COMMUNITY BENEFIT REPORT
FISCAL YEAR 2017
JULY 1, 2016 – JUNE 30, 2017

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

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

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

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

As provided by federal regulation (26 CFR §1.501(r)—3(b)(6)) and for purposes of this report, a **COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)** report is a

written document that has been adopted for the hospital facility by the organization's governing body (or an authorized body of the governing body), and includes:

(A) A definition of the community served by the hospital facility and a description of how the community was determined;

(B) A description of the process and methods used to conduct the CHNA;

(C) A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;

(D) A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant; and prioritizing those significant health needs;

(E) A description of the resources potentially available to address the significant health needs identified through the CHNA; and

(F) An evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).

Required by federal regulations, the **IMPLEMENTATION STRATEGY** is a written plan that is adopted by the hospital organization's governing body or by an authorized body thereof, and:

With respect to each significant health need identified through the CHNA, either—

(i) Describes how the hospital facility plans to address the health need; or

(ii) Identifies the health need as one the hospital facility does not intend to address and explains why the hospital facility does not intend to address it.

The FY2017 – FY2019 Community Health Needs Assessment and the University of Maryland Capital Region Health Implementation Strategy are included as attachments to this report.

UNIVERSITY OF MARYLAND PRINCE GEORGE'S HOSPITAL CENTER:

Located in Cheverly, Maryland, University of Maryland Prince George's Hospital Center (UM PGHC) is a private not-for-profit acute care teaching hospital and regional referral center which has been providing quality healthcare services to the southern Maryland region since 1944. Over the past 70 years, University of Maryland Prince George's

Hospital Center has grown to become the region's major tertiary care center and one of its largest employers. UM PGHC is a member of the University of Maryland Capital Region Health (UM Capital), formerly Dimensions Healthcare System.

Leadership:

Chairman, UM Capital Board of Directors – Bradford Seamon

President & CEO, UM Capital – Neil Moore, MBA, MPA, MPH

Executive Vice President/Chief Operating Officer, UM Capital - Sherry Perkins PhD, RN

Senior Vice President & Chief Nurse Executive, UM Capital – Ron Laxton, DNP, RN

Location: 3001 Hospital Drive, Cheverly, Maryland 20785

Facility type: Acute care teaching hospital and regional referral center

Number of licensed beds: 233 (plus 52 bassinets)

Number of inpatient admissions: 10,948, plus 1,367 births

Number of Employees: 1785

Specialty services:

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

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

  - Neonatal intensive care unit (designated Level III, regional center for Prince George's County)
  - Inpatient pediatric unit
  - Chronic pediatric inpatient unit and outpatient program

Other specialty services:

- Ambulatory and outpatient services
  - Surgical short-stay center
  - Special procedures
  - Diabetes treatment center
  - Mt. Washington Pediatric Hospital at UM Prince George's Hospital Center
  - University of Maryland Bowie Health Center
  - University of Maryland Capital Region Surgery Center (a freestanding ambulatory surgery center located on the University of Maryland Bowie Health Center campus)
  - University of Maryland Family Health and Wellness Center at Cheverly (Honoring Gladys Noon Spellman)
  - University of Maryland Family Health and Wellness Center at Laurel
  - University of Maryland Family Health and Wellness Center at Suitland
  - University of Maryland Senior Health Center (Honoring Rachel H. Pemberton)
- 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 UM 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.

- UM PGHC also has a licensed, freestanding emergency department, located on the Bowie Health Center campus. The emergency department was recently renovated and expanded from 15 beds to a total of 27 beds, including two cardiac rooms, 2 suture rooms and an isolation room. The department also has a stat lab, and radiology services, including CT and ultrasound.

Ownership:

University of Maryland Prince George's Hospital Center is a member of University of Maryland Capital Region Health (formerly Dimensions Healthcare System), the largest not-for-profit provider of healthcare services in Prince George's County, Maryland. UM Capital also includes University of Maryland Laurel Regional Hospital, Laurel, Maryland and University of Maryland Bowie Health Center, Bowie, Maryland. University of Maryland Capital Region Health is wholly owned by the University of Maryland Medical System.

HSCRC COMMUNITY BENEFIT REPORTING REQUIREMENTS

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Please list the following information in Table I below. (For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate during the most recent 12-month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all acute care hospitals by the HSCRC. Specialty hospitals should work with the Commission to establish their primary service area for the purpose of this report).

   a. Bed Designation – The total number of licensed beds

   b. Inpatient Admissions: The number of inpatient admissions for the FY being reported;

   c. Primary Service Area (PSA) zip codes;

   d. Listing of all other Maryland hospitals sharing your PSA;

   e. The percentage of the hospital's uninsured patients by county. (Please provide the source for this data, e.g., "review of hospital discharge data");

   f. The percentage of the hospital's patients who are Medicaid recipients. (Please provide the source for this data (e.g., "review of hospital discharge data.")

   g. The percentage of the hospital's patients who are Medicare beneficiaries. (Please provide the source for this data (e.g., "review of hospital discharge data.")

Table I

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County	Percentage of Patients who are Medicaid Recipients, by County
233 Beds + 52 Bassinets	10,948 Births: 1,367	20785 20743 20019 20774 20747 20784 20706 20737 20721 20710 20772 20746	Doctors Community Holy Cross Washington Adventist Southern Maryland Laurel Regional Fort Washington	19% (UM PGHC total patient pop.) PG County: 76% DC: 9.8%	37% (UM PGHC total patient pop., includes Medicaid pending) PG County: 75% DC: 14%

PRINCE GEORGE'S COUNTY DEMOGRAPHICS:

University of Maryland Prince George's Hospital Center is located in Prince George's County, Maryland, which is part of the Washington, D.C. metropolitan area. UM PGHC is located in the western and central part of the county. The UM PGHC Primary Service Area consists of 12 zip codes within Western and Central Prince George's County and Washington, District of Columbia.

UM PGHC's Primary Service Area differs from its Community Benefit Service Area (CBSA) in that its CBSA encompasses 20 zip codes in Western and Central Prince George's County. Patients from these 20 zip code areas make up approximately 75% of PGHC's total inpatient and outpatient admissions. The UM PGHC CBSA also includes two zip code areas in the eastern portion of the District of Columbia (DC) – patients from this area make up 6.9% of PGHC's inpatient and outpatient admissions. An estimated 572,929 people make up the UM PGHC CBSA: 76.7% are African-Americans, 6.1%

White (non-Hispanic), 12.4% of Hispanic origin, 2.3% of Asian origin, and 0.2% of other ethnic origin.

2. For purposes of reporting on your community benefit activities, please provide the following information:
   a. Use Table II to provide a detailed description of the Community Benefit Service Area (CBSA), reflecting the community or communities the organization serves. The description should include (but should not be limited to):
      (i) A list of the zip codes included in the organization's CBSA, and
      (ii) An indication of which zip codes within the CBSA include geographic areas where the most vulnerable populations (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.
      (iii) A description of how the organization identified its CBSA, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, e.g., individuals with > 3 hospitalizations in the past year). This information may be copied directly from the community definition section of the organization's federally-required CHNA Report (26 CFR § 1.501(r)–3).

Statistics may be accessed from:

The Maryland State Health Improvement Process (http://dhmh.maryland.gov/ship/);

The Maryland Vital Statistics Administration (http://dhmh.maryland.gov/vsa/Pages/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 Chart Book of Minority Health and Minority Health Disparities, 2nd Edition (http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Health%20Disparities%20Data%20Chartbook%202012%20corrected%202013%2002%2022%2011%20AM.pdf);

The Maryland State Department of Education (The Maryland Report Card) (http://www.mdreportcard.org) Direct link to data– (http://www.mdreportcard.org/downloadindex.aspx?K=99AAAA)

Community Health Status Indicators (http://wwwn.cdc.gov/communityhealth)

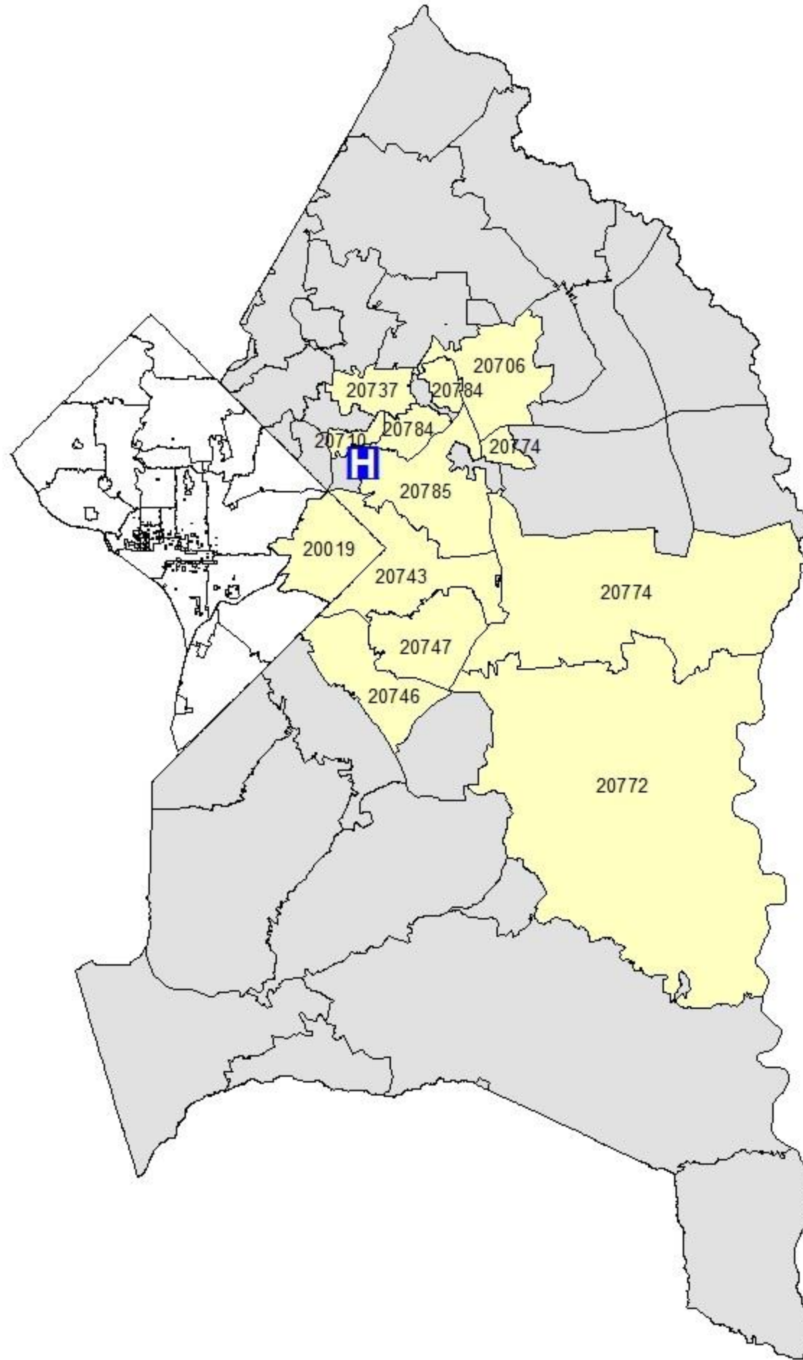
Table II

Demographic Characteristic	Description	Source
Zip codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.	**20785**, **20743**, **20019**, 20774, **20747**, **20784**, **20706**, **20737**, 20721, **20710**, **20772**, **20746**, 20748, **20744**, 20745, 20716, 20770, 20715, 20020, 20781 ***Bold** indicates geographic areas where the most vulnerable populations (including but not necessarily limited to medically underserved, low-income, and minority populations) reside*	PCA Executive Marketing Reporting (New Health Analytics) (2017) CHNA & Prince George's Hospital Center Service Profile
Median Household Income within the CBSA (county level)	Prince George's County: $79,184 DC: $75,506	U.S. Census Bureau, 2016 ACS 1-Year Estimates
Percentage of households in the CBSA with household income below the federal poverty guidelines	Prince George's County: 6.4% DC: 13.7%	U.S. Census Bureau, 2016 ACS 1-Year Estimates
For the counties within the CBSA, what is the percentage of uninsured for each county? This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtmlwithin the CBSA	Prince George's County: 15.7% DC: 5%	U.S. Census Bureau, 2016 ACS 1-Year Estimates
Percentage of public health insurance coverage recipients by County within the CBSA.	Prince George's County: 33.4% DC: 52.3%	U.S. Census Bureau, 2016 ACS 1-Year Estimates
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/Pages/Home.aspx	**Prince George's County**: All Races: 79.9 years White: 80.5 Black: 79.3 **DC:** 77.5 years	Maryland Vital Statistics Annual Report 2015 District of Columbia Community Health Needs Assessment, 2014

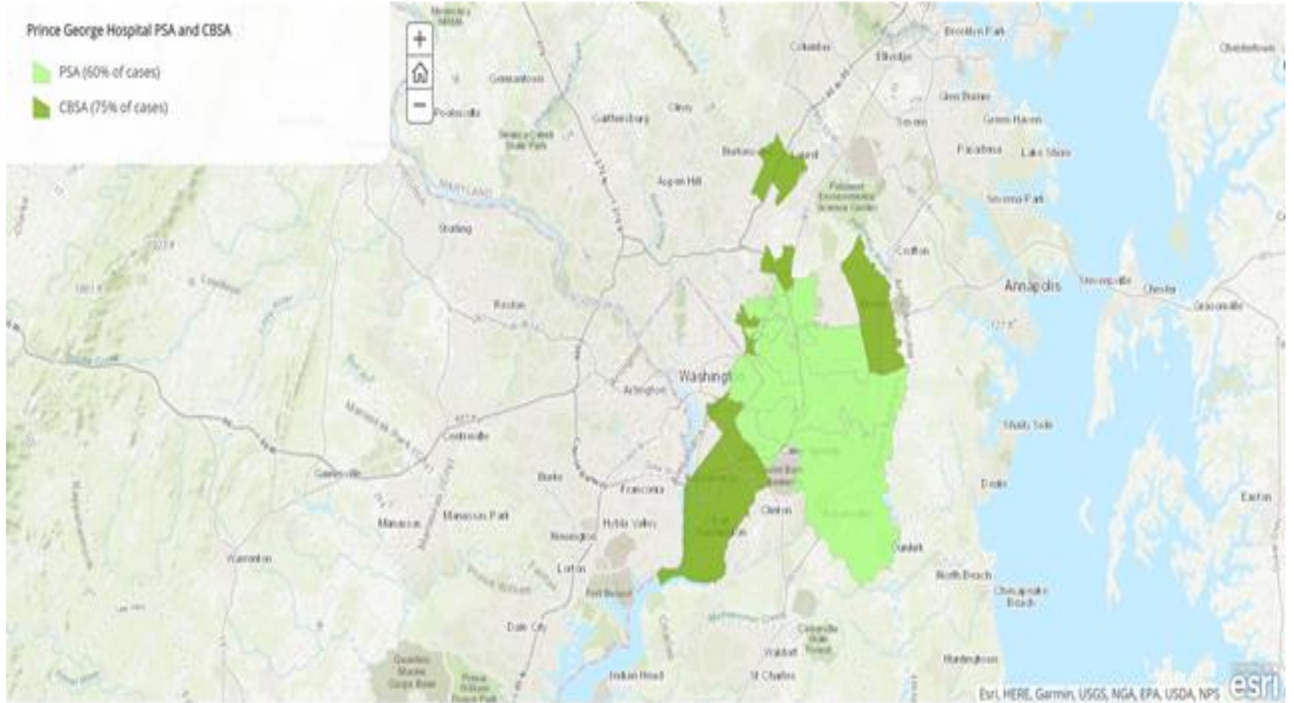
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	**Prince George's County :** All Races: 630.0/100,000 White: 1151.0/100,000* Black: 665.3/100,000 Asian/Pacific Islander: 340.3/100,000 Hispanic: 149.9/100,000 **DC:** 743.8/100,000 **As reported in the Maryland Vital Statistics Annual Report 2015, p.147. Note: Represents a significant change from 2014 of 643.8/100,000 (Maryland Vital Statistics Annual Report 2014, p. 153)*	Maryland Vital Statistics Annual Report 2015 CDC National Vital Statistics Reports Vol. 65 No. 4 (June 30, 2016) (DC)
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://ship.md.networkofcare.org/ph/county-indicators.aspx	Risk factors for premature death in Prince George's County and DC: -- Physical Inactivity PG: 24% DC: 17% -- Food Environment Index PG: 7.5 DC: 8.0 -- Adult Obesity PG: 33% DC: 22% -- High blood pressure PG: 34.2% **DC: 29.4% -- Adult Smoker PG: 13% DC: 16% -- Has diabetes PG: 12.5% DC: 8.3% -- HIV prevalence rate ***PG: 930.2/100,000 DC: 1,928.7/100,000	County Health Rankings, 2017 **D.C. Department of Health: Annual Epidemiology & Surveillance Report (December 2016); ***http://www.pgchealthzone.org (retrieved November 9, 2017, last updated July 2017)

	-- Violent crime rate PG: 624/100,000 DC: 1,259/100,000	
Available detail on race, ethnicity, and language within CBSA.	*See charts on pages 15 and 16, which provide detail on race and ethnicity within the CBSA.*	See cited sources in Charts
Other Vulnerable populations	Vulnerable populations in Prince George's County: -- Are unemployed Prince George's County: 5.3% DC: 6.9% --Uninsured Prince George's County: 14%	County Health Rankings, 2017
Other Access to primary care	Ratio of population to primary care physicians – Prince George's County – 1,910:1 DC: 880:1 Nat'l Benchmark –1040:1 (Prince George's County has substantially lower per capita numbers of primary care physicians when compared to neighboring jurisdictions.)	County Health Rankings, 2017

CHNA Primary Service Area Map



Community Benefit Service Area Map



UM PGHC COMMUNITY BENEFIT SERVICE AREA
FY 2017

UM PGHC Primary Service Area (PSA) 2017 Total UM PGHC Discharges (all counties) 2017: **12,361**				
ZIP	**NAME**	**COUNTYNAME**	**# Cases**	**% of Total Cases**
20785	Hyattsville	Prince George's Co	1,471	11.9%
20743	Capitol Heights	Prince George's Co	1,372	11.1%
20019	Washington	District of Columbia	681	5.5%
20774	Upper Marlboro	Prince George's Co	652	5.3%
20747	District Heights	Prince George's Co	649	5.2%
20784	Hyattsville	Prince George's Co	645	5.2%
20706	Lanham	Prince George's Co	610	4.9%
20737	Riverdale	Prince George's Co	359	2.9%
20721	Bowie	Prince George's Co	313	2.5%
20710	Bladensburg	Prince George's Co	312	2.5%
20772	Upper Marlboro	Prince George's Co	299	2.4%
20746	Suitland	Prince George's Co	295	2.4%
Running Total			**7658**	**61.9%**

UM PGHC Community Benefits Service Area (CBSA) Area 2017 (includes all above zip codes, adds below zip codes)				
20748	Temple Hills	Prince George's Co	284	2.3%
20744	Fort Washington	Prince George's Co	228	1.8%
20745	Oxon Hill	Prince George's Co	218	1.8%
20716	Bowie	Prince George's Co	211	1.7%
20770	Greenbelt	Prince George's Co	191	1.5%
20715	Bowie	Prince George's Co	187	1.5%
20020	Washington	District of Columbia	170	1.4%
20781	Hyattsville	Prince George's Co	166	1.3%
Running Total			**9,313**	**75.3%**
CBSA list represents approximately 75% of cases				

University of Maryland Prince George's Hospital Center Community Benefit Service Area (CBSA)

	UM PGHCCBSA Area	% of Total
2016 Total Population	572,929	100.0%
Total Male Population	268,840	46.9%
Total Female Population	304,089	53. 1%

Source: PCA Executive Marketing Reporting (New Health Analytics) (2017)

RACE/ETHNICITY	**Race/Ethnicity Distribution**		
Race/Ethnicity	**2016 Pop**	**% of Total**	**USA % of Total**
White Non-Hispanic	35,019	6.1%	61.1%
Black Non-Hispanic	439,531	76.7%	12.7%
Hispanic	70,835	12.4%	*17.8%
Asian & Pac. Isl. Non-Hispanic	13,577	2.3%	5.6%
All Others	13,967	2.4%	5.9%
TOTAL	**572,929**	**100.0%**	

Source: U.S. Census Bureau, ACS Community Survey (2016) and PCA Executive Marketing Reporting (New Health Analytics) (2017)

**Hispanic (of any race)*

POPULATION DISTRIBUTION			
	Age Distribution		
Age Group	**2016Pop**	**% of Total**	**USA % of Total**
0 – 17	**135,154**	**26.3%**	**22.8%**
18 - 64	**364,778**	**63.7%**	**61.9%**
65 +	**72,997**	**12.7%**	**15.2%**
TOTAL	**572,929**	**100.0%**	**100.0%**

Source: U.S. Census Bureau, 2016 ACS and PCA Executive Marketing Reporting (New Health Analytics) (2017)

UNINSURED % of Total Population			
Race/Ethnicity	**Prince George's County**	**Maryland**	**USA**
Average, All Races	**10.3%**	**6.1%**	**8.6%**
White Non-Hispanic	**15.8%**	**4.9%**	**7.7%**
Black Non-Hispanic	**8.8%**	**5.9%**	**9.7%**
Hispanic	**28.7%**	**22.0%**	**18.0%**
Asian	**10.2%**	**5.3%**	**6.8%**
Some other race alone	**34.7%**	**29.0%**	**19.8%**

Source: U.S. Census Bureau, ACS 2016, 1 Year Estimates

University of Maryland Prince George's Hospital Center Vital Statistics Data

COMPARATIVE VITAL STATISTICS	**PRINCE GEORGE'S COUNTY**	**MONTGOMERY COUNTY**	**STATE OF MARYLAND**
Age Adjusted Mortality Rates: 2012-2014			
All Causes of Death	**683.6**	**488.7**	**703.1**
Disease of the Heart	**171.4**	**107.5**	**169.4**
Malignant Neoplasms	**155.5**	**119.9**	**159.3**
Cerebrovascular Disease	**37.8**	**34.5**	**37.1**
Diabetes Mellitus	**27.9**	**12.3**	**19.0**
Accidents	**25.5**	**17.6**	**37.5**
Chronic Lower Respiratory Diseases	**19.7**	**17.4**	**30.8**
Septicemia	**14.7**	**11.6**	**14.6**
Alzheimer's Disease	**13.0**	**11.9**	**15.0**
Influenza and Pneumonia	**14.6**	**13.5**	**16.8**
HIV	**4.4**	***	**3.0**
Nephritis, Nephrotic Syndrome and Nephrosis,	**13.8**	**8.0**	**11.7**
Assault (Homicide)	**8.4**	**2.5**	**8.0**
Intentional Self-Harm (Suicide)	**4.4**	**7.3**	**9.1**

Source: Maryland Vital Statistics Annual Report: 2015

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. Within the past three fiscal years, has your hospital conducted a Community Health Needs Assessment that conforms to the IRS requirements detailed on pages 1-2 of these Instructions?

   __**X**_Yes Provide date approved by the hospital's governing body or an authorized body thereof here: 01/26 /17 (mm/dd/yy)

   ____No

   If you answered yes to this question, provide a link to the document here. (Please note: this may be the same document used in the prior year report).

   https://umcapitalregion.org/about/mission-vision-values/community-involvement/

2. Has your hospital adopted an implementation strategy that conforms to the IRS requirements detailed on pages 3-4?

   __**X**_Yes Enter date approved by governing body/authorized body thereof here: 01/ 26/17 (mm/dd/yy)

   ___No

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

   https://umcapitalregion.org/about/mission-vision-values/community-involvement/

In 2016, UM Capital Region Health completed a Community Health Needs Assessment (CHNA) for Fiscal Years 2017 – 2019 in collaboration with other area hospitals (Doctor's Community Hospital, Fort Washington Medical Center, MedStar Southern Maryland Hospital Center). The joint community health needs assessment process was led by the Prince George's County Health Department ("Health Department"). The objective of the joint effort was to design and produce the first County-wide community health needs assessment. The CHNA stakeholders engaged in a collaborative process to conduct a comprehensive community health needs assessment process in Prince George's County, Maryland that complies with the CHNA requirements as set forth by the Internal Revenue Code and Public Health Department certification requirements.

The process involved the collection and analysis of valid data (quantitative and qualitative) to ascertain residents' health status, identify trends in health problems, as well as the social and economic determinants impacting the health of Prince George's County residents. A written report of the community health need assessment process and findings was prepared and presented to the Health Department and hospitals. The report included recommendations to address health need and other areas of concern to the Health Department and County-based hospitals, based on the CHNA findings. Recommendations include public health policy, processes, programs or interventions.

The joint CHNA assessed and identified significant community health needs in the County. Input was solicited from County residents using key informants interviews and surveys. Through a prioritization process involving a variety of community stakeholders and community-based organizations, the following were identified as CHNA priority community health needs:

- **Behavioral Health**
    - Mental Health
    - Substance Abuse
    - Domestic Violence/Violence
- **Metabolic Syndrome**
    - Obesity
    - Diabetes
    - Heart Disease
    - Hypertension/Stroke
- **Cancer**

The most recent Community Health Needs Assessment (2017 – 2019) included the following findings:

Over three-fourths of the population in Prince George's County is comprised of minorities, led by 62.1% Black, Non-Hispanic (NH) followed by the Hispanic population (16.9%). Between 2010 and 2014, the Hispanic population grew the fastest with an 18.3% increase. The Asian population grew by 13.6% and the Black or African American population grew by 2.3%. The White, Non-Hispanic population declined slightly, from 129,668 in 2010 to 128,234 in 2014.

Overall, the demographics of Prince George's County differ from the state of Maryland. While Maryland has a majority White, Non-Hispanic (NH) population, Prince George's County has a majority Black, NH population. Prince George's County also has a higher proportion of Hispanics than the state. Prince George's County has a younger population compared to Maryland and the U.S. The median age in the county is 36.1 years, while the state is at 38.3 and the U.S. is at 37.7. A larger percent of the County's population is under 45 years of age.

There are some variations by race and ethnicity, as demonstrated in Table 2, with the median age of the Hispanic population of 28.4, which is much younger compared to other residents. In contrast, the White, NH population is older, with a median age of 44.6.

Foreign Born Residents. In Prince George's County, 1 out of every 5 residents (21.8%) is born outside the United States. The countries that contribute the most to the foreign-born population include El Salvador, Guatemala, Nigeria, Mexico, and Jamaica: these five countries account for nearly half of the total foreign-born population. Of the nearly 200,000 foreign born residents in the County, 40% are naturalized U.S. citizens with a

median household income of $72,093, compared to $56,274 for the 60% who are not U.S. citizens.

Approximately 7% of families in Prince George's County live in poverty, which is similar to Maryland at 7.1% and lower than the United States at 11.3%. Fewer married couple families experience poverty (3.4%), but 12.4% of families with a female head of household lived in poverty. This figure increases to 17.6% among single-mother households with children under 18 years of age. Family poverty by race and ethnicity shows a disparity with approximately two times the percent of Hispanic families lived in poverty across the different families types.

Education. Approximately 85% of County residents age 25 years and older have at least a high school degree, which is lower than Maryland (90%) and the U.S. (87%) While Prince George's County is similar to the U.S. for those with Bachelor's Degrees and higher (31% and 30%), the County falls behind when compared to Maryland (38%). There is more of disparity when comparing the County to the neighboring jurisdiction of Washington, D.C., which has 55% of residents with a Bachelor's Degree or higher.

There are noticeable differences within the County by race and ethnicity, with Asian residents having high educational attainment, followed by White, Non-Hispanic (NH) residents. Most Black residents do have a High School Degree, but fewer have a college degree compared to Asian and White, NH residents. The County's Hispanic residents have the most significant disparity, with over 50% lacking a High School Degree or equivalent, and less than 10% having a Bachelor's Degree or higher.

In 2015, 127,576 County children and adolescents enrolled in public schools. While the overall graduation rate has increased since 2012, Hispanic students are still less likely to complete high school in the County. Overall, Prince George's County has a lower graduation rate (78.75%) compared to Maryland (86.98%) in 2015. Part of that difference may be due to the graduation rate for Hispanic students in Maryland being over 10 percent higher (76.89% compared to 67.37% for the County).

Employment. In 2014, 9.1% of Prince George's County residents were unemployed, which is higher than both Maryland and the U.S. at 7.2%. The county unemployment rate varies by education, disability status, and by race and Hispanic ethnicity. Overall, one-third of residents age 16 and older living in poverty are unemployed. Unemployment can result in residents being unable to acquire basic resources such as healthy food, housing, transportation, and health care and medication.

Income. The median household income in the County is $72,290 which is lower than Maryland ($73,971), but is higher than the U.S. When looking at income by groups, Maryland has more residents making below $25,000 compared to Prince George's County; however, Maryland also has more residents making above $150,000 compared to Prince George's County, which helps to explain the higher mean and median income for the state.

Income by Race and Ethnicity in the County shows both that more White, Non-Hispanic (NH) and Asian households have an income over $100,000. The Hispanic population has an income disparity, with nearly half of the households with an income under $50,000, and only 3% of households earning over $150,000 compared to over 15% Black, Asian, and White, NH households.

Challenges & Health Statistics

The CHNA identified specific drivers of poor health outcomes that significantly impact County residents. They are:

1. *Poor social determinants of health drive many of our health disparities.* Poverty, food insecurity, access to healthy food, affordable housing, employment, lack of educational attainment, inadequate financial resources, and a disparate built environment result in poorer health outcomes for Prince George's county residents. Resources may be available in communities with greater needs, but are of poorer quality. For example, a recent study in access to healthy foods in an urban area of the county show that there are many grocery stores, but they lack quality healthy food options.

2. *Access to health insurance through the Affordable Care Act has not helped everyone.* Many residents still lack health insurance (some have not enrolled, some are not eligible). Those with health insurance cannot afford healthcare (co-pays).

3. *Residents lack knowledge of or how to use available resources.* The healthcare system is challenging to navigate, and providers and support services need more coordination. There are services available, but they are perceived as underutilized because residents do not know how to locate or use them. Low literacy and low health literacy contribute to poor outcomes.

4. *The county does not have enough healthcare providers to serve the residents.* There is a lack of behavioral health providers, dentists, specialists, and primary care providers (also noted in the 2015 Primary Healthcare Strategic Plan for the county).

5. *Cancer.* By cancer site, Black residents in the county had higher incidence and mortality rates for breast, colorectal, and prostate cancers. However, overall, White non-Hispanic residents had a higher cancer mortality rate (2014).

6. *HIV.* Prince George's County had the second highest rate of HIV diagnoses in the state in 2013, and had the highest number of actual cases in the state.

7. *Asthma.* For adults, Black county residents have an age-adjusted hospitalization rate due to asthma that is more than twice as high as White, non-Hispanic residents (2010-2012).

Although the joint CHNA encompassed the needs of the County's hospitals as a whole it was not a series of hospital-specific needs assessments. The assessment utilized quantitative and qualitative data, as available. The joint County-wide CHNA provides required data and information for the hospitals to use. Each hospital used the data collected in the CHNA process to: 1) identify their own geographical priority issues; 2) develop and implement strategies and action plans for each priority issue, and 3) establish accountability to ensure measurable health improvement. It is believed the proposed community involvement in the County-wide CHNA process will meet the requirements of the Internal Revenue Service (IRS) for CHNA for the hospitals, including implementation plans that outline the hospitals' approaches to addressing the needs identified in the joint CHNA.

The final County-wide CHNA was submitted to the hospitals in early June 2016. Each participating hospital then produced its Community Health Implementation Plan (CHIP), which outline the priorities for each hospital and initiatives it will implement to address the needs identified in the CHNA.

University of Maryland Prince George's Hospital Center FY 2017 CHIP Priorities

- **Priority Area 1: Social Determinants of Health Risk Factors**
- **Priority Area 2: Physical Health and Chronic Disease Management***
  - *Improve Chronic Disease Management*
  - *Improve Transitional Care*
- **Priority Area 3: Behavioral Health***
  - *Develop Behavioral Health Outreach and Education Programs in Clinical and Community-based Settings*

* *Selected CHIP priorities and goals for FY2017*

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. Are Community Benefits planning and investments part of your hospital's internal strategic plan?

__X_ Yes
____ No

If yes, please provide a specific description of how CB planning fits into the hospital's strategic plan. If this is a publicly available document, please provide a link here and indicate which sections apply to CB planning.

The Dimensions Healthcare System Strategic Plan for Fiscal Years 2015 – 2017 establishes six major goals:

I. Leadership & Cultural Transformation
II. Exceptional Patient Experience
III. Efficient Operational Performance
IV. Integrated, Value-Based Healthcare
V. Strong Financial Performance
VI. Expanded Market Position

The Goal IV goal statement provides that DHS will: "Achieve clinical and financial integration of information resulting in more effective healthcare delivery among the health system & other community providers." The Strategic initiatives under Goal IV are:

- Develop a population health management infrastructure to reduce unnecessary utilization of hospital resources.
- Develop a formal structure / integrated network of community providers and institutions (e.g., FQHCs, Health Department, post-acute care facilities, and other agencies) to improve access and coordination of care.
- Develop the necessary IT platforms to support clinical decision-making, clinical integration, access of health information to community providers, and provide linkages of clinical and financial data.

The hospital's community benefit program has established strategic objectives to achieve the Goal IV initiatives under the DHS strategic plan. They are:

- Align Dimensions Health Care System with Local Community Agencies and Business Community to Assess and Respond to Community Need
  - Establish DHS Initiatives in Alignment with Strategic Plan, Community Needs Assessment, Public Health Study, MOU.
- Improve Community Health - Dimensions will become the *key* partner with State and County governments and local community groups in addressing the major health needs identified by State and County health plans.
- Support Community Benefit
  - Address community needs and priorities primarily through disease prevention and improvement of health status, including: health services provided to vulnerable or underserved populations
  - Financial or in-kind support of public health programs

- Donations of funds, property or other resources that contribute to a community priority
- Healthcare cost containment activities
    - Health education screening and prevention services

b. What stakeholders within the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and describe the role each plays in the planning process (additional positions may be added as necessary)

i. Senior Leadership

1. __**X**_CEO
2. __**X**_CFO
3. __**X**__Other (please specify – COO, VP Population Health, SVP, Strategy, VP Community Relations)

Describe the role of Clinical Leadership: Clinical leadership participated in County-wide CHNA process; participated in meetings; participated in community health needs prioritization sessions; participated in development of implementation strategy plan

ii. Clinical Leadership

1. _**X**__Physician
2. _**X**__Nurse
3. _**X**__Social Worker
4. _**X**__Other (please specify) Clinical Director Ambulatory Operations

Describe the role of Clinical Leadership: Clinical leadership participated in County-wide CHNA process; participated in meetings; participated in community health needs prioritization sessions; participated in development of implementation strategy plan

iii. Population Health Leadership and Staff

1. __X_ Population health VP or equivalent (please list)

   Tiffany Sullivan

2. Other population health staff

Describe the role of population health leaders and staff in the community benefit process.

iv. Community Benefit Operations

1. __X_The Title of Individuals(s) (please specify FTE) - Vice President Community Relations (1.0 FTE); Community Health Program Manager (1.0 FTE)

2. Committee (please list members): Director of Case Management; Nurse Practitioner, Cardiac Cath Lab (responsible for community outreach for Cardiac Program); Director of Marketing; Stroke Program Coordination (responsible for community outreach for Stroke Program); Manager Volunteer Services; VP for Reimbursement; Volunteer Services Coordinator; VP Population Health; Corporate Director, Finance Decision Support; Vice President Medical Affairs; Chief Medical Officer; VP Strategic Planning

   The Committee reviews CHNA and Implementation Plans and advise concerning prioritization of needs, implementation of initiatives; oversight of program; tracking of data, etc.). Certain committee members support community benefit reporting on a quarterly (internally) and annual basis.

3. Department: Community Relations (management and operations); Marketing (production of health education and publications); Strategic Planning (planning and progress review consistent with strategic plan and annual operating plan); Finance; Ambulatory Operations (population health programs; health fairs and community events); Laboratory (health fairs and events); Dimensions Healthcare Associates, Inc. (provider support for community events); Nursing (population health programs; health fairs; community events)

4. Task Force: N/A

5. Other (please describe)

   Briefly describe the role of each CB Operations member and their function with the hospital's CB activities planning and reporting process.

   Vice President of Community Relations provides executive oversight for the Community benefit operations; represents organization in various forums; facilitates the development of

community partnerships and population health programs and implementation of community benefit program plan initiatives.

Manager, Community Health manages daily community benefit activities including scheduling and coordinating events related to Implementation plan initiatives, collecting data, coordinating with internal departments; development of health education programs and materials; participates in community partnerships and facilitates the establishment population health programs in program target areas

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

Spreadsheet ___X__yes _____no

Narrative ___X__yes _____no

If yes, describe the details of the audit/review process (who does the review? Who signs off on the review?)

Prior to submission, the report is reviewed by the University of Maryland Medical System Senior Vice-President, Government, Regulatory Affairs & Community Health. In addition the spreadsheet is prepared with the assistance and oversight of designated Finance Department representatives that assure accuracy of the submission.

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

Spreadsheet __X___yes _____no

Narrative __X___yes _____no

If no, please explain why.

e. Are Community Benefit investments incorporated into the major strategies of your Hospital Strategic Transformation Plan?

___X___Yes _______No

If Community Benefit investments are incorporated into the major strategies of your Hospital Strategic Transformation Plan please list these strategies and indicate how the Community Benefit investments will be utilized in support of the strategy.

The University of Maryland Capital Region Health ("UM Capital" (formerly Dimensions Healthcare System)) Population Health Management Strategic Transformation Plan includes the following strategic objectives:

> **Strategic Objective 1:** Using analysis of [University of Maryland Capital Region Health] strengths and opportunities and Community Health Needs Assessment data to determine the need, recruit and hire primary care and multiple specialty care physicians and mid-level providers to support the development of effective primary and multi-specialty clinics at the [University of Maryland Capital Region Health] sites to increase access to care.
>
> **Strategic Objective 2:** Develop effective care continuum models and strategies for preventing Potentially Avoidable Utilizations to reduce readmissions and improve quality of care.
>
> **Strategic Objective 3:** Identify community partners equipped to assist in order to expand current programs or develop supportive programs for behavioral health, chronic disease self-management and diabetes prevention to improve disease management and prevent complications.
>
> **Strategic Objective 4:** Develop a strategy for improved transitional care support for patients at risk for readmission who are being transferred to post-acute care sites (PACS).
>
> **Strategic Objective 5:** Develop an integrated Corporate, Departmental and IT population health management infrastructure to support clinical decision making, clinical integration and access to health information for community providers, and provide linkages of clinical and financial data in order to reduce unnecessary admissions/hospital utilization, while promoting utilization of primary care and ambulatory services, in coordination with other healthcare initiatives to improve overall community health status.
>
> **Strategic Objective 6:** Collaborate with community based organizations and healthcare providers to develop a formal structure/ integrated network of community providers and institutions (e.g., FQHCs, Health Department, post-acute care facilities, and other agencies) to improve access and coordination of care.

Strategic Objective 1 states that UM Capital will rely on Community Health Needs Assessment data to determine the need, recruit and hire primary care and multiple specialty care physicians and mid-level providers to support the development of effective primary and multi-specialty clinics. As a result, UM Capital has invested in the development a comprehensive Medical Staff Development Plan. The plan was crafted with the support of the Advisory Board and will guide the recruitment of primary care and specialty providers to ensure enhanced access to care in the Hospitals service area.

Consistent with the plan, UM Capital has hired new physicians to provide comprehensive women health services and expanded primary and specialty care services into zip codes with limited health care access. This investment supports the operation of a mobile health unit that provides free care to women and children in under-served communities.

In addition, to achieve Strategic Objectives 3, 4 and 6, UM Capital hospitals are currently involved in a variety of collaborative initiatives to expand current programs or develop supportive programs for behavioral health, chronic disease self-management and diabetes prevention to improve disease management and prevent complications. The partners and programs are described in a table on pages 25 and 26 of the Narrative Report. The specific investments related to these programs are included in the data table submitted with the Hospital's report.

UM Capital's population health plan is consistent with UM Capital's mission, vision, and its corporate strategic plan. UM Capital has identified several Critical Success Factors (CSFs) that are relevant to position itself as a strong and sustainable healthcare system. These CSFs include:

1. ***Gaining operational and clinical process efficiencies across all three facilities to minimize variations of care, reduce costs of care, and improve financial performance.***

2. ***Improving care coordination and abilities to share health information among hospitals, physicians, ambulatory sites, post-acute care facilities, and other community providers. Dimensions must transform itself from providing episodic/siloed care to clinically integrated/coordinated care. Clinical integration with financial integration will need to be achieved for provider alignment.***

3. ***Developing a population health management infrastructure designed to reduce unnecessary admissions/hospital utilization, while promoting utilization of primary care and ambulatory services, in coordination with other healthcare initiatives to improve the overall community health status.***

By achieving these CSFs the Hospital also addresses the priority community needs identified in the CHNA. Minimizing variations of care, reducing costs of care, improving care coordination and reducing unnecessary admissions/hospital utilization will achieve the Community Health Improvement Plan objective of improving the overall community health status.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

External collaborations are highly structured and effective partnerships with relevant community stakeholders aimed at collectively solving the complex health and social problems that result in health inequities. Maryland hospital organizations should demonstrate that they are engaging partners to move toward specific and rigorous

processes aimed at generating improved population health. Collaborations of this nature have specific conditions that together lead to meaningful results, including: a common agenda that addresses shared priorities, a shared defined target population, shared processes and outcomes, measurement, mutually reinforcing evidence based activities, continuous communication and quality improvement, and a backbone organization designated to engage and coordinate partners

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

__X__Other hospital organizations

__X__ Local Health Department

__X__ Local health improvement coalitions (LHICs)

__X__ Schools

__X__ Behavioral health organizations

__X__ Faith based community organizations

__X__ Social service organizations

__X__ Post-acute care facilities

b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct the CHNA. Provide a brief description of collaborative activities indicating the roles and responsibilities of each partner and indicating the approximate time period during which collaborative activities occurred (please add as many rows to the table as necessary to be complete).

Organization	**Name of Key Collaborator**	**Title**	**Collaboration Description**
Totally Linking Care Maryland	Camille Bash	Member & CFO, Doctors Community Hospital	Coalition of hospitals to improve health outcomes in Southern Maryland March 2015 to present
Prince George's County Health Department	Pamela Creekmur	Health Officer, Prince George's County Health Department	LHIC, Community Care Coordination Team; Health Enterprise Zone April 2014 to

			present
Prince George's County Schools	Yolanda Tully	Director, Youth Career Connect, Prince George's Economic Development Corp.	Career development program in partnership with Blandensburg High School, Health Care Career Academy and others January 2015 to present
Prince George's County Area Agency on Aging Comprehensive Care Alliance, LLC	Tim McNeill	President , Medical Mall Health Services	Care transitions February 2017 to present
First Baptist Church of Glenarden	Cheryl Cook	Health Ministries Director	Health Promotion & Education; Health Screenings 2014 to present
Access to Wholistic and Productive Living Institute	Bettye Muwwakkil, PhD	Executive Director	Health Education Programs, Care Coordination 2014 to present
Prince George's County Fire and Emergency Medical Services	Kenneth Hickey Brian Goldfeder	Emergency Medical Technician	Mobile integrated health program August 2016 to present
University of Maryland School of Pharmacy	Magaly Rodriguez de Bittner, PharmD	Professor and Associate Dean for Clinical Services and Practice Transformation	Inter-Professional Care Transition Clinic (transitional care program) August 2016 to present

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

_____yes __X___no

If the response to the question above is yes, please list the counties for which a member of the hospital organization co-chairs the LHIC

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

__X__yes _____no

If the response to the question above is yes, please list the counties in which a member of the hospital organization attends meetings or is a member of the LHIC.

Prince George's County

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

Please use Table III to provide a clear and concise description of the primary need identified for inclusion in this report, the principal objective of each evidence based initiative and how the results will be measured (what are the short-term, mid-term and long-term measures? Are they aligned with measures such as SHIP and all-payer model monitoring measures?), time allocated to each initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on the measured outcomes, and the current FY costs associated with each initiative. Use at least one page for each initiative (at 10-point type). Please be sure these initiatives occurred in the FY in which you are reporting.

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

a. 1. Identified need: This may have been identified through a CHNA, a documented request from a public health agency or community group, or other generally accepted practice for developing community benefit programs. Include any measurable disparities and poor health status of racial and ethnic minority groups. Include a description of the collaborative process used to identify common priority areas and alignment with other public and private organizations.

   2. Please indicate how the community's need for the initiative was identified.

b. Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based community health improvement initiatives may be found on the CDC's website using the following links: http://www.thecommunityguide.org/ or http://www.cdc.gov/chinav/), or from the County Health Rankings and Roadmaps website, here: http://tinyurl.com/mmea7nw.
(Evidence based clinical practice guidelines may be found through the AHRQ website using the following link: www.guideline.gov/index.aspx)

c. Total number of people within the target population (how many people in the target area are affected by the particular disease or other negative health factor being addressed by the initiative)?

d. Total number of people reached by the initiative (how many people in the target population were served by the initiative)?

e. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need,

f. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative? (please be sure to include the actual dates, or at least a specific year in which the initiative was in place)

g. Key Collaborators in Delivery: Name the partners (community members and/or hospitals) involved in the delivery of the initiative. For collaborating organizations, please provide the name and title of at least one individual representing the organization for purposes of the collaboration.

h. Impact of Hospital Initiative: Initiatives should have measurable health outcomes and link to overall population health priorities such as SHIP measures and the all-payer model monitoring measures.

   Describe here the measure(s)/health indicator(s) that the hospital will use to evaluate the initiative's impact. The hospital shall evaluate the initiative's impact by reporting (in item "i. Evaluation of Outcome"):

   (i) Statistical evidence of measurable improvement in health status of the target population. If the hospital is unable to provide statistical evidence of measurable improvement in health status of the target population, then it may substitute:

   (ii) Statistical evidence of measureable improvement in the health status of individuals served by the initiative. If the hospital is unable to provide statistical evidence of measureable improvement in the health status of individuals served by the initiative, then it may substitute:

   (iii) The number of people served by the initiative.

   Please include short-term, mid-term, and long-term population health targets for each measure/health indicator. These should be monitored and tracked by the hospital organization, preferably in collaboration with appropriate community partners.

i. Evaluation of Outcome: To what degree did the initiative address the identified community health need, such as a reduction or improvement in the health indicator? To what extent do the measurable results indicate that the objectives of the initiative were met? (Please refer to the short-term, mid-term, and long-term population health targets listed by the hospital in response to item h, above, and provide baseline data when available.)

j. Continuation of Initiative:
   What gaps/barriers have been identified and how did the hospital work to address these challenges within the community? Will the initiative be continued based on the outcome? If not, why? What is the mechanism to scale up successful initiatives for a greater impact in the community?

k. Expense:
   A. what were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, and grants associated with the fiscal year being reported.
   B. Of the total costs associated with the initiative, what amount, if any, was provided through a restricted grant or donation?

2. Were there any primary community health needs identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples: the fact that another nearby hospital is focusing on that identified community need, or that the hospital does not have adequate resources to address it.) This information may be copied directly from the section of the CHNA that refers to community health needs identified but unmet.

The joint CHNA assessed and identified significant community health needs in the County. Through a prioritization process involving a variety of community stakeholders and community-based organizations, the following were identified as CHNA priority community health needs:

- **Behavioral Health**
  - Mental Health
  - Substance Abuse
  - Domestic Violence/Violence
- **Metabolic Syndrome**
  - Obesity
  - Diabetes
  - Heart Disease
  - Hypertension/Stroke
- **Cancer**

University of Maryland Prince George's Hospital Center selected and addressed the following FY 2017 CHIP Priorities:

- **Priority Area 1: Social Determinants of Health Risk Factors**
- **Priority Area 2: Physical Health and Chronic Disease Management**
  - *Improve Chronic Disease Management*
  - *Improve Transitional Care*
- **Priority Area 3: Behavioral Health**
  - *Develop Behavioral Health Outreach and Education Programs in Clinical and Community-based Settings*

In FY 2017 the Hospital did not implement a specific initiative to address the need for additional programs and services to address Cancer. However, UM Capital Region Health is currently developing a plan for a regional cancer program designed to address

those needs. That plan will guide the development of a Comprehensive Cancer Center that will serve the Southern Region of Maryland, which includes University of Maryland Laurel Regional Hospitals and the University of Maryland Prince George's Hospital Center service areas.

UM Capital Region Health developed a "Cancer Program Development Business Plan - Phase I" in 2016. This plan was developed with a minimum timeline of 18 months, to be the roadmap on building the infrastructure for an oncology program. An internal analysis demonstrated the foundational aspects required for the development of a cancer program exists within the system. UM Capital Region Health has made significant progress on the foundational aspects that now allows us to develop specific tumor programs.

During FY2017, UM Capital Region Health continued work on the objectives of the Phase 1 Plan. In addition, a second phase of planning has began which is focused on the development of a market assessment/feasibility study /business model for a new regional cancer center to be located on the campus of the University of Maryland Regional Medical Center, to be located in Largo, Maryland. Services would include medical oncology and radiation oncology, as well as a multi-disciplinary approach to care. UM Capital worked with Oncology Resource Consultants, a nationally known oncology consulting firm, to assist with completing this complex work. UM Capital is also working with the University of Maryland School of Medicine Radiation Oncology Department as well as representatives from the Greenebaum Cancer Center to fine-tune the financial aspects and the space planning for the cancer center which is anticipated to be located in the ambulatory care building next to the new hospital under construction.

3. How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health? (see links below for more information on the State's various initiatives)

   MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP)
   http://dhmh.maryland.gov/ship/SitePages/Home.aspx

   COMMUNITY HEALTH RESOURCES COMMISSION
   http://dhmh.maryland.gov/mchrc/sitepages/home.aspx

The *Maryland Population Health Improvement Plan: Planning for Population Health Improvement* encourages health systems, practitioners and providers of health care services and supports to elevate social determinants of health, health equity, and sustainability of priority actions in order to encourage the creation of a portfolio of feasible and effective priorities that drive change. Furthermore, the Plan prompts an ongoing discussion to consider return on investment and net savings as concepts and, potentially, as tools that can be mobilized when planning for population health improvement. Finally, the plan outlines future and continuing work including the following: population health priority development, continued stakeholder engagement and alignment, exploration of sustainable funding mechanisms for population health improvement, continued alignment with the All-Payer Model, the Maryland

Comprehensive Primary Care Model, Maryland Medicaid and Medicaid Dual Eligibles care delivery strategy, and integration with the State Health Improvement Process (SHIP). Under the Maryland All-Payer model and with the implementation of hospital global budgets, the business model shifted from generating volume in the hospital setting to encouraging population health management strategies that can reduce avoidable utilization and improve quality of care in the hospital.

UM Capital, like other Maryland health systems, has responded by focusing on high utilizers and well-defined areas for quality of care improvements. UM Capital has formed Totally Linking Care – Maryland with other local hospitals and health systems to achieve its stated population health objectives. The TLC-MD coalition plans to reduce frightening or unstable health-related situations for persons living with serious or advanced illnesses and disabilities. The goal is to improve the patient experience, the health of the population and to reduce the need to resort to the hospital. TLC-MD'S quantitative goals are closely aligned with the goals for Maryland.

In addition, University of Maryland Capital Region Health is improving and adapting current health programs into sustainable community-based programs to positively impact the overall health and wellness of the community and achieve population health management objectives. As the Maryland health care system increasingly migrates toward adopting public health approaches in order to meet the performance goals of the All-Payer Model, UM Capital population health improvement activities have moved beyond the clinical space to address all factors that determine health; the social determinants of health and health equity. This service expansion and adaptation is being achieved through collaborative partnerships with community organizations as well as state and local health agencies. UM Capital management actively solicits information from community stakeholders and other community-based organizations to assess the health needs in our community. UM Capital representatives serve as members of a variety of healthcare focused community organizations and provide staff expertise and other resources, including hosting meetings at our facility and the provision of health screening services at local community events.

UM Capital contributed to the development of the Prince George's County Health Improvement Plan. Also, UM Capital leadership and staff participate on several of the Prince George's Health Action Coalition committees which focus on improving the overall health of residents. As part of the State Health Improvement Process (SHIP) the Prince George's Healthcare Action Coalition is working within all three main components of SHIP- Public Engagement, Accountability and Local Action- as we develop and implement actionable strategies to improve the health of Prince George's County residents.

TABLE III

HOSPITAL COMMUNITY BENEFIT PROGRAMS AND INITIATIVES

A. 1. Identified Need: A. 2. How was the need identified:	A.1) **Physical Health & Chronic Disease Management** A.2) Needs were identified as a result of the 2016 Community Health Needs Assessment conducted in partnership with the county's five hospitals and the Prince George's County Health Department. The process included key informant interviews with county residents from diverse backgrounds with varying perspectives on health in the county. The needs were prioritized by hospital and Health Department representatives and key community stakeholders representing Local government; patient advocates; faith-based organizations; the public school health service; local politicians; safety net providers; state government; physician providers; academia; private industry; local philanthropy and special populations – seniors, Hispanics, the Piscataway Indian tribe; veterans, and the disabled. The representatives live and work in all areas of the County. A Key CHNA finding was that the leading physical health concerns are a result of the incidence and prevalence of chronic disease-cardiovascular disease, hypertension, Type 2 diabetes in adults and Type 2 diabetes and asthma in children.
B: Name of hospital initiative	B.1 *Hospital to Home Program* B.2) *Inter-professional Care Transition Clinic*
C: Total number of people within target population	The PGHC CBSA total population is 579,929 (based on 2016 estimates). The target population resided in zip codes that are in PGHC's primary service area, located within Prince George's County. The total target population is 377,088
D: Total number of people reached by the initiative	408 reviewed for services
E: Primary objective of initiative:	Improve health of the community through Transitional Care by achieving:

	Objective 1: Maintain collaboration with the Health Department and other community health stakeholders. Objective 2: Promote use of the 2016 Community Health Needs Assessment (CHNA) findings to better target community health initiatives Objective 3: Support the development of effective community health programming Objective 4: Build a network of non-profit community based organizations (CBOs) in Prince George's County that can help to carry out Community Benefit strategic initiatives
F: Single or multi-year plan:	Multi-year
G: Key collaborators in delivery:	University of Maryland Family Health & Wellness Centers. UM Chest Pain Program UM Stroke Center UM School of Pharmacy eHealth Services Center Prince George's County Family Service Department (Area on Aging) Comprehensive Care Alliance
H: Impact of hospital initiative:	Metric 1: # of High Risk Assessments Outcome: 76 patients have been assessed and referred to the Transitional Care clinic (eQhealth center). Metric 2: # of patients participating in chronic disease self-management/lifestyle change programs Outcome: 23 patients have been scheduled in the clinic.
I: Evaluation of outcome	Evaluation of outcomes will be reported in FY 18. Outcomes will assessed using 30 Day Readmission/Total Admissions • Emergency Room visits • Resolution of Medication Related Problems • Referrals to community resources/health care resources • Patient Satisfaction Surveys

J: Continuation of initiative:	Continuation of initiatives in FY2018 with plans to expand services related to ICTC and well-mobile clinic.	
K: Expense:	a. $238,663.00	b. $80,000

A. 1. Identified Need: A. 2. How was the need identified:	A.1) **Physical Health & Chronic Disease Management** A.2) Needs were identified as a result of the 2016 Community Health Needs Assessment conducted in partnership with the county's five hospitals and the Prince George's County Health Department. The process included key informant interviews with county residents from diverse backgrounds with varying perspectives on health in the county. The needs were prioritized by hospital and Health Department representatives and key community stakeholders representing Local government; patient advocates; faith-based organizations; the public school health service; local politicians; safety net providers; state government; physician providers; academia; private industry; local philanthropy and special populations – seniors, Hispanics, the Piscataway Indian tribe; veterans, and the disabled. The representatives live and work in all areas of the County. A Key CHNA finding was that the leading physical health concerns are a result of the incidence and prevalence of chronic disease- cardiovascular disease, hypertension, Type 2 diabetes in adults and Type 2 diabetes and asthma in children.
B: Name of hospital initiative	B.1) *Diabetes Self-Management Class* B.2) *Chronic Disease Screenings*
C: Total number of people within target population	The PGHC CBSA total population is 579,929 (based on 2016 estimates). The target population resided in zip codes that are in PGHC's primary service area, located within Prince George's County. The total target population is 377,088
D: Total number of people reached by the initiative	Chronic Disease Management encounters: 1,925
E: Primary objective of initiative:	Improve Chronic Disease Management for patients by achieving: Objective 1: Maintain collaboration with the Health Department and

	other community health stakeholders. Objective 2: Promote use of the 2016 Community Health Needs Assessment (CHNA) findings to better target community health initiatives Objective 3: Support the development of effective community health programming Objective 4: Build a network of non-profit community based organizations (CBOs) in Prince George's County that can help to carry out Community Benefit strategic initiatives
F: Single or multi-year plan:	Multi-year
G: Key collaborators in delivery:	University of Maryland Family Health & Wellness Centers. UM Chest Pain Program UM Stroke Center UM School of Pharmacy eHealth Services Center Access to Wholistic & Productive Institute, Greater Baden Medical Center
H: Impact of hospital initiative:	Metric 1: # of High Risk Assessments Outcome: A total of 750 Chronic Disease Screenings (Hypertension, Diabetes & COPD) were conducted within the target population. A total of 806 community health screenings have been conducted focusing on hypertension, Diabetes and COPD. Metric 2: # of patients participating in chronic disease self-management/lifestyle change programs Outcome: 61 participants in Chronic Disease/Diabetes Living Well Self-Management Classes.
I: Evaluation of outcome	Evaluation of outcomes will be reported in FY 18.Outcomes will assessed using 30 Day Readmission/Total Admissions • Emergency Room visits • Resolution of Medication Related Problems • Referrals to community resources/health care resources • Patient Satisfaction Surveys
J: Continuation of initiative:	Planned continuation of initiatives with plans to expand health and wellness screenings and educational

	activities specifically related to chronic disease self-management classes.	
K: Expense:	a. $7,443.00	b.

A. 1. Identified Need: A. 2. How was the need identified:	A.1) **Behavioral Health** A.2) Needs were identified as a result of the 2016 Community Health Needs Assessment conducted in partnership with the county's five hospitals and the Prince George's County Health Department. The process included key informant interviews with county residents from diverse backgrounds with varying perspectives on health in the county. The needs were prioritized by hospital and Health Department representatives and key community stakeholders representing Local government; patient advocates; faith-based organizations; the public school health service; local politicians; safety net providers; state government; physician providers; academia; private industry; local philanthropy and special populations – seniors, Hispanics, the Piscataway Indian tribe; veterans, and the disabled. The representatives live and work in all areas of the County. Key Findings from the CHNA indicate behavioral health problems are on the rise among adults and children due to the stigma around seeking help for mental conditions and limited access to behavioral health services due to a lack of providers.
B: Name of hospital initiative	B.1) Develop Behavioral Health Outreach and Education Programs in Clinical and Community-based Settings
C: Total number of people within target population	The UM Family Health & Wellness Center Physicians conduct Annual Behavioral Health Depression Screenings at a Mega Church located in Prince George's County.
D: Total number of people reached by the	75 encounters were reported during this

initiative	outreach.
E: Primary objective of initiative:	Objective 1 : To educate the public about behavioral health risk factors, behavioral health promotion, and basic wellness issues; To promote engagement in appropriate primary and specialty care; To educate service providers and educators on behavioral health first aid; To increase screening and referral activities in clinical, community, school-based, and worksite settings
F: Single or multi-year plan:	Multi year
G: Key collaborators in delivery:	UM Family Health & Wellness Centers Access to Wholistic and Productive living Institute Mosaic Community Services Faith & Community based organizations
H: Impact of hospital initiative:	Objective 1- Metric: # of Mental Health First Aid Workshops conducted, # of attendees. Outcome: Mental health screenings conducted at health fair in faith-based setting. Workshops to be implemented in FY 18.
I: Evaluation of outcome	Evaluation metrics will focus on the # of Mental Health First Aid Workshops conducted both within the hospital and at community locations in collaboration with UM PGHC.
J: Continuation of initiative:	Continuation of initiatives with plans to implement Mental Health First Aid workshops at UM PGHC and UM LRH and initiate mental health education and awareness activities/events.
K: Expense:	a. $680.00 b.

A. 1. Identified Need: A. 2. How was the need identified:	A.1) **Social Determinants of Health Risk Factors** A.2) Needs were identified as a result of the 2016 Community Health Needs Assessment conducted in partnership with the county's five hospitals and the Prince George's County Health Department. The process included key informant interviews with county residents from diverse backgrounds with varying perspectives on health in the county. The needs were prioritized by hospital and Health Department representatives and key community stakeholders representing Local government;

	patient advocates; faith-based organizations; the public school health service; local politicians; safety net providers; state government; physician providers; academia; private industry; local philanthropy and special populations – seniors, Hispanics, the Piscataway Indian tribe; veterans, and the disabled. The representatives live and work in all areas of the County. Key CHNA finding is Social Determinants of health - Poverty, food insecurity, access to healthy food, affordable housing, employment, lack of educational attainment, inadequate financial resources, and a disparate built environment – are drivers of poor health outcomes
B: Name of hospital initiative	The Prince George's County *Youth Career Connect Program (PGC-YCC)*
C: Total number of people within target population	2594 high school students in participating schools
D: Total number of people reached by the initiative	Number of Participants Served: 767
E: Primary objective of initiative:	Work with community partners and schools to organize education and awareness events for their constituencies to address social determinants of health.
F: Single or multi-year plan:	Multi-year
G: Key collaborators in delivery:	• Prince George's County Economic Development Corporation. • Prince George's County Public Schools • UM Prince George's Hospital Internal Medicine Residency • National Institutes of Health • Community-based organizations including youth support groups
H: Impact of hospital initiative:	New Enrollees: 312 Number of Internships: 204 (23 at UM Capital) designed to educate and expose students to careers in health care and Information Technology Currently 237 students are enrolled in the Health and Bioscience Career academy at Bladensburg High School. UM Capital is

	strategically aligned with Bioscience to support students interested in careers in health care, but also provides opportunities for students in other career academies.
I: Evaluation of outcome	Assessed performance against established program metrics: Avg. Program Retention: 89.4% Avg. Number of Post-Secondary Credits earned: 3.5 Achieved 110% of Year 3 Enrollments (696 Enrollments was the Required USDOL Performance Target by June 30, 2017) 2017 Second YCC Graduating Cohort of Students: Total 83 93% College Placement (Bladensburg and Fairmont Heights Combined)
J: Continuation of initiative:	Continuation of initiatives for final grant year and transition consistent with approved sustainability plan

K: Expense:	a. $3648.00	b.

A. 1. Identified Need: A. 2. How was the need identified:	A.1) **Social Determinants of Health Risk Factors** A.2) Needs were identified as a result of the 2016 Community Health Needs Assessment conducted in partnership with the county's five hospitals and the Prince George's County Health Department. The process included key informant interviews with county residents from diverse backgrounds with varying perspectives on health in the county. The needs were prioritized by hospital and Health Department representatives and key community stakeholders representing Local government; patient advocates; faith-based organizations; the public school health service; local politicians; safety net providers; state government; physician providers; academia; private industry; local philanthropy and special populations – seniors, Hispanics, the Piscataway Indian tribe;

	veterans, and the disabled. The representatives live and work in all areas of the County. Key CHNA finding is Social Determinants of health - Poverty, food insecurity, access to healthy food, affordable housing, employment, lack of educational attainment, inadequate financial resources, and a disparate built environment – are drivers of poor health outcomes
B: Name of hospital initiative	*Access to Wholistic and Productive Living Institute* (AWPLI).
C: Total number of people within target population	See Hospitals' target populations above.
D: Total number of people reached by the initiative	Approximately 50 encounters.
E: Primary objective of initiative:	• Work with community partners and schools to organize education and awareness events for their constituencies to address social determinants of health risk factors • Partner with AWPLI to expand its program outreach and support sustainability
F: Single or multi-year plan:	Multi-year
G: Key collaborators in delivery:	• UM Prince George's Hospital Internal & Family Medicine • Community-based organizations including youth support groups
H: Impact of hospital initiative:	20 HIV screenings
I: Evaluation of outcome	Expansion of HIV screening and education
J: Continuation of initiative:	Program will continue and expand services to targeted population
K: Expense:	c. $1239 d.

VI. PHYSICIANS

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

2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please use Table IV to 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.

The Health Department prepared the *2016 Prince George's County Community Health Needs Assessment* that includes a detailed description of the process and the major. The Health Department also produced a comprehensive inventory of community resources and assets and hospital specific profiles, including *Prince George's Hospital Center Service Profile* and *Laurel Regional Hospital Center Service Profile*. These documents are included as appendices to this report.

The County-wide CHNA found that many of the health disparities in the County were driven by social determinants of health including poverty, food insecurity, lack of access to healthy food, affordable housing, low employment, lack of educational attainment, inadequate financial resources and disparate built environment. Findings also indicated that, while progress has been made with implementation of components of the primary healthcare strategic plan, the County continues to have a shortage of primary care providers, medical specialists, behavioral health providers, and dentists.

Table IV – Physician Subsidies

Category of Subsidy	Explanation of Need for Service
Hospital-Based physicians	UM PGHC's emergency departments, and other specialties including intensive care, anesthesia, cardiology, endocrinology, internal medicine, 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. By providing emergency and other specialty services to the County's uninsured and underinsured population, UM PGHC provides an ongoing community benefit to residents unable to obtain much needed health care services.
Non-Resident House Staff and Hospitalists	The subsidies cover gaps in physician services due to lack of adequate community providers who practice within the hospital. Additionally the hospital supports a disproportionate share of underinsured or uninsured patients.
Coverage of Emergency Department Call	The subsidies cover gaps in physician income that are the outcome of UM PGHC's disproportionate share of underinsured or uninsured patients.
Physician Provision of Financial Assistance	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.
Physician Recruitment to Meet Community Need	The UM PGHC physician subsidies also include expenses incurred for ongoing physician recruitment consistent UM

	Capital Region Health's Medical Staff Development Plan. 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, UM PGHC's mission provides that all patients should receive the highest level of care regardless of economic standing. UM 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
Other – (provide detail of any subsidy not listed above – add more rows if needed)	

VII. 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;
- Besides English, in what language(s) is the Patient Information sheet available;
- 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. Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014 (label appendix II).

c. Include a copy of your hospital's FAP (label appendix III).

d. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) Please be sure it conforms to the instructions provided in accordance with Health-General §19-214.1(e). Link to instructions: http://www.hscrc.state.md.us/documents/Hospitals/DataReporting/FormsReportingModules/MD_HospPatientInfo/PatientInfoSheetGuidelines.doc (label appendix IV).

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

Attachment A

MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP) SELECT POPULATION HEALTH MEASURES FOR TRACKING AND MONITORING POPULATION HEALTH

- Increase life expectancy
- Reduce infant mortality
- Prevention Quality Indicator (PQI) Composite Measure of Preventable Hospitalization
- Reduce the % of adults who are current smokers
- Reduce the % of youth using any kind of tobacco product
- Reduce the % of children who are considered obese
- Increase the % of adults who are at a healthy weight
- Increase the % vaccinated annually for seasonal influenza
- Increase the % of children with recommended vaccinations
- Reduce new HIV infections among adults and adolescents
- Reduce diabetes-related emergency department visits
- Reduce hypertension related emergency department visits
- Reduce hospital ED visits from asthma
- Reduce hospital ED visits related to mental health conditions
- Reduce hospital ED visits related to addictions
- Reduce Fall-related death rate

APPENDIX I

FINANCIAL ASSISTANCE PROGRAM

UM 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. UM 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.

APPENDIX II

The following additional changes were also made to the hospital's financial assistance policy pursuant to the most recent 501(r) regulatory requirements:

1. LANGUAGE TRANSLATIONS

a. Requirement: The new 501(r) regulations lowered the language translation threshold for limited English proficient (LEP) populations to the lower of 5% of LEP individuals in the community served/1000-LEP individuals. University of Maryland Capital Region Health translated its financial assistance policy into the following languages: Arabic, Chinese, English, French, German, Gujarati, Haitian Creole, Hindi, Igbo, Korean, Oromo, Spanish, Swahili, Tagalog, Urdu, Vietnamese and Yoruba.

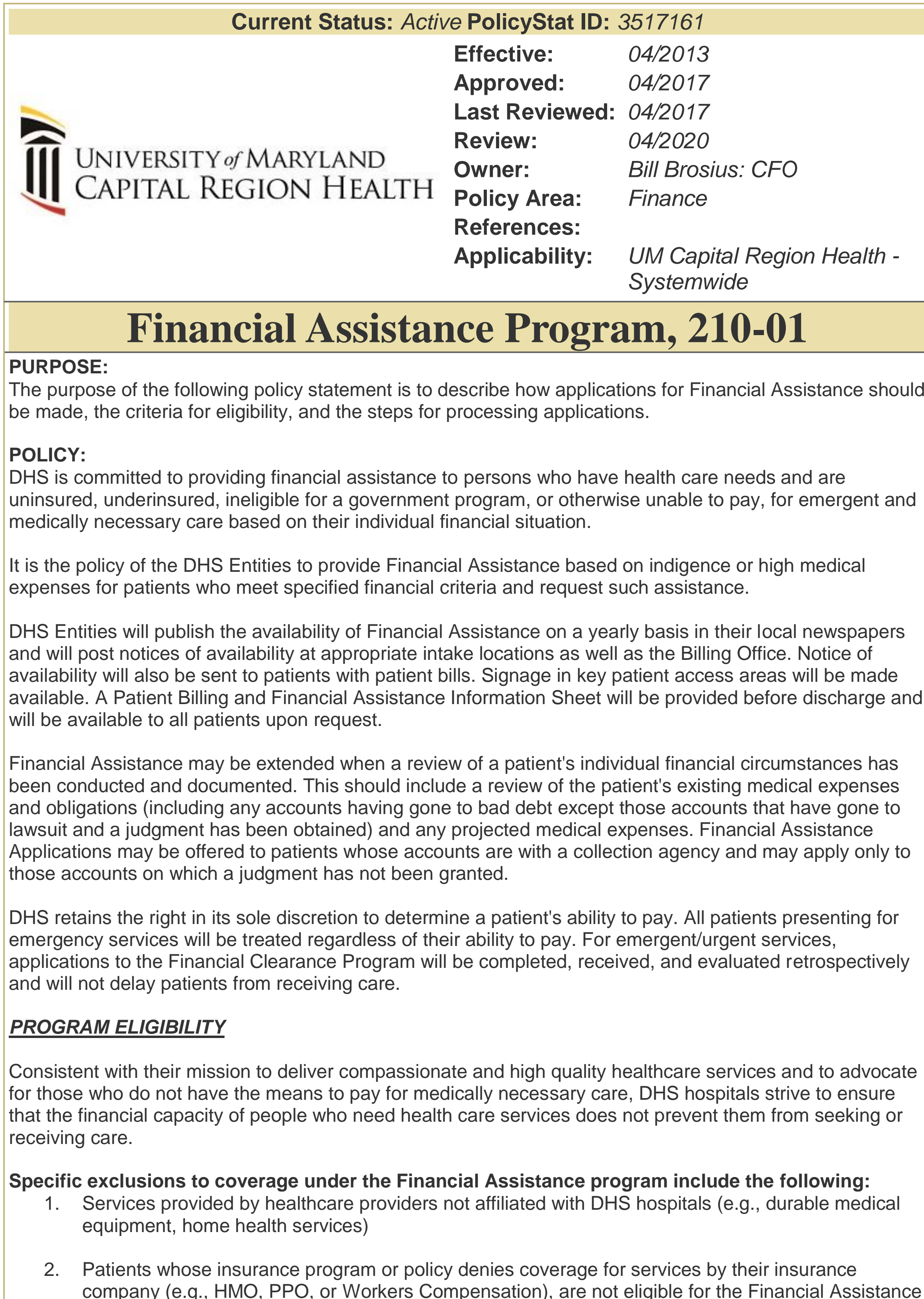
2. PLAIN LANGUAGE SUMMARY

a. Requirement: The new 501(r) regulations require a plain language summary of the FAP that is clear, concise, and easy for a patient to understand. University of Maryland Capital Region Health created a new plain language summary of its financial assistance policy in addition to its already-existing patient information sheet. The plain language summary is translated into the following languages: Arabic, Chinese, English, French, German, Gujarati, Haitian Creole, Hindi, Igbo, Korean, Oromo, Spanish, Swahili, Tagalog, Urdu, Vietnamese and Yoruba.

3. PROVIDER LISTS

a. Requirement: The new 501(r) regulations require each hospital to create and maintain a list of all health care providers (either attached to the FAP or maintained as a separate appendix) and identify which providers on that list are covered under the hospital's FAP and which providers are not. University of Maryland Capital Region Health maintains that list which is available for review.

APPENDIX III



Current Status: *Active* **PolicyStat ID:** *3517161*

UNIVERSITY *of* MARYLAND
CAPITAL REGION HEALTH

Effective:	*04/2013*
Approved:	*04/2017*
Last Reviewed:	*04/2017*
Review:	*04/2020*
Owner:	*Bill Brosius: CFO*
Policy Area:	*Finance*
References:	
Applicability:	*UM Capital Region Health - Systemwide*

Financial Assistance Program, 210-01

PURPOSE:
The purpose of the following policy statement is to describe how applications for Financial Assistance should be made, the criteria for eligibility, and the steps for processing applications.

POLICY:
DHS is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for emergent and medically necessary care based on their individual financial situation.

It is the policy of the DHS Entities to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance.

DHS Entities will publish the availability of Financial Assistance on a yearly basis in their local newspapers and will post notices of availability at appropriate intake locations as well as the Billing Office. Notice of availability will also be sent to patients with patient bills. Signage in key patient access areas will be made available. A Patient Billing and Financial Assistance Information Sheet will be provided before discharge and will be available to all patients upon request.

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing medical expenses and obligations (including any accounts having gone to bad debt except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses. Financial Assistance Applications may be offered to patients whose accounts are with a collection agency and may apply only to those accounts on which a judgment has not been granted.

DHS retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services will be treated regardless of their ability to pay. For emergent/urgent services, applications to the Financial Clearance Program will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

PROGRAM ELIGIBILITY

Consistent with their mission to deliver compassionate and high quality healthcare services and to advocate for those who do not have the means to pay for medically necessary care, DHS hospitals strive to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

Specific exclusions to coverage under the Financial Assistance program include the following:

1. Services provided by healthcare providers not affiliated with DHS hospitals (e.g., durable medical equipment, home health services)

2. Patients whose insurance program or policy denies coverage for services by their insurance company (e.g., HMO, PPO, or Workers Compensation), are not eligible for the Financial Assistance

Program.

a. Generally, the Financial Assistance Program is not available to cover services that are denied by a patient's insurance company; however, exceptions may be made on a case by case basis considering medical and programmatic implications.

3. Unpaid balances resulting from cosmetic or other non-medically necessary services

4. Patient convenience items

5. Patient meals and lodging

6. ***Physician charges related to the date of service are excluded from DHS financial assistance policy. Patients who wish to pursue financial assistance for physician-related bills must contact the physician directly.***

Patients may be ineligible for Financial Assistance for the following reasons:

1. Refusal to provide requested documentation or provide incomplete information.

2. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to the hospital due to insurance plan restrictions/limits.

3. Failure to pay co-payments as required by the Financial Assistance Program.

4. Failure to keep current on existing payment arrangements with DHS.

5. Failure to make appropriate arrangements on past payment obligations owed to DHS (including those patients who were referred to an outside collection agency for a previous debt).

6. Refusal to be screened for other assistance programs prior to submitting application to the Financial Clearance Program.

7. Refusal to divulge information pertaining to a pending legal liability claim

8. Foreign-nationals traveling to the United States seeking elective, non-emergent medical care

Patients who become ineligible for the program will be required to pay any open balances and may be submitted to a bad debt service if the balance remains unpaid in the agreed upon time periods.

Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance Eligibility criteria. If the patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor/Coordinator and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

Coverage amounts will be calculated based upon 200-500% of income as defined by federal poverty guidelines published each year in the Federal Register. The new guidelines are effective with the first month following publication.

Presumptive Financial Assistance

Patients may also be considered for Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. There is adequate information provided by the patient or through other sources, which provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, DHS reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% write-off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

a. Active Medical Assistance pharmacy coverage

b. SLMB coverage

c. PAC coverage

d. Homelessness

e. Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs

f. Medical Assistance spend down amounts

g. Eligibility for other state or local assistance programs

h. Patient is deceased with no known estate

i. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program

j. Non-US Citizens deemed non-compliant

k. Non-Eligible Medical Assistance services for Medical Assistance eligible patients

l. Unidentified patients (Doe accounts that we have exhausted all efforts to locate and/or ID)

m. Bankruptcy, by law, as mandated by the federal courts

Specific services or criteria that are ineligible for Presumptive Financial Assistance include:

a. Purely elective procedures (example – Cosmetic) are not covered under the program.

b. Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered under the presumptive financial assistance program until the Maryland Medicaid Psych program has been billed.

PROCEDURE:

1. There are designated persons who will be responsible for taking Financial Assistance applications. These can be Financial Counselors, Patient Financial Receivable Coordinators, Customer Service Representatives, etc.

2. Every possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.

    a. Staff will complete an eligibility check with the Medicaid program for Self-Pay patients to verify whether the patient has current coverage.

    b. Preliminary data will be entered into a third party data exchange system to determine probable eligibility. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.

    c. Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance. Determination of Probable Eligibility will be provided within two business days following a patient's request for charity care services, application for medical assistance, or both

    d. Upon receipt of the patient's application, they will have thirty (30) days to submit the required documentation to be considered for eligibility. If no data is received within the 30 days, a denial letter will be sent notifying that the case is now closed for lack of the required

documentation. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to. The Financial Assistance application process will be open up to at least 240 days after the first post-discharge patient bill is sent.

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

3. There will be one application process for all DHS facilities. The patient is required to provide a completed Financial Assistance Application orally or in writing. In addition, the following may be required:

   a. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return); proof of disability income (if applicable), proof of social security income (if applicable). If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc ...

   b. A copy of their most recent pay stubs (if employed) or other evidence of income.

   c. A Medical Assistance Notice of Determination (if applicable).

   d. Copy of their Mortgage or Rent bill (if applicable), or written documentation of their current living/housing situation.

   A written request for missing information will be sent to the patient. Oral submission of needed information will be accepted, where appropriate.

4. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on DHS guidelines.

   a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Coordinator will recommend the patient's level of eligibility and forward for a second and final approval.

      i. If the patient does qualify for Financial Assistance, the Financial Coordinator will notify clinical staff who may then schedule the patient for the appropriate hospital-based service.

      ii. If the patient does not qualify for Financial Assistance, the Financial Coordinator will notify the clinical staff of the determination and the non-emergent/urgent hospital-based services will not be scheduled.

         1. A decision that the patient may not be scheduled for hospital-based, non-emergent/urgent services may be reconsidered by the Financial Clearance Executive Committee, upon the request.

         2. The Financial Clearance Committee consists of Asst. Director of PFS, Sr Director of Revenue Cycle, DHS Risk Manager, and CFO.

         3. The CFO shall sign off on any charity cases greater than $50,000.

5. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.

6. Once a patient is approved for Financial Assistance, Financial Assistance coverage may be effective for the month of determination, up to 3 years prior, and up to six (6) calendar months in to the future. However, there are no limitations on the Financial Assistance eligibility period. Each eligibility period will be determined on a case-by-case basis. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance. In addition, changes to the patient's income, assets, expenses or family status are expected to be

communicated to the Financial Assistance Program Department. All Extraordinary Collections Action activities, as defined below, will be terminated once the patient is approved for financial assistance and all the patient responsible balances are paid.

Extraordinary Collection Actions (ECAs) may be taken on accounts that have not been disputed or are not on a payment arrangement. Except in exceptional circumstances, these actions will occur no earlier than 120 days from submission of first bill to the patient and will be preceded by notice 30 days prior to commencement of the ECA action. Availability of financial assistance will be communicated to the patient and a presumptive eligibility review will occur prior to any action being taken.

i. Garnishments may be applied to these patients if awarded judgment.

ii. A lien may be placed by the Court on primary residences. The facility will not pursue foreclosure of a primary residence but may maintain our position as a secured creditor if a property is otherwise foreclosed upon.

iii. Closed account balances that appear on a credit report or referred for judgment/garnishment may be reopened should the patient contact the facility regarding the balance report. Payment will be expected from the patient to resolve any credit issues, until the facility deems the balance should remain written off.

iv. Extraordinary Collection Actions require the approval of the Financial Clearance Committee.

7. If a patient is determined to be ineligible, all efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.

8. A letter of final determination will be submitted to each patient who has formally submitted an application.

9. Refund decisions are based on when the patient was determined unable to pay compared to when the patient payments were made. Refunds may be issued back to the patient for credit balances, due to patient payments, resulted from approved financial assistance on considered balance(s). Payments received for care rendered during the financial assistance eligibility window will be refunded, if the amount exceeds the patient's determined responsibility by $5.00 or more.

10. Patients who have access to other medical care (e.g., primary and secondary insurance coverage or a required service provider, also known as a carve-out), must utilize and exhaust their network benefits before applying for the Financial Assistance Program.

Financial Hardship

The amount of uninsured medical costs incurred at any DHS facility will be considered in determining a patient's eligibility for the Financial Assistance Program. The following guidelines are outlined as a separate, supplemental determination of Financial Assistance, known as Financial Hardship. Financial Hardship will be offered to all patients who apply for Financial Assistance.

Medical Financial Hardship Assistance is available for patients who otherwise do not qualify for Financial Assistance under the primary guidelines of this policy, but for whom:

1. Their medical debt incurred at DHS facilities exceeds 25% of the Family Annual Household Income, which is creating Medical Financial Hardship; and

2. who meet the income standards for this level of Assistance.

For the patients who are eligible for both the Reduced Cost Care under the primary Financial Assistance criteria and also under the Financial Hardship Assistance criteria, DHS will grant the reduction in charges that are most favorable to the patient for medically necessary treatment by a family household over a twelve (12) month period that exceeds 25% of that family's annual income.

Medical Debt is defined as out of pocket expenses for the facility charges incurred for medically necessary treatment.

Once a patient is approved for Financial Hardship Assistance, coverage will be effective starting the month of the first qualifying date of service and up to the following twelve (12) calendar months from the application evaluation completion date. Each patient will be evaluated on a case-by-case basis for the eligibility time frame according to their spell of illness/episode of care. It will cover the patient and the immediate family members living in the household for the approved reduced cost and eligibility period for medically necessary treatment. Coverage shall not apply to elective or cosmetic procedures. However, the patient or guarantor must notify the hospital of their eligibility at the time of registration or admission. In order to continue in the program after the expiration of each eligibility approval period, each patient must reapply to be reconsidered. In addition, patients who have been approved for the program must inform the hospitals of any changes in income, assets, expenses, or family (household) status within 30 days of such change(s).

All other eligibility, ineligibility, and procedures for the primary Financial Assistance program criteria apply for the Financial Hardship Assistance criteria, unless otherwise stated above.

Appeals

- Patients whose financial assistance applications are denied have the option to appeal the decision.
- Appeals can be initiated verbally or written.
- Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.
- Appeals are documented within the third party data and workflow tool. They are then reviewed by the next level of management above the representative who denied the original application.
- If the first level of appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.
- The escalation can progress up to the Chief Financial Officer who will render a final decision.
- A letter of final determination will be submitted to each patient who has formally submitted an appeal.

Judgments

If a patient is later found to be eligible for Financial Assistance after a judgment has been obtained or the debt submitted to a credit reporting agency, DHS shall seek to vacate the judgment and/or strike the adverse credit information.

Attachments:

Financial Assistance Application
Financial Assistance Program Sliding Fee Scale - 2017

Approval Signatures

Approver	Date
Joe Smith: Acting Chief Financial Officer	04/2017

DIMENSIONS HEALTHCARE CORPORATION
FINANCIAL ASSISTANCE PROGRAM

Sliding Fee Scale - 2016

% Of Write Off	**100%**	**100%**	**70%**	**60%**	**50%**	**25%**
Family Size	**Income**	**Income**	**Income**	**Income**	**Income**	**Income**
1	$12,060	$24,120	$27,135	$30,150	$36,180	$60,300
2	$16,240	$32,480	$36,540	$40,600	$48,720	$81,200
3	$20,420	$40,840	$45,945	$51,050	$61,260	$102,100
4	$24,600	$49,200	$55,350	$61,500	$73,800	$123,000
5	$28,780	$57,560	$64,755	$71,950	$86,340	$143,900
6	$32,960	$65,920	$74,160	$82,400	$98,880	$164,800
7	$37,140	$74,280	$83,565	$92,850	$111,420	$185,700
8	$41,320	$82,640	$92,970	$103,300	$123,960	$206,600
For families/households with more than 8 persons, add $ 4,180 for each additional person.						
% of Income at or above 2017 Poverty Guidelines	**100%**	**200%**	**225%**	**250%**	**300%**	**500%**

Effective: January 31, 2017

APPENDIX IV

Patient Information Sheet

UNIVERSITY of MARYLAND
CAPITAL REGION HEALTH

Help for Patients to Pay Hospital Care Costs

If you cannot pay for all or part of your care from our hospital, you may be able to get free or lower cost services.

PLEASE NOTE:

1. We treat all patients needing emergency care, no matter what they are able to pay.
2. There may be services provided by physicians or other providers that are not covered by the hospital's Financial Assistance Policy.
3. Services provided at one of the UM Capital Region Health clinics may be considered for financial assistance at that clinic or practice. You can call 301-618-6979 or 301-618-2273 if you have questions.

HOW THE PROCESS WORKS:

When you become a patient, we ask if you have any health insurance. We will not charge you more for hospital services than we charge people with health insurance. The hospital will:

1. Give you information about our financial assistance policy or
2. Offer you help with a counselor who will help you with the application.

HOW WE REVIEW YOUR APPLICATION:

The hospital will look at your ability to pay for care. We look at your income and family size. You may receive free or lower costs of care if:

1. Your income or your family's total income is low for the area where you live, or
2. Your income falls below the federal poverty level if you had to pay for the full cost of your hospital care, minus any health insurance payments.

PLEASE NOTE: If you are able to get financial help, we will tell you how much you can get. If you are not able to get financial help, we will tell you why not.

HOW TO APPLY FOR FINANCIAL HELP:

1. Fill out **a Financial Assistance Application Form**.
2. Give us all of your information to help us understand your financial situation.
3. Turn the Application Form into us.

PLEASE NOTE: The hospital must screen patients for Medicaid before giving financial help.

OTHER HELPFUL INFORMATION:

1. You can get a **free copy** of our Financial Assistance Policy and Application Form:
    - Online at www.umcapitalregion.org
    - In person at the Financial Assistance Office Prince George's Hospital Center, 3001 Hospital Drive, Cheverly, MD, 2nd floor, Eligibility Services/Financial Assistance Program
    - By mail by sending your request to:

      Financial Assistance Program
      Prince George's Hospital Center
      3001 Hospital Drive 2nd Floor
      Cheverly, MD 20785
2. You can call the Financial Assistance Office if you have questions or need help applying. You can also call if you need help in another language. Call: 301-618-3250.

Updated 02 01 2017

PATIENT INFORMATION SHEET

WHAT YOU
SHOULD KNOW
AS A PATIENT

UM Bowie Health Center

UM Capital Surgery Center

UM Family Health

UM Laurel Regional Hospital

UM Prince George's Hospital Center

Rachel H. Pemberton Senior Health Center

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 UM Prince George's Hospital Center, call (301) 618-3857. To contact the patient representative at UM Laurel Regional Hospital, call (240) 456-4764.

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. UM Capital Region Health's visitation policies are aimed at protecting the health and safety of all patients.

Complaints / Grievances

- Complaint: A verbal expression of dissatisfaction or allegation of hospital wrong doing from a patient/patient representative or visitor which can be successfully resolved by staff present at the time of the complaint.

- Grievance: Formal or informal written complaint a grievance is also a verbal complaint that is made by a patient/patient representative regarding the patient's care that is not successfully resolved at the time by staff. UM Capital Region Health 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 defi ned by the patient/family member and may include a meeting with all involved parties.

If you have a complaint pertaining to the following UM Capital Region Health facilities: **UM Bowie Health Center; UM Capital Surgery Center; Family Health and Wellness Center; UM Prince George's Hospital;** 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 fi le a grievance, you may do so by telephone, letter or e-mail, at the following:

UM Capital Region Health / UM 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 **UM Laurel Regional Hospital** that has not been resolved by the healthcare staff at the time of your complaint and you wish to fi le a grievance, you may do so by telephone, letter or in person, at the following:

UM Laurel Regional Hospital
Attn: Patient Relations Department
7300 Van Dusen Road
Laurel, MD 20707
Phone: (240) 456-4764

UM Capital Region Health'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. 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 UM Capital Region Health facility. Your grievance will be reviewed and investigated, and you will receive a written response within seven (7) 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@dhmh.state.md.us

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:

KePro
5201 West Kennedy Blvd. Suite 900
Tampa, FL 33609
(844) 455-8708
TTY (855) 843-4776

For mental and behavioral health services:

Maryland Disability Law Center
1500 Union Avenue, Suite 2000
Baltimore, MD 21211
Phone: (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: DMHM.MDBOP@Maryland.gov

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 UM Capital Region Health for facility fees and from individual physicians for professional fees.

If you are unable to pay your bill, you may call (301) 681-3250 for information about applying for Medical Assistance. If you need financial assistance, you may qualify for UM Capital's Financial Assistance program or arrange a payment plan for your facility fees. You may call (301) 618-3250 for help with applying for financial assistance.

There may be services provided by physicians or other providers that are not covered by the hospital's Financial Assistance. Services provided at one of the UM Capital Region Health may be considered for Financial Assistance. You may call (301) 618-6979 or (301) 618-2273 if you have any questions.

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 fi le 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) 468-2000 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 UM Capital Region Health 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

UM Capital Region Health 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 UM Prince George's Hospital Center by calling (301) 618-2740 or at UM 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 UM Laurel Regional Hospital, there is a chapel available to patients and their families for prayer, meditation and reflection. UM 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.umcapitalregion.org for additional information.

Corporate Compliance

UM Capital Region Health 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 UM Capital Region
Health 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 UM Capital Region Health nor any of its facilities will accept responsibility for patient property or valuables.

Smoking

To provide a healthy environment, UM Capital Region Health 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.

APPENDIX V

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

UNIVERSITY *of* MARYLAND
CAPITAL REGION HEALTH

Effective:	*06/2006*
Approved:	*05/2014*
Last Reviewed:	*05/2014*
Review:	*05/2017*
Owner:	*Ronald Laxton: SVP Clinical Services*
Policy Area:	*Administration/General*
References:	
Applicability:	*UM Capital Region Health – Systemwide*

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: