by e-mail at complaint@jointcommission.org or
   Office of Quality Monitoring
   The Joint Commission
   One Renaissance Boulevard
   Oakbrook Terrace, IL 60181.

ADVANCE DIRECTIVES

FWMC will make reasonable efforts to comply with the expressed wishes of the patient in an Advance Directive regarding the provision, refusal or discontinuation of medical care or treatments. However, the Hospital is under no obligation to carry out the wishes of a patient when such wishes would be illegal, unethical or contrary to reasonable medical practices.

An Advance Directive which demands a treatment, therapy or procedure which is not medically indicated will not be honored.

Patients cannot be required to write an Advance Directive and shall not be discriminated against in any manner based upon whether or not they have written an Advance Directive. The existence or lack of an Advance Directive will not determine an individual's access to care, treatment or services. Patients have the option to review or revise Advance Directives.

Know Your Patient Rights & Responsibilities

Fort Washington Medical Center

PATIENT SAFETY

Your safety is very important to us. Some mistakes are more serious than others, but most medical mistakes can be prevented.

- The most important way to prevent errors is to **TALK** with your care workers and **SPEAK UP** about any questions/concerns.
- Make sure the health care worker checks your wristband and asks your **NAME and DATE OF BIRTH** prior to medications, lab work, X-Rays, procedures, or surgery.
- It is okay to ask anyone who touches you if they have **washed their hands**.
- Call for help to get out of bed or chair. **CALL, don't FALL!**
- Call for help by pressing your call bell or informing any staff member. In an emergency, you may pull the call bell out of the wall.
- Report any side effects from medications.
- If you have concerns about your health care safety, you may call:
  - Administration at 301-203-2210
  - Joint Commission at 1-800-994-6610
  - Office of Healthcare Quality at 1-877-402-8218

Revised April 11, 2013

We at Fort Washington Medical Center are committed to providing you with the highest quality of medical care we have available, and to ensure that you are treated with respect and dignity.

As a patient at Fort Washington Medical Center you are the central part of your health care team. Your understanding of your condition and your participation in your care are important. You have both rights and responsibilities.

YOU HAVE THE RIGHT TO:

- Respectful and considerate treatment;
- Know by name the doctors, nurses and staff members who care for you;
- Know the hospital rules and regulations which apply to your conduct as a patient;
- Obtain complete and current information from your doctor concerning your condition and treatment;
- Know the reason you are given various tests and treatments;
- Know the nature and risks of procedures and treatments prescribed for you;
- Have your pain assessed and managed;
- Have visitors or to limit the number of visitors you receive;
- Expect all communications and other records pertaining to your care; including the source of payment to be kept confidential;
- Request an amendment to inaccurate or incomplete medical information contained in your medical record;
- Request an amendment to inaccurate or incomplete medical information contained in your medical record;
- Request an accounting of certain disclosures of your medical information;
- Request to receive communications on a confidential basis by using alternative means for receipt of information or by receiving the information at alternative locations;
- Request restrictions on medical information we use or disclose about you for treatment, payment or health care operations;
- Refuse release of your medical records, except as required by law;
- Examine your hospital bill and have it explained to you;
- from another doctor;
- Change doctors or hospital;
- Allow a family member, friend or other individual be present with the patient for emotional support.
- Have impartial access to the medical resources of the hospital indicated for your care without regard to race , color, creed, national origin, age, sex, handicap, or source of payment;
- Designate an individual to represent you in making decisions regarding your treatment and health care. Please ask your nurse for a copy of our Advance Directive Form;
- Refuse treatment to the extent permitted by law and to be informed of the consequences of your refusal;
- Refuse to participate in research or educational projects;
- Be informed of the services available at this hospital;
- Participate in the planning of your medical treatment through discussions with the health care team; and
- Be given advance notice of transfer or discharge when required for medical reasons or your welfare.

NOTICE UNDER SECTION 504 OF THE REHABILITATION ACT OF 1973

In accordance with the requirement of Section 504 of the Rehabilitation Act of 1973 (Section 504), the Fort Washington Medical Center (FWMC) does not discriminate on the basis of disability in admission to, participation in, or receipt of services and benefits under any FWMC program or activity. FWMC does not retaliate or discriminate against, or coerce, intimidate or threaten any individual who (1) opposes any act or practice made unlawful by Section 504 or (2) files a grievance and/or complaint, testifies, assists, or participates in any investigation, proceeding, or hearing under Section 504.

Provision of Auxiliary Aids and Effective Communication: FWMC will generally, upon request, provide appropriate auxiliary aids leading to effective communication for qualified persons with disabilities so they can participate equally in FWMC services, programs or activities, including qualified sign language interpreters, and other ways of making information and communications accessible to people who have speech, hearing, or vision impairments. FWMC will not place a surcharge on a particular qualified individual with a disability or any group of qualified individuals with disabilities to cover the cost of measures, such as the provision of auxiliary aids or program accessibility, that are required to provide that individual or group with nondiscriminatory treatment required by Section 504.

Anyone who requires an auxiliary aid for effective communication to participate in an FWMC service, program or activity, should notify their healthcare worker or program coordinator, as soon as possible but no later than 48 hours before the scheduled event.

Grievances alleging that an FWMC service, program or activity is not accessible to persons with disabilities should be directed to the 504 Coordinator, at 301-203-2210. Filing a grievance with the Section 504 Coordinator does not prevent the applicant, resident and/or his family member or guardian from filing a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services.

YOU HAVE RESPONSIBILITIES ALSO, AND WE ASK YOU TO:

PROVIDE INFORMATION

- Bring with you information about past illnesses, hospitalizations, medications and other matters relating to your health. To the best of your knowledge provide accurate and complete information including when there are unexpected changes in your condition;
- Provide feedback about services, needs, and expectation. You may be contacted by phone by HealthStream Research, our vendor who conducts patient satisfaction surveys to inquire about your satisfaction with your visit.

APPENDIX IV:

FWMC Patient Financial Information Sheet

IMPORTANT FINANCIAL INFORMATION

Visit the Insurance Verification Representative/ Financial Counselor located in the Admitting Office or call 301-203-2271 or 2154, if you need assistance with:

- Understanding your hospital bill;
- Your rights and obligations with regard to your hospital bill;
- How to apply for free and reduced cost care;
- How to apply for the Maryland Medical Assistance Program and any other programs that may help pay the bill.

If it is after hours, a holiday or a weekend, you can pick up/drop off an application at FWMC's Registration or Information desk. If you need additional assistance, please call and leave a message with a Financial Counselor and someone will return your call within two business days.

Maryland Medical Assistance Program (HealthChoice):
1-800-977-7388 (TDD 1-800-977-7389)

All determinations of eligibility are solely at the discretion of FWMC.

This information is to be provided to the patient, the patient's family/significant other, or the patient's authorized representative before discharge or upon request.

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BILLING INSTRUCTIONS on how to obtain financial information is communicated on the first hospital bill. Physician charges are not included in the hospital bill and are billed separately.

EXCLUSION: FWMC has the option to designate certain elective procedures for which no financial assistance option will be given.

TERMS OF AGREEMENT FOR FINANCIAL ASSISTANCE: Financial Assistance will remain valid for three months based on the initial date of the final determination letter. For recurring patients, patients may qualify for Financial Assistance for up to six months on the basis of a single application.

FWMC
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Fort Washington Medical Center
11711 Livingston Road
Fort Washington, MD 20744
(301) 292-7000 • www.fortwashingtonmc.org

Find us on Facebook

Financial Assistance
PROGRAM & PRACTICES

at Fort Washington Medical Center

FINANCIAL ASSISTANCE PLAN

Fort Washington Medical Center (FWMC) follows a specific and compassionate policy for payment practices for financial assistance and uninsured billing. As a not-for-profit organization, one of the ways FWMC demonstrates its commitment to the community is through providing financial assistance to those in need. Our practices are an outgrowth of our mission and values.

FWMC'S RESPONSIBILITIES:

- FWMC will serve all patients regardless of their ability to pay.
- Be respectful of the individual's personal dignity and his/her ability to pay.
- Treat all patients equitably, whether insured, underinsured or uninsured.
- Consider the financial resources of patients and their families when establishing a maximum annual patient responsibility.
- Be diligent in our efforts to keep patients notified of their payment options and the opportunities for assistance.
- Ensure that our policies are consistent with the guidelines that have been issued by the American Hospital Association, federal, state and local legislative bodies, and other organizations.
- Provide financial assistance to those in need.

PATIENT'S RESPONSIBILITIES:

- Follow through with the application process.
- Provide all required documents necessary in order to be granted financial assistance.

FWMC PROCEDURE SUMMARY:

1. **An evaluation for financial assistance will be conducted when a:**
   - Patient with a self-pay balance due notifies Patient Accounts that he/she cannot afford to pay the bill and requests assistance.
   - Patient presents at registration or a clinical area without insurance and states that he/she cannot afford to pay the medical expenses.
   - Physician or other clinician refers a patient for a financial assistance evaluation.
2. **A Financial Counselor/Insurance Verification Representative will meet with the patient, upon request, to provide instructions on the Financial Assistance Application.** If it is after hours, a holiday or a weekend, the patient will be issued a copy of the Financial Assistance Program brochure and referred to call 301-203-2271 or 2154 and someone will contact them within two business days.
3. **To make a determination of probable eligibility for Financial Assistance, the applicant must complete the Maryland State Uniform Application for Financial Assistance.**
   - The Insurance Verification Representative/Financial Counselor will perform an assessment to determine if the patient meets preliminary criteria based on the family size/income as defined by Medicaid regulations.
   - A Letter of Conditional Approval for probable eligibility will be sent to the patient within two business days. The person seeking assistance may also call Insurance Verification at the end of the second business day to learn of the determination.
   - Applications received and preliminary determinations made by the Insurance Verification Representative/Financial Counselor will be sent daily to Patient Accounts for review.
4. **During the final determination of eligibility, the patient must provide a copy of the following to the Financial Counselor:**
   - Most recent Federal Income Tax Return.
   - Three most recent pay stubs (if employed).
   - Medical Assistance Notice of Determination (if applicable).
   - Proof of disability income (if applicable).
   - Reasonable proof of other declared expenses.
5. **The following are also necessary for a final determination:**
   - The patient must apply for Medical Assistance unless the Financial Counselor can readily determine that the patient would fail to meet the disability requirement.
   - Review possibility of a reasonable payment plan agreement.
   - All insurance benefits have been exhausted.
6. **The completed Maryland State Uniform Financial Assistance Application and required forms will be forwarded from the Financial Counselor to the Director of Patient Accounts for approval.**
7. **A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses.**
8. **Once a patient is approved for Financial Assistance, it is expected that the patient will continue to meet his/her required financial commitments to FWMC.** If a patient does not make the required payment within 60 days, the Financial Assistance allowance will be reversed and the patient will owe the entire amount. It is recommended that the patient make a good faith payment at the beginning of the Financial Assistance period.

Fort Washington Medical Center

Mission, Vision and Values

MISSION

- The mission of Fort Washington Medical Center is to make a positive difference in the lives of those we serve by providing quality, responsive healthcare services and treating each patient with dignity, care and compassion.

VISION

- The vision of Fort Washington Medical Center is to be recognized as a superior, innovative health care system exhibiting excellence in patient/resident care and safety, illness prevention and the wellness needs of our communities.

Core Values

CARING
Doing the best we can to make the condition or situation better

COMPASSION
Providing inspired care for others as you would want done for yourself or loved ones

DIGNITY
Treating all with respect and worthiness

DIVERSITY
Accepting and respecting all individuals

EXCELLENCE
Exceeding expectations in all aspects of care with every patient encounter

SAFETY
Operating with the intention to keep patients, customers, and employees from harm or danger while maintaining a safe (hazard free) physical environment

TEAMWORK
Working in harmony with empathy for others and a shared passion for the success of the organization to make FWMC a place where we want to come to work

Fort Washington Medical Center;

Nexus Health Inc.

June 27, 2013

Fort Washington Medical Center – 11711 Livingston Rd. Fort Washington, MD 20744

(Phone) 301-292-7000

TrippUmbach
Research • Strategy • Impact

FORT WASHINGTON MEDICAL CENTER 2013

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FORT WASHINGTON MEDICAL CENTER 2013

Overview

Fort Washington Medical Center (FWMC) is owned by Nexus Health of Maryland. Of the many Maryland Hospitals, FWMC provides quality healthcare in an intimate and accessible setting. It's conveniently located in Southern Prince George's County, Maryland, just outside of Washington, D.C, and is proud to provide medical services in their community.

In the late 1970's, residents of Fort Washington, Maryland met to discuss the idea of constructing a hospital in their community. Their dream was partially realized through the opening of the Fort Washington Ambulatory Care Center in 1983.

The first capital campaign through the "Buy-A-Brick" program was conducted to raise money for equipment for the new patient care building. In February 1991, the dream became a reality. Fort Washington opened with a limited number of beds acquired from the now closed Parkwood Hospital in Clinton, Maryland.

Today, Fort Washington Medical Center is the newest hospital in the Maryland system. Licensed for 42 beds (37 are in actual operation), it admits more than 2,800 patients through its medical-surgical unit and sees nearly 45,000 patients through its Emergency Room.

It provides inpatient and outpatient care, diagnostic laboratory and radiology services, inpatient pharmacy, rehabilitation, and ambulatory surgical services. Fort Washington Medical Center maintains its ties with area residents through community programs, dedicated services, and responsive staff.

Fort Washington Medical Center's Mission:

To make a positive difference in the lives of those we serve by providing quality, responsive healthcare services and treating each patient with dignity, care, and compassion.

Fort Washington Medical Center's Vision:

To be recognized as a superior, innovative healthcare system exhibiting excellence in patient/resident care and safety, illness prevention, and the wellness needs of our communities.

Prince George's County and the community which surrounds Fort Washington Medical Center is diverse in culture and ethnicity. In examining the data, Fort Washington has the highest percentage of Black/African-Americans, Asians, and populations with two or more races residing in the community. A large and increasing Hispanic population in the region also contributes to the growing minority population which has defined Prince George's County. 21.9% of residents in Prince George's County are Caucasian compared to the U.S. population at 74.1%, Maryland (59.2%), and Washington, D.C. (38.9%).[1]

In reviewing the community health needs assessment data, we see that the inability to speak English when navigating the healthcare system is problematic for those whose primary language is not English. Only 8.6% of respondents speak English less than "very well" in the county. In Prince George's County, 19.8% of county residents reported that they speak a language other than English at home. This rate is noteworthy, especially when compared to the U.S. population at 20.3%, 16.2% in Maryland, and 14.5% in Washington, D.C.[1]

The population in Prince George's County is also projected to grow. The current county population is 858,539 and the median household income is $73,447, higher than the U.S. median of $52,762 according to the U.S. Census Bureau. Over one-quarter of county residents holds a bachelor's degree or more (29.7%) compared to 28.2% of the U.S. population.[1]

[1] U.S. Census Bureau 2011

Introduction

The healthcare landscape is constantly changing, and Maryland is no exception. A challenging economy, coupled with major changes in healthcare programs such as Medicare, provides unique opportunities to maximize existing resources while minimizing costs associated with starting and creating new programs.

Fort Washington Medical Center has a long history of partnering with community organizations, providing strategies to improving care for the medically underserved, vulnerable populations, and serving the general community. Healthcare organizations and providers understand the growing needs of their communities. They are committed to their mission, and most importantly, committed to the community they serve. Fort Washington Medical Center has a unique opportunity to evaluate current strategies, deliver high-quality services, and be the leader for the community.

Fort Washington Medical Center has felt the impact of the struggling economy; however, their demographic profile runs the gamut in terms of household income. Fort Washington's community has the highest recorded median household income when compared to the U.S. population, Washington, D.C., the state of Maryland, Charles County, and Prince George's County overall.[1]

In reviewing the overall community need index scores (CNI) for the study area, it is clear that Washington, D.C. (20020, 20032) and Oxon Hill (20745) are the three zip code areas with the greatest number of socio-economic barriers to healthcare access, thus indicating at-risk populations in regards to community health. (There are five socio-economic barriers to community health that are quantified in the CNI: Income, Cultural/Language, Educational, Insurance, and Housing Barriers.)

Washington, D.C. zip codes 20020 and 20032 both have unemployment rates over 16%, which is higher than the Maryland rate (6.6% as of March 2013), and the U.S. rate, which is most recently reported at 7.6%. While there are multiple community organizations that residents can receive health and social service assistance from, most often these organizations work independently and/or in silos. In order for a collective effort to exist, healthcare leaders, community providers, and community-based agencies must be linked to form better strategies to assist those in need.

FORT WASHINGTON MEDICAL CENTER 2013

Prince George's County faces many challenges. The demand for healthcare and social services will continue to increase and local healthcare service providers must be ready to address those needs. The growing uninsured and underinsured populations, rising healthcare costs, the pressures to reduce services, and the need to continue to help those in need are continuous challenges Fort Washington Medical Center will face for years.

In March 2013, Fort Washington Medical Center initiated a community health needs assessment (CHNA) to identify the needs of those living in Prince George's County, Charles County, and Washington, D.C.; (specific zip codes in Prince George's County, Charles County, and Washington, D.C. were provided to Tripp Umbach) this was considered the study area. This community health needs assessment was conducted to evaluate and understand the region's health needs.

The CHNA conducted by Tripp Umbach[2] identifies specific community health needs and evaluates how those needs are being met in order to better connect health and human services with the needs of residents in the region.

The CHNA represented a comprehensive process, where Fort Washington Medical Center connected with a wide range of organizations, health-related professionals, local government officials, human service organizations, and faith-based organizations to evaluate the community's health and social needs. The assessment included primary data collection and interviews with community stakeholders. Tripp Umbach's independent data analysis, in concert with community forums and prioritization of the community health assessment findings, resulted in the identification of key community health needs. The community health needs were prioritized based upon discussions held at Fort Washington Medical Center's June 20, 2013 presentation meeting.

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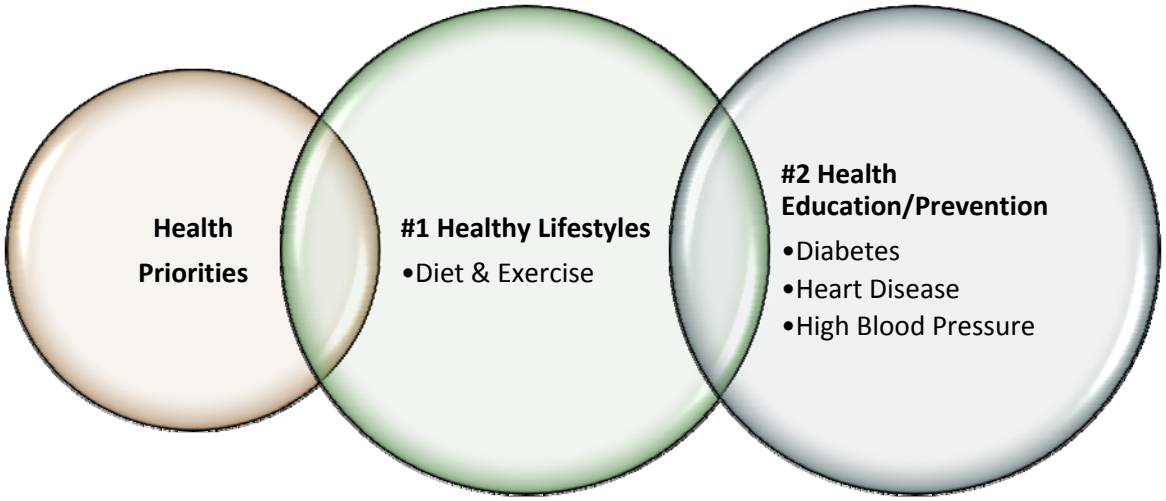
[2]Tripp Umbach (TU) is a recognized national leader in completing community health needs assessments (CHNA), having conducted CHNAs over the past 20 years. Tripp Umbach's projects are national pilots and have received statewide and national recognition. Tripp Umbach managed all aspects of the community health needs assessment to identify and evaluate community health needs of residents in study area. TU worked in direct collaboration with Fort Washington Medical Center to better understand the risk indicators, population trends, and healthcare barriers of those in their community.

The identified needs below (not in priority order) were based upon quantitative and qualitative data collected during the CHNA. The findings were presented to and evaluated by members of the executive leadership team from Fort Washington Medical Center. Tripp Umbach recommends that the following community health needs be developed into an implementation phase by Fort Washington Medical Center that further explores ways in which the hospital can assist in meeting the needs of those in the communities they serve.

Regional Community Health Needs:



This report fulfills the requirements of a new federal statute established within the Patient Protection and Affordable Care Act (PPACA) requiring that non-profit hospitals conduct a CHNA every three years. The CHNA process undertaken by Fort Washington Medical Center, with project management and consultation by Tripp Umbach, included input from senior leadership to accomplish and complete the assessment.

Key Community Needs

Throughout the CHNA process, Tripp Umbach reviewed primary and secondary data to identify the regional health needs of residents of Southern Maryland. The data included in-depth interviews with community stakeholders who represented a cross-section of community-based agencies, and data from hand-distributed and online-administered health surveys. The information obtained resulted in the identification of three key community health needs in the Fort Washington Medical Center community. The regional community health needs were considered to be the top needs and concerns by hospital leadership.

Healthy Lifestyles (Diet & Exercise)

The community health needs assessment for Southern Maryland, in particular for Fort Washington Medical Center, identified the need to promote healthy lifestyles with a particular focus on diet and exercise. There are multiple reasons to begin living and engaging in a healthy lifestyle. Participating in a healthy lifestyle will not only improve one's exterior appearance, but can improve mental health, boost energy levels, and prevent certain diseases. An active approach to healthy living will ultimately improve one's health in the long term.

Specific factors identified by primary data and secondary data resulted in the need to promote a healthy lifestyle with a focus on diet and exercise. A strong support structure that starts at home, to community programs and services that provide and promote physical activity, will enable community residents to be more engaged and active in maintaining a healthy lifestyle. Community leaders reported that obesity is a growing problem in the community and it's affecting residents of all ages. Key stakeholders were concerned about the growing obesity epidemic in children. Unfortunately, many schools have lost or lack financial support to continue health education programs which educate students on healthy behaviors. Funding cuts have also reduced the number of sports-related school programs, unfortunately, these cuts dramatically impact students whose only physical outlet is through their school district. Families and schools are not taking an active role to identify ways to assist

students in obtaining physical health education. A strong coordinated effort between parents and schools can identify ways and or provide a resolution to assist and benefit students to proactively live a healthy lifestyle.

Overall, results from the hand survey indicated that roughly 20% of survey respondents do not engage in any physical activity to stay healthy. Upon further examination, we see that with respondents 45 years old and older, physical activity starts to decrease. Information on how to exercise safely as we age could be a strategy to help increase the number of middle-aged residents who continue to be physically active. County Health Rankings reported that Prince George's County ranked 20 in diet and exercise (1 being the healthiest county, 24 being the unhealthiest county).[3] This ranking aligns with the state's high overweight/obesity rate.

Unaffordable fitness facilities, lack of an environment infrastructure to exercise (no walking/bike paths, no sidewalks), cost, transportation, and lack of available activities are just a few factors that prohibit community residents from engaging in regular physical activities. County Health Rankings rated Prince George's County at 22 out of 24 (unhealthiest) in built environment. Built environment refers to human-made (versus natural) resources and infrastructure designed to support human activity, such as buildings, roads, parks, restaurants, grocery stores, and other amenities. Key stakeholder statements regarding the infrastructure of Prince George's County correspond with County Health Rankings findings. Providing information to community residents on how to stay active without the expense could be funneled through grassroots organizations. Regional fitness organizations need to promote (if applicable) their sliding-fee scale for families on a limited budget. Health fairs that are sponsored by health organizations, religious groups, and social organizations are strong outlets that enable community residents to learn ways to reduce stress, remain active, eat properly, understand and apply methods to live a healthy lifestyle. It is important that community organizations continue to promote, provide, and relay the long-term health benefits of being physically active to reduce chronic diseases and ailments.

[3] County Health Rankings 2013

Significant factors such as physical inactivity and obesity contribute to type 2-diabetes. Geography, household income, culture, and family history also influence disease rates. However, some population groups such as African-Americans, Hispanics, American Indians/Alaska Natives, some Asian-Americans, and Pacific Islanders are at a higher risk for type 2-diabetes. Moderate exercise and losing 5% to 7% of body weight can reduce the risk of developing type 2-diabetes by 58% in populations of people at higher risk for the disease.[4]

27.1% of Maryland adults 18 years and older are obese.

12.2% of Maryland's adolescents in grade 9-12 are obese.

Centers for Disease Control and Prevention

It must be noted that community leaders also reported that many families do not have the ability to afford healthy food options which is also another important component to living a healthy lifestyle. While survey results indicated that a large majority of respondents were able to obtain and eat fresh foods (approx. 96% overall), many families are struggling economically and rely on food pantries and church donations. Fresh foods are not typically an option through those avenues. Access to food disparities is common for those who live an urban lifestyle. It was reported that low-income zip codes in the U.S. population have 25% fewer chain supermarkets compared with middle-income zip codes. Predominately, African American zip codes have about one-half the number of chain supermarkets compared with predominantly Caucasian zip codes, and predominately Latino areas have only one-third as many.[5] Many adults living in neighborhoods with no supermarkets and access to only convenience stores and/or smaller grocery stores had the highest rates of obesity (32% to 40%) and were overweight (73% to 78%).[3] There are multiple reports on communities struggling to obtain and eat healthy foods, luckily; Maryland has taken an active approach to addressing this access issue. According to the CDC, Maryland Healthy Stores aims to improve healthy food availability in convenience stores and small grocery stores primarily in communities

[4] Centers for Disease Control and Prevention: www.cdc.gov/Features/dsPhysicalInactivity

[5] Robert Woods Johnson Foundation: Childhood Obesity www.rwjf.org/en/about-rwjf/program-areas/childhood-obesity.html

lacking access to healthy foods.[6] This is a significant benefit to communities who otherwise do not have healthy food options.

Community residents need education on diet, nutrition, and exercise. Residents specifically need assistance on reading and understanding food labels. Residents are often confused when interpreting nutrition labels and how it applies to their daily eating habits. Educational programs and services on nutrition should be encouraged at an early age and reinforced through their school years. It is important to begin instilling proper nutritional habits at an early age with assistance from schools, a strong healthy home environment, and good modeling behaviors from parents and other family members.

Obesity is a growing epidemic in the U.S., and children are part of this growing issue. Prince George's County residents are 32.0% obese, while the U.S. population in obesity is 25.0%.[7] In 2010, more than one-third of children and adolescents were overweight or obese.[8] According to the Centers for Disease Control and Prevention, 12.2% of Maryland students are obese. This figure can be reduced with healthy lifestyle habits, which includes healthy eating and physical activity and a collaborative effort with schools, a supportive home environment, and community support. Some key strategies for reducing childhood obesity in Maryland consist of: improving school lunches, mandating physical education in schools, making healthier food available in low-income neighborhoods, reducing the amount of television children watch, and increase access to parks.[9] The strategy presented by Advocates for Children and Youth is therefore, imperative to begin at an early age.

Obesity has doubled in Maryland over the past 20 years.

Advocates for Children & Youth

[6] Centers for Disease Control and Prevention

[7] Centers for Disease Control and Prevention: National Center for Chronic Disease Prevention & Health Promotion

[8] Centers for Disease Control and Prevention: Childhood Obesity www.cdc.gov/healthyyouth/obesity/facts.htm

[9] Advocates for Children & Youth: www.acy.org

Engaging in regular physical activity and creating a routine of exercising from adolescence into adulthood is important to overall health. Regular physical activity in childhood and adolescence improves strength and endurance, helps build healthy bones and muscles, helps control weight, reduces anxiety and stress, increases self-esteem, and may improve blood pressure and cholesterol levels.[10] Exercise habits formed in childhood translate into long-term healthy lifestyles. Schools must recognize their duty to provide, create, and endorse a comprehensive school-based educational program that caters to all age groups. An effective partnership between community health and social organizations along with school support will be beneficial to all in the region.

Community residents must understand that there is often failure in one's attempt to change a lifetime of unhealthy behaviors. Modifying or altering habits is difficult and does not occur overnight. Residents create behaviors (healthy or unhealthy) over years of repetitive actions. Information on the long-term effects of obesity, physical inactivity, and chronic diseases is needed in the region. Community residents need assistance on how to obtain, understand, and most importantly, utilize health information that will impact them and their families. Health information can be difficult to comprehend, grasp, and intimidating for those who cannot fully understand the consequences of living a healthy lifestyle. While it is important to provide information, it is also vital to encourage and promote healthy change. Creating achievable goals and utilizing community resources to achieve those goals can ultimately lead to notable healthy behaviors.

[10] Centers for Disease Control and Prevention: www.cdc.gov/healthyyouth/physicalactivity/facts.htm

Health Education/Prevention

> "About 730,000 African Americans have diabetes but do not know they have the disease. Identifying these undiagnosed cases and providing clinical care for their diabetes is a major challenge for the health care community."
>
> *National Institute of Health*

Learning and understanding about one's own behavior and others' behaviors is the role of health education and health prevention. Health education and prevention is the manner in which people are provided with the knowledge, skills, and the inspiration to make healthier, positive life choices. There are varieties of avenues in how health education/prevention information is presented and delivered. Health education is typically centered on how one can improve their own health. Increasing knowledge that relates to improving, changing, and modifying negative health behaviors and attitudes into positive health outcomes is the ultimate goal of health education and prevention. Overall, health education and prevention is a vital component in improving the health of oneself or of one's community. With appropriate information, educational reinforcement, and positive messages, health education and prevention can assist and strengthen messages that need to be promoted. Health education and prevention will focus primarily on diabetes, heart disease, and high blood pressure.

Health education and prevention measures on addressing and tackling major health diseases such as diabetes, heart disease, and high blood pressure need involvement from healthcare providers, service organizations, service providers, grassroots organizations, and the school districts. It is important that health education and prevention provides information and ways to tackle diabetes, heart disease, and high blood pressure; in addition, ways to help residents manage the disease. Health educators, community leaders, and healthcare providers are constantly trying to address ways to stem these health diseases from developing. Developing action plans and implementation strategies should start at an early age and reinforced in the school system.

Primary data from community leaders reported that African-Americans in particular, are in great need for prevention and education on heart disease, diabetes management, and hypertension (high blood

pressure) education. Key stakeholders reported that within this population, the behavioral risk factor rates are high and early education could prompt healthy lifestyle changes. Community leaders believe additional educational measures and strategies are needed for people who have existing health conditions with hypertension, diabetes, high cholesterol, and heart disease.

There are staggering statistics among the African-American population in regards to diabetes. Diabetes, unfortunately, is a serious health challenge facing many African-Americans in the U.S. population. In 1998, of 35 million African-Americans, about 1.5 million have been diagnosed with diabetes. This is almost four times the number known to have diabetes in 1968. According to data from the National Institutes of Health, diabetes is particularly common among middle-aged and older adults and among African American women. Among African-Americans age 50 years or older, 19% of men and 28% of women have diabetes. African-Americans with diabetes are more likely to develop diabetes complications and experience greater disability from the complications than Caucasians with the disease. Death rates for people with diabetes are 27% higher for African-Americans compared with Caucasians.[11] These statistical figures when funneled down to the county level reflect what community leaders and healthcare providers confront on a regular basis.

According to the Centers for Disease Control and Prevention, the five leading causes of death among African-Americans are (in order of prevalence): heart disease, cancer, stroke, diabetes, and unintentional injuries.[12] Heart disease is the leading cause of death among minorities in the U.S. (Table 1).

Table 1: Race of Ethnic Group (Center for Disease Control and Prevention)	**% of Deaths**
African-Americans	24.5
American Indians or Alaska Natives	18.0
Asians or Pacific Islanders	23.2
Hispanics	20.8
Whites	25.1
All	25.0

[11] National Diabetes Information Clearinghouse; National Institute of Health, 1998

[12] Centers for Disease Control and Prevention: www.cdc.gov/minorityhealth/populations/REMP/black.html

In reviewing data collected from the survey, slightly more than one-half of survey respondents reported having high blood pressure (50.7%). The likelihood of being diagnosed with high blood pressure or hypertension increases as we age. With the diagnosis of this disease, we also increase the chances of having a stroke, heart attack, heart failure, kidney disease, or early death. Residents are at a higher risk of having high blood pressure if they are (not in order of prevalence): African-American, obese, often stressed or anxious, drink too much alcohol, have too much salt in your diet, have a family history of high blood pressure, have diabetes, and/or smoke.[13]

A key approach to successfully supplying educational materials and information must be targeted to populations from different cultural backgrounds. Prince George's County is culturally diverse, and community-based organizations play a pivotal role in helping disseminate information to those different cultural groups. Community organizations build trust, hope, and empower its residents to be proactive in living and leading a healthy lifestyle. The need for preventive healthcare measures is great in a community where healthcare services cannot adequately serve its population.

Reviewing the County Health Rankings, Prince George's County ranked poorly in education when compared to other counties in Maryland.[14] It is important to note that Prince George's County ranked 20, only four above the bottom in education for the entire state of Maryland. Creating and streamlining new or old health education/prevention information materials must be targeted towards residents who can grasp and understand the information at a rudimentary level.

Fort Washington Medical Center will focus on health education and prevention. Addressing behavioral factors such as diabetes, heart disease, and high blood pressure (hypertension) are specific diseases FWMC believes is an area that requires specific attention. However, additional behavioral risk factors that may be address should include stroke, respiratory diseases, etc.

Currently, one avenue in how community residents receive health education and prevention materials is through health fairs. Health fairs are sponsored throughout the community and while they supply health education and prevention information, a majority of the population does not obtain their

[13] U.S. National Library of Medicine: www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001502/

[14] County Health Rankings 2013

information through his avenue. Fort Washington Medical Center will need to focus and direct their efforts in drawing, appealing, and providing health education/prevention information to it community.

It is important that health education/prevention identifies community behaviors that are unhealthy and often life threatening, but FWMC also needs to develop methods and skills needed to motivate change. Community residents will be better prepared with ways to reduce stress, quit smoking, eat healthier, understand nutrition, and participate in an active lifestyle, because the ultimate goal is to change behaviors that will lead to a healthier lifestyle.

Conclusions and Recommendations

Continuous communications are needed to promote the findings of the community health needs assessment. Information in a variety of formats from healthcare providers and social service organizations through local community groups can provide needed information to a community in need.

Fort Washington Medical Center needs to continue to fully partner and support new, existing, and expanded programs to service those in the community. The community surrounding the hospital is rich in services and programs; residents must be able to utilize those resources. Fort Washington Medical Center, in collaboration and with support from community organizations within the region should offer multiple programs and services to specifically address the needs based upon the results from the community health needs assessment. Existing community relationships need to be strengthened, and creating new partnerships will be an important step in developing strategies to address the regional community needs.

Common themes throughout the assessment speak to the need to increase community resident's knowledge on how to live healthy lifestyles, understand, and apply health education/prevention information, while building a culture that supports this environment both at the individual and at the community level.

The need for more health-related information, prevention, and educational materials is vital and is supported throughout the document as secondary data, input from community leaders, and results from the surveys related to the need for more programs and services that will lead to improved community health outcomes in the long term.

The specific community health needs identified included:

1) Healthy lifestyles (with a focus on diet and exercise);

2) Health education and prevention (with a focus on diabetes, high blood pressure/hypertension, and heart disease).

Additional data and greater detail related to the inventory of available resources within the community will identify programs and services to meet such needs (this document is available in a separate form provided to Fort Washington Medical Center). Fort Washington Medical Center worked closely with community organizations and understands that the CHNA document is only a first step in an ongoing process. The next phase of the community health needs assessment may include the following steps:

1) **Internal Communication:** Communicate the results of the community health needs assessment document to Fort Washington Medical Center's staff, providers, leadership, and boards.

2) **External Communication:** Communicate the results of the community health needs assessment document to residents through multiple avenues. Make the results of the CHNA available to the public via the Internet and through community-based organizations.

3) **Community Engagement:** Review existing community outreach efforts and consider the impact of CHNA data on the community benefit programs. Coordinate existing community resources to better serve the community across the continuum of healthcare.

4) **Internal Strategic Planning:** Pinpoint specific implementation strategies to be undertaken by Fort Washington Medical Center based on the identified needs in the community health assessment report.

Appendices

Appendix A: Objectives

Appendix B: Community Definition

Appendix C: Process Overview

Appendix D: Consultant Qualifications

Appendix A: Objectives

Fort Washington Medical Center completed a comprehensive community health needs assessment on behalf of the residents of West Central Maryland. Fort Washington Medical Center has a long history of providing quality programs and services to people within the shared regional service area. To better serve the residents of Fort Washington Medical Center's community, a comprehensive approach was used to assess the community's needs and plan a community benefits program for the purpose of improving the health of those in the community.

The objective of this assessment is to analyze traditional health-related indicators as well as social, demographic, economic, and environmental factors. The CHNA project was commissioned to:

- Obtain information on the health status and socio-economic/environmental factors related to the health of residents of multi-community service areas from Centers for Diseases Control and Prevention; CDC, State Health Department, and other existing data sources.
- Ensure that community members, including representatives of under-represented residents are included in the needs assessment process. In addition, educators, health-related professionals, media representatives, local government, human service organizations, institutes of higher learning, religious institutions, and the private sector can be engaged at some level during the process.
- Develop accurate comparisons to baseline health measures utilizing the most current and cost-effective data.
- Facilitate a process resulting in the identification of key community health needs, and an inventory of available programs and services to meet the needs identified in the process.
- Develop a project report that includes results from primary and secondary data collection, inventory, and planning process.

Appendix B: Community Definition

A community can be defined in many different ways for the community assessment process – 12 zip codes were provided by Fort Washington Medical Center to represent the service area of the community health assessment area. (Table 2)

Note: Areas highlighted in red constitute Fort Washington Medical Center's Primary Service Area.

TABLE 2: OVERALL STUDY AREA COMMUNITY ZIP CODES

Zip	City	State or District	County
20603	Waldorf	MD	Charles County
20616	Bryans Road	MD	Charles County
20640	Indian Head	MD	Charles County
20607	Accokeek	MD	Prince George's County
20735	Clinton	MD	Prince George's County
20744	Fort Washington	MD	Prince George's County
20745	Oxon Hill	MD	Prince George's County
20746	Suitland	MD	Prince George's County
20747	District Heights	MD	Prince George's County
20748	Temple Hills	MD	Prince George's County
20020	Washington	DC	District of Columbia
20032	Washington	DC	District of Columbia

CHNA Demographic Profile

- There is an even distribution of gender in the U.S. population, State, County, and City levels.
- Maryland's senior population is higher than Charles and Prince George's Counties, however; the senior population in Fort Washington CDP surpasses the U.S. population, State, County and Washington, D.C.
- Fort Washington CDP residents earn double the amount of income compared to the U.S. population. One-third of residents in Charles County and Prince George's County earn more than $100k a year.
- Washington, D.C. (50.5%) has the highest educational attainment (bachelor's degree or more) when compared to the U.S. population, State, County, and Fort Washington CDP.
- Fort Washington CDP has the highest percentage of Black/African-Americans, Asians, and populations with two or more races residing in the community; while Charles County has the largest population of Caucasians at the county level.
- More than one-third (42.7%) of grandparents in Washington, D.C. are responsible for their grandchildren, higher than the U.S. population. 21.5% of Washington, DC grandparents reported being responsible for their grandchildren for more than five years.

Appendix C: Process Overview

Tripp Umbach directed and managed a comprehensive community health needs assessment (CHNA) for Fort Washington Medical Center — resulting in the identification and prioritization of community health needs at the community level. The diagram below outlines the process and depicts each project component piece within the community health needs assessment. Each project component is further described in following the graphic.

Process Diagram:

CHNA Kick-Off Meeting

The CHNA was initiated on March 2013. Members of Fort Washington Medical Center were introduced to the Tripp Umbach project team. Fort Washington Medical Center was provided with an overall project scope, which included a timeline for project completion, roles, and expectations.

Community Leader Interviews

Interviews with community leaders throughout the region were conducted to gain an understanding of the community's health needs from organizations and agencies that have a deep understanding of the populations in the greatest need. Fort Washington Medical Center provided Tripp Umbach with a list of community leaders to interview. Interviews were conducted with an array of members from community-based organizations, public health departments, religious organizations, and government officials. The information collected provided knowledge about the community's health status, risk factors, service utilization, and community resource needs, as well as gaps and service suggestions.

Tripp Umbach mailed an introduction letter to each organization announcing the health assessment. In total, six interviews were completed between the months of April 2013 – June 2013.

The overarching themes collected from community leader interviews were:

1) Access to Care
2) Unhealthy Lifestyles
3) Healthy Education and Prevention
4) Local Economy

Secondary Data

Tripp Umbach collected and analyzed secondary data from multiple sources, including: Centers for Diseases Control and Prevention; CDC, Center for Substance Abuse Research, County Health Rankings, Maryland County Health Statistics, Maryland State Department of Education, Maryland Department of Planning, Metropolitan Washington Council of Governments (COG), Maryland Vital Statistics, National Alliance to End Homelessness, National Cancer Institute, Prince George's County Health Department, Community Need Index (CNI); Truven Health Analytics, and Substance Abuse and Mental Health Services Administration; SAMHSA.

The data resources were related to disease prevalence, socio-economic factors, and behavioral habits. Tripp Umbach benchmarked data against state and national trends where applicable.

Tripp Umbach obtained data through Truven Health Analytics to quantify the severity of health disparities for every zip code in the needs assessment area, based on specific barriers to healthcare access. Truven Health Analytics provides data and analytics to hospitals, health systems, and health-supported agencies. Community Need Index (CNI) was a data source that was used in the health assessment.

CNI considers multiple factors that are known to limit healthcare access; the tool is useful in identifying and addressing the disproportionate unmet health-related needs of neighborhoods. Five prominent socio-economic barriers to community health quantified in the CNI are: Income Barriers, Cultural/Language Barriers, Educational Barriers, Insurance Barriers, and Housing Barriers.

The information below reflects key information collected from the overall study area from the community needs index.

- There are three zip code areas that fall in the CNI score range of 5.0 to 4.0 (zip code areas 20020 and 20032 in Washington, D.C. and 20745 in Oxon Hill); these areas have the highest rates of any of the individual socio-economic markers as compared to the rest of the study area. This indicates an at-risk population in regards to community health.

  - Washington, D.C. zip codes 20020 and 20032 have high rates in community health need indicators for: highest poverty in seniors, highest poverty for families with children, highest poverty for single parents with children, highest unemployment, and highest uninsured)
  - Oxon Hill (20745) has a low-income quintile (2) and an average insurance ranking (3). However, it is interesting to note that their 2012 CNI score is a 4, which indicates a great number of socio-economic barriers related to healthcare access.

- Zip codes 20020 and 20032 both have unemployment rates over 16%; this is higher than the Maryland rate (6.6% as of March 2013), and the U.S. rate (7.6%). Zip code 20745 (Oxon Hill) also has a high unemployment rate (12.9%) when compared to all of Prince George's County at 6.5%.
- Out of the 12 zip codes in the study area analyzed, five of those zip code areas are considered to have low levels of socio-economic barriers to healthcare access. This is a positive sign for those specific zip codes.
- When comparing the 2011 CNI scores vs. 2012 CNI scores, zip codes 20746 (Suitland) and 20747 (District Heights) have improved in their overall standings for 2012. Both zip codes went from a "4" ranking in 2011 to a "3" ranking in 2012.
- Of the 10 zip codes, all of the zip codes indicate a high socio-economic barrier in the areas of culture/language. (This indicates higher levels of non-Caucasian adults over the age of 25 with limited English proficiency.)
- Zip codes 20746 (Suitland), 20747 (District Heights), and 20748 (Temple Hills) have the highest number of residents renting homes when compared to the remaining seven zip codes.
- The overall study area (all 12 zip codes) indicates a high language barrier value. This indicates that residents have barriers to healthcare access related to residents' having a language obstacle.
- Washington, D.C., Oxon Hill, Suitland, District Heights, and Temple Hills have a high housing barrier value indicating healthcare access restrictions related to residents' housing issues.
- We must also remember that each zip code area is unique; it is important to look at each zip code areas' individual barrier ranks when determining the best ways to address barriers to community

health. For example, Bryans Rd. (20606) has an average CNI score in education barriers and Fort Washington (20744) has an average CNI score in housing barriers.

Hand-Distributed Surveys

Tripp Umbach worked with Fort Washington Medical Center to disseminate a community health assessment and quality of life survey instrument. A survey was employed to collect input from populations within the study area to identify health risk factors and health needs. The survey was finalized in April 2013.

Tripp Umbach, along with Fort Washington Medical Center, employed a hand-distributed methodology designed to capture the health status of underserved communities throughout the region. Tripp Umbach worked with Fort Washington Medical Center to distribute the hand survey to underserved segments of identified populations. As part of the distribution methodology, an online survey link was also provided to residents in the community. The online survey link was promoted through various community-based organizations that assisted Fort Washington Medical Center.

Fort Washington Medical Center attended health fairs and other various locations, and distributed the hand survey to end-users in the community. A total of 339 surveys were collected. 299 surveys were collected in-person, which yielded a response rate of 88.2% and 40 via online (an 11.8% response rate).

The hand survey was distributed at local events and fairs such as: FWMC Diabetes Seminars, Harmony Hall Health Fair, Mental Health Fair, Grace UMC Health Fair, Grace UMC Health Fair, Glassmanor Community Center Health Fair, Oxon Hill Elementary School Health Fair, YMCA Health Fair, Fort Washington Park (Clipperthon), Oxon Hill Library “Friends & Family Day,” FWMC Hospital, Harmony Hallers Senior Group Meeting at Harmony Hall, Woodside Village Senior Home, strip malls, and barber shops.

Gender[15]

- The rate of female respondents was much higher than male responses (72.8% female, 27.2% male).

Age

- The largest group of respondents fell in the 55-64 year old age range (26.2%). Individuals aged 65-74 were also a large group at 21.7%. Individuals over the age of 75 years old only comprised 5.7% of the surveyed population.
- Slightly less than one-half of all respondents (47.6%) were middle-aged (45-64 years old).
- There were higher rates of younger females (88.9%) who responded to the survey (18-24 years old).
- More than one-half of respondents (70.2%) are 45-74 years old from zip code 20744[16] (Fort Washington). Slightly more than one-half of respondents (57.5%) are from zip code (20745 Oxon Hill) and are middle-aged (45-64 years old).

County

- 92.6% of those surveyed indicated that they resided in a zip code area in Prince George's County, 3.6% in Charles County, 1.5% in Washington DC, and 2.4% in "Other" Counties.
- Overall, there was an even age distribution of respondents in Prince George's County; with the exception of respondents aged 25-34 years old (75.0%).

Having a Physician

- Overall, the majority of respondents indicated that they had a family physician (89.7%); however, 10.3% indicated that they did not have a doctor. The top reason, by far, for an individual not having

[15] Note: There is slight sampling bias in the gender cross-tabulations in that such a larger percentage of women responded to the survey than men. While the survey percentages are accurate and the sampling size is strong; with many more females responding, we get more of an accurate indication of the normal value for women; whereas with only 89 men responding, we have a less complete view of men in these areas.

[16] Survey analyses for this report were cross-tabulated with three specific zip codes: 20744 (Fort Washington), 20745 (Oxon Hill), 20748 (Temple Hills).

a family physician was the inability to afford one (32.3%); while 25.8% indicated that they could not find a doctor.

- Overall, 44.8% of respondents visit their doctor one to two times a year, compared to more than one-third (38.7%) of respondents who visit their doctor three to four times a year.
- The rate at which women report having a family physician is lower than the rate reported by men (87.0% vs. 95.5% respectively).
- Slightly more than one-half of male respondents (50.6%) visit their doctor one to two times a year compared to their female counterparts at 42.0%.
- Overall, 40.7% of female respondents visited their doctor three to four times per year compared to males at 32.6% respectively.
- Younger females 18-24 years old were less likely to report having a family doctor (66.7%). This age group also reported that not having insurance (66.7%), doesn't accept insurance (33.3%), and can't find a doctor (33.3%) were reasons why they did not have a primary care physician.
- More than one-quarter of respondents from zip codes (Fort Washington; 91.8%, Oxon Hill; 75.0%, Temple Hills; 91.9%) have a family doctor.
- Respondents from zip code 20748 (Temple Hills) reported the reason they do not have a family doctor was lack of insurance acceptance (100.0%); while Fort Washington respondents reported affordability (36.4%) as Oxon Hill (41.7%) reported affordability and no insurance as reasons (41.7%).

<u>Where People Go for Care</u>

- Overall, the vast majority of respondents go to their doctor's office for care (83.7%); while 6.9% go to a clinic, and 4.5% go to the emergency room for care.
- Both women and men were likely to go to their doctor's office for care (85.0% and 82.6% respectively); men were slightly more likely to go to a clinic than women (7.0% vs. 5.6% respectively).

- Seniors citizens (65 years old and older) were more likely to go to a doctor's office for care, while younger respondents 18-24 years old (25.0%) utilized the emergency room and urgent care (12.5%).
- While a majority of respondents from all three zip codes seek care from their doctor's office; 12.0% of Fort Washington respondents seek care from a clinic, urgent care, or hospital emergency room. One-third of Oxon Hill (31.9%) and 17.6% of Temple Hills' respondents also seek care from clinic, urgent care, or hospital emergency room.
- Slightly less than one-quarter of respondents from Oxon Hill (72.5%) go to their doctor one to two times a year; while more than one-third of Fort Washington respondents go to their doctor one to two times per year (38.2%).

Health Insurance Coverage

- Overall, a majority of respondents have health insurance (89.3%); however this means that 10.7% of the respondents do not have health insurance. The top reasons that individuals reported not having health insurance was due to affordability (53.8%) or because they lost it (38.5%). Another 30.8% of the respondents do not qualify for health insurance.
- The rate at which men reported having insurance was slightly higher than the rate of women (91.6% vs. 88.4% respectively).
- Men reported affordability as a factor in not having health insurance (75.0%), compared to the rate of women (47.6%).
- The rate of men was also higher at losing health insurance coverage (75.0%) compared to one-third of women (33.3%).
- Younger respondents were the most likely age group not to have health insurance (66.7%). Senior citizens (65 years old and older) were the most likely age group to have health insurance.

- 66.7% of respondents aged 25-34 years old reported that they do not have health insurance; all of which indicated that it was because they did not qualify. 80.0% of respondents who reported not having health insurance aged 35-44 years old could not afford coverage
- More than one-half of younger respondents 18-24 years old (60.0%) do not seek care due to lack of health insurance coverage.
- 92.9% of Fort Washington respondents have health insurance; while 70.5% from Oxon Hill and 88.6% from Temple Hills have health insurance coverage.
- More than one-half of respondents from Temple Hills had insurance but lost it (66.7%); while 16.7% of Fort Washington respondents do not quality for health insurance and another 50.0% cannot afford health insurance. More than one-half of respondents from Oxon Hill reported that they do not qualify (54.5%) and cannot afford health insurance (54.5%).

Getting Care

- Overall, 16.1% of respondents do not seek care because they lack health insurance.
- More females reported not seeking care (18.9%) due to not having health insurance coverage compared to men (13.5%).
- Both Oxon Hill (25.0%) and Temple Hills' (26.7%) respondents do not seek care due to their lack of health insurance.

Method of Care

- Overall, the most common resource that individuals use when they cannot get care is over-the-counter medications (14.1%). It is concerning that more than one-half (63.8%) of the respondents indicated that they simply ignore their health problem when they cannot receive care.
- Both men and women were likely to get over-the-counter medication to treat their problems when they could not get care (63.6% vs. 65.2% respectively).
- More than one-half the rate of men reported seeking care in the ER/Hospital as another alternative when care was needed (60.0%).

- Unfortunately, younger respondents 18-24 years old ignore the problem when they cannot get care (57.1%); while a large percentage within the same age group get over-the-counter medication if they cannot get care (85.7%).
- 73.3% of Temple Hill respondents get over-the-counter medication when they cannot get care.
- 60.0% of respondents from Fort Washington obtain care from the ER/Hospital or self-pay if they cannot get care they need.
- More than one-half of respondents from all zip code regions get over-the-counter medication if they cannot get care (Fort Washington 57.1%; Oxon Hill 66.7%; Temple Hills 73.3%). Respondents from Oxon Hill were more likely to ignore the problem (18.5%) compared to Fort Washington and Temple Hills.

General Health

- Overall, most people say their health is good (36.1%), with 11.4% reporting that their health as being excellent, and less saying their health is poor (1.2%).
- Men were slightly more likely to rate their general health as being very good (39.5%), whereas women were more likely to report excellent health (12.0%).
- One-third of younger respondents 18-24 reported being in excellent health (33.3%); while respondents 55-64 years old being in very good health (44.2%). Interestingly, 31.6% of seniors aged 75 years and older reported their health as very good, while slightly more than one-third in the same age group reported their health as being fair (36.8%).
- Respondents from Oxon Hill were more likely to report that their health was either fair/poor (20.9%) compared to Fort Washington and Temple Hills. More than one-third of respondents from Fort Washington reported that they were in good general health (38.9%).

Healthy Behaviors

- Overall, 80.1% of individuals reported participating in regular physical activity to stay healthy. Close to one-half of those respondents (47.5%) reported engaging in a physical activity three to four times a week.
- The rate at which women reported engaging in physical activity was slightly lower than the rate reported by men (79.0% vs. 81.4% respectively).
- Women and men are very similar in the amount of times they engage in physical activity (47.0% for women and 49.3% for men).
- The rate at which men reported having diabetes (22.5%) was higher than the rate reported by women (18.5%).
- There is a gradual decline in respondents aged 45 years and older engaging in regular physical activity to stay healthy.
- Respondents aged 75 years and older reported the highest rate of participating in regular physical activity three to four times a week (60.0%); whereas only 38.5% of individuals aged 25-34 and 37.9% of respondents aged 45-54 reported engaging in regular physical activity three to four times a week.
- 96.3% of the individuals responded that they have access to healthy foods, and slightly less (96.0%), reported that they do eat fresh foods.
- Both men and women were able to get (96.4% vs. 96.1%) fresh healthy foods and eat fresh healthy foods (96.5% vs. 95.6%).
- Compared to the rest of those in their age group, 92.9% of respondents aged 55-64 years old were the less likely group to be able to get fresh healthy foods. Again, the least likely group (compared to the other age groups) to indicate that they eat fresh healthy foods were respondents 25-34 years old (93.3%).

- There were a large majority of respondents from Fort Washington (76.1%), Oxon Hill (93.8%), and Temple Hills (86.5%) who reported that they engage in regular physical activity to stay healthy.
- Only 34.9% of respondents from Oxon Hill reported that they engage in physical activity three to four times a week; the lowest percentage when compared to Fort Washington and Temple Hills.
- There were a large majority of respondents from Fort Washington, Oxon Hill, and Temple Hills who all reported that they are able to get and eat fresh healthy foods. (Percentages in all three zip codes were 89% and more).

High Blood Pressure

- Overall, more than one-half of the population reported having high blood pressure (50.7%).
- The rate at which women reported having high blood pressure was lower than the rate reported by men (48.7% vs. 57.3% respectively).
- The rate at which women report having a weight problem was higher than the rate reported by men (35.3% vs. 21.3% respectively).
- There is a steady increase of respondents aged 55 years and older reporting that they have high blood pressure. More than one-quarter of seniors 65-74 years old have diabetes (30.1%). More than one-third of respondents aged 35-44 years (37.2%) reported that they have a weight problem.
- 22.2% of younger respondents reported having asthma; while 24.7% of respondents aged 65-74 years old reported having a heart problem. Unfortunately, 15.8% of seniors aged 75 years and older reported that they had cancer.
- 40.5% of respondents from Temple Hills have a weight problem. This is the highest percentage compared to Fort Washington and Oxon Hill.
- More than one-half of Fort Washington respondents reported they have high blood pressure (56.0%); while Oxon Hill (47.9%) and Temple Hills (51.4%) were not far behind.
- Diabetes (22.6%) and heart problems (12.6%) were also health conditions that were reported from Fort Washington Medical Center respondents.

- More than one-quarter of the population reported having a weight problem (31.3%).

Caregiving

- Overall, within the 'last month', the majority of individuals (53.3%) reported giving care or support to family or friends, and more than one-third (39.9%) reported receiving care. With healthcare costs rising, more individuals felt the need to provide for family and friends.
- Overall, 75.9% of respondents reported not having limitations (physical, mental, emotional, or spiritual) to their daily activities. However, 20.1% of the surveyed population reported having some type of physical limitations to their abilities.
- The rate at which women reported giving care or support to family or friends was lower than the rate reported by men (50.7% vs. 61.4% respectively).
- Men and women who reported receiving care or support from family or friends within the past month were roughly the same (38.6% vs. 43.4% respectively).
- More than one-third of respondents 25-34 years old gave and received care or support to family or friends within the past month (58.6% and 46.7% respectively); while 50.6% of respondents 55-64 years old received care or support from family and friends.
- Not surprisingly, respondents aged 65 years and older reported having a physical limitation (28.4% 65-74 years old and 41.7% 75 years and older)
- Those aged 24 and younger reported the highest rate of not having limitations to their activities (100.0%).
- 53.3% of respondents in Fort Washington gave care or support; and more than one-third (34.2%) received care or support from family or friends within the past month.
- Respondents from Temple Hills, when compared to Fort Washington and Oxon Hill, had a higher percentage of having a physical limitation that impedes their daily activities (22.1%).

Flu Shots

- Overall, a large number of individuals reported not getting the flu shot last year (41.5%).

- Of those who did not get a flu shot, 34.8% reported that they do not believe in it and 25.0% do not want it.
- Men reported getting the flu shot slightly more than women (59.5% for men and 57.2% for women).
- Of those who did not receive a flu shot, more than one-third of men (39.1%) rated that they do not need it or did not want it compared to females (27.2%).
- As the age of the respondents increased, the percentages of those who received a flu shot also increased from ages 18-74 years of age. Surprisingly, 62.5% of respondents aged 75 years and older received a flu shots; which is a 5.6% decrease from respondents aged 65-74 years old.
- Of those who did not get a flu shot, 14.3% of respondents 18-24 years of age did not need it, 47.1% of respondents 35-44 years old do not believe in it. Seniors 75 and older did not receive a flu shot due to an allergic/bad reaction (33.3%) and do not believe in it (33.3%).
- More than one-half of respondents from Fort Washington received a flu shot (62.3%); with 51.1% from Oxon Hill and 50.0% from Temple Hills also receiving one.
- More than one-half of respondents from Fort Washington, Oxon Hill, and Temple Hills do not want or do not believe in receiving a flu shot (Fort Washington 59%, Oxon Hill 60.0%, and Temple Hills 50.0%). One-quarter of respondents from Temple Hills had no reason to receive a flu shot (25.0%).

Children Immunizations

- A large majority of individuals reported that their children are up-to-date on their immunizations (59.4%).
- Close to three-quarters of respondents 35-44 years old (72.5%) reported that their children are up-to-date on their immunizations.
- 13.2% of respondents from Fort Washington did not know if their children are up-to-date on their immunizations.

Accessing Information

- The top three avenues in which individuals receive information in their community are: word-of-mouth (53.7%), television (51.1%), and newspaper (48.6%).
- The top three avenues in how men rated receiving information in their community were: TV (54.4%), word-of-mouth (51.9%), and newspaper (48.1%).
- The top three avenues in how women reported receiving information in their community was: word-of-mouth (55.7%), newspaper (48.9%), and the Internet (44.3%).
- Seniors 75 years old and older reported receiving most of their information from TV and word-of-mouth (80.0% and 86.7% respectively). The Internet was the least reported method among this age group (13.3%).
- More than one-third of respondents aged 18-64 years old most likely receive their information from the Internet, TV, word-of-mouth, and newspaper.
- The least likely top five ways respondents from Oxon Hill receive information is via clinics (7.0%), faith or religious organizations (11.6%), radio (23.3%), word-of-mouth (25.6%), and Internet (37.2%).
- The most likely top five ways respondents from Fort Washington receive information in their community is via word-of-mouth (61.6%), TV (58.3%), newspaper (56.3%), Internet (46.4%), and radio (39.1%).
- The most likely top five ways respondents from Temple Hills receive information in their community is via word-of-mouth (62.5%), newspaper (53.1%), radio (43.8%), TV (40.6%), and Internet (37.5%).

Transportation

- Overall, not surprisingly, an individual's own car is the most common mode of transportation among respondents (84.0%).

- Both men and women rated their main mode of transportation as a car (82.7% vs. 84.5% respectively).
- More than one-half of all respondents in all age groups reported their own car as being the most common mode of transportation.
- 19.6% of respondents from Oxon Hill second main form of transportation is public transportation. Respondents from Fort Washington utilize public transportation and assistance from friends and family as their secondary form of transportation (11.1%).
- Seat Belt Use
- Overall, the vast majority of individuals reported 'always' wearing a seat belt when in a car (93.6%).
- Both men and women 'always' rated wearing their seat belt when in a car (92.4% vs. 94.1% respectively).
- More than one-quarter of all respondents in each age category always wear their seat belt when in a car.
- A vast majority of respondents from Fort Washington (94.5%), Oxon Hill (93.5%), and Temple Hills (97.1%) always wear their seat belts when in a car.

Safety

- Overall, the largest percentage of individuals reported feeling 'somewhat safe' in their community (71.9%). Of those who did not feel safe, the main reason they did not feel safe is because of crime (93.3%).
- The rate at which men reported feeling extremely safe was higher than women (25.3% vs. 14.9% respectively).
- Overall, two of the top-rated reasons why respondents didn't feel safe were crime and overall unsafe neighborhood in both men and women (100% in crime and 66.7% in unsafe neighborhood for men and 91.7% in crime and 58.3% in unsafe neighborhood for women).

- More than one-half of all respondents in each age category felt somewhat safe in their neighborhood.
- A large majority of respondents aged 35-64 years old reported that crime was the reason they felt unsafe in their neighborhood.
- 11.4% of respondents from Oxon Hill do not feel safe in their neighborhood/community; this is the highest percentage when compared to Fort Washington (3.4%) and Temple Hills (8.8%).
- For those respondents who did not feel safe, crime was the main factor. Respondents from Temple Hills also reported poorly lit streets as being a factor why they did not feel safe in their community.

Hospital Choice

- Overall, 31.0% of respondents reported that they would choose Fort Washington Medical Center if they needed hospitalization.
- The rate of men and women were comparable in choosing Fort Washington Medical Center when needing care (31.3% vs. 32.7% respectively).
- As age increases, the likelihood of respondents also reported choosing Fort Washington Medical Center when needing care.
    - 16.7% — 18-24 years old
    - 20.0% — 25-34 years old
    - 21.9% — 35-44 years old
    - 28.0% — 45-54 years old
    - 34.5% —55-64 years old
    - 38.3% — 65-74 years old
    - 45.5% — 75+ years old
- Seniors 75 years old and older reported that Washington Hospital Center was their hospital preference (36.4%).
- More than one-third (41.1%) of respondents from Fort Washington preferred Fort Washington Medical Center and Washington Hospital Center (16.9%); while respondents from Temple Hills

preferred Washington Hospital Center (19.2%) and Southern Maryland (15.4%). Respondents from Oxon Hill preferred Fort Washington Medical Center (24.1%) and Washington Hospital Center (13.8%).

Services

- The services in which individuals reported they can find in the lowest rates were:
  - Services for people with HIV/AIDS (14.6%)
  - Services for drug use/abuse (15.0%)
- The services in which individuals reported they can find in the highest rates were:
  - Services for people with dental (71.1%)
  - Services for people with eye care (68.7%)
- The services in which men rated they can find in the lowest rates were:
  - Services for smoking cession (19.2%)
  - Services for pregnancy care (16.4%)
- The services in which men rated they can find in the highest rates were:
  - Services for dental care (71.0%)
  - Services for eye care (69.0%)
- The services in which women rated they can find in the lowest rates were:
  - Services for HIV (12.6%)
  - Services for drug use/abuse (13.7%)
- The services in which women rated they can find in the highest rates were:
  - Services for dental care (71.3%)
  - Services for eye care (68.0%)

- Respondents 18-24 years old and Seniors 75 years and older were less likely to find education programs (37.5% and 28.6%).
- Slightly more than one-half of respondents aged 45-54 can find employment assistance (50.8%).
- Seniors 65 and older were the less likely to find mental health care services compare to the rest of those in the age group (42.1%).
- 17.4% of respondents aged 55-64 can find services for housing assistance, however; they were the least likely to find these services compared to others in their age category.
- 27.7% of respondents aged 45-54 can find services for alcohol use/abuse.
- The least available service respondents from Fort Washington indicated was pregnancy care (9.4%) and HIV/AIDS (11.6%); while respondents from Oxon Hill reported drug use/abuse (20.0%) and HIV/AIDS (15.0%). Respondents from Temple Hills indicated STDs (18.5%) and HIV/AIDS (18.5%).

Provider Inventories

An inventory of programs and services available in the region was developed by Tripp Umbach. This inventory highlights available programs and services within the entire region that fall under each of the priority need areas.

The inventory identifies the range of organizations and agencies in the community that are serving the various target populations within each of the priority needs. It provides program descriptions and collects information about the potential for coordinating community activities and creating linkages among agencies.

Final Reports/Presentation

Top community health needs were identified by analyzing secondary data, primary data collected from key stakeholder interviews, and hand-distributed surveys. The analysis process identified the health needs revealed in each data source. Tripp Umbach followed a process where the top needs identified

in the assessment were supported by secondary data and strong consensus was provided by both key community stakeholders and hospital leadership input.

A final report was developed that summarized key findings from the community health assessment process and an identification of top community health needs.

Appendix D: Consultant Qualifications

Fort Washington Medical Center contracted with Tripp Umbach, a private healthcare consulting firm headquartered in Pittsburgh, Pennsylvania to complete the community health needs assessment.

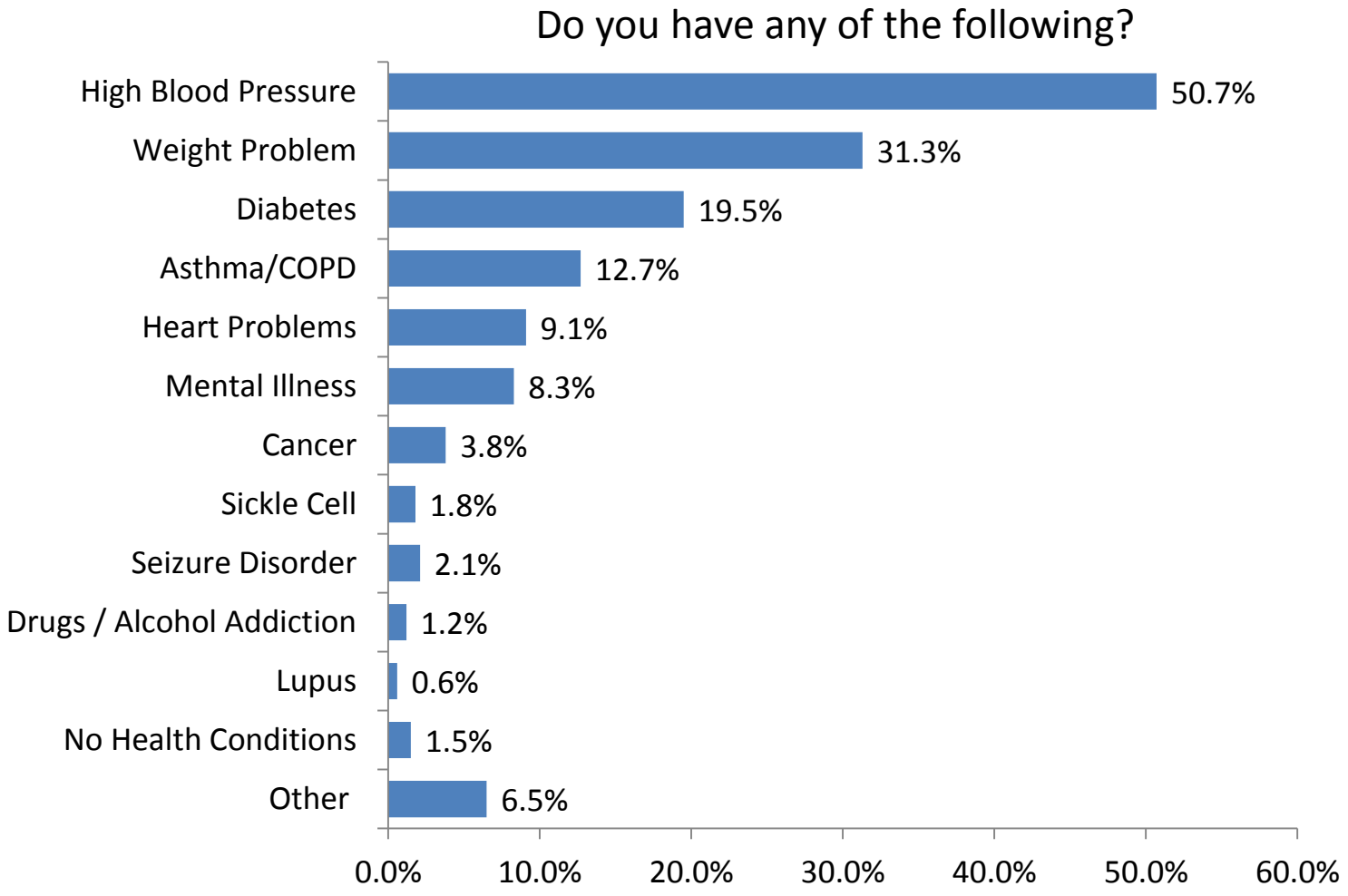
Tripp Umbach is a recognized national leader in completing community health needs assessments, having conducted more than 200 community health needs assessments over the past 20 years. Today, more than one in five Americans lives in a community where Tripp Umbach has completed a community health assessment.

FORT WASHINGTON MEDICAL CENTER
COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) RESULTS / STRATEGY RECOMMENDATIONS

FWMC
FORT WASHINGTON MEDICAL CENTER
A Nexus Health Company

TrippUmbach
Research • Strategy • Impact

Health Conditions
Overall (N=339)



- High blood pressure (50.7%), followed by weight problem (31.3%) were the top two health conditions reported by respondents.

Other responses included: High cholesterol, Arthritis, M.S., Thyroid condition, Allergies, Anemia, Anxiety, Fibromyalgia, Knee problem, Osteoporosis, P.D., Sarcoidosis

Identification of Community Needs

What is required?

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. 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. **The hospital shall also:**

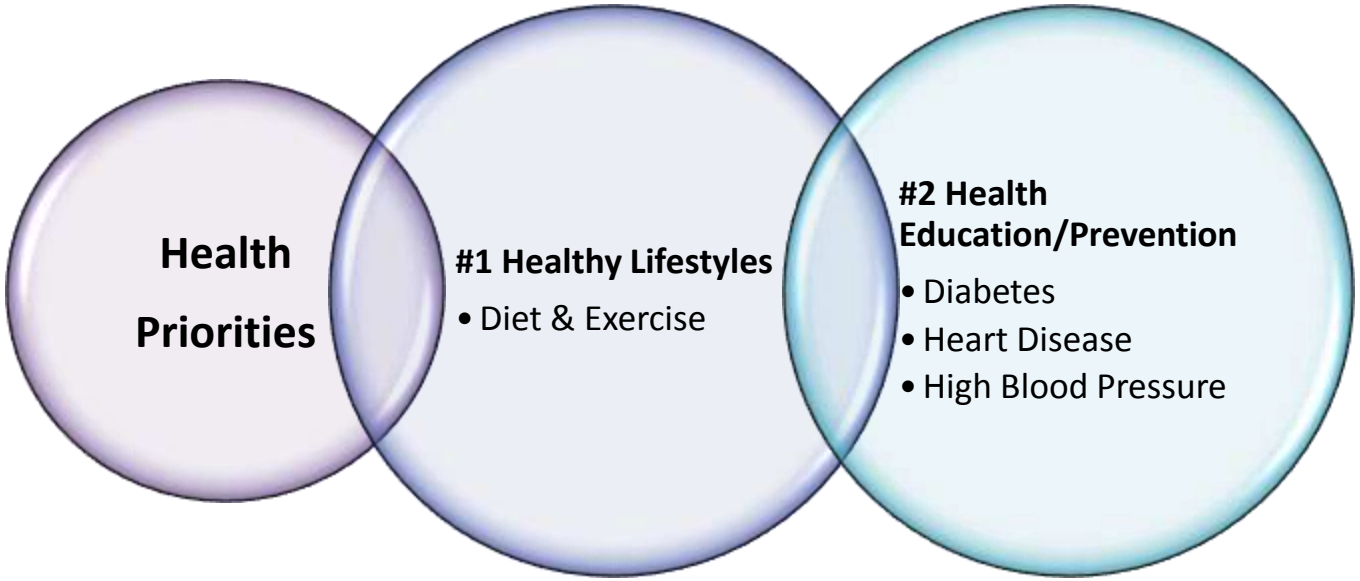
- ❖Make the CHNA widely available to the public;

- ❖Adopt an implementation strategy to meet the health needs identified by the CHNA by the end of the same taxable year. **The strategy must:**
  - -- **Be approved by an authorized governing body of the hospital organization;**
  - -- **Describe how the hospital facility plans to meet the health need; or**
  - -- **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; and**

- ❖Perform an assessment at least every three years.

Identification of Community Health Needs

Community Health Needs



The identified needs above (not in priority order) were based upon quantitative and qualitative data collected during the CHNA. Tripp Umbach recommended that the following community health needs be developed into an implementation phase by Fort Washington Medical Center that further explores ways in which the hospital can assist in meeting the needs of those in the communities they serve.

Identification of Programs to Address Community Health Needs

Healthy Eating Active Living (HEAL) Program

4th Qtr. 2013

Fort Washington Medical Center is partnering with the Behavioral Health Navigators and the YMCA Potomac Overlook to assist individuals in modifying their lifestyle to reduce their risk of developing chronic diseases through the HEAL program. The 12-month grant-funded program is designed to encourage participants to become more active through a program of regular exercise and physical fitness by adopting better eating habits to include healthier food choices.

What priorities will we address?

Healthy Eating Active Living: (4Q2013)
Target Population: 30 -75 residents in our primary service area (Fort Washington, Oxon Hill and Temple Hills)
Objectives/Goals: The participants will:

- Engage in moderate physical activity at least 5 days a week for 30 minutes a day;
- Increase the number of residents who engage in healthy eating;
- Eat fruits and vegetables, increase calcium intake and reduce transfats;
- Reduce body fat;
- Somatic Coordination – coordinating behavior changes; and
- Capture other addictive behaviors, such as smoking.

First year: Effectively change the lifestyle/behaviors/choices of a minimum of 30 -75 residents
Outcome measures: Reduce body mass index; Increase exercise; Adopt healthy food choices, such as fruits and vegetables; Increase calcium intake; and Self-report regarding eating habits
Second year: Evaluate the effectiveness of program components to (based on resources / funding) to determine future programming.
Costs: 12-month Grant Funded Program (Grant $49,000)

Identification of Programs to Address Community Health Needs

#2

Comprehensive

Diabetes Self-Management Education Program

1st Qtr. 2014

Fort Washington Medical Center is developing a **Comprehensive Diabetes Self-Management Education Program** to address community healthcare needs. The multi-year diabetes self-management program will target individuals who have recently been diagnosed with diabetes, had a change in their treatment regimen, or are having difficulty maintaining glycemic control.

What priorities will we address?

Diabetes Self-Management Education Program (1Q2014)

Target Population: Individuals recently diagnosed with diabetes, who had a change in their treatment regimen or are having difficulty maintaining glycemic control.

Description: The participants will:

- Take a one-hour initial individual assessment
- Participate in a Diabetes Educational Overview to include Basics of Control; Meal Planning; Benefits of Exercise; Medication; Chronic Complications; American with Disabilities Act (ADA) Standards of Care; Goal Setting, etc.
- Attend Diabetes Self-Management Education classes and Follow-up Educational Sessions for ongoing support (topics range from diabetes and holiday eating tips to stroke and heart disease)

First year: Educate and assist individuals with diabetes to maintain glycemic control, through proper goal setting, meal planning, and exercise.

Outcome measures: Achieve and maintain appropriate glycemic control; hypertension and cholesterol levels and reduction in participating patients diabetes-related hospital re-admissions

Second year: Evaluate the effectiveness of program components to determine feasibility or other collaborative relationships.

Costs: $58,000

Identification of Programs to Address Community Health Needs

#3

"Community Walking Program"

1st Qtr. 2014

FWMC will partner with the Prince George's County Parks & Recreation Department to enhance its Walking Program at the Southern Regional Technology and Recreational Complex in Fort Washington, Maryland.

The Community Walking Education Program will include an educational component to provide health education on keeping fit, diabetes, hypertension, and other health-related topics.

What priorities will we address?

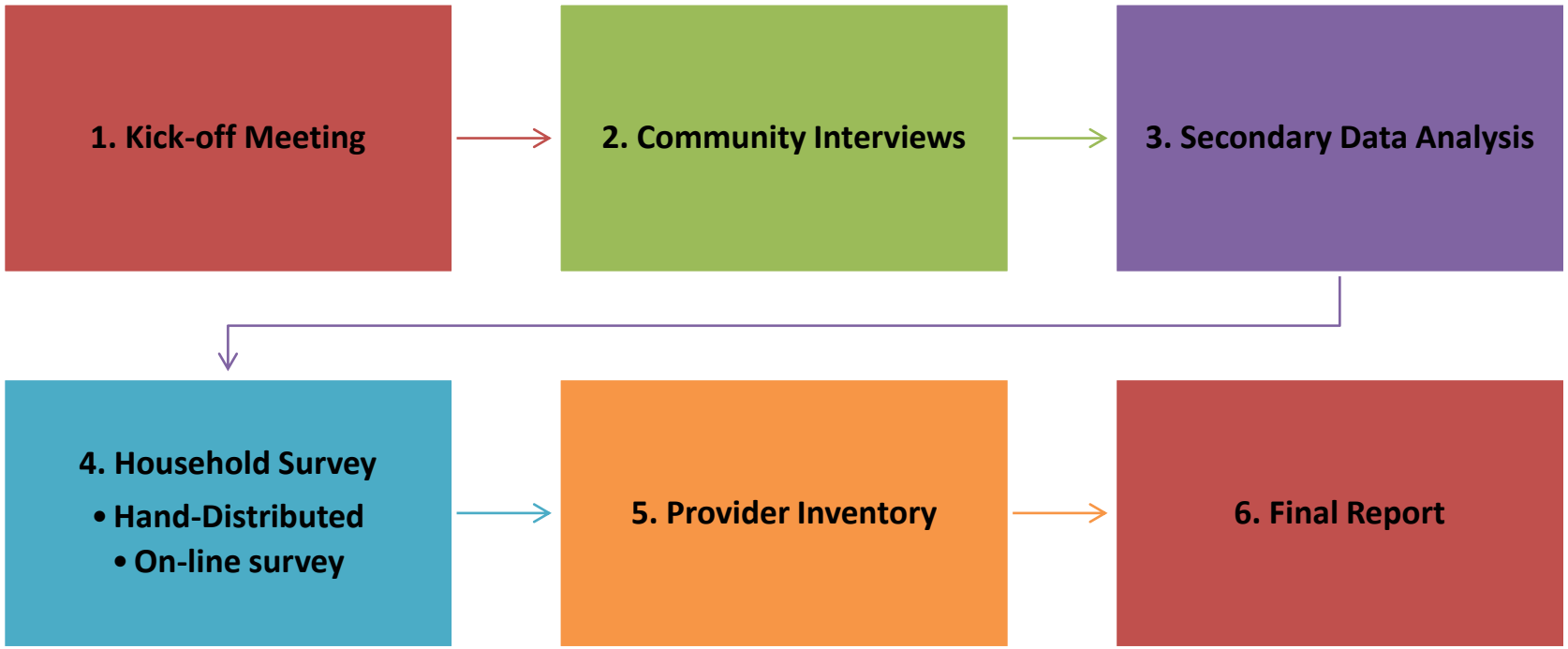
Community Walking Education Program: (1Q2014)
Target Population: Fort Washington Medical Center patients and area residents
Description: According to the American Heart Association, walking briskly can lower your risk of high blood pressure, high cholesterol and diabetes. This program will:

- Aim to reduce the occurrence of preventable chronic diseases, particularly those that are associated with being overwieght, such as hypertension and diabetes by promoting a need to walk 3- 5 times a week.
- FWMC will offer medical tips and tidbits from medical experts and provide educational materials/seminars on various health-related topics.

First year: Encourage walking as a continuous method of exercise to prevent chronic health issues; increase local participation, and educate and empower patients/residents regarding high blood pressure, heart disease, obesity and other chronic illnesses.
Outcome measures: Increased participation/exercise and awareness/education regarding ways to maintain good health
Second year: Evaluate the effectiveness of program components annually to determine future programming.
Costs: $2,000 (Marketing, Promotional items)

Reference Information

Project Work Plan



Community Leader Interview Results

Community Leader Interviews

- Tripp Umbach completed six phone interviews between April and June, 2013 with key stakeholders throughout the region.

- The information collected from community leaders is presented in an aggregated format. Tripp Umbach summarized the shared themes and ideas in the below information (in no order of importance).

  A. Access to Care

  B. Unhealthy Lifestyles

  C. Healthy Education and Prevention

  D. Local Economy

- Community Leaders who were interviewed represented:

  1. YMCA
  2. Prince George's Health Department
  3. Prince George's County District (2 representatives)
  4. Fort Foote Baptist Church
  5. River Jordan Project

Access to Care

- Patients seeking care cannot afford services at regular physician offices.
- There are not enough clinics in the region to support the growing number of residents needing healthcare services.
- There are government roadblocks
- Follow-up care is another road block because many do not have a primary care physician.
- Dental and mental health services are additional health services that are needed.
- There is a growing demand for additional mental health professionals and treatment centers in Prince George's County.

Unhealthy Lifestyles

- Obesity is a growing problem and is affecting residents of all ages.
- Community leaders indicated that many families do not have the ability to afford healthy food options
- Community residents need education on diet and exercising.
- Community leaders believe that positive messages such as the promotion of healthy eating and exercising will create a sense of self-awareness for families.

Health Education & Prevention

- Residents, especially African Americans are in need for prevention and education on heart disease and diabetes management.
- Educational materials and information must be able to address residents from different cultural backgrounds.

Community Leader Recommendations

- Promote and increase awareness of current community programs, resources and services to county residents. Many in the community may not be aware on the different types of available programs and geographic locations.
- Address the growing need to provide additional preventive healthcare services to those in the community. Organizations need to collaborate more closely to reduce costs.
- Increase funding to community organizations for services and programs that assist residents.

Community Leader Recommendations

- Build upon current community programs that actively involve grass-roots organizations.
- Increase the availability, affordability and quality of healthcare services in the communities
- Create new partnership opportunities with existing health clinics and streamline services so that they are utilized in a more efficient manner. Having a strong community partnership model will increase usage within the service population and will ultimately help residents live healthier lives.

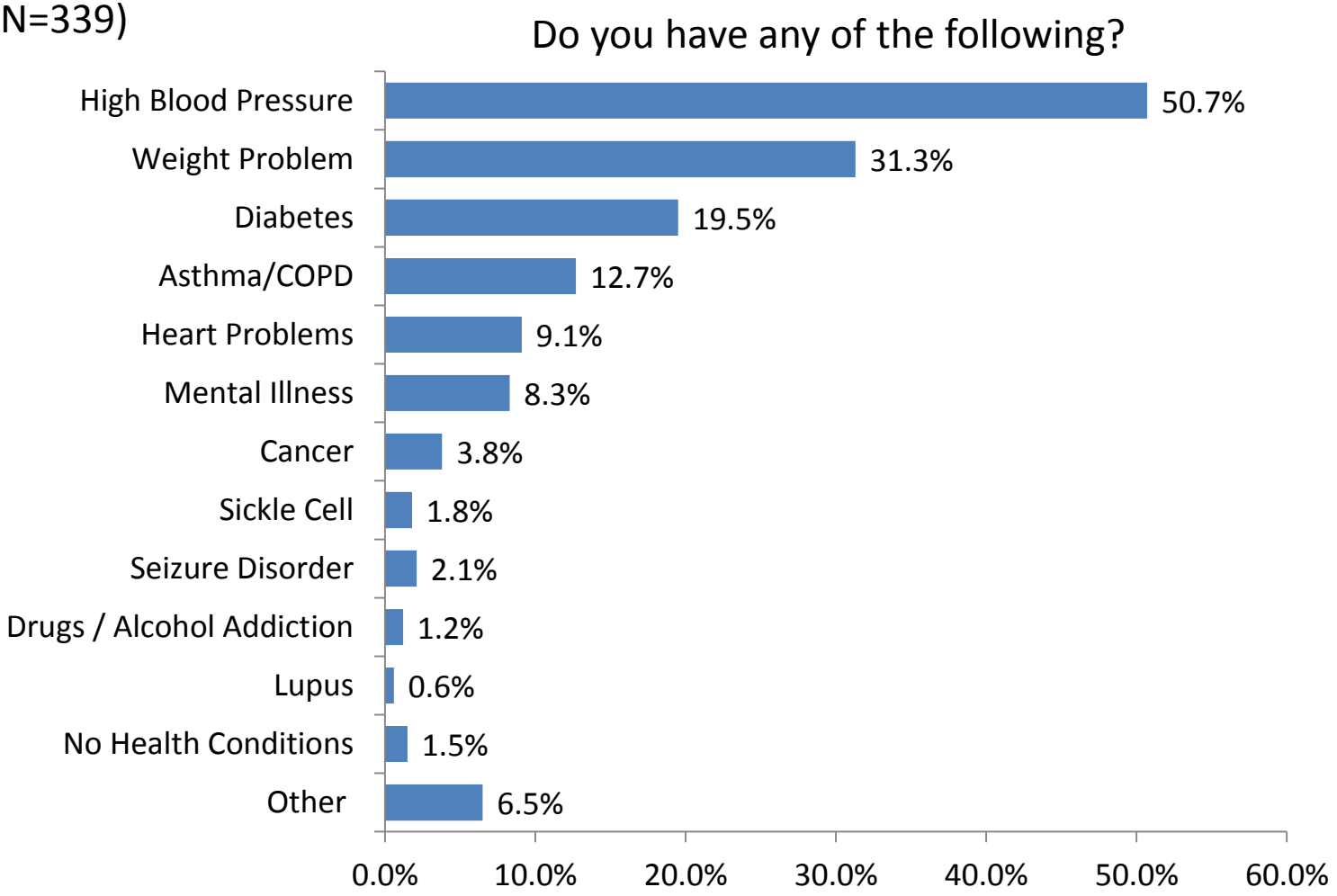
Survey Recommendations / Results

Community Leader Recommendations

- Promote and increase awareness of current community programs, resources and services to county residents. Many in the community may not be aware of the different types of available programs and geographic locations.
- Address the growing need to provide additional preventive healthcare services to those in the community. Organizations need to collaborate more closely to reduce costs.
- Increase funding to community organizations for services and programs that assist residents.

Community Health Conditions/ Results

Health Conditions
Overall (N=339)



- High blood pressure (50.7%), followed by weight problem (31.3%) were the top two health conditions reported by respondents.

Other responses included: High cholesterol, Arthritis, M.S., Thyroid condition, Allergies, Anemia, Anxiety, Fibromyalgia, Knee problem, Osteoporosis, P.D., Sarcoidosis

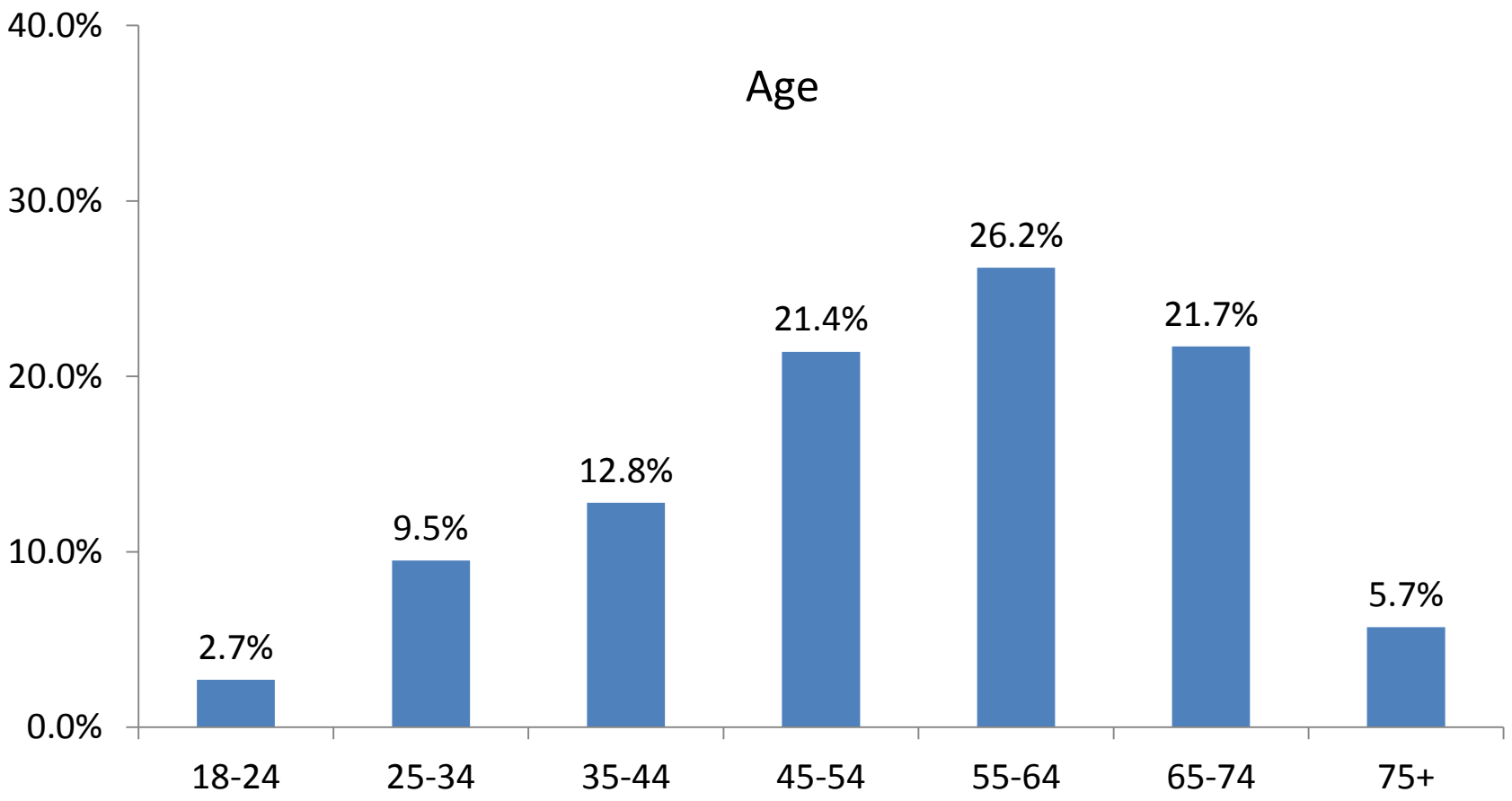
Survey Results

Household and On-Line Survey Results

- A survey was employed to collect input from populations within the study area to identify health risk factors and health needs. A hand survey was distributed and an on-line survey was employed. The survey was finalized in April 2013.
- A total of 339 surveys were collected
  - 299 via in-person / hand-survey collection; 88.2% of the completed surveys
  - 40 via online collection; 11.8% of the completed surveys
- Fort Washington Medical Center working with community-based organizations, attended health fairs, and distributed the hand survey to end-users in the study area.
- The hand survey was distributed at local events and fairs such as: FWMC Diabetes Seminars, Harmony Hall Health Fair, Mental Health Fair, Grace UMC Health Fair, Grace UMC Health Fair, Glassmanor Community Ctr. Health Fair, Oxon Hill Elementary School Health Fair, YMCA Health Fair, Fort Washington Park (Clipperthon), Oxon Hill Library "Friends & Family Day," FWMC Hospital, Harmony Hallers Senior Group Meeting at Harmony Hall, Woodside Village Senior Home, strip malls, and barber shops.

Respondent Demographics

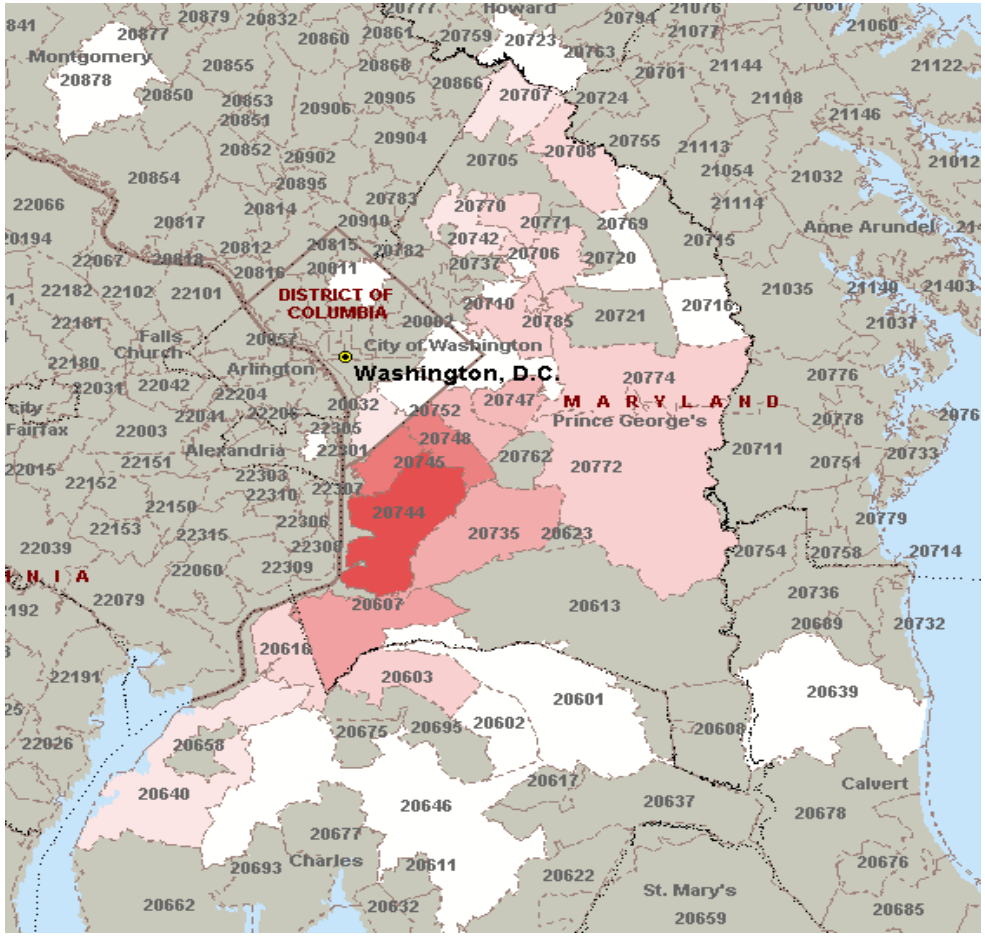
Overall (N=336)



- Almost half of respondents (47.6%) are considered middle aged (45-64 years old).
- 27.4% of respondents are senior citizens (65+)

Respondents by Zip Code

Overall (N=338)



# of Respondents by ZIP Code

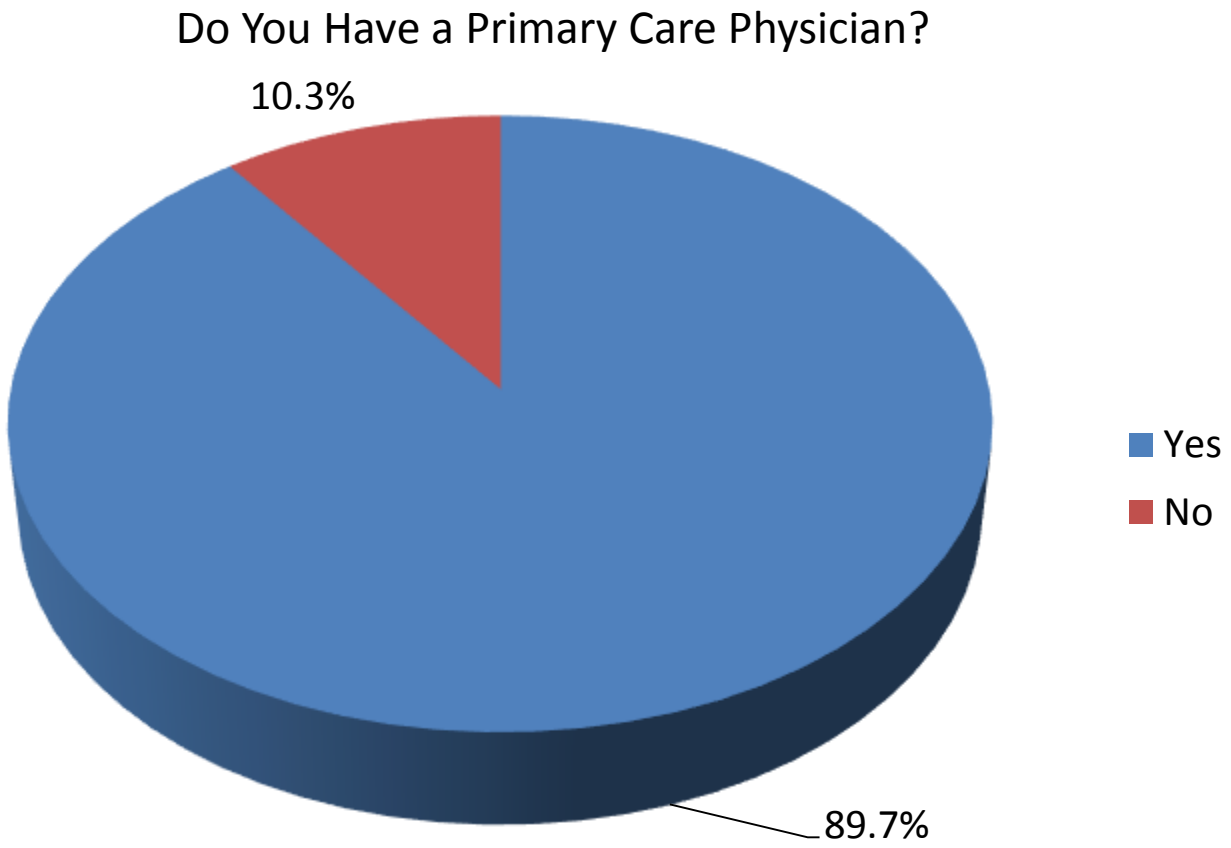
160

13

1

Respondents with a Family Doctor

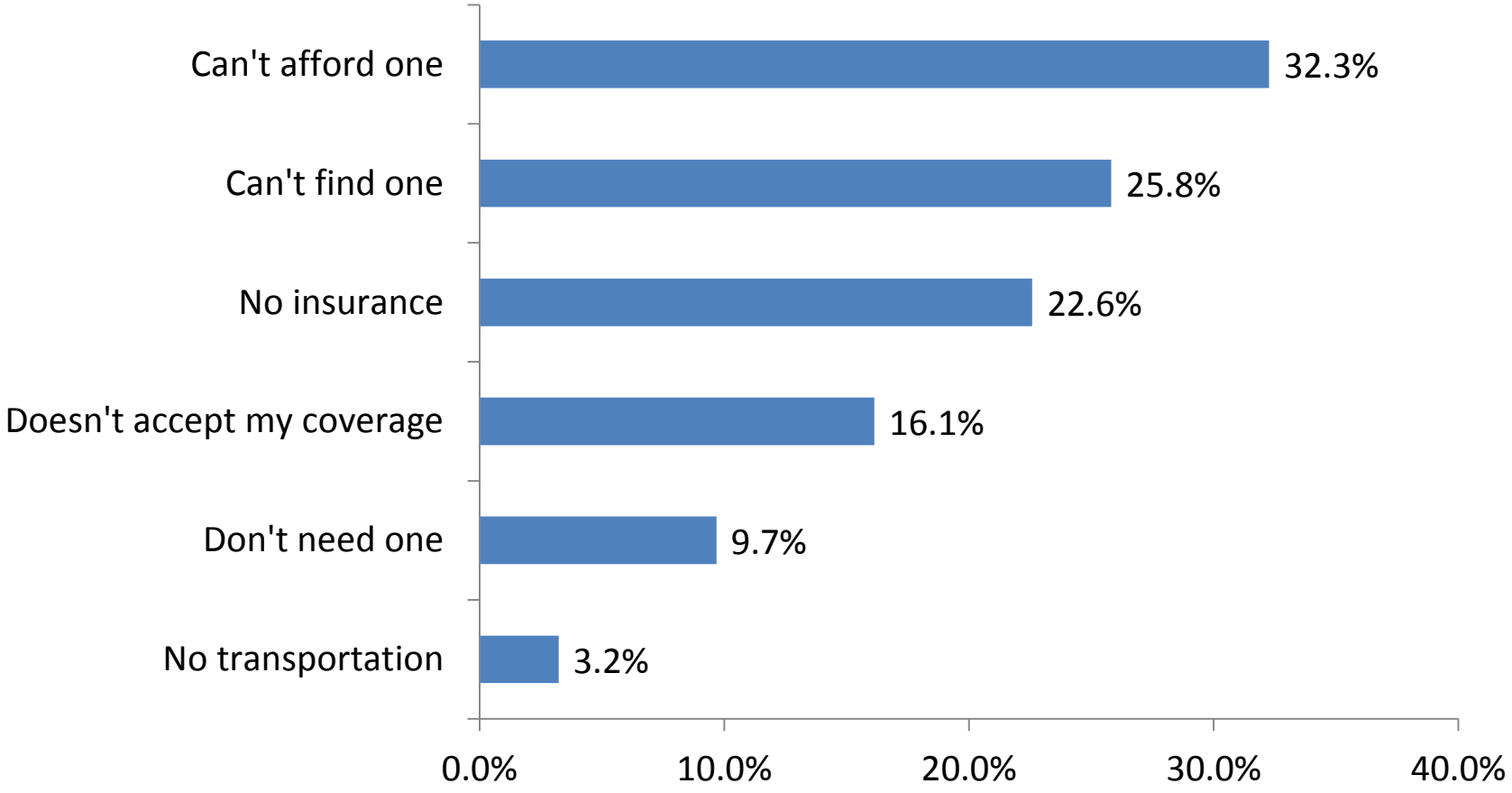
Overall (N=339)



- Approximately 9 out of every 10 respondents have a primary care physician (89.7%). However, on the other hand, this means that more than 1 in every 10 respondents report not having a PCP.

Reasons for Not Having a Doctor

Overall (N=31, 4 missing responses)

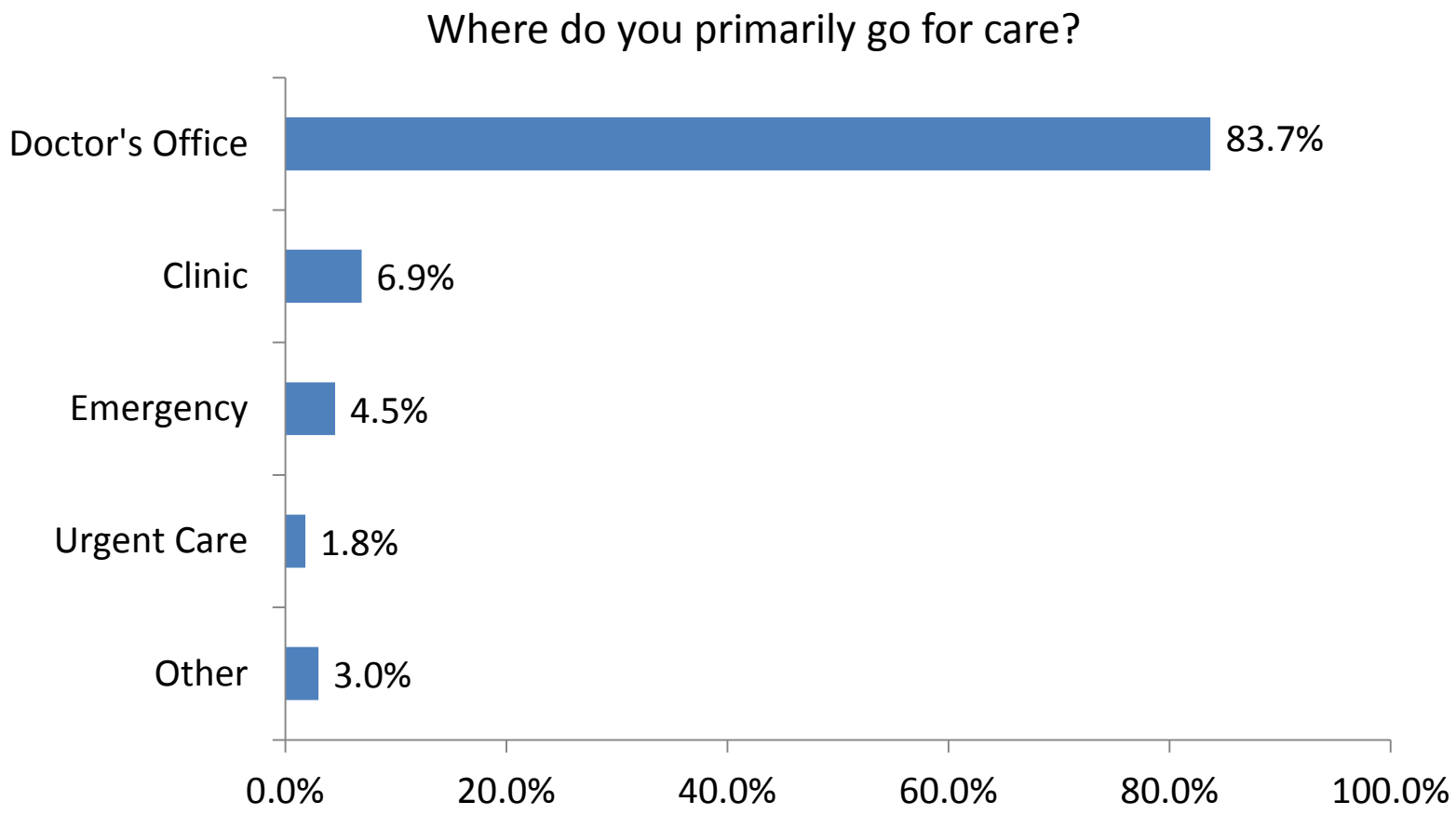


- Of those respondents who did not have a primary care physician, affordability and the inability to find a doctor were the top two reasons.

Note: filtered and run for those who only responded “no” to not having a family doctor.

Primary Place for Care

Overall (N=332)

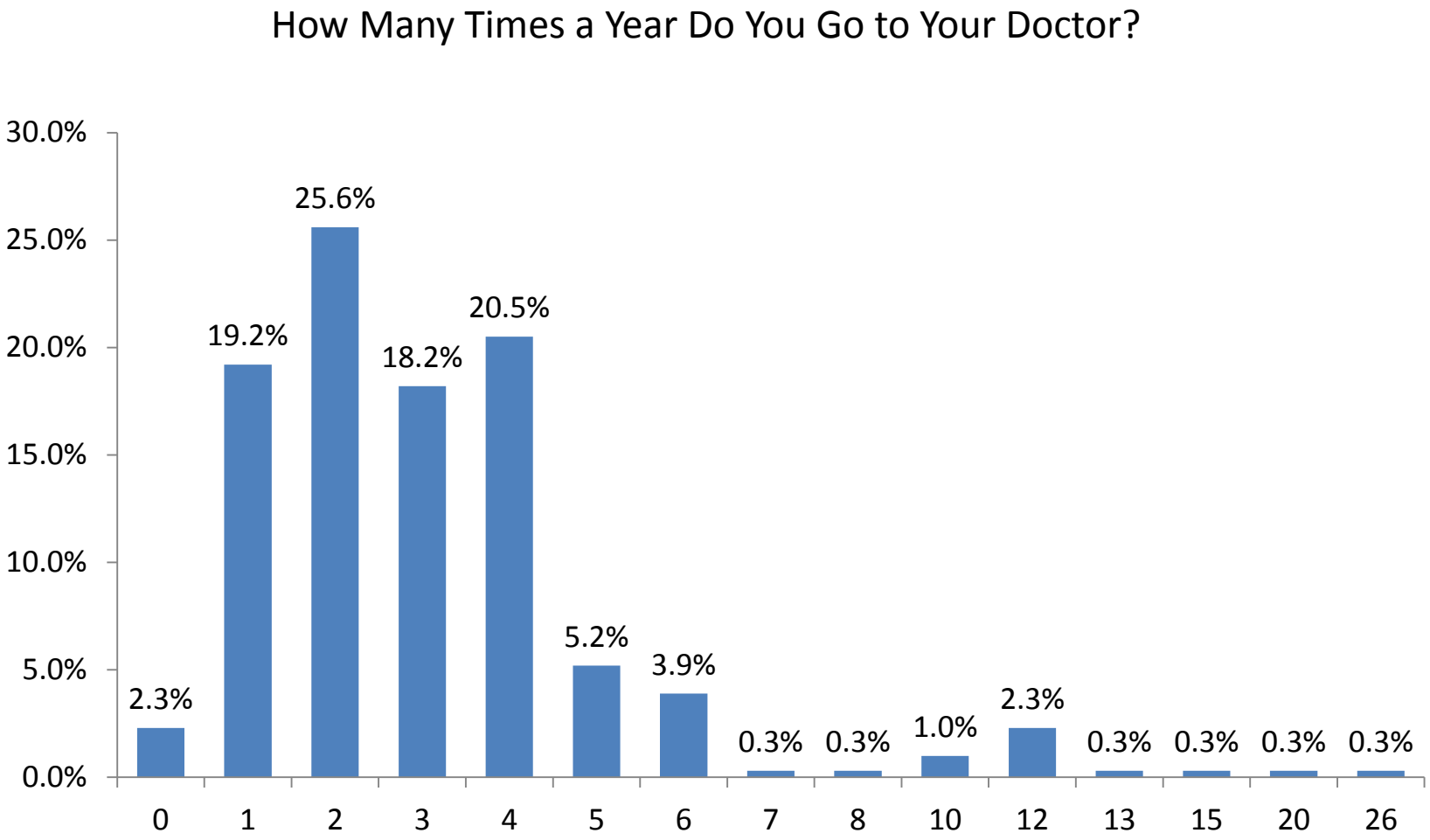


- 13.2% of all respondents seek care outside of their doctor's office at clinics, emergency rooms, and urgent care facilities.

Other responses included: VA, Air Force, Kaiser, Nowhere, N/A

Frequency of Seeking Care

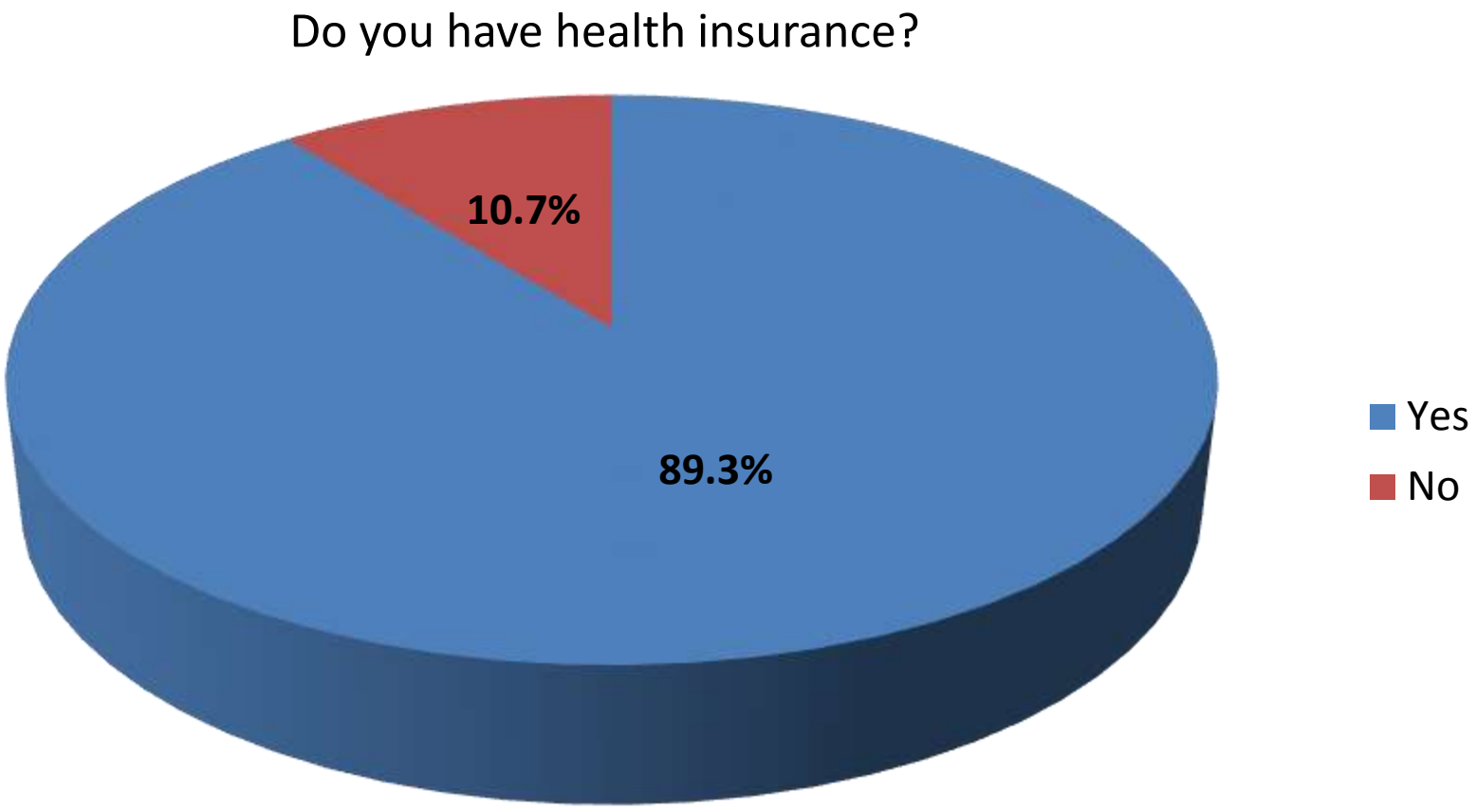
Overall (N=308)



- 14.2% of all respondents go to their doctor's office 5 or more times per year.

Health Insurance Coverage

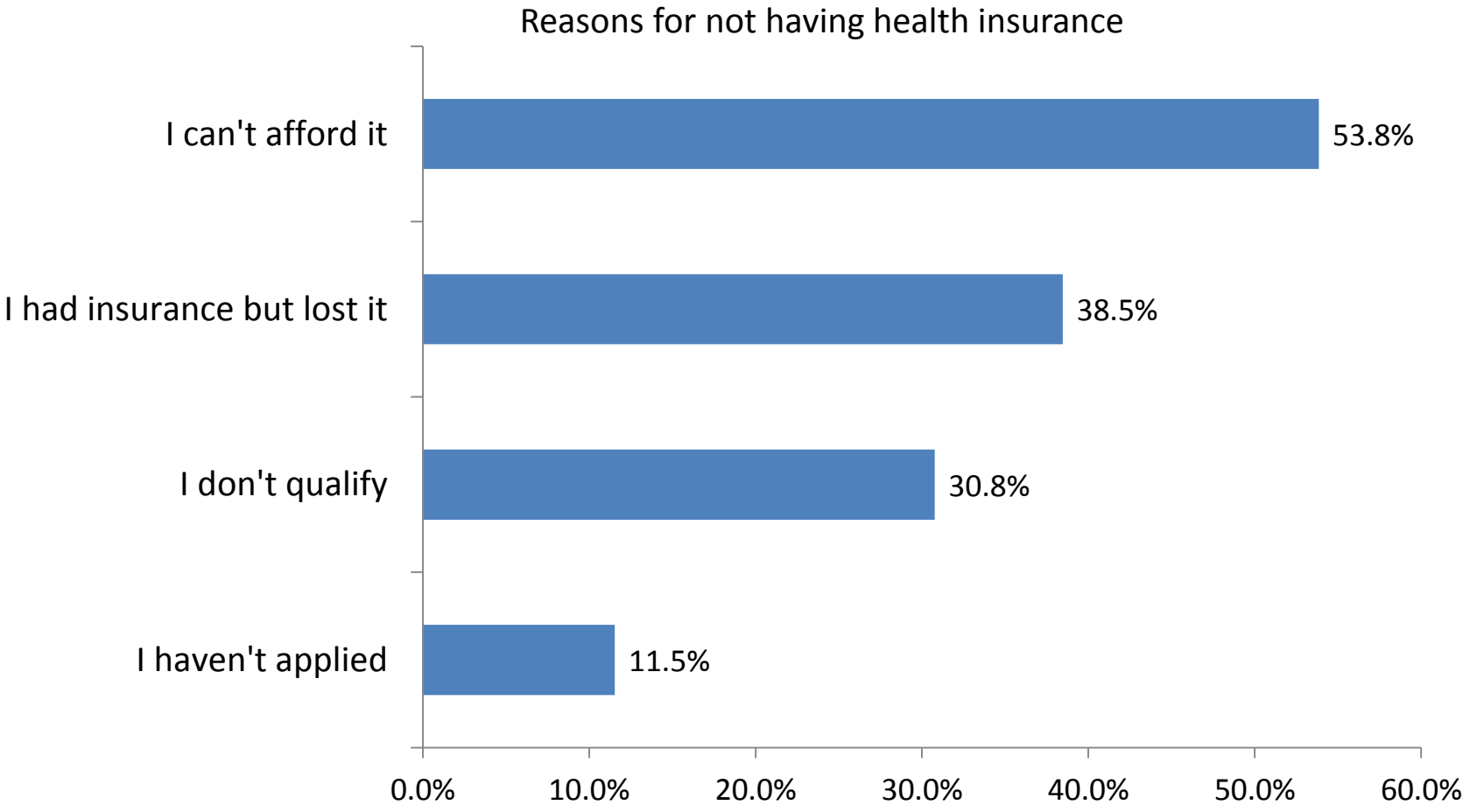
Overall (N=326)



- A large majority of respondents reported that they have health insurance (89.3%).

Health Insurance Coverage

Overall (N=26, 9 missing responses)

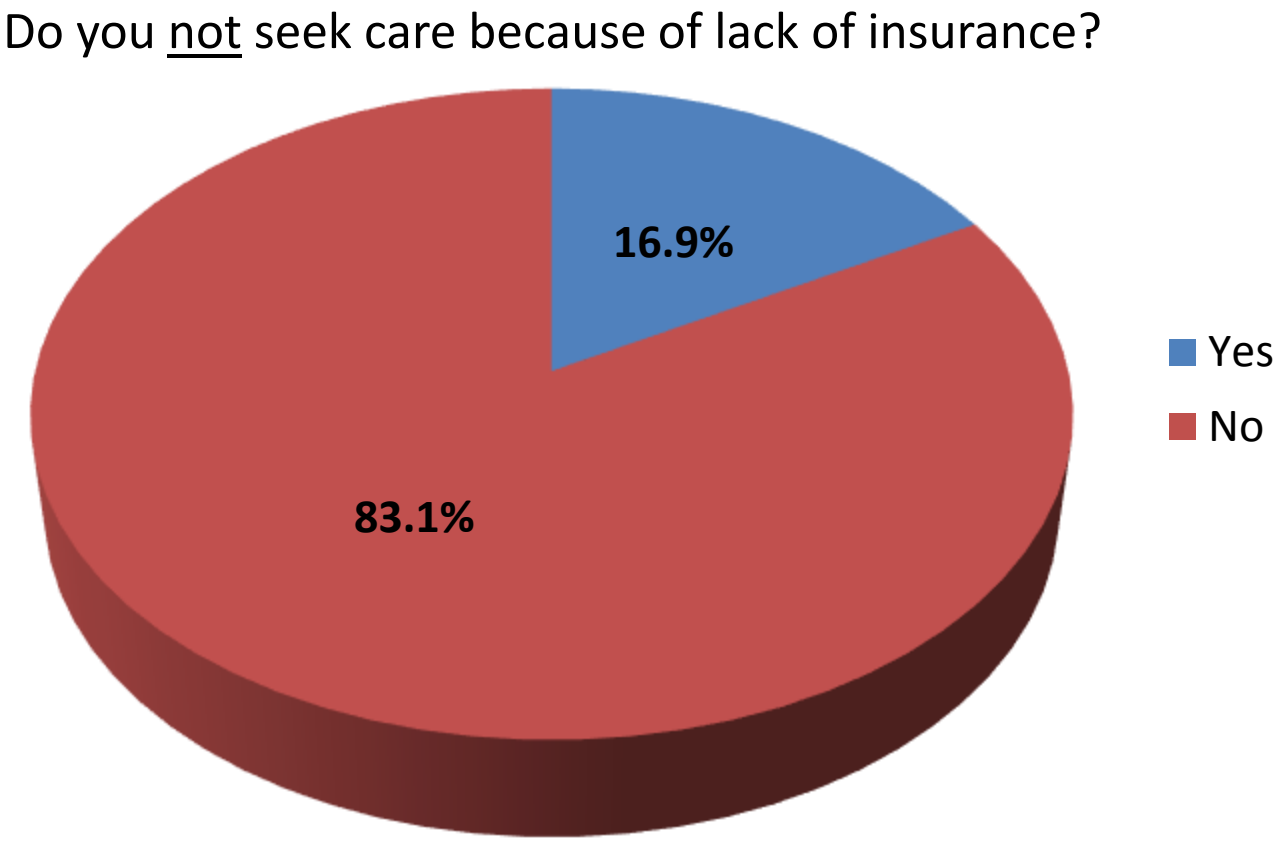


- Of those respondents who do not have health insurance, affordability was the top reason (53.8%), followed by 'had insurance but lost it' (38.5%).

Note: filtered and run for those who only responded "no" to not having insurance.

Health Insurance Coverage

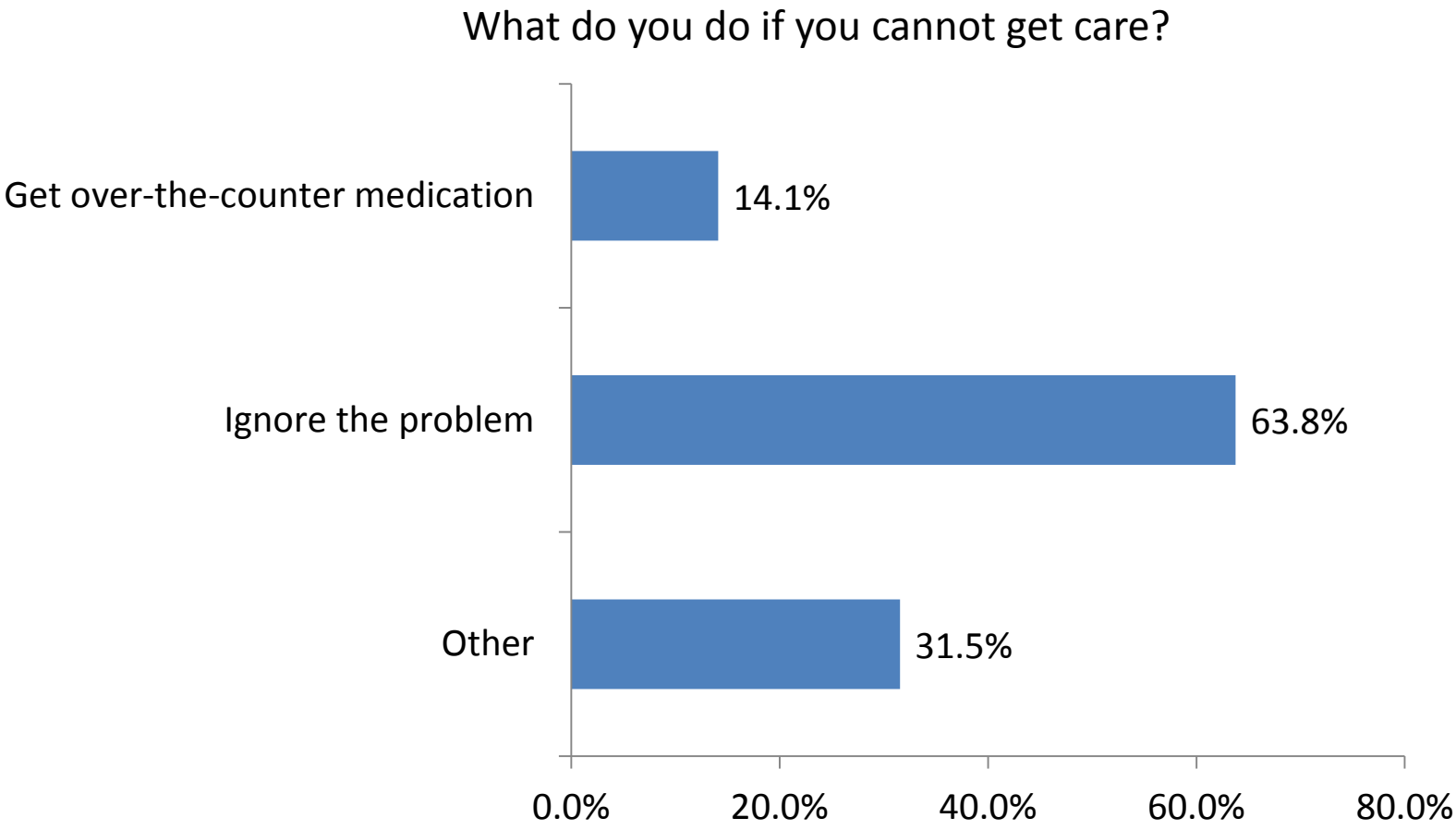
Overall (N=148)



- 16.9% of respondents do not seek care due to their lack of health insurance coverage.

Method of Care

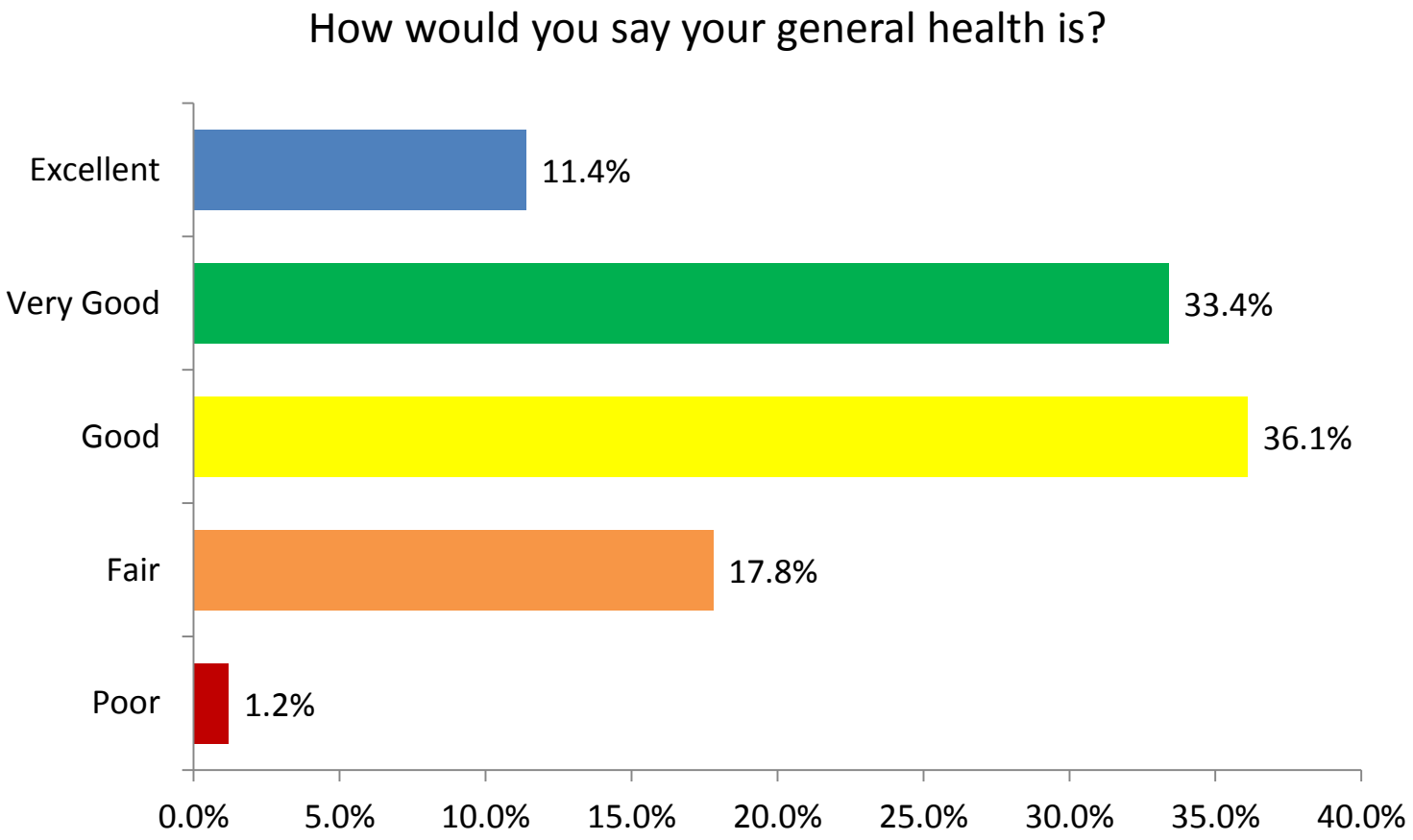
Overall (N=149)



- Unfortunately, 63.8% of respondents ignore their health problem if they cannot get care.

Health Status

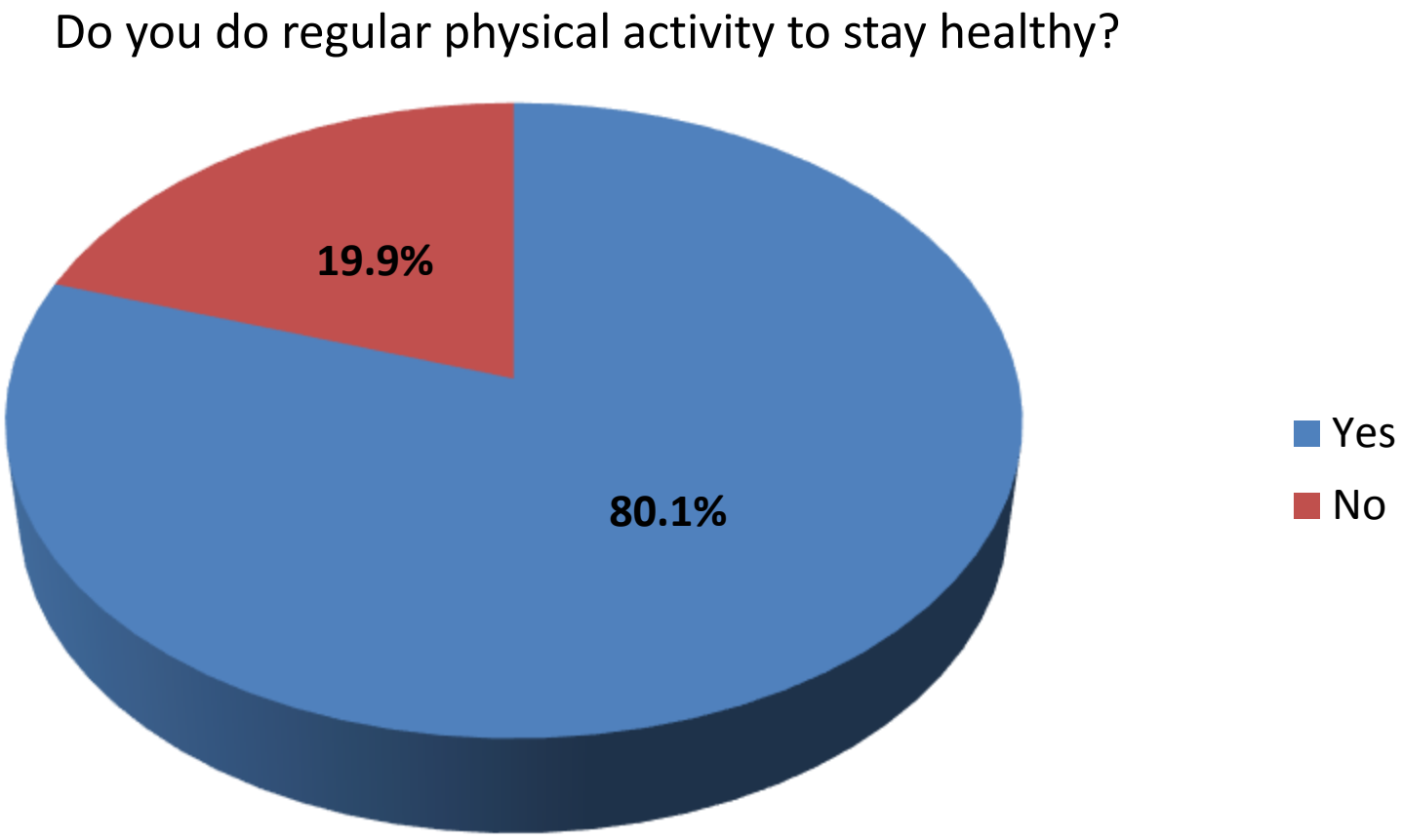
Overall (N=332)



- More than one-third of respondents (44.8%) reported having ‘excellent’ or ‘very good’ health.

Physical Activity

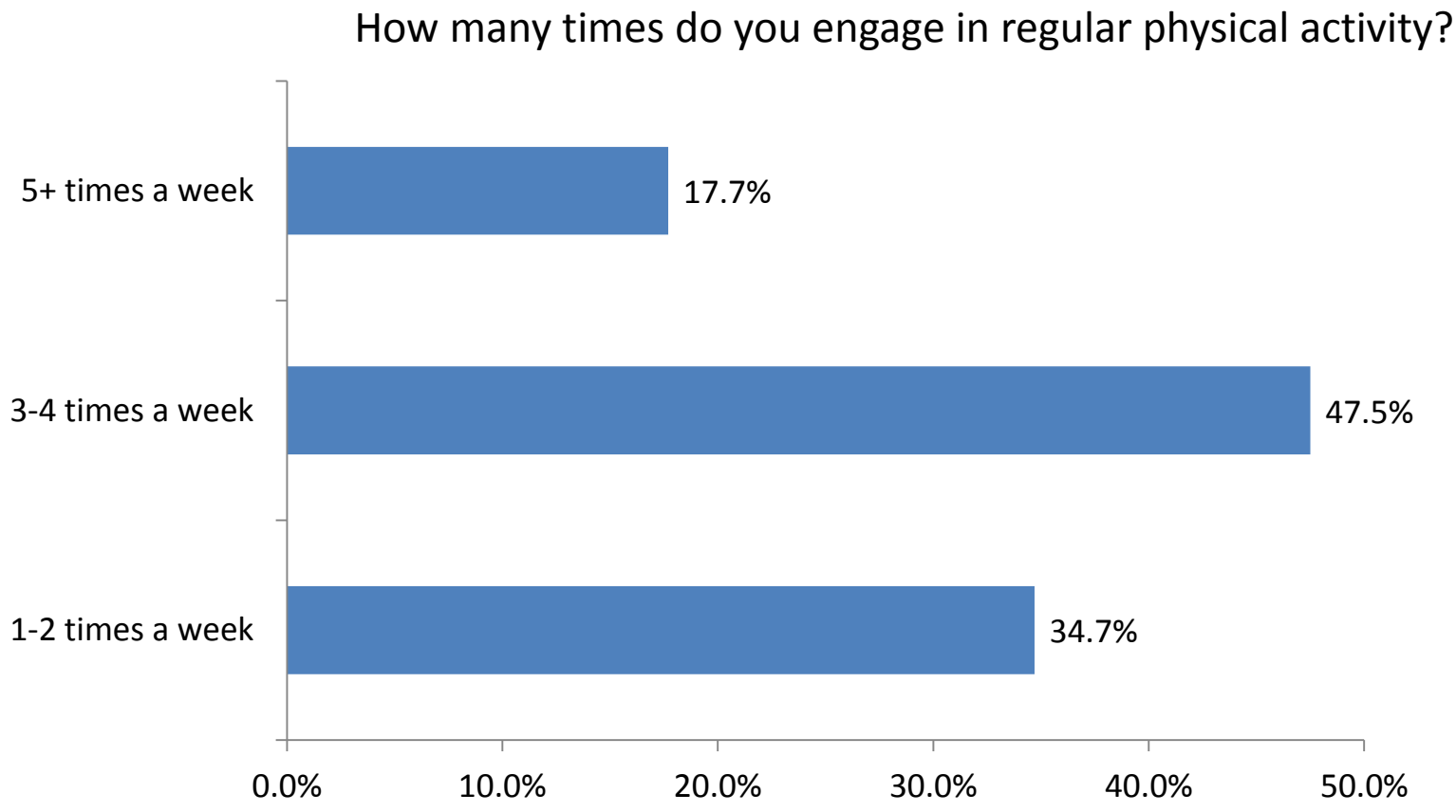
Overall (N=331)



- The majority of respondents report engaging in regular physical activity (80.1%).

Physical Activity Rate

Overall (N=265)

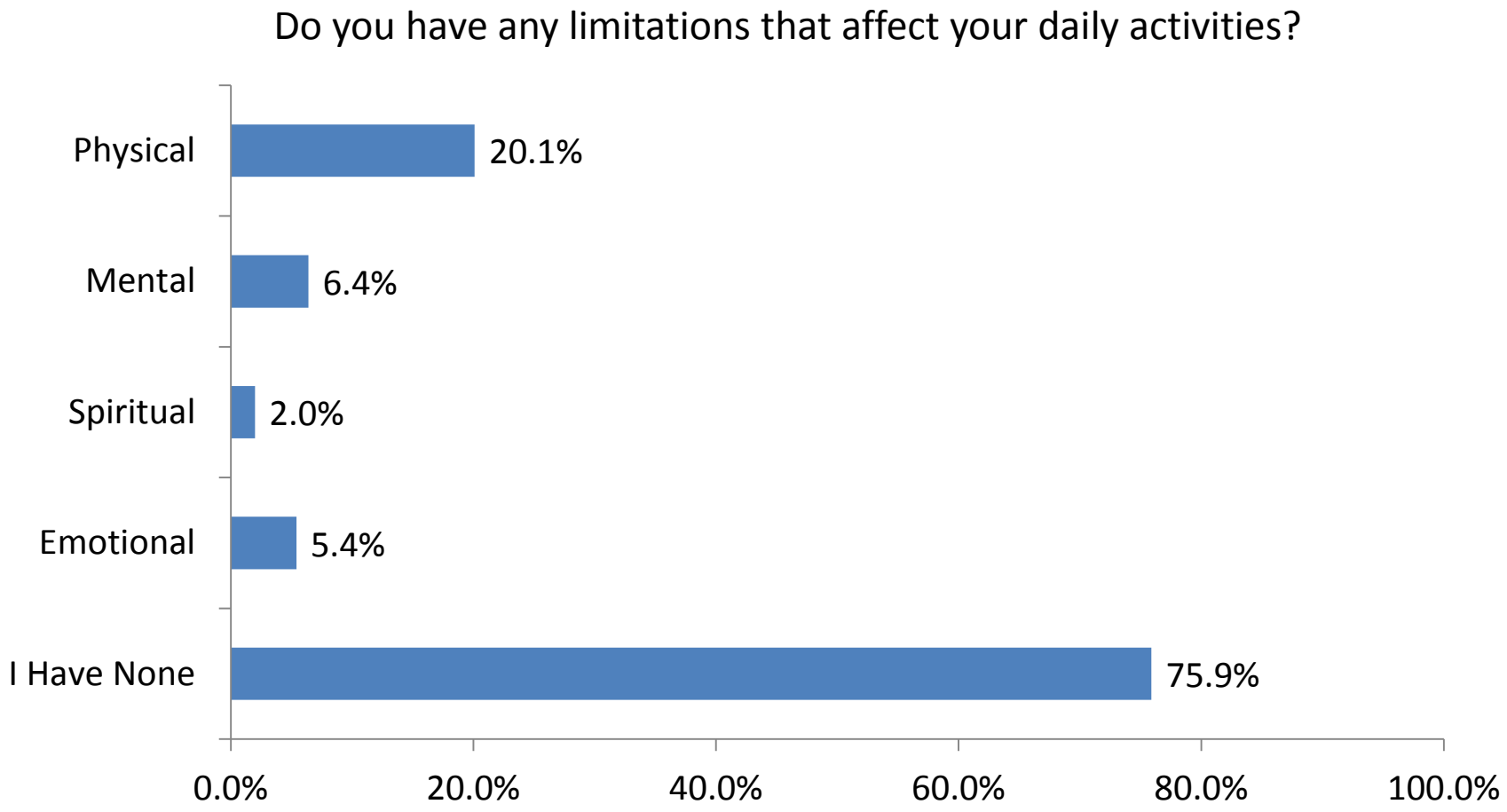


- More than one-third of respondents (34.7%) engage in physical activity only 1 to 2 times a week.

Note: filtered and run for those who only responded "yes" to engaging in physical activity.

Limitations on Daily Activities

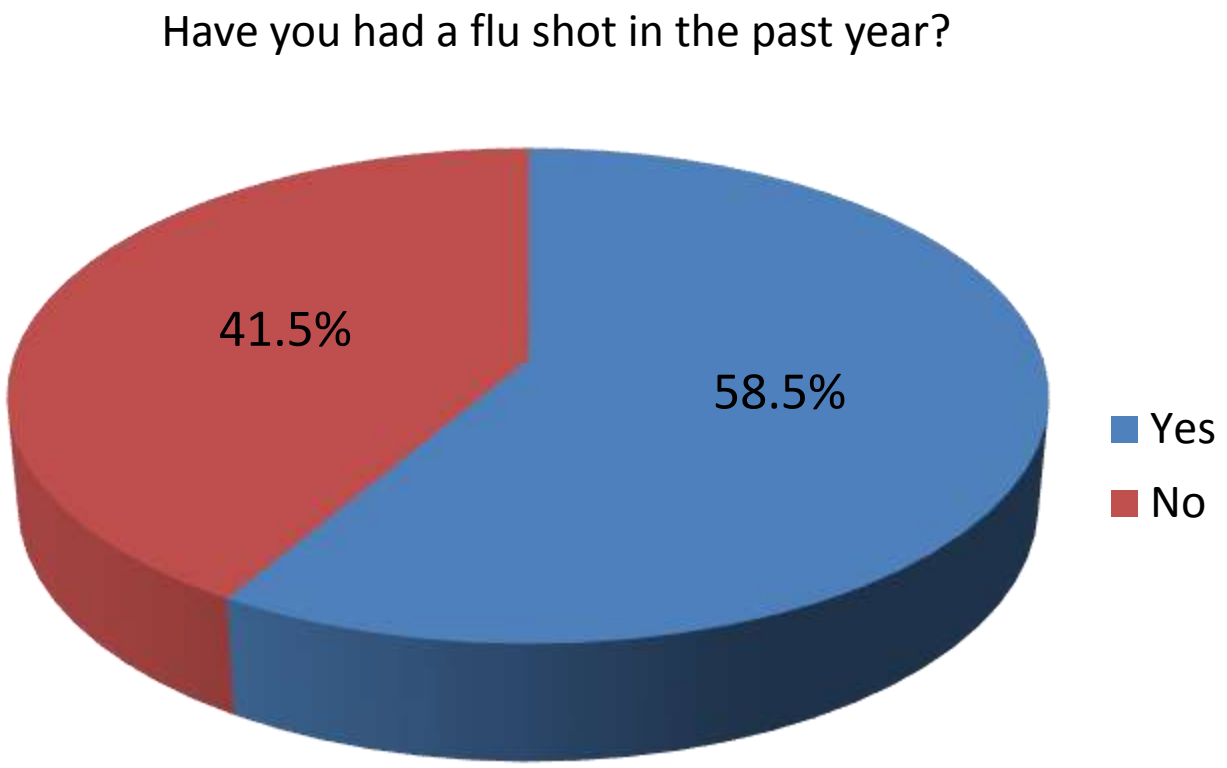
Overall (N=299)



- More than one-third of respondents (33.9%) reported having some type of limitation (physical, mental, and spiritual) that affects their daily activities.

Flu Shot in the Past Year

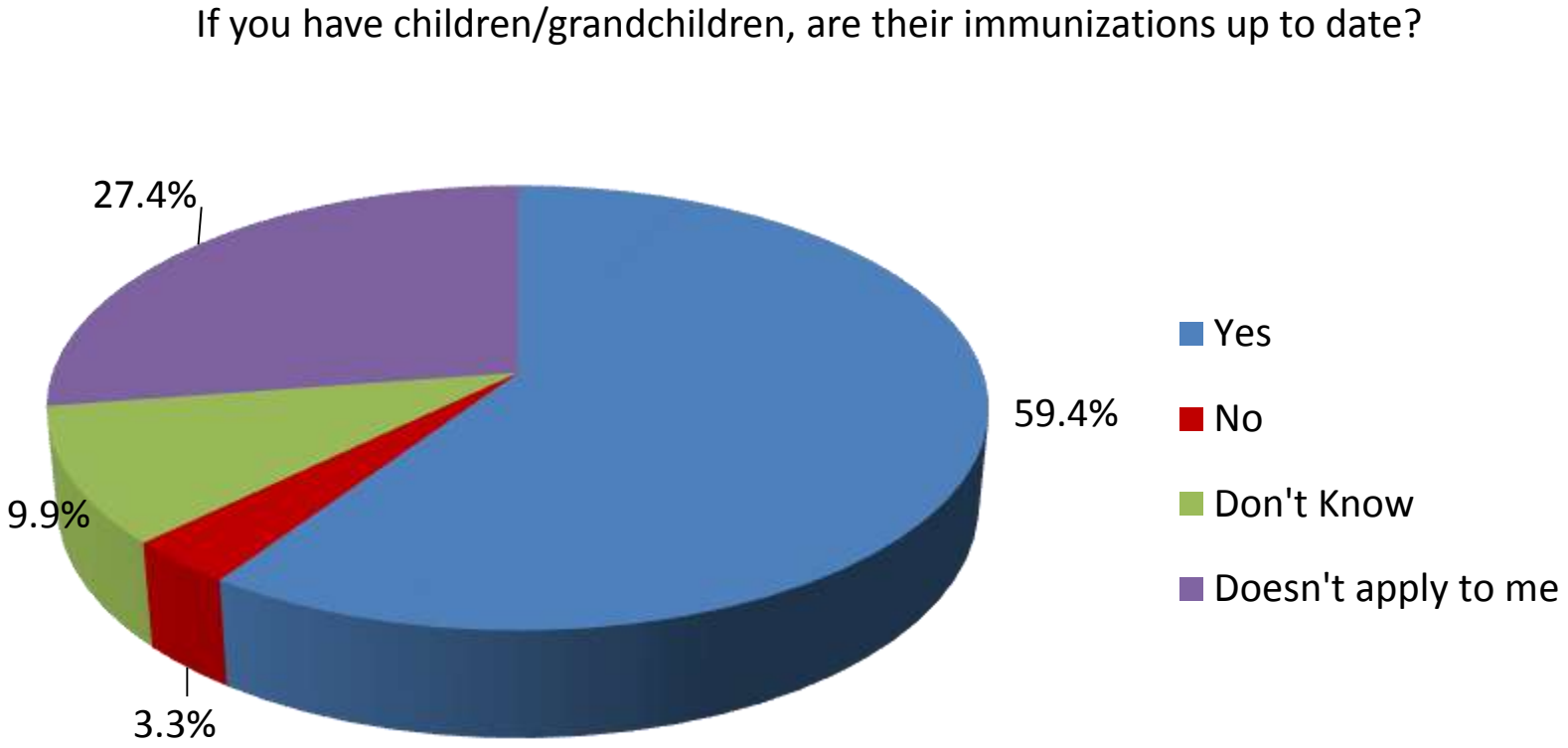
Overall (N=325)



- More than half of all respondents had a flu shot in the past year (58.5%).

Immunizations

Overall (N=303)

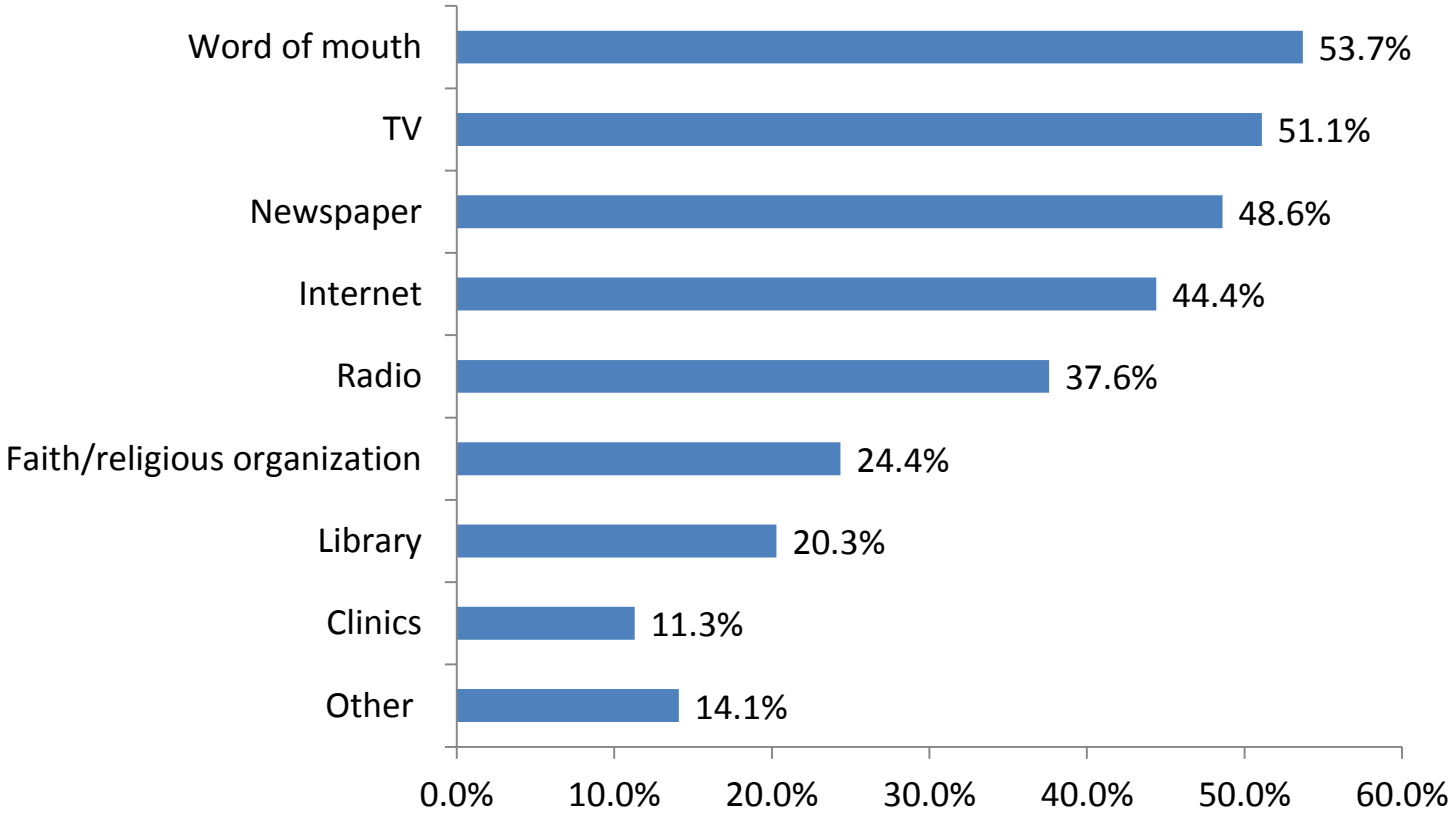


- 9.9% of respondents do not know if their children/grandchildren are up to date on their immunizations.

Dissemination of Information

Overall (N=311)

How do you find out about information in your community?

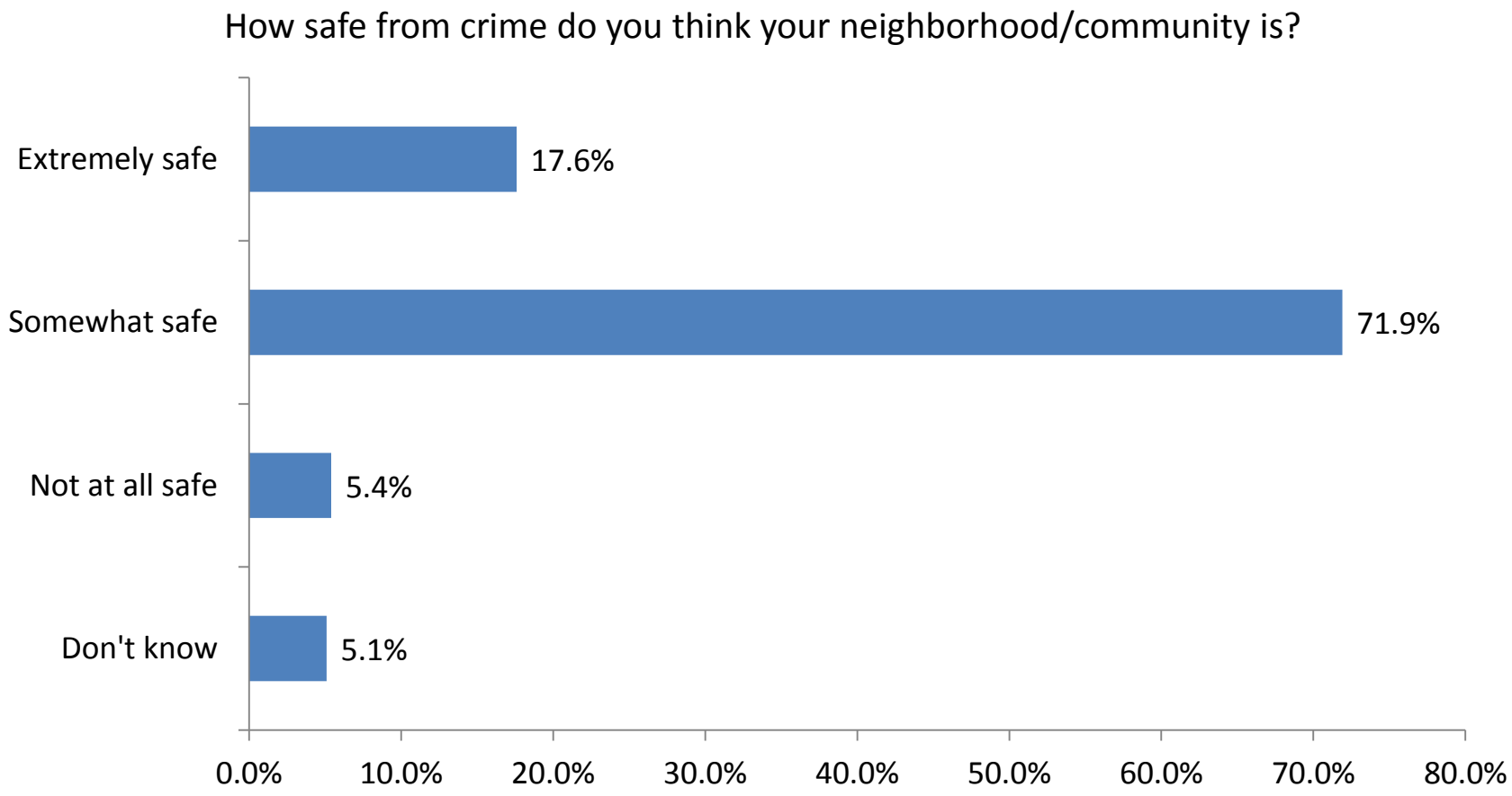


- Word of mouth (53.7%) and TV (51.1%) were the top two avenues by which how respondents find out about information in their community.

Other responses included: Mailings, Harmony Hallers, Local organizations, Doctor, Schools, Facebook, Don't get info.

Community Safety

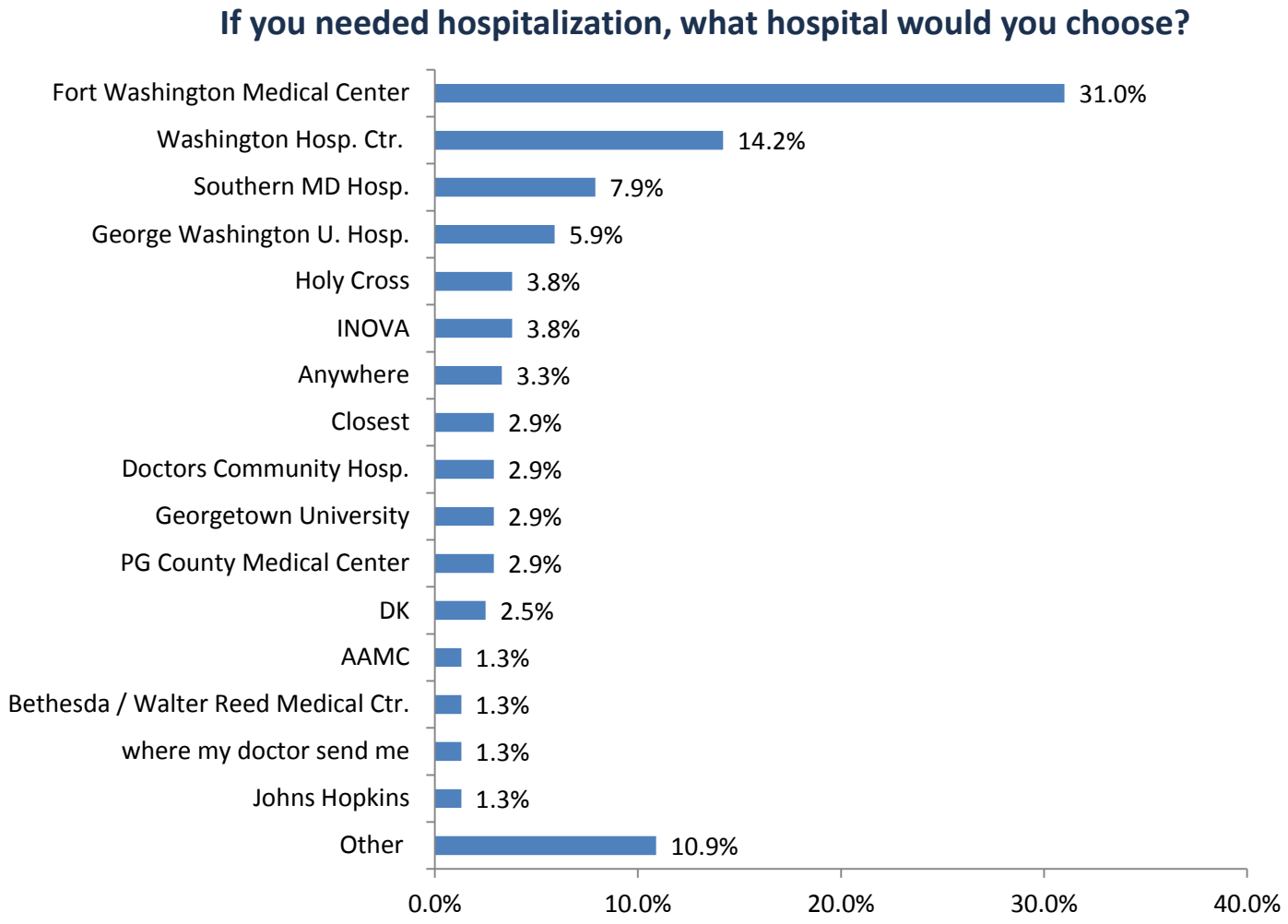
Overall (N=313)



- Close to three-quarters of respondents (71.9%) felt ‘somewhat safe’ in their neighborhood/community.

Hospital of Choice

Overall (N=239)

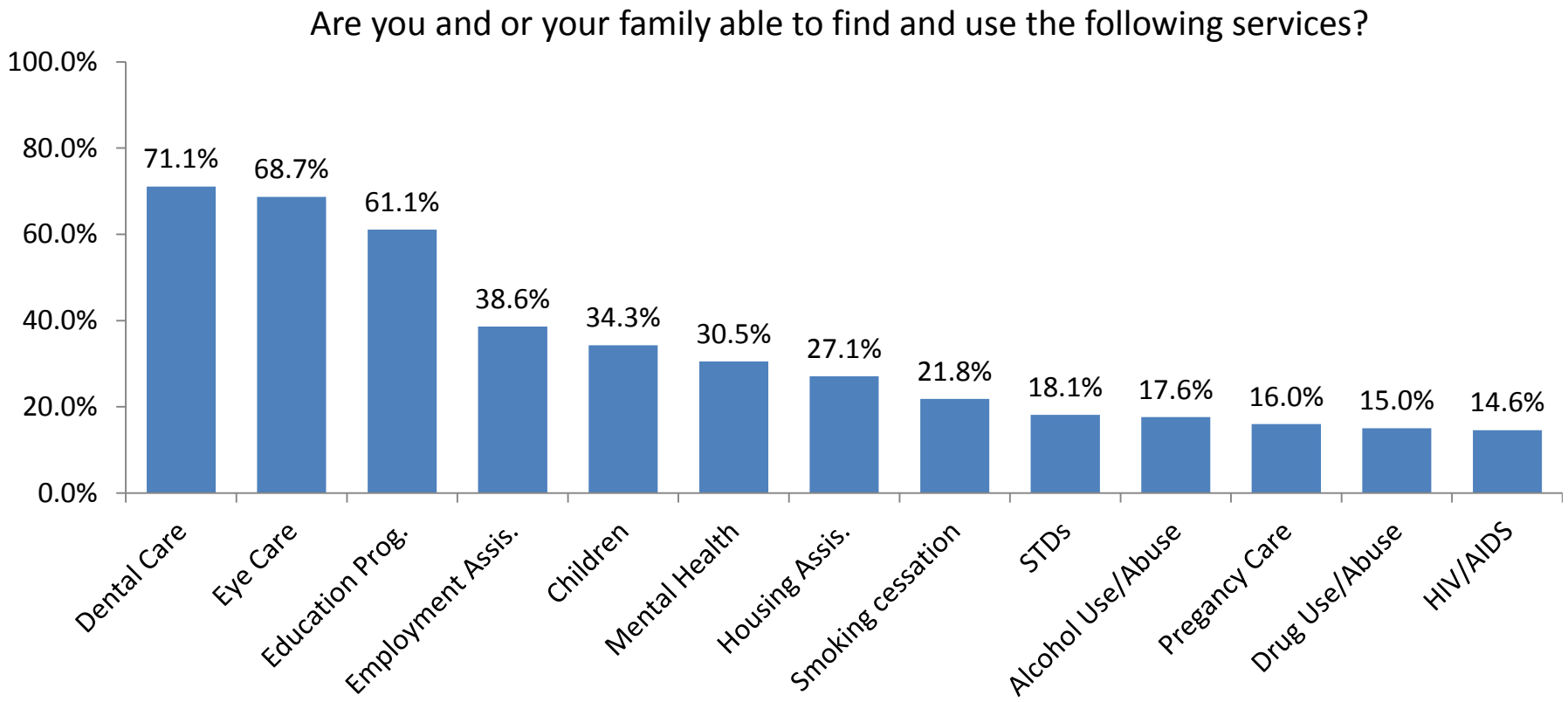


- Fort Washington Medical Center followed by Washington Hospital Center were the top two hospitals respondents would choose if they needed hospitalization.

Other responses included: Adventist, Bowie, Children's Hospital, VA, Providence Hospital, Fairfax County Hospital, Kaiser, Montgomery, Howard, Laurel,…

Availability of Services

Overall (Varying N numbers, 273+)



- The top three programs respondents can find are dental care, eye care, and educational programs. The bottom three are pregnancy care, drug use/abuse, and HIV/AIDS services.

Tripp Umbach completed an inventory of community resources available in the Fort Washington Medical Center's service area using resources identified by the Hospital and online research. Using state information, more than 70 community resources were identified with the capacity to meet the two community health needs identified in the Fort Washington Medical Center's CHNA. (Please refer to t Community Health Needs Assessment Report to review the detailed community needs.)

An inventory of the resources in the Fort Washington Medical Center's community found that there is at least one and often multiple resources available to meet each identified community health need following table meets CHNA community inventory requirements set forth in IRS Notice 2011-52. (See Table)

INVENTORY OF COMMUNITY RESOURCES AVAILABLE TO ADDRESS COMMUNITY HEALTH NEEDS IDENTIFIED IN THE FORT WASHINGTON MEDICAL CENTER CHNA

Organization/ Provider	Counties Served	Contact Information	Internet Information	Population Served	Services Provided	Healthy Lifestyles	Exercise	Diet	Education/Prevention	Diabetes	Heart Disease
"DC EAT SMART/MOVE MORE" Food Stamp Nutrition Education Program	Washington, DC	Nutrition Programs Administration WIC State Agency 2100 Martin Luther King Jr. Avenue, SE Suite 409 Washington, DC 20020 202.645-5663	More information	Low-income D.C. residents	Provides free group nutrition education classes. Classes occur at various community settings throughout D.C. (e.g., schools, community centers, senior centers, day cares). Class topics include: food preparation, food budget and resource management, safety, feeding infants and children, and physical activity.	x	*	*			
A Touch of Life for Health and Wellness	Prince George's	Energy Institute of the Healing Arts Foundation 12911 Woodmore Road Mitchellville, MD 20721 301.249.2445	More information	Low-income Prince George's County residents	Provides 2-hour classes on food and nutrition education, physical activity information, weight management information, and relaxation.	x	*	*			
A Touch of Life for Health and Wellness	Washington, DC	Energy Institute of the Healing Arts Foundation 2913 Georgia Avenue Washington, DC 20002	More information	Low-income Washington, DC residents	Provides 2-hour classes on food and nutrition education, physical activity information, weight management information, and relaxation.	x	*	*			

Organization/ Provider	Counties Served	Contact Information	Internet Information	Population Served	Services Provided	Healthy Lifestyles	Exercise	Diet	Education/Prevention	Diabetes	Heart Disease
Adult Health Programs of Prince George's CountyHealth Department	Prince George's	Headquarters Building 1701 McCormick Drive Suite 200 Largo, Maryland 20774 301.883.7879	More information	Adults residing in Prince George's County	Provides adult health programs, including physical activity and nutrition education.	x	*	*			
American Cancer Society	Charles, Prince George's	7500 Greenbelt Center Drive Suite 300 Greenbelt, MD 20770 202.483.2600	More information	General population	Offers nutritional counseling, one-on-one support, and referrals to local community resources.	x		*			
American Diabetes Assocation: National Capital Area	Washington, DC	1400 16th Street Northwest #410 Washington, DC 20036 202.331.8303	More information	General population	Provides resources on diabetes and diabetes prevention, includingweight management information, nutrition education materials/information, and physical activity information on the website and inprint.	x	*	*	x	*	
Beacon House Recreational Activities	Washington, DC	601 Edgewood Street, NE Washington, DC 20017 202.529.7376	More information	At-risk children, ages 5-18 years old, who reside in and around the Edgewood Terrace community in Ward 5	Provides free recreational, physical activity, and sports programs.	x	*				
Bellydancers of Color	Washington, DC	MamaSita's Cultural Center 6906 4th Street, NE Washington, DC 20012 202.545.8888	More information	Residents of African American, Hispanic/Latino, Pacific Islander, Asian, Native America, Rom, Middle Eastern, Mediterranean, and/or East Indian background	Organizes bellydancers of color for physical activity.	x	*				

Organization/ Provider	Counties Served	Contact Information	Internet Information	Population Served	Services Provided	Healthy Lifestyles	Exercise	Diet	Education/Prevention	Diabetes	Heart Disease
BodyWorks	Washington, DC	Children's Health Center 2501 Good Hope Road, SE Washington, DC 20020 202.476.6944	More information	Overweight/obese girls ages 9-13 and their mothers	Provides free physical activity and nutrition education classes. Weight management information is also included. Classes are taught throughout D.C. For those classes taught at the Children's Health Center, a referral from a healthcare provider is required.	x	*	*			
Camp Springs Senior Activity Center	Prince George's	6420 Allentown Road Camp Springs, MD 20748 301.449.0490	More information	Seniors ages 60+ years old	Offers fitness programs and health education classes, information, and referrals.	x	*	*	x	*	
Capital Area Food Bank Operation Frontline Program	Washington, DC	645 Taylor Street, NE Washington, DC 20017 202.526.5344	More information	General population	Cooking-based nutrition program that focuses on teaching cooking skills, nutrition basics, and food budgeting.	x		*			
Charles County Parks and Recreation	Charles	Department of Public Works 1001 Radio Station Road La Plata, Maryland 20646 301.932.3470	More information	General population	Operates five swimming pools, two year-round indoor facilities, and three outdoor seasonal facilities that offer a variety of classes and programs in addition to 15 parks that cover 3,600 acres of open space, sports fields, 50 miles of trails, fishing opportunities, five boating access facilities, a golf course and equestrian facilities.	x	*				
Charles Regional Medical Center	Charles	5 Garrett Avenue La Plata, MD 20646 301.609.4000	More information	General population	Offers a variety of community health programs including a heart healthy eating class, a cardiac support group, and yoga.	x	*	*	x		*
City of College Park Seniors' Program	Prince George's	Spellman House 4711 Berwyn House Road College Park, MD 20740 301.474.0025	More information	Senior residents of the city of College Park	Offers periodic Presentations on Senior Topics in wellness and health.	x	*	*			

Organization/ Provider	Counties Served	Contact Information	Internet Information	Population Served	Services Provided	Healthy Lifestyles	Exercise	Diet	Education/Prevention	Diabetes	Heart Disease
City of College Park Seniors' Program	Prince George's	Attick Towers 9014 Rhode Island Avenue College Park, MD 20740 301.345.8100	More information	Senior residents of the city of College Park	Offers periodic Presentations on Senior Topics in Safety, Wellness, and Health.	x	*	*			
College of Southern Maryland: La Plata Campus	Charles	8730 Mitchell Road P.O. Box 910 La Plata, MD 20646 301.934.2251	More information	Participants must be at least 13 years of age to take group fitness classes unless otherwise specified in the class description.	Various courses offered in nutrition, fitness, aquatics, and recreation.	x	*	*			
COOL Kids	Washington, DC	1630 Euclid Street NW Washington, DC 20009 202.476.5539		Latino children and youth ages 7-16 and their families.	Offers a free obesity reduction program that includes weekly classes that provide individual family counseling, behavior modification techniques, and information about nutrition, physical activity, and weight management. One parent attends each class session. Classes for parents are in Spanish; classes for children are in English. Both parents need to be Latino.	x	*	*			
Cora B. Wood Senior Center	Prince George's	3601 Taylor Street Brentwood, MD 20722 301.699.1238		Seniors ages 60+ years old	Exercise classes provided by the National Institutes of Health Heart Center at Suburban Hospital	x	*		x		*
D.C. Child Development Center	Washington, DC	Easter Seals Greater Washington-Baltimore Region, Inc. 2800 13th Street, NW Washington, DC 20009 202.387.4434	More information	Children with and without disabilities	Provides fitness and recreational programs and services and nutrition education.	x	*	*			
D.C. Department of Parks and Recreation Fitness andExercise Classes	Washington, DC	District of Columbia Department of Parks and Recreation 3149 16th Street, NW Washington, DC 20010 202.698.2250	More information	D.C. residents of all ages	Offers physical activity classes and some nutrition education classes, many for free or at low-cost. Scholarships are available for D.C. residents who qualify for classes with fees based on income. Location, age group, date, time, and cost vary depending on class.	x	*	*			
DC Scores	Washington, DC	202.393.6999	More information	Children ages 8-14 at select elementary and middle schools throughout the DC area	Provides an after-school program with physical activity and health education.	x	*	*			

Organization/ Provider	Counties Served	Contact Information	Internet Information	Population Served	Services Provided	Healthy Lifestyles	Exercise	Diet	Education/Prevention	Diabetes	Heart Disease
Dimensions Healthcare System Prince George's Hospital Center	Prince George's	3001 Hospital Drive Cheverly, Maryland 20785 301.497.7914	More information	General population	Offers a wide range of services and programs-such as support groups, health screenings, and informative seminars-to help individuals make healthier choices and lifestyle changes.	x	*	*	x	*	*
District of Columbia Head Start	Washington, DC	Head Start State Collaborative Office, Early Care and Education Administration, D.C. Department of Health 717 14th Street, NW Suite 450 Washington, DC 20005 202.727.8113	More information	Children enrolled in Head Start	Program seeks to increase daily moderate to vigorous physical activity (MVPA), improve the quality of movement activities intentionally planned and facilitated by adults, and promote healthy food choices every day.	x	*	*			
Doctors Community Hospital	Prince George's	8118 Good Luck Road Lanham, Maryland 20706 301.552.8661	More information	General population	Offers free diabetes education and screenings at convenient Prince George's County locations, including community centers, faith-based organizations, health clinics and other localities.				x	*	
Dwelling Place Senior Center	Washington, DC	2812 Pennsylvania Avenue, SEWashington, DC 20020 202.582.7112	More information	Seniors residing in the DC area	Provides free nutrition education classes are also held through the KEEN (Keeping the Elderly Eating Nutritiously) program. Free diabetes education classes and food pantry classes are also available for seniors.	x		*	x	*	
Eat Smart Program	Washington, DC	P.O. Box 4921 Washington, DC 20008 202.362.8349	More information	General population	Provides nutrition education to empower adults to choose healthier foods. Classes are two hours and go for 9 weeks. Cost is $20, and scholarships are available for those who qualify based on income.	x		*			
Evelyn Cole Senior Activity Center	Prince George's	5720 Addison Road Seat Pleasant, MD 20743 301.386.5525	More information	Seniors ages 60+ years old	Offers fitness programs and health education classes, information, and referrals.	x	*	*	x		
Food & Friends Nutritional Counseling	Washington	219 Riggs Road, NE Washington, DC 20011 202.269.2277	More information	Clients and community members who have chronic diseases	Provides free nutrition education (counseling). Services include individualized counseling, nutrition and wellness workshops, cooking classes, food safety and nutrition information, and body composition tests.	x		*			
Fort Washington Medical Center	Prince George's	11711 Livingston Rd Fort Washington, MD 20744 301.292.7000	More information	General population	Offers a variety of medical screenings, preventative medicine, and health education programming.	x	*	*	x	*	*

Organization/ Provider	Counties Served	Contact Information	Internet Information	Population Served	Services Provided	Healthy Lifestyles	Exercise	Diet	Education/Prevention	Diabetes	Heart Disease
Girls Fitness and Nutrition (FitNut) Program	Washington, DC	Project HEALTH Children's National Medical Center c/o General & Community Pediatrics, 2nd Floor 111 Michigan Avenue, NW Washington, DC 20010 202.476.5780		Families in wards 6, 7 and 8 with girls ages 7-15 who are obese or at-risk for obesity	Provides a free after-school weight management program. Referral from physician/pediatrician required. The program includes nutrition education, daily physical activity (dance), family healthy living strategies, and self-esteem improvement.	x	*	*			
Gwendolyn Britt Senior Activity Center	Prince George's	4009 Wallace Road North Brentwood, MD 20722 301.699.1238	More information	Seniors ages 60+ years old	Offers fitness programs and health education classes, information, and referrals.	x	*	*	x		
Health Partners Free Clinic	Charles	3070 Crain Highway, Suite 101 Waldorf, MD 20601 301.645.3556	More information	General population, including the developmentally and physically disabled, and the chemically dependent. Income eligibility restrictions apply.	Community outreach, classroom education, nutrition and health education programs, case management, clinical health services, health testing and screening.	x		*	x	*	*
Health Promotion and Education Services	Charles	301.609.6830		General population	Educators are available to conduct presentations, activities and health fairs for community groups, churches, schools and businesses. Topics include: nutrition, tobacco prevention, employee wellness, disease prevention, and general wellness.	x	*	*	x	*	*
Howard University Hospital Family Health Center	Washington, DC	2339 Georgia Avenue, NW 4th Floor Washington, DC 20060 202.865.3250	More information	General population	Provides primary health care, weight management information and supervision, and nutrition information.	x	*	*			
HSC Healthy Living Center	Washington, DC	2124 Martin Luther King, Jr. Avenue, SE Washington, DC 20020 202.467.2708		Children and young adults with special needs	Provides a rotating variety of physical activities such as yoga, belly dancing, and Jazzercise for both adults and families. Classes are free and childcare is provided.	x	*				

Organization/ Provider	Counties Served	Contact Information	Internet Information	Population Served	Services Provided	Healthy Lifestyles	Exercise	Diet	Education/Prevention	Diabetes	Heart Disease
I.D.E.A.L. Clinic	Washington, DC	Children's Health Center of the Children's National Medical Center 1st Floor 111 Michigan Avenue, NW Washington, DC 20010 202.476.5925	More information	Families with overweight children, especially minorities and the underserved	Provides individual nutrition education or counseling, group health education classes, physical activity sessions, parenting sessions, pediatrician weight management counseling, and specialist counseling(e.g., psychologist, endocrinologist, GI, cardiologist).	x	*	*			
John E Howard Senior Activity Center	Prince George's	4400 Shell Street Capitol Heights, MD 20743 301.735.2400	More information	Seniors ages 60+ years old	Offers fitness programs and health education classes, information, and referrals.	x	*	*	x		
La Clínica del Pueblo	Washington, DC	2831 15th Street, NW Washington, DC 20009 202.462.4788	More information	Patients with obesity-related diseases or conditions, including cardiovascular disease, hypertension, high cholesterol, and diabetes, or those who are at-risk.	Provides screenings, services, and education and may help with weight management supervision and information. Clinic fees are based on a sliding scale.	x	*	*	x	*	*
Langley Park Senior Activity Center	Prince George's	1500 Merrimac Drive Hyattsville, MD 20783 301.408.4343	More information	Seniors ages 60+ years old	Offers fitness programs and health education classes, information, and referrals.	x	*	*	x		
Laurel-Beltsville Senior Activity Center	Prince George's	7120 Contee Road Laurel, MD 20707 301.206.3350	More information	Seniors ages 60+ years old	Offers fitness programs and health education classes, information, and referrals.	x	*	*			
MedStar Southern Maryland Hospital Center	Prince George's, Charles	7503 Surratts Road Clinton, Maryland 20735 301.877.5700	More information	General population	The hospital supplies a licensed practical nurse to travel to local churches, senior centers, active living communities, local businesses, and health fairs and provides free cardiac and diabetes risk assessment, including cholesterol, blood sugar, triglycerides, blood pressure testing, and seasonal vaccinations when available. Also has a screening center located in Waldorf, Maryland which holds free health screenings by appointment.				x	*	*
National Center on Black Aged Housing Development Corporation of DC	Washington, DC	2801 14th Street, NW Washington, DC 20009 202.387.4022	More information	Seniors age 62 years and over	Provides a variety of services for low-income seniors of Ward 1, including free nutrition education and physical activity (exercise) classes.	x	*	*			

Organization/ Provider	Counties Served	Contact Information	Internet Information	Population Served	Services Provided	Healthy Lifestyles	Exercise	Diet	Education/Prevention	Diabetes	Heart Disease
National Youth Sports Program	Washington, DC	University of District of Columbia 4200 Connecticut Avenue, NW Washington, DC 20008 202.274.7124/5031		Youth ages 10-16.	Offers programs to promote healthy habits.	x	*	*			
Port Town's Community Health Partnership	Prince George's	N/A	More information	Residents of Bladensburg, Colmar Manor, Cottage City, and Edmonston, Maryland	works collaboratively with youth and adult residents, non-profit organizations, schools, businesses, and local and state government leaders because together we can help shape the important decisions that affect people's opportunities to eat healthy foods and be physically active within their communities.	x	*	*			
Prince George's County, Department of Family Services, Aging Services Division Health Promotion and Disease Prevention	Prince George's	6420 Allentown Road Camp Springs, MD 20748 301.265.8450	More information	Prince George's County resident at least age 60 years or older	Provide knowledge, skills, and training to assist in improving overall health and working towards a healthier lifestyle. Programs and activities are provided the following areas: Health Screening – Blood Pressure Checks, Diabetes screening, Cholesterol Checks Health Education – Healthy Lifestyle Lectures, Monitoring Over-The-Counter Medications Education, Fall Prevention Activities Physical Activities – Chair exercises, Tai Chi classes, Walking Programs, Exercise Classes, Strength Training	x	*	*	x	*	
Prince George's Community College	Prince George's	301 Largo Road Largo, MD 20774 301.336.6000	More information	General population	Offers a variety of fitness classes.	x	*				
Prince George's County Department of Parks and Recreation Community Centers	Prince George's	6600 Kenilworth Avenue Riverdale, MD 20737 301.699.2255	More information	Classes are open to residents and non-residents of Prince George's County	43 community centers located through the county offer a variety of recreation and fitness activities.	x	*				

Organization/ Provider	Counties Served	Contact Information	Internet Information	Population Served	Services Provided	Healthy Lifestyles	Exercise	Diet	Education/Prevention	Diabetes	Heart Disease
Prince George's County Health Department: Division of Maternal and Child Health- Healthy Women/Healthy Lives	Prince George's	Prince George's County Health Department Headquarters Building 1701 McCormick Drive, Suite 100 Largo, Maryland 20774 301-583-3340	More information	Women of childbearing age	Provides complete health screenings to ensure health and well-being during the reproductive period and an optimal health status prior to pregnancy. Services include nutrition counseling, cholesterol, diabetes and high blood pressure screenings, and referrals to other health services	x		*	x		
Prince George's County Public Schools Food and Nutrition Services	Prince George's	13300 Old Marlboro Pike Room 8 Upper Marlboro, MD 20772 301.952.6580	More information	Students attending Prince George's County Public Schools	Provides a total learning environment that enhances the development of lifelong healthy habits in wellness, nutrition, and regular physical activity.	x	*	*			
Prince George's Sports and Learning Complex	Prince George's	8001 Sheriff Road Landover, Maryland 20785 301.583.2400	More information	General population	Fitness equipment, individual fitness training, group fitness classes.	x	*				
RX for Healthy Weight Management	Washington, DC	Capital Area Food Bank 645 Taylor Street, NE Washington, DC 20017 202.526.5344, ext. 250	More information	Low-income overweight or obese Latino/Hispanic children	Provides free nutrition education classes for children, whose families are also involved. Topics include food preparation, healthy eating behavior, budget food shopping, and food safety. The first half of the class focuses on nutrition education, while a cooking demonstration takes place during the second half of the class. Two hour weekly classes for six weeks.	x		*			
Southern Maryland WIC Program	Charles	4545 Crain Highway P.O. Box 1050 White Plains, MD 20695 301.609.6857	More information	Income/nutrition-eligible pregnant and postpartum women, infants and children to age 5.	Nutrition education, food, nutrition screening.	x		*			

Organization/ Provider	Counties Served	Contact Information	Internet Information	Population Served	Services Provided	Healthy Lifestyles	Exercise	Diet	Education/Prevention	Diabetes	Heart Disease
Start Early, Start Right	Washington, DC	The Family Place 3309 16th Street, NW Washington, DC 20010 202.476.5539		Latino children ages 1-5 and their families	Offers a free obesity prevention/reduction program. Program consists of weekly classes that provide individual family counseling, behavior modification techniques, and information about nutrition, physical activity, and weightmanagement. One parent attends each class session. Classes for parents are in Spanish; classes for children are in English. Both parentsneed to be Latino.	x	*	*			
The Local Food Alliance – Healthy Cooking Project	Washington, DC	Brookland Farmer's Market 10th and Otis Streets, NE 202.526.4848		General population	Provides free cooking demonstrations at D.C. area farmers' markets and stands. Free recipes and nutrition education materials are distributed.	x		*			
TOPS Club Weight Loss Program	Charles, Prince George's, Washington, DC	12223 Marne LaneBowie, MD 20715 301.262.6447	More information	Ages 9 years old to adults	Provides support system for people trying to lose weight naturally as well as by surgical means. Includes physical activity information, nutrition education, and weight management assistance. Nutrition education includes lessons on portion control and food planning, among other lessons.	x	*	*			
Total Family Care Coalition	Washington, DC	4818 Jay Street, NE Washington, DC 20019 202.678.0060	More information	Families residing in the DC area	Provides education, essential information, resources and support. Provides free individualized food shopping instruction, nutrition education, weight management information, and other services to help people adopt healthy lifestyles.	x	*				
Triple Play Program	Washington, DC	Boys and Girls Clubs of America – Butler Wyatt Clubhouse Metropolitan Police Clubhouses 128 M Street, NW Washington, DC 20001 202.727.4455	More information	Youth 5-18 years old.	Provides wellness instruction on eating nutritiously and keeping fit.	x	*	*			