



Prince George's Hospital Center

**COMMUNITY BENEFITS REPORT
FOR THE FISCAL YEAR
JULY 1, 2014 – JUNE 30, 2015**

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

INTRODUCTION AND BACKGROUND:

HSCRC Community Benefit Report:

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

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

PRINCE GEORGE'S HOSPITAL CENTER:

Prince George's Hospital Center (PGHC) has been providing quality healthcare services to the southern Maryland region since 1944. Over the past 70 years, Prince George's Hospital Center has grown to become a major tertiary care center for the region and one of its largest employers. However, our greatest service to the community is that Prince George's Hospital Center is a private not-for-profit hospital with a tremendous public mission.

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

Leadership:

Chairman, Board of Directors, DHS – C. Phillip Nichols, Jr.
Chairwoman, Board of Directors, PGHC –Tawanna P. Gaines
CEO – Neil J. Moore
Interim COO, DHS – John H. Spearman

COO, PGHC – K. Singh Taneja
Chief Nursing Officer – Candace Hanrahan

Location: 3001 Hospital Drive, Cheverly, Maryland 20785

Facility type: Acute care teaching hospital and regional referral center

No. of licensed beds: 215 (plus 52 bassinets)

No. of inpatient admissions: 14,270

No. of Employees: 1733

Specialty services:

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

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

Other specialty services:

- Ambulatory and outpatient services
 - Surgical short-stay center
 - Special procedures
 - Diabetes treatment center

- Dimensions Surgery Center (a freestanding ambulatory surgery center located on the Bowie Health Campus)
- Gladys Spellman Family Health and Wellness Center, Cheverly, Maryland) (formerly the Glenridge Medical Center) Family Medicine Practice (located at the Gladys Spellman Family Health and Wellness Center, Cheverly, Maryland)
- Rachel H. Pemberton Senior Health Center, Brentwood, Maryland
- Family Health and Wellness Center, Suitland, Maryland
- Behavioral health services
 - Inpatient psychiatric unit for adults
 - Hospital-based sexual assault center
 - Partial hospitalization program
 - Emergency psychiatric services
- Domestic Violence and Sexual Assault Center
- Graduate medical education, internal medicine and family medicine residency programs

Facilities:

- The Surgical Services and Critical Care Center Pavilion houses a 24 bed intensive care unit, 10 operating suites, a 15 bay Post Anesthesia Care Unit, 11 private room Short Stay Center, two state-of-the-art cardiac catheterization labs with 10 Transcare bays and 2 endoscopy suites with 9 recovery bays.
- The PGHC Emergency Department includes 15 acute care rooms, 4 hall area beds, a 4 bed resuscitation area, 2 isolation rooms, 2 dedicated trauma rooms, an 8 bed ambulatory emergency area, with 2 minor trauma/suture rooms and a designated ENT room, point-of-care testing, a 16-bed distinct observation unit and a blood bank.
- PGHC also has a licensed, freestanding emergency department, located on the Bowie Health Center campus, with a total of 15 beds, including two cardiac rooms, 2 suture rooms, a GYN room, an isolation room, a stat lab, and radiology services.

Ownership:

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

Reporting Requirements

- I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:
 1. Please list the following information in Table I below. For the purposes of this section, “primary services area” means the Maryland postal ZIP code areas from which the first 60 percent of a hospital’s patient discharges originate during the most recent 12 month period available, where the discharges from

each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all hospitals by the HSCRC.

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County	Percentage of Patients who are Medicaid Recipients, by County
215 Beds + 52 Bassinets	14,270	20743 20785 20747 20784 20706 20774 20737 20710 20746 20019 20772	Doctors Community Holy Cross Washington Adventist Southern Maryland Laurel Regional Fort Washington	7.8% (PGHC total patient pop.) PG County: 13% DC: 5.3%	49.3% (PGHC total patient pop., includes Medicaid pending) PG County: 30.3% DC: 5.0%

Table I

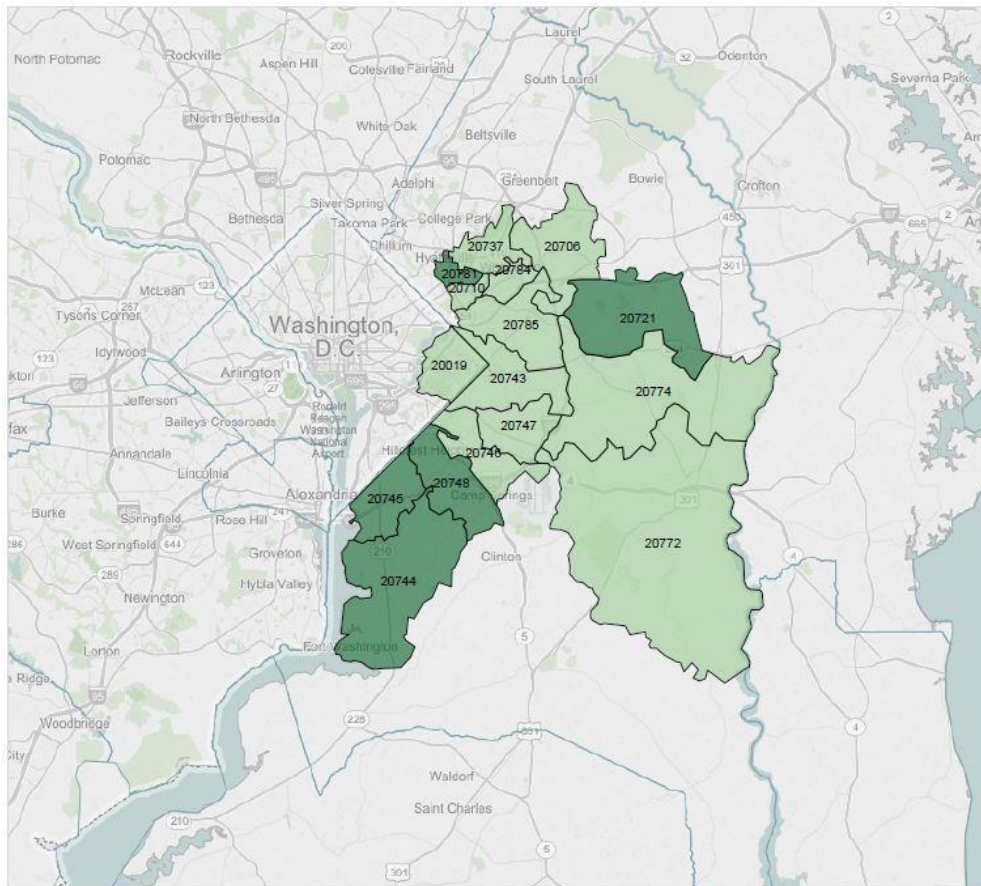
2. For purposes of reporting on your community benefit activities, please provide the following information:
 - a. Describe in detail the community or communities the organization serves. (For the purposes of the questions below, this will be considered the hospital’s Community Benefit Service Area – “CBSA”. This service area may differ from your primary service area on page 1.) This information may be copied directly from the section of the CHNA that refers to the description of the Hospital’s Community Benefit Community.

PRINCE GEORGE’S COUNTY DEMOGRAPHICS:

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

PGHC’s Primary Service Area differs from its Community Benefit Service Area (CBSA) in that its CBSA encompasses 16 zip code areas in Western and Central Prince George’s County, patients from these zip code areas make up approximately 75% of PGHC’s total inpatient and outpatient admissions. The PGHC CBSA also includes one zip code area in the eastern portion of the District of Columbia (DC) – patients from this area make up 7.5% of PGHC’s inpatient and outpatient admissions. An estimated 555,420 people make up the PGHC CBSA. The PGHC Prince George’s County and DC CBSA has a population that is 78.8% African-Americans, 6.3% White (non-Hispanic) and reported as 10.8% of Hispanic origin, 2.1% of Asian origin, 0.1% of other ethnic origin.

**COMMUNITY BENEFIT SERVICE AREA
FY 2014**



PSA Zip Codes (60% of total cases)	
Added CBSA Area Zip Codes (73% of total cases)	

PGHC Primary Service Area (PSA) 2015				
Total PGHC Cases (all counties) 2015: 14,269				
ZIP	NAME	COUNTYNAM E	# Cases	% of Total Cases
20785	Hyattsville	Prince George's Co	1,712	12.0%
20743	Capitol Heights	Prince George's Co	1,632	11.4%
20747	District Heights	Prince George's Co	932	6.5%
20784	Hyattsville	Prince George's Co	795	5.6%
20774	Upper Marlboro	Prince George's Co	787	5.5%
20706	Lanham	Prince George's Co	677	4.7%
20019	Washington	District of Columbia	544	3.8%
20737	Riverdale	Prince George's Co	512	3.6%
20746	Suitland	Prince George's Co	461	3.2%
20710	Bladensburg	Prince George's Co	460	3.2%
20772	Upper Marlboro	Prince George's Co	355	2.5%
Running Total		8,867	62.00%	
PGHC Community Benefits Service Area (CBSA) Area 2015				
(includes all above zip codes, adds below zip codes)				
20748	Temple Hill	Prince George's Co	345	2.4%
20721	Bowie	Prince George's Co	344	2.4%
20745	Oxon Hill	Prince George's Co	324	2.3%
20744	Fort Washington	Prince George's Co	287	2.0%
20781	Hyattsville	Prince George's Co	236	1.7%
Running Total		10,403	72.8%	

b. In Table II, describe significant demographic characteristics and social determinants that are relevant to the needs of the community and include the source of the information in each response. For purposes of this section, social determinants are factors that contribute to a person's current state of health. They may be biological, socioeconomic, psychosocial, behavioral, or social in nature. (Examples:

gender, age, alcohol use, income, housing, access to quality health care, education and environment, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary).

Some statistics may be accessed from the Maryland State Health Improvement Process, (<http://dhmh.maryland.gov/ship/>) and its County Health Profiles 2013, (<http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx>), the Maryland Vital Statistics Administration (<http://dhmh.maryland.gov/vsa/SitePages/Home.aspx>), The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) http://dhmh.maryland.gov/mhhd/Documents/Maryland_Health_Disparities_Plan_of_Action_6.10.10.pdf, the Maryland ChartBook of Minority Health and Minority Health Disparities, 3rd Edition ([http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Chartbook%20of%20Minority%20Health%20and%20Minority%20Health%20Disparities%20Data,%20Third%20Edition%20\(December%202012\).pdf](http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Chartbook%20of%20Minority%20Health%20and%20Minority%20Health%20Disparities%20Data,%20Third%20Edition%20(December%202012).pdf)); [Prince George’s County Health Department, Health Report 2015](#) (<http://www.princegeorgescountymd.gov/sites/Health/Resources/Data-Policies-Laws/Data/Documents/2015%20Health%20Report%20FINAL%2009-22-15%20web.pdf>), [Prince George’s County Health Improvement Plan 2011 to 2014](#) (<http://www.princegeorgescountymd.gov/sites/Health/About/Documents/Health-LocalhealthPlanPrefinal.pdf>); [Prince George’s Primary Care Strategic Plan](#) (http://www.princegeorgescountymd.gov/sites/ExecutiveBranch/CommunityEngagement/RegionalMedCtr/Documents/Primary_Healthcare_Strategic_Plan.pdf)

Table II

<p>Community Benefit Service Area(CBSA) Target Population (target population, by sex, race, and average age)</p>	<p>PGHC Total CBSA Population: 555,420</p> <p>PG Cty CBSA Population: 496,286</p> <p>DC CBSA Population: 59,134</p> <p>Sex M – 46.6% F – 53.4%</p> <p>White (non-Hispanic)– 6.3% African-American – 78.8%</p> <p>Hispanic/Latino –10.8% Asian – 2.1%</p> <p>Other Race – 0.1%</p> <p><i>Source: PCA Executive Marketing Reporting (New Health Analytics) (2015)</i></p> <p>Prince George’s County:</p> <p>% age < 20 years – 25.8%</p> <p>% age 65 and older – 11.2%</p>
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	<p>DC:</p> <p>% age < 20 years – 20.8%</p> <p>% age 65 and older – 11.3%</p> <p><i>Source: U.S. Census Bureau, 2014 ACS 1-Year Estimates</i></p>
Median Household Income within the CBSA (county level)	<p>Prince George’s County: \$72,290</p> <p>DC: \$71,648</p> <p><i>Source: U.S. Census Bureau, 2014 ACS 1-Year Estimates</i></p>
Percentage of households with incomes below the federal poverty guidelines within the CBSA	<p>Prince George’s County: 7.2%</p> <p>DC: 14.2%</p> <p><i>Source: U.S. Census Bureau, 2014 ACS 1-Year Estimates</i></p>
Please estimate the percentage of uninsured people by County within the CBSA	<p>Prince George’s County: 13%</p> <p>DC: 5.3%</p> <p><i>Source: U.S. Census Bureau, 2014 ACS 1-Year Estimates</i></p>
Percentage of public health insurance coverage recipients by County within the CBSA.	<p>Prince George’s County: 30.3%</p> <p>DC: 36.5%</p> <p><i>Source: U.S. Census Bureau, 2014 ACS 1-Year Estimates</i></p>
Life Expectancy by County within the CBSA.	<p>Prince George’s county:</p> <p>All Races: 79.6 years</p> <p>White: 80.6</p> <p>Black: 78.9</p> <p><i>Source: Maryland Vital Statistics Profile: 2013</i></p> <p>DC: 77.5 years</p> <p><i>Source: District of Columbia Community Health Needs Assessment, 2013</i></p>
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	<p>Prince George’s County : 695.4/100,000</p> <p><i>Source: Maryland Vital Statistics Profile: 2013</i></p> <p>DC: 730.0/100,000</p>

	<p><i>Source: CDC Mortality Multiple Cause Micro-data Files Final Data 2013</i></p>
<p>Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources)</p>	<p>Risk factors for premature death in Prince George’s County and DC:</p> <ul style="list-style-type: none"> -- Physical Inactivity PG: 23% DC: 18% -- Food Environment Index PG: 7.4 DC: 8.0 -- Adult Obesity PG: 34% DC: 22% -- High blood pressure PG: 26.2% **DC: 26.5% -- Adult Smoker PG: 14% DC: 16% -- Has diabetes PG: 10.4% **DC: 8.3% -- HIV prevalence rate *PG: 787.2/100,000 **DC: 2540.5/100,000 -- Violent crime rate PG: 624/100,000 DC: 1,400/100,000 <p><i>Source: County Health Rankings, 2015; *Prince George’s County Health Department, Health Report 2015; **D.C. Department of Health: Annual Epidemiology & Surveillance Report (December 2013); Diabetes in the District of Columbia; The Burden of Cardiovascular Disease in the District of Columbia (www.doh.dc.gov, retrieved November 24, 2015)</i></p>
<p>Available detail on race, ethnicity, and language within CBSA.</p>	<p><i>Please see charts on pages 10 and 11, which provide detail on race and ethnicity within the CBSA.</i></p>
<p>Other Vulnerable populations</p>	<p>Vulnerable populations in Prince George’s County:</p> <ul style="list-style-type: none"> -- Are unemployed <p>Prince George’s County: 6.8%</p> <p>DC: 8.3%</p> <p><i>Source: County Health Rankings, 2015</i></p>
<p>Other Access to primary care</p>	<p>Ratio of population to primary care physicians –</p> <p>Prince George’s County – 1,708:1 DC: 878:1</p> <p>Nat’l Benchmark –1051:1</p> <p>(Prince George’s County has substantially lower per capita numbers of primary care physicians when compared to neighboring jurisdictions.)</p> <p><i>Source: County Health Rankings, 2015</i></p> <p>Number of Safety Net Clinics –</p> <p>Prince George’s County: 5</p>

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

	PGHC CBSA Area	% of Total
2014 Total Population	555,420	100.0%
Total Male Population	258,815	46.6%
Total Female Population	296,603	53.4%

Source: PCA Executive Marketing Reporting (New Health Analytics) (2015)

RACE/ETHNICITY			
Race/Ethnicity Distribution			
Race/Ethnicity	2014 Pop	% of Total	USA % of Total
White Non-Hispanic	34,780	6.3%	73.8%
Black Non-Hispanic	437,596	78.8%	12.6%
Hispanic	59,891	10.8%	16.9%
Asian & Pac. Isl. Non-Hispanic	11,649	2.1%	5.2%
All Others	10,564	2.1%	4.7%
TOTAL	555,420	100.0%	

Source: U.S. Census Bureau, ACS Community Survey (2014) and PCA Executive Marketing Reporting (New Health Analytics) (2015)

POPULATION DISTRIBUTION			
Age Distribution			
Age Group	2014 Pop	% of Total	USA % of Total
0 – 17	135,560	24.4%	23.5%
18 - 64	354,483	63.8%	62.8%
65 +	40,661	7.3%	13.7%
TOTAL	555,420	100.0%	100.0%

Source: U.S. Census Bureau, 2013 ACS and PCA Executive Marketing Reporting (New Health Analytics) (2015)

UNINSURED			
% of Total Population			
Race/Ethnicity	Prince George's County	Maryland	USA
Average, All Races	13.0%	7.6%	11.7%
White Non-Hispanic	17.4%	6.2%	10.4%
Black Non-Hispanic	7.8%	7.9%	13.6%
Hispanic	38.8%	26.6%	23.5%
Asian	11.6%	8.5%	10.6%
Some other race alone	43.1%	33.8%	26.1%

Source: U.S. Census Bureau, ACS 2014, 1 Year Estimates

Prince George's Hospital Center Vital Statistics Data

COMPARATIVE VITAL STATISTICS	PRINCE GEORGE'S COUNTY	MONTGOMERY COUNTY	STATE OF MARYLAND	PG CTY % VARIANCE TO MONT CTY	PG CTY % VARIANCE TO STATE
Age Adjusted Mortality Rates: 2011- 2013					
All Causes of Death	695.45	506.3	708.3	27.2%	-1.6%
Disease of the Heart	180.0	114.6	171.7	36.3%	4.6%
Malignant Neoplasms	157.7	124.6	163.8	20.9%	-3.8%
Cerebrovascular Disease	35.0	26.5	36.5	24.3%	-4.3%
Diabetes Mellitus	27.2	13.5	19.6	50.4%	27.9%
Accidents	25.7	16.8	26.5	34.6%	-3.1%
Chronic Lower Respiratory Diseases	20.3	18.9	32.9	6.9%	-62.1%
Septicemia	14.6	10.7	14.1	26.7%	3.4%
Alzheimer's Disease	13.8	12.8	14.6	7.2%	-5.8%
Influenza and Pneumonia	14.6	12.6	16.6	13.7%	-13.7%
HIV	5.3	1.5	3.8	71.7%	28.3%
Nephritis, Nephrosis, and Nephrotic Syndrome	13.4	7.9	11.4	41.0%	14.9%
Assault (Homicide)	8.8	2.1	7.3	76.1%	14.8%
Intentional Self-Harm (Suicide)	5.8	7.3	9.0	-25.9%	-55.2%

Source: Maryland Vital Statistics Annual Report: 2013

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

Community Challenges & Health Statistics:

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

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

According to the CDC document Summary Health Statistics of the U.S. Population: National Health Interview Survey being poor and uninsured are two of the strongest determinants of whether a person “did not receive medical care”, or whether they “delayed” seeking care. In its “Health Report 2015”, the Prince George’s County Health Department reported that in 2013, 21.1% (or one in five) of adults, ages 18-64 years did not have health insurance. This data is prior to the implementation of the Affordable Care Act in 2014, which is expected to reduce the number of people without health insurance.

Diabetes mortality, heart disease, hypertension, stroke, deaths from breast, colorectal and prostate cancers, HIV and infant mortality continue to represent significant health challenges for community members. The Prince George’s County Primary Healthcare Strategic Plan (2015) finds that Prince George’s County residents experience higher rates of asthma, diabetes, hypertension, heart disease, and cancer when compared to state averages and rates were found to be higher within the African-American population. Persistent disparities in mortality and health status for several health indices are seen in various racial and ethnic populations. Among Prince George’s residents, relatively high rates of obesity and homicide are additional areas of concern. These are certainly planning considerations in this majority minority community. Additionally, the racial and ethnic minorities are approximately 2/3 of Prince George’s County Medicaid beneficiaries. County and Maryland State health statistics are similar to national trends regarding the status of minority health.

Furthermore, many county residents struggle with mental health issues: in 2013, over 12% of adults reported at least eight poor mental health days within the past thirty days. In 2013, 53 residents lost their lives due to suicide. In 2014, the Health Department began a behavioral health work group with community partners to ensure more coordinated care for county residents. In 2015 this group is conducting an assessment of community mental health services.

IDENTIFICATION OF COMMUNITY HEALTH NEEDS:

PGHC management actively solicits information from the Prince George's County Health Department and other community-based organizations to assess the health needs in our community. PGHC representatives serve as members on a variety of healthcare focused community organizations and provide staff expertise and other resources, including

hosting meetings at our facilities, and participating in events by providing the health screening services. Some of these organizations include:

- Prince George’s Health Enterprise Zone
- Prince George County Health Department Community Care Coordination Team
- Totally Linking Care – Maryland Coalition
- Health Action Forum of Prince George's County
- Prince George's Healthcare Action Coalition
- National Capital Area Breast Health Quality Consortium
- The Prince George's County Local Health Disparities Committee
- The Health Empowerment Network of Maryland, Inc. (HENM) - a Community Based Organization made up of partners such as the Prince George's County Health Department, University of Maryland Prevention Resource Center, Prince George's County Area Agency on Aging, Department of Health and Mental Hygiene, Integrity Health Partners and the City of Seat Pleasant, among others.
- Primary Care Coalition of Montgomery County
- Susan G. Komen Foundation

PGHC has partnered with community-based organizations to increase their capacity to provide services to the community. This includes providing healthcare providers and support at various Federally Qualified Health Centers (FQHC) sites in Prince George's County to facilitate access to sub-specialty services for uninsured and underinsured residents, including Community Clinic, Inc. Greater Baden Medical Services and the Pregnancy Aid Center.

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

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

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

- “Assessing Health and Health Care in Prince George’s County”, completed by the RAND Corporation (RAND) (February 2009)
- “Prince George’s County Health Improvement Plan 2011 to 2014 – Blueprint for a Healthier Community”, completed by the Prince George’s County Government (September 2011)

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

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

The two largest community benefit expenditures made by PGHC are the mission-driven, non-reimbursed subsidies paid to its physicians, and charity care expenditures -- expenditures that both guarantee the continuation of the PGHC safety net mission. However, beginning FY2015 PGHC, has more actively engaged the community and community-based organizations to support programs and initiatives that align with its CHNA priorities. Focus has been on increasing access to health care services and programs that address chronic disease management, including self-management education and special programs designed to improve health, avoid unnecessary hospital utilization and readmissions.

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

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

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

The written document (CHNA) must include the following:

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

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

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

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

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

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

The IMPLEMENTATION STRATEGY must:

- a. Be approved by an authorized governing body of the hospital organization;
- b. Describe how the hospital facility plans to meet the health need; or
- c. Identify the health need as one the hospital facility does not intend to meet and explain why it does not intend to meet the health need.

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

Yes

No

Provide date here. / / (mm/dd/yy)

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

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

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

Yes

No

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

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

Multiple methods were used to study the significant health needs within PGHC hospital service area (HSA). Specifically, the PGHC CHNA included a six step process:

- Step 1: Analysis of PGHC hospital discharge data to identify the most frequent diseases within PGHC HSA.

- Step 2: Analysis of a household survey among Prince George’s County resident in 2012 to evaluate resident’s perception of health needs.
- Step 3: Professionally facilitated meeting among Prince George’s County community leaders to get in-depth opinions of community health needs.
- Step 4: Professionally facilitated meeting among Prince George’s County health experts to get in-depth opinions of community health needs.
- Step 5: Collection of the existing county, state, and national statistics of health needs as the reference to the PGHC CHNA findings.
- Step 6: Identification of top 3-5 significant health needs of PGHC HAS through the analyses from steps 1 - 5; recommendations of meaningful health improvement plans will be developed and discussed as well.
- Final CHNA that documents the CHNA methods, results, and recommendations.

Based on CHNA, PGHC developed an implementation strategy to address selected community health needs. The objective is to engage in community benefits activities that effectively improve community health.

The primary data sources were PGHC Inpatient, Outpatient, and Emergency Department (ED) Discharge Data from January 2010 through November 2012. These hospital discharge data provided detailed information on patients, including age, gender, ICD9 codes, as well as the zip codes of their residence.

The top zip codes listed in the PGHC CBSA represented 62% of all PGHC inpatient discharge data from 2010-2012, and hence were considered as PGHC Hospital Services Area (HSA). We summarized patient demographic characteristics and health insurance coverage, and calculated the ICD9 codes by frequency to identify the most common diseases reported in each of these three departments (i.e. inpatient, outpatient, and ED) at PGHC HSA (i.e. among the listed zip codes).

Identified needs were reviewed, selected and prioritized for implementation based on community needs, existing programming, strengths, resource allocation, operational alignment and partnerships.

The three areas of focus identified for Prince George’s Hospital Center for implementation of community health improvement programs and initiatives included:

- diabetes;
- heart disease; and
- pregnancy and childbirth complications.

These were then linked to key healthcare administration areas that included:

- health access and primary care;

- disease prevention and management; and
- health integration and coordination.

III. COMMUNITY BENEFIT ADMINISTRATION

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

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

Yes

No

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

i. Senior Leadership

1. CEO

2. CFO

3. Other (please specify – COO, General Counsel, SVP, Strategy, VP, Community Relations)

ii. Clinical Leadership

1. Physician

2. Nurse

3. Social Worker

4. Other (please specify)

iii. Community Benefit Department/Team

1. Individual (please specify 2.0)

2-FTE dedicated to Community Benefit

2. Committee (please list members)
3. Other (please describe)

Committee: CEO, COO, CFO, CMO, CNO, General Counsel, VP Reimbursement, VP Medical Affairs, VP – Community Relations, Director – Finance, SVP, Strategy, Community-Based Health Manager.

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

Spreadsheet yes no

Narrative yes no

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

Spreadsheet yes no

Narrative yes no

If you answered no to this question, please explain

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

1. Please use Table III (see attachment) to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each initiative and how the results will be measured, time allocated to each initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on the measured outcomes, and the current FY costs associated with each initiative. Use

at least one page for each initiative (at 10 point type). Please be sure these initiatives occurred in the FY in which you are reporting. Please see attached examples of how to report.

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

- a. Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups.
- b. Name of Initiative: insert name of initiative.
- c. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics that will be used to evaluate the results (Use several pages if necessary)
- d. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?
- e. Key Partners in Development/Implementation: Name the partners (community members and/or hospitals) involved in the development/implementation of the initiative. Be sure to include hospitals with which your hospital is collaborating on this initiative.
- f. How were the outcomes of the initiative evaluated?
- g. Outcome: What were the results of the initiative in addressing the identified community health need, such as a reduction or improvement in rate? (Use data to support the outcomes reported). How are these outcomes tied to the objectives identified in item C?
- h. Continuation of Initiative: Will the initiative be continued based on the outcome?
- i. Expense: What were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.

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

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

- Diabetes Education

For the fiscal years ending June 30, 2014 and June 30, 2015 PGHC had total community benefit expenditures (as a percent of total operating expenditures) of 27.46% and 28.96%, respectively. Each year, PGHC's total CB expenditures rank as one of the highest for all hospitals in the State of Maryland. PGHC's fiscal year 2015 CB expenditures are primarily made up of mission-driven physician subsidies at \$43,236,526 or 21.3% and charity care at \$15,079,327 or 6.8% -- 28.1% total combined for the fiscal year ending June 30, 2015.

PGHC provided \$458,316,173 in mission-driven physician subsidies and charity care in the fiscal year ending June 30, 2015. To fund this high level of physician subsidies and charity care, PGHC depends on State and County financial support. Because of the reliance on State and County financial resources, PGHC has limited funds or other resources to earmark for other high-level CB initiatives. However, improvement of PGHC's financial picture is evident and moving in a positive direction. DHS has established an Office of Community Relations to develop the infrastructure required to effectively plan and implement community benefit initiatives that respond to the PGHC CHNA.

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

While the total range of community health needs is important, during this reporting cycle PGHC is not currently focusing on top health concerns identified by the CHNA such as respiratory health and septicemia due to the lack of available resources to make the most impactful changes in these areas. These needs did not emerge as community health needs focus areas, but they as well as other chronic diseases and co-morbidities were taken into account and incorporated into the strategic plan where appropriate. PGHC currently provides emergency psychiatric, inpatient behavioral health and outpatient partial hospitalization services to assist with the mental health needs in the community. As a result, this area was not selected as one of the community health needs focus areas.

However, as part of its work with the Prince George's Health Enterprise Zone and the Community Care Coordination Team, DHS has developed a plan to test and implement a model designed to incorporate behavioral services as part of its specialty care practices. DHS will also coordinate with patient-centered medical homes to test the impact of coordinated primary care, specialty and behavioral health service on chronic disease management.

V. PHYSICIANS

1. As required under HG§19-303, provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.
2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand. The categories include: Hospital-based physicians with whom the hospital has an exclusive contract; Non-Resident house staff and hospitalists; Coverage of Emergency Department Call; Physician provision of financial assistance to encourage alignment with the hospital financial assistance policies; and Physician recruitment to meet community need.

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

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

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

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

the Report, when comparing Prince George’s County health resources to those of neighboring jurisdictions, the differences are remarkable:

Jurisdiction	Number of uninsured Under Age 65*	Number of Safety Net Clinics	Number of Primary Care Physicians per 100,00 Population (2012)**
Prince George’s County	95,993	5	74.3
Montgomery County	75,141	11	171.8
Baltimore County	58,691	44***	145.8
Washington, D.C.	26,286	38 - 40	198.6

* U.S. Census, American Community Survey (2014)

**CDC, Health Indicators Warehouse (<http://www.healthindicators.gov/>), retrieved December 2, 2015

***Mid-Atlantic Community Health Center Association (1/2009)

****RAND Report (Area Resource File 2005 and U.S. Census Bureau)

In light of the County’s high uninsured or underinsured population providing little or no reimbursement, the County’s level of private-practice primary care doctors and primary care clinics has not kept pace with the health care needs of County residents. Although, expanded coverage under the ACA has reduced the uninsured and underinsured population, there remain a significant number of uncovered lives in the PGHC service area. The capacity of community-based care, including safety-net clinics, remains severely limited. This lack of primary care services and patient “medical homes” has resulted in increased use of the Hospital’s emergency departments and other specialty health care services. For the fiscal year ending June 30, 2015, PGHC had a patient and third party payer mix that included 48% Medicaid and uninsured self-pay patients.

Category 1 – Hospital-Based Physician Subsidies

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

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

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

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

Category 5 – Physician Recruitment to Meet Community Need

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

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

VI. APPENDICES

To Be Attached as Appendices:

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

For *example*, state whether the hospital:

- Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
 - in a culturally sensitive manner,
 - at a reading comprehension level appropriate to the CBSA’s population, and
 - in non-English languages that are prevalent in the CBSA.
- posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
- provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
- provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
- includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills; and/or

- discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.
 - b. Include a copy of your hospital's FAP (label appendix II).
 - c. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) (label appendix III).
2. Attach the hospital's mission, vision, and value statement(s) (label appendix IV).

1. a. APPENDIX I -- FINANCIAL ASSISTANCE PROGRAM

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

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

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

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

appropriate for the facility's service area in accordance with the State's Language Assistance Services Act.

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

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

c. APPENDIX III – PATIENT INFORMATION SHEET (Attached)

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

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

Description of the DHS Mission, Vision and Value Statements (shared by each of its member facilities):

- Within the Dimensions Healthcare System, it is our mission to provide comprehensive health care of the highest quality to residents, and others who use our services while strengthening our relationships with universities, research and health care organizations to ensure best in class patient care.
- The vision of DHS is to be the healthcare system of choice, recognized for clinical, academic, and service excellence, through compassion and innovative healthcare.
- The values of DHS include respect, excellent service, personal accountability, quality, open communication, innovative environment, and safety.

TABLE III

**HOSPITAL COMMUNITY BENEFIT PROGRAMS
AND INITIATIVES**

APPENDIX II

FINANCIAL ASSISTANCE PROGRAM POLICY
#210-01

APPENDIX III

PATIENT INFORMATION SHEET “WHAT YOU SHOULD KNOW AS A PATIENT”

APPENDIX IV

MISSION, VISION, AND VALUES STATEMENT
#200-24

Initiative 1

1. Identified Need Diabetes

2. Was this identified through the CHNA process? Yes, this was identified through the CHNA process.

Hospital Initiative A. Living Well- Diabetes Self- Management Program
B. Diabetes Outpatient program

Total Number of People Within the Target Population Prince George's County Residents who are currently diabetic or qualify as pre-diabetic.

Total Number of People Reached by the Initiative Within the Target Population Diabetes Outpatient Patient Program reported 96 encounters.

Primary Objective of the Initiative A. The Diabetes Self- Management program is an evidence-based 6 week program created by the Stanford University Patient Education Resource Center, designed to educate individuals on techniques to manage their systems, communicate with healthcare providers and make informed decisions.
B. The Diabetes Outpatient Program provides continuous assistance and support in the management of Diabetes.

Single or Multi-Year Initiative –Time Period Multi Year

Key Collaborators in Delivery of the Initiative Clinical staff located at two different Dimensions Healthcare System clinic locations; Suitland Family Health and Wellness Center and the Gladys noon Spellman Family Health & Wellness Center.
Prince George's County Department of Family Services.
Clinical staff and educators at Prince George's Hospital Center and Laurel Regional Hospital.

Impact/Outcome of Hospital Initiative? A. At the completion of the program participants showed a significant improvement in the ability to manage and control symptoms, improved knowledge of community resources, better communication and an overall increase in knowledge of diabetes.
B. Follow-up survey calls found patients had an increased level of knowledge related to the benefits of active living in addition, to a self-reported increase in exercise activity. Participants also reported an increase level of healthy eating, glucose and medication monitoring

Evaluation of Outcomes:

- A. The DSMP program was assessed by Stanford University using a randomized controlled study. Participants showed a significant improvement in depression, management of symptoms, communication with healthcare providers and self-efficacy compared to the control group.
- B. Outcomes were evaluated using a self-reported survey conducted through follow-up calls.

Continuation of Initiative?

Yes, we will continue all initiatives and collaborations with partners.

Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue

Total Cost of Initiative
\$ 379,493

Direct Offsetting Revenue from Restricted Grants

Initiative 2

1. Identified Need Heart Disease

2. Was this identified through the CHNA process? Yes, this was identified through the CHNA process.

Hospital Initiative

- A. Provide on-going heart health focused health screenings in collaboration with community partners. Screenings include blood pressure, cholesterol, and EKG Screenings.
- B. WomenHeart – an organization that seeks to improve the health and quality of life of women living with or at risk of heart disease, and to advocate for their benefit. WomenHeart raises awareness about the importance of prevention and early detection, accurate diagnosis and proper treatment of women’s heart disease.
- C. Prince George’s County Health Department Health Enterprise Zone (HEZ) Community Care Coordination Team.

Total Number of People Within the Target Population

A & C. Prince George’s County residents who reside in the zip-codes identified as high utilizes of the ED for non-urgent reasons. Zip codes include: 20743,20731,20781,20785,20791,20747,20753.

B. Women in Prince George’s County who are living with or at risk for heart disease.

Total Number of People Reached by the Initiative Within the Target Population

- A. Over 1,000 heart healthy screenings have been provided to community members
- B. The WomenHeart Support group reaches 240 women on an annual basis.
- C. Total numbers for HEZ have not yet been reported

Primary Objective of the Initiative

Initiatives are aimed at providing awareness, education and screenings to continuously educate the community about heart disease and provide techniques to improve modifiable risk factors for heart disease.

The Primary Objective of HEZ is to increase access to care and care coordination within the zip codes identified as having high rates of re-admissions due to non-urgent Emergency Department visits. Target diseases include Cardiovascular diseases.

Single or Multi-Year Initiative –Time Period Multi Year

Key Collaborators in Delivery of the Initiative

- Doctors Community Hospital
- Sodexo Healthcare
- The National Coalition for Women with Heart Disease
- Prince George’s County Health Department
- Local Community Centers & Faith-based Institutions.

Impact/Outcome of Hospital Initiative?

Clinical staff members and nurse educators at PGHC continue to work towards providing free heart health screenings to the community in effort to raise awareness and increase knowledge about the risk for developing various cardiovascular diseases.

Due to our increase in heart health related screenings, we were able to successfully link many participants to care within our system.

Evaluation of Outcomes:

Evaluation of the Prince Georges’ County Health Department HEZ initiative have not yet been formally conducted however, preliminary progress shows program efforts as successful in both care coordination and improved access.

Continuation of Initiative?

Yes, with plans to increase screenings and programming aimed at heart disease awareness

Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue

Total Cost of Initiative
\$ 4,075

Direct Offsetting Revenue from Restricted Grants

Initiative 3

1. Identified Need Pregnancy & Child Birth Complications

2. Was this identified through the CHNA process? Yes, this was identified through the CHNA process.

Hospital Initiative Expand Access to Prenatal Care

Total Number of People Within the Target Population Prince George's County Health Department 2015 Health Report shows that Prince George's County's percent of births with late or no prenatal care was 11.4% compared to the State of Maryland average of 9.3%. Black/African American mothers represented the highest percentage of births with late or no prenatal care at 13.8% of births. Hispanic women followed at approximately 10.2% of total births.

Total Number of People Reached by the Initiative 1780

Within the Target Population CCI Program volumes not yet reported

Primary Objective of the Initiative Enhance access to obstetrical care providers to include Maternal Fetal Medicine Specialists

Provide Continuity of Care through a seamless process that supports the patient/family need of education, care coordination, and psychological support for high risk pregnancy

Single or Multi-Year Initiative –Time Period Multi Year

Key Collaborators in Delivery of the Initiative Participating Hospital Staff (PGHC OB/GYN, Perinatal Diagnostic Center Center), Maternal Child Health Department Leadership and Nursing Staff, Prince George's County Health Department, Community Clinic, Inc.,

Impact/Outcome of Hospital Initiative? Provider Services Agreement with CCI to provide free DHA Physician and Midwife services at CCI Greenbelt to meet substantial community needs for OB/GYN health services for uninsured and underinsured residents

Provider support provide to Prince George's County Health Department to support prenatal care for uninsured

24-hour coverage of inpatient OB/GYN service including emergency triage. Ensure appropriate care of uninsured patients and high risk patient who present to the Emergency Room without adequate prenatal care

Evaluation of Outcomes:

Indicators from the 2015 Prince George’s County Health Department Maternal and Infant Health Report show the adequacy of prenatal care in Prince George’s County has improved: From 2010 to 2013, the percentage of mothers who received adequate prenatal care increased from below 58% to 64%. The percentage of mothers who had inadequate prenatal care and intermediate prenatal care decreased during the same time period.

Continuation of Initiative?

Yes, there has been an improvement in the adequacy of prenatal care in Prince George’s County

Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue

Total Cost of Initiative
\$4,931,846

Direct Offsetting Revenue from Restricted Grants



Dimensions Healthcare System

Effective: 04/2013
 Approved: 07/2014
 Last Revised: 07/2014
 Expiration: 07/2017
 Owner: Lisa Goodlett
 Policy Area: Finance
 References:
 Applicability: Dimensions Healthcare System

Financial Assistance Program, 2010-01

PURPOSE:

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

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

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

CANCELLATION:

This is a new corporate policy. It supersedes all policies on this subject at the facility level.

POLICY:

Dimensions Healthcare System has a long tradition of serving the poor, the needy, and all who require health care services. However, our hospitals alone cannot meet every community need. They can practice effective stewardship of resources in order to continue providing accessible and effective health care services. In keeping with effective stewardship, provision for financial assistance will be budgeted annually. Our hospitals

will continue to play a leadership role in the community by helping to promote community-wide responses to patient needs, in partnership with government and private organizations.

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

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

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

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

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

SPECIAL INSURANCE POLICIES AND FORMS TO BE USED: DEFINITIONS:

- A. 1. *Assets*: Assets include immediately available cash and investments such as savings and checking as well as other investments, including retirement or IRA funds, life insurance values, trust accounts, etc. The following are to be considered exempt and shall not be considered in determining whether the uninsured patient qualifies for an uninsured discount:
- a. Homestead property
 - b. \$2,000 for the uninsured patient, or \$3,000 for the uninsured patient and one dependent residing together.
 - c. \$50 for each additional dependent residing in the same household.

- d. Personal effects and household goods that have a total value of less than \$2,000.
 - e. A wedding and engagement ring and items required due to medical or physical condition.
 - f. One automobile with fair market value of \$4,500 or less.
 - g. Patient must have less than \$10,000 in net assets.
2. *Bad Debt Expense*: Uncollectible accounts receivable that were expected to result in cash inflows (i.e. the patient did not meet the facility's Financial Assistance eligibility criteria). They are defined as the provision for actual or expected uncollectible resulting from the extension of credit.
 3. *Financial Assistance*: Health care services that were never expected to result in cash inflows. Financial Assistance results from a provider's policy to provide health care services free or at a discount to individuals who meet the established criteria.
 4. *Financial Assistance Committee*: A committee consisting of the Chief Financial Officer, the Corporate Director of Patient Financial Services, the Risk Manager, the Director of Case/Care Management, and the Director of Patient Relations, or a similar mix of individuals.
 5. *Contractual Adjustments*: Differences between revenue at established rates and amounts realized from third party payers under contractual agreements.
 6. *Disposable Income*: Annual family income divided by 12 months, less monthly expenses as requested on the application in Attachment II.
 7. *Family*: The patient, his/her spouse (including a legal common law spouse) and his/her legal dependents according to the Internal Revenue Service rules. Therefore, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.
 8. *Family Income*: Gross wages, salaries, dividends, interest, Social Security benefits, workers compensation, veterans benefits, training stipends, military allotments, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates and trusts.
 9. *Qualified Patient*:
 - a. *Financially Needy*: A person who is uninsured or underinsured and is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the medical facility's eligibility criteria set forth in this policy.
 - b. *Medically Needy*: A patient who does not qualify as financially needy, but whose medical or hospital bills, even after payment by third-party payers, exceed 50% of their gross income. The patient who incurs catastrophic medical expenses is classified as medically needy when payment would require liquidation of assets critical to living or would cause undue financial hardship to the family support system.
 10. *Medically Necessary Service*: Any inpatient or outpatient hospital service that is covered by and considered to be medically necessary under Title XVIII of the federal Social Security Act. Medically necessary services do not include any of the following:
 - a. Non-medical services such as social, educational, and vocational services.
 - b. Cosmetic surgery.

B. Financial Assistance Guidelines and Eligibility Criteria (see P&S Department)

- a. To be eligible for a 100 percent (100%) reduction from the patient portion of billed charges (i.e. full write-off) the patient's household income must be at or below 200 percent of the current Federal Poverty Guidelines. 200 percent (200%) of the Federal Poverty Guidelines represents an individual earning minimum wage.
- b. Patients with household income that exceeds 200 percent (200%) but is less than 500 percent (500%) of the Federal Poverty Guidelines will be eligible for a sliding scale discount of the patient portion of billed charges.
- c. Medically needy patient accounts will be considered on a case-by-case basis by the Financial Assistance Committee. The discounts to be applied will be based on a determination of what the family could reasonably be expected to pay, based on a review of current disposable income and expenses.
- d. Individuals who are deemed eligible by the State of Maryland to receive assistance under the Violent Crime Victims Compensation Act or the Sexual Assault Victims Compensation Act shall be deemed eligible for financial assistance at a level to be determined on a case-by-case basis by the Financial Assistance Committee.
- e. Financial assistance applications will be considered as long as an account is open or when a change in patient financial status is determined.
- f. After the financial assistance adjustment has been computed, the remaining balances will be treated in accordance with Patient Financial Services policies regarding self-pay balances. Payment terms will be established on the basis of a reasonable proportion of disposable income negotiated with the patient. No interest charges will accrue to the account balance while payments are being made. This also applies to payments made through a collection agency.
- g. Effective October 1, 2010, if the hospital has collected more than \$25 from a patient or patient's guarantor and the patient was found to be eligible for free care on the date of service within a two-year period, the hospital must refund the patient or guarantor any amount collected above \$25. If a judgment or adverse credit report has been entered on a patient who was later found to be eligible for free care on the date of service, the hospital must vacate the judgment or strike the adverse information. The hospital may reduce the two-year period to not less than 30 days after relevant information needed to determine eligibility for financial assistance is requested from the patient as long as it is documented that the patient or guarantor did not cooperate in providing the requested information.

PROCEDURE:

A. Identification of Potentially Eligible Patients:

Admitting

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

- b. Complete information regarding all existing third party coverage.
2. Identification of potentially eligible patients can take place at any time during the rendering of services or during the collection process.
3. Those patients who may qualify for financial assistance from a governmental program should be referred to the appropriate program, such as Medicaid, prior to consideration for financial assistance.

Dir., PFS

4. All self pay accounts will be run through a Charity Care eligibility software program used by vendors to determine if the patient meets eligibility for the federal poverty guideline up to 500%. Any patient with a self pay balance will be sent through this program when they are in a self pay status or in a bad debt status. Once it has been determined that the patient falls into this category, the account(s) will be written off to the Financial Assistance Program (FAP) with or without a completed FAP application.
5. Prior to an account being authorized for the filing of suit, a final review of the account will be conducted and approved by the Corporate Director of Patient Financial Services to make sure that no application for financial assistance was ever received. Prior to a summons being filed, the CFO's approval is required. Dimensions Healthcare System Facilities will not request body attachments from the court system for payment of an outstanding account; however it is recognized that the court system may take this action independently.

B. Determination of Eligibility:

PFS

1. All patients identified as potential financial assistance recipients should be offered the opportunity to apply for financial assistance. If this evaluation is not conducted until after the patient leaves the facility, or in the case of outpatients or emergency patients, a Patient Financial Services representative will mail a financial assistance application to the patient for completion. In addition, whenever possible, patient billing and collection communications will inform patients of the availability of financial assistance with appropriate contact information. When no representative of the patient is available, the facility should take the required action to have a legal guardian/trustee appointed.
2. Requests for financial assistance may be received from:
 - a. the patient or guarantor
 - b. Church-sponsored programs
 - c. physicians or other caregivers
 - d. various intake department of the institutions
 - e. administration
 - f. other approved programs that provide for primary care of indigent patients.
3. The patient should receive and complete a written application (Attachment II) and provide all supporting data required to verify eligibility.
4. In the evaluation of an application for financial assistance, a patient's total resources will be taken into account which will include, but not be limited to, analysis of assets (identified as those convertible to cash and unnecessary for the patient's daily living expense), family income and

medical expenses. A credit report may be generated for the patient as well as for the purpose of identifying additional expense, obligations, assets and income to assist in developing a full understanding of the patients' financial circumstances.

5. If a patient qualifies as medically needy, then the application should be referred to the Financial Assistance Committee for review and determination.

Dir., PFS or Asst Dir PFS

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

PFS

7. Upon completion of the application and submission of appropriate documentation, the Patient Financial Services representative will complete the Financial Assistance Worksheet (Attachment III). The information shall be forwarded to the Assistant Director or the Director of Patient Financial Services or their designee for determination. Financial assistance approval will be made in accordance with the guidelines and documented on the worksheet (Attachment III).
8. Accounts where patients are identified as medically needy or accounts where the collector or Director has identified special circumstances that affect the patient's eligibility for financial assistance will be referred for consideration and final determination. The review of accounts that do not clearly meet the criteria and the decisions and rationale for those decisions will be documented and maintained in the account file (See Attachment III).
9. A record, paper or electronic, should be maintained reflecting authorization of financial assistance (Attachment III). These documents shall be kept for a period of seven (7) years.

C. Notification of Eligibility Determination:

PFS

1. Clear guidelines as to the length of time required to review the application and provide a decision to the patient should be provided at the time of application. A prompt turnaround and a written decision, which provides a reason(s) for denial will be provided, generally within thirty (30) days of receipt of a complete application. Patients will be notified in the denial letter that they may appeal this decision and will be provided contact information to do so.

FAC

2. If a patient disagrees with the decision, the patient may request an appeal process in writing within seven (7) days of the denial. The Financial Assistance Committee will review the application. Decisions reached will normally be communicated to the patient within two (2) weeks, and reflect the organization's final and executive review.
3. Collection activity will be suspended during the consideration of a completed financial assistance application or an application for any other healthcare bracket (i.e., Medicare, Medicaid, etc.). A note will be entered into the patient's account to suspend collection activity until the financial assistance process is complete. If the account has been placed with a collection agency, the agency will be notified by telephone to suspend collection efforts until a determination is made. This notification will be documented in the account notes. The patient will also be notified verbally that the collection activity will be suspended during consideration. If a financial assistance determination allows for a

percent reduction but leaves the patient with a self-pay balance, payment terms will be established on the basis of disposable income.

4. If the patient complies with a payment plan that has been agreed to by the Hospital, the Hospital shall not otherwise pursue collection action against the patient.

Patient

5. If the patient has a change in their financial status, the patient should promptly notify Patient Financial Services. The patient may request and apply for financial assistance or a change in their payment plan terms.

D. Availability of Policy:

PFS

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

E. Application Forms:

PFS

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

F. Monitoring and Reporting:

PFS

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

- a. account number,
- b. date of service,
- c. application mailed (y/n),
- d. application returned and complete (y/n),
- e. total charges,
- f. self-pay balances,
- g. amount of financial assistance approved,
- h. date financial assistance was approved.

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

ORIGINATOR:

Finance Patient Financial Services

ATTACHMENTS:

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

Attachments:

-  [Dimensions Healthcare Corporation Financial Assistance Program](#)
-  [Discharge against Medical Advice](#)

COPY

Access to Care

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

Interpretive Services

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

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

Patient Representative

A patient representative is available to meet with patients and families, who have questions and concerns about their stay, to facilitate problem resolution and to assist with special needs. To contact the patient representative at Prince George's Hospital Center, call 301-618-3857. To contact the patient representative at Laurel Regional Hospital, call 301-497-8765.

Visitors / Patient Guests

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

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

Complaints / Grievances

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

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

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

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

Laurel Regional Hospital
Attn: Patient Relations Department
7300 Van Dusen Road
Laurel, MD 20707
Phone: 301-497-8765

(Business Hours: Monday – Friday: 9:30 a.m. – 6:00 p.m.)

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

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

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

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

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

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

OR

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

For Medicare discharge and appeal rights:

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

For mental and behavioral health services:

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

For medication concerns:

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

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

Financial Information

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

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

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

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

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

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

Patient Rights and Responsibilities

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

You Have the Right to:

- Receive considerate, respectful and compassionate care in a safe setting regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity or disabilities.

- Receive care in a safe environment free from all forms of abuse, neglect or mistreatment.

- Be called by your proper name and to be in an environment that maintains dignity and adds to a positive self-image.

- Know the names of your doctors, nurses and all healthcare team members directing and/or providing your care.

- Have a family member or person of your choice, as well as your own doctor, notified promptly of your admission to the hospital.

- Have someone remain with you for emotional support during your hospital stay, unless your visitor's presence compromises your or others' rights, safety or health.

- Deny visitation at any time (see Visitors/Patient Guests section for additional information).

- Have your doctor inform you about your diagnosis and possible prognosis, the benefits and risks of treatment, and the expected and unexpected outcomes of treatment. You have the right to give written informed consent before any non-emergency procedure begins.

- Have your pain assessed and to be involved in decisions about treating your pain.

- Be free from restraints and seclusion in any form that is not medically required.

- Expect full consideration of your privacy and confidentiality in care discussions, exams and treatments. You may ask for an escort during any type of exam.

- Access protective and advocacy services in cases of abuse or neglect. The hospital will provide a list of these resources.

- Be free from neglect, exploitation and abuse that could occur while the patient is receiving care, treatment and services.

- Have your family and friends, with your permission, participate in decisions about your care, your treatment and services, including the right to refuse treatment to the extent permitted by law.

- Give or withhold informed consent for care.

- Have your end of life wishes honored to include forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services, in accordance with the law and regulations.

- Agree or refuse to take part in medical research studies. You may withdraw from a study at any time without impacting your quality of care.

- Communication that you can understand. The hospital will provide, at no cost to you, sign language and foreign language interpreters as needed.

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

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

Your Responsibilities Are to:

- Provide complete and accurate information, including your full name, address, home telephone number, date of birth, Social Security number, insurance carrier and employer when it is required.
- Provide the hospital or your doctor with a copy of your advance directive if you have one.
- Provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products and any other matters that pertain to your health, such as perceived safety risks.
- Communicate in a direct and honest manner with doctors, nurses and other hospital staff members about matters or conditions that concern your health.
- Follow instructions regarding your care and treatment. If you leave the hospital against the advice of your doctor, the hospital and doctors will not be responsible for any medical consequences that may occur.
- Inform the staff of your whereabouts and probable return time if you leave the patient unit/ancillary department.
- Ask questions when you do not understand information or instructions. If you believe you cannot follow through with your treatment plan, you are responsible for telling your doctor. You are responsible for outcomes, if you do not follow the care, treatment and service plan.
- Actively participate in your pain management plan and to keep your doctors and nurses informed of the effectiveness of your treatment.
- Leave valuables at home and bring only necessary items for your hospital stay.

- Treat all hospital staff, other patients and visitors with courtesy and respect; abide by all hospital rules and safety regulations; and be mindful of noise levels, privacy and number of visitors/guests.
- Accept accountability for your financial obligations for health care provided and to pay your bills in a timely manner.
- Keep appointments and be on time, and to call your healthcare provider if you are unable to do so.
- ***SPEAK UP™**: Be an active member of your healthcare team and help us make your health care safer.
- Speak-up if you have questions or concerns. If you still don't understand, ask again.
- Pay attention to your care. Always make sure you're getting the right treatments and medicines by the right healthcare professionals. Don't assume anything.
- Educate yourself about your condition. Learn about the medical tests and your treatment plan.
- Ask a trusted family member or friend to be your advocate (advisor or supporter).
- Know what medicines you take and why you take them. Medicine errors are the most common healthcare mistakes.
- Use a facility, clinic, surgery center or healthcare facility that has been carefully checked out.
- Participate in all decisions about your treatment. You are the center of the healthcare team.

*Speak Up is a Joint Commission Patient Safety Program Initiative

Healthcare Decisions

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

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

Advance Directives

Advance directive decisions can include:

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

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

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

Pastoral Care

Patients and family members often turn to their faith for emotional support in a time of illness or grief. We work with the community faith

system to provide support to patients and family who desire pastoral care. Please ask your caregiver if you would like to request a pastoral care visit.

Chapel/Meditation Room

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

Support Groups

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

Corporate Compliance

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

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

Safety and Security

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

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

We encourage you to notify us if you have concerns about your safety. To report a concern at Laurel Regional Hospital, please call Safety & Security at 301-497-8752. To report a concern at any other Dimensions Healthcare System facility, please call the Safety Hotline at 301-618-6400.

Patient Property and Valuables

For your own protection, you should not bring items of value to the facility and we request that you send any personal property home. Neither Dimensions Healthcare System nor any of its facilities will accept responsibility for patient property or valuables.

Smoking

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

If you wish to stop smoking, a free smoking cessation program is offered. The program is four weeks in length (one group session per week for 1½ hours). Day and evening sessions are available. To participate, you must be 18 years old and a Maryland resident. For more information, you can call 301-618-6363.

Follow-up Phone Call

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

Copy of your Medical Record

If you need a copy of your medical record, you can request a copy by visiting the medical records department.

WHAT YOU SHOULD KNOW AS A PATIENT



Dimensions Healthcare System

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

DimensionsHealth.org

ALL *we* DO IS
careSM



Dimensions Healthcare System

Effective: 05/2007
 Approved: 05/2014
 Last Revised: 05/2014
 Expiration: 05/2017
 Owner: Carl Jean-Baptiste
 Policy Area: Corporate - Legal
 References:
 Applicability: Dimensions Healthcare System

Patient's Rights And Responsibilities, 200-2

PURPOSE:

To outline the basic rights and responsibilities of patients and individuals who participate in care, treatment and services at Dimensions Healthcare System (DHS).

CANCELLATION:

This policy supersedes DHS Policy No. 200-27: "Patients' Rights and Responsibilities," dated May 12, 2013, which is cancelled.

POLICY:

It is the policy of Dimensions Healthcare System to respect the rights of the patient during his/her encounter with a DHS owned/operated facility. DHS will demonstrate its support of these rights through the ways that all members of the healthcare team interact with the patient and involve him or her in care, treatment, and services.

Dimensions Healthcare System will inform all patients and their representatives of patient rights and responsibilities through one or more of the following forms of communications: brochures, wall signage or patient handbooks available in both English and Spanish.

PROCEDURE:

A. PATIENTS/PATIENT REPRESENTATIVES RIGHTS

1. To access care, treatment and services that are available or medically indicated free of discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.
2. Be informed of the patient's rights in advance of furnishing or discontinuing patient care whenever possible.
3. Be informed of the process for prompt resolution of grievances and whom to contact to file a grievance regardless of whether he/she has first used the facility's grievance process.
 - a. Receive information about the complaint resolution process
 - b. Receive the phone number and address needed to file a complaint with the relevant state authority and accreditation agency

- c. Voice complaints and recommend changes freely without being subject to coercion, discrimination, reprisal or unreasonable interruption of care.
4. To participate in the development and implementation of his or her plan of care, treatment and services.
 - a. To have a surrogate decision-maker make decisions when the patient is unable to make decisions about his or her care, treatment, and services.
 - b. To have DHS respect the surrogate decision-maker's right to refuse care, treatment, and services on the patient's behalf, in accordance with law and regulation when a surrogate decision-maker is responsible for making care, treatment, and services decisions.
 - c. To involve the patient's family in care, treatment, and services decisions to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation.
5. To receive information about the outcomes of care, treatment, and services that the patient needs in order to participate in current and future health care decisions.
6. To have the licensed independent practitioner responsible for managing the patient's care, treatment, and services, or his or her designee, inform the patient about unanticipated outcomes of care, treatment, and services related to sentinel events when the patient is not already aware of the occurrence or when further discussion is needed.
7. To refuse care, treatment and services in accordance with law and regulation.
8. To formulate advance directives and to have the health care team comply with these directives, in accordance with law and regulation
9. To have a family member or representative of his/her choice and his/her own physician notified promptly of his/her admission to the hospital.
10. To personal privacy.
11. To receive care in a safe setting.
12. To the confidentiality of his/her medical records.
13. To access, request amendment to, and obtain information on disclosures of his or her health information, within a reasonable time frame in accordance with law and regulation.
14. To be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.
15. To receive the visitors he/she designates including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. Also included is the right to withdraw or deny such consent at any time.
16. To effective communication
 - a. Receive information in a manner tailored to the patient's age, language and ability to understand.
 - b. Receive interpretative and translation services, as necessary
 - c. Communicate in a manner that meets the need(s) of the patient with vision, speech, hearing or cognitive impairments
17. To respect for his/her cultural and personal values, beliefs, and preferences.

18. To be treated in a dignified and respectful manner that supports his/her dignity and contributes to a positive self-image.
 - a. Allows the patient to keep and use personal clothing and possessions, unless this infringes on other's rights or is medically or therapeutically contraindicated, based on the setting or service.
 - b. Offers telephone and mail service, based on the setting and population
 - c. Have access to a telephone for a private telephone conversation in a private space, based on the setting and population
19. To pain management.
20. To religious and other spiritual services.
21. To have a family member, friend, or other individual to be present with the patient for emotional support during the course of stay
22. To give or withhold informed consent to produce or use recordings, films, or other images of the patient for purposes other than his or her care.
23. To consent or refuse to participate in research, investigation, or clinical trials,
24. To know the name of the physician, clinical psychologist, or other practitioner who has primary responsibility for his or her care, treatment, or services
25. To be free from neglect, exploitation and verbal, mental, physical and sexual abuse that could occur while receiving care, treatment, and services
26. To access protective and advocacy services

B. PATIENTS' PATIENT REPRESENTATIVE RESPONSIBILITIES

1. Provision of information

- a. Provide, to the best of his/her knowledge, accurate and complete information upon admission/visit that may include information about past hospitalizations, previous and concurrent health problems, medications and treatment (including any vitamins or herbal supplements), insurance data, executed Advance Directives, and all other matters pertaining to your health status.
 - b. Communicate in a direct and honest manner with doctors, nurses, and other hospital staff members about matters or conditions that concern your health will help us care for you.
2. **Ask questions** or acknowledging when he or she does not understand the treatment course or care decision
 3. **Follow instructions, policies, rules, and regulations** in place to support quality care for patients and a safe environment for all individuals in the hospital
 - a. Respect and follow the rules and regulations regarding patients while you are admitted to the hospital and/or receiving care in an outpatient facility.
 - b. Refrain from social behavior that may offend others or be dangerous to health, including the use of alcohol, tobacco products, non-prescribed medications, or drugs.
 4. **Support mutual consideration and respect** by maintaining civil language and conduct in interactions with staff and licensed independent practitioners
 5. **Meet financial commitments:** Accept responsibility for your financial obligations for healthcare provided by DHS

6. Immediately inform the staff of any perceived unsafe, unclear, or unreasonable request or situation.
7. Inform the staff of your whereabouts and probable return time if you leave the patient unit/ancillary department
8. **Compliance with Instruction**
 - a. Keep your appointments or schedules, and notify the appropriate individual when you cannot keep them.
 - b. Fully participate in your plan of care
 - c. Follow the prescribed therapies and treatments ordered.
9. **Refusal of treatment:** Accept responsibility for the outcome when you fail to follow the instructions of the physicians and hospital staff.
10. **Speak Up and help us make your healthcare safer: Participate in making your care safe by becoming an active member of your healthcare team**
 - a. **Speak-up** if you have questions or concerns. If you still don't understand, ask again.
 - b. **Pay attention** to the care you get. Always make sure you're getting the right treatments and medicines by the right healthcare professionals. Don't assume anything.
 - c. **Educate yourself** about your illness. Learn about the medical tests you get and your treatment plan.
 - d. **Ask a trusted family member or friend** to be your advocate (advisor or supporter).
 - e. **Know what medicines you take** and why you take them. Medicine errors are the most common healthcare mistakes.
 - f. **Use a hospital, clinic, surgery center or other type of healthcare organization** that has been carefully checked out.
 - g. **Participate in all decisions** about your treatment. You are the center of the healthcare team.
11. Before you go home understand all of your discharge instructions. Generally, these instructions will include information on: diet, activity, medications, follow-up appointments, what to do if you feel worse.
 - a. **Review all prescriptions** with your caregiver, make sure you can read the prescription, and know how to take the medication.
 - b. **Review all follow-up appointments** and ask if they already have been made or if you must call the physician or health service to make the appointment.
 - c. **Review all home health arrangements** including how to contact the home health agency if needed.

ORIPINATOR:

Administration

Attachments:

No Attachments



Current Status: *Active*

PolicyStat ID: 1177597



Dimensions Healthcare System

Effective: 06/2006

Approved: 05/2014

Last Revised: 05/2014

Expiration: 05/2017

Owner: *Al Campbell: Executive Administrator*

Policy Area: *Corporate - General*

References:

Applicability: *Dimensions Healthcare System*

Mission, Vision and Values Statements, 200-24

MISSION

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

VISION

To be recognized as a premier regional health care system.

VALUES

Dimensions Healthcare System:

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

Attachments:

No Attachments