

COMMUNITY BENEFIT NARRATIVE REPORTING
DOCTORS COMMUNITY HOSPITAL

DECEMBER 15, 2014

Effective for FY2014 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

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BACKGROUND

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

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

Reporting Requirements

GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Please list the following information in Table I below.

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

Table I

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:
198	9,709			Prince Georges County 20%	Prince George’s County 16%
				Source: http://www.countyhealthranking	Source: http://www.md-medicaid.org/eligibility/new/index.cfm
		20706	Lanham Holy Cross of Silver Spring Laurel Regional Prince George’s Hospital Center		
		20785 20784	Cheverly/Landover Prince George’s Hospital Center Laurel Regional		
		20743 20747	Capital Heights/District Heights Prince George’s Hospital Center Medstar Southern Maryland		
		20774	Kettering/Upper Marlboro Holy Cross of Silver Spring MedStar Southern Maryland Prince George’s Hospital Center Anne Arundel Medical Center		
		20770	Greenbelt Laurel Regional Prince George’s Hospital Center		
		20721 20720	Bowie No other Maryland Hospital		
		20737	Riverdale Washington Adventist Prince George’s Hospital Center		

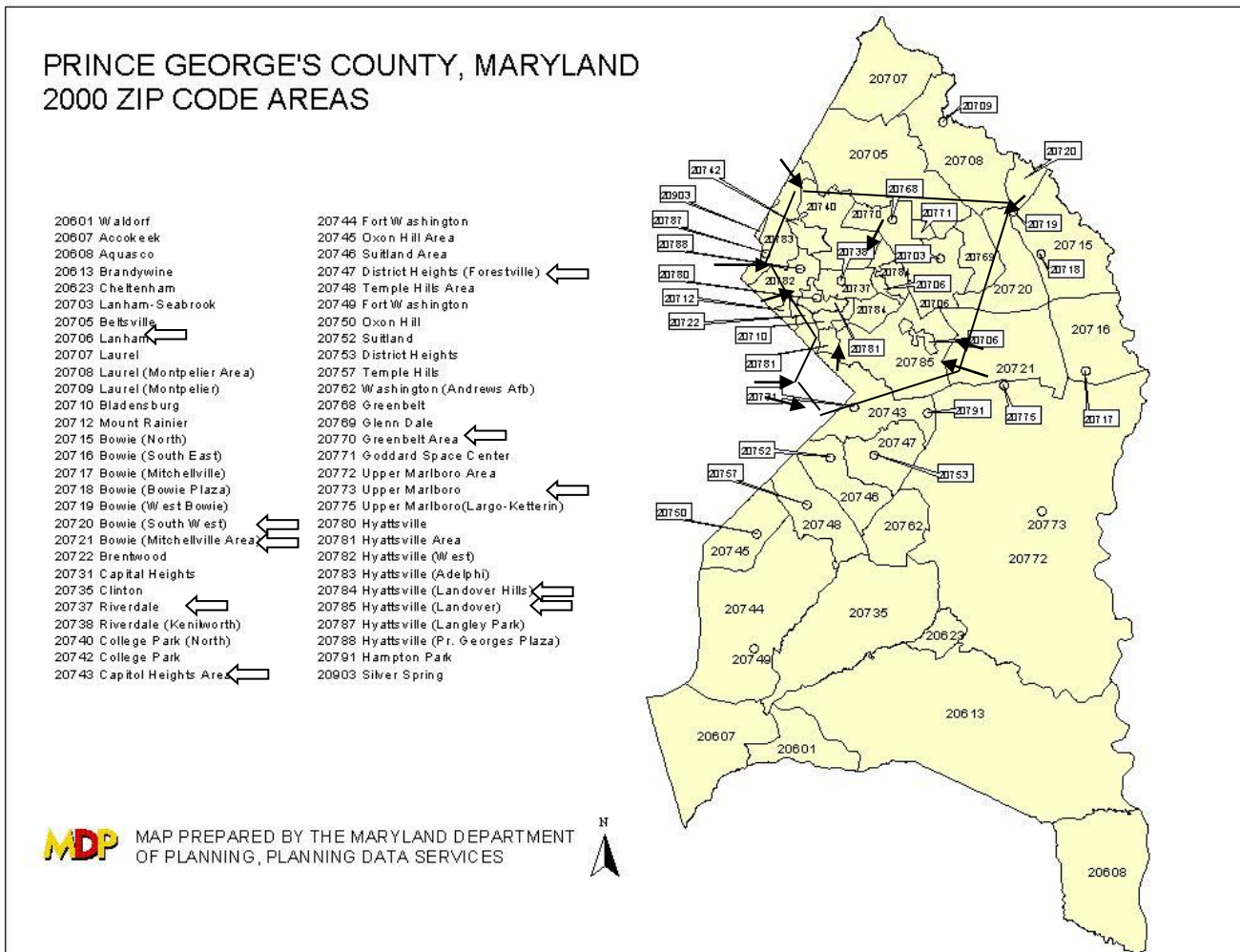


Figure 1 Prince George's County by Zip Code (Zip Codes with 60% of discharges)

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

a. Describe in detail the community or communities the organization serves.

(For the purposes of the questions below, this will be considered the hospital's Community Benefit Service Area – "CBSA". This service area may differ from your primary service area on page 1. Please describe in detail.)

(1) General Description of the Prince George's County that encompasses the majority of Doctors Community Hospital's Community Benefit Service Area.

Doctors Community Hospital serves a large portion of Prince George's County residents. Prince George's County consists of 93% of our *Community Benefit Service Area (CBSA)*. An estimated 881,138 residents live in Prince George's County, or 15% of Maryland's residents.

Over 80,000 patients were seen in FY2014 at Doctors Community Hospital, of which 88% of the patients live in Prince George's County catchment area (see Figure 2). Source for this data is from the hospital's system as reported using Medisolv computer software.

Per the County Health Rankings Figure 3, our CBSA has an average household income of \$69,258 which is less than the state's average and down from prior year. The population is 63% African American while the state is 29% African American. This is the same as prior year, as is many of the other demographic factors.

Other health outcomes, the social/economic and physical environment factors are noted in Figure 3 on the next page.

	Prince George's County			Maryland
	2012	2013	2014	2014
Demographics				
Population	834,560	871,233	881,138	5,884,563
% below 18 years of age	25%	24%	23%	23%
% 65 and older	10%	10%	10%	13%
% African American	66%	63%	63%	29%
% American Indian and Alaskan Native	1%	1%	1%	1%
% Asian	4%	4%	4%	6%
% Native Hawaiian/Other Pacific Islander	0%	0%	0%	0%
% Hispanic	14%	15%	15%	8%
% Non-Hispanic white	n/a	n/a	15%	54%
% not proficient in English	9%	5%	5%	3%
% Females	52%	52%	52%	52%
% Rural	3%	2%	2%	13%
Health Outcomes				
Diabetes	11%	11%	11%	10%
Health care costs	\$8,110	\$8,484	\$8,592	\$9,131
Uninsured adults	20%	21%	20%	15%
Could not see doctor due to cost	14%	14%	15%	11%
Social & Economic Factors				
Median household income	\$69,524	\$70,114	\$69,258	\$71,169
Children eligible for free lunch	37%	46%	46%	33%
Homicide rate	18	16%	16%	9%
Physical Environment				
Commuting alone	64%	64%	64%	73%
Limited access to healthy food		3%	4%	3%

Figure 3: Prince George's County Data provided by County Health Rankings (<http://www.countyhealthrankings.org/app/#!/maryland/2014/rankings/prince-georges/county/outcomes/overall/additional>)

(2) General Description, by Zip Code, of the communities that comprise the majority of Doctors Community Hospital's Community Benefit Service Areas

- ***Lanham, Maryland – Zip Code 20706***

Lanham is an unincorporated community and census-designated place in Prince George's County, Maryland, in the United States.^[1] As of the 2010 census it had a population of 10,157.^[2] The terminal of the Washington Metro's Orange Line, as well as an Amtrak station, are across the Capital Beltway in New Carrollton, Maryland. Doctors Community Hospital is located in Lanham.^[3])

The Thomas J. Calloway House was listed on the National Register of Historic Places in 2005.^[4]

Demographics

According to the U.S. Census Bureau, Lanham has a total area of 3.6 square miles (9.2 km²), of which 3.5 square miles (9.1 km²) is land and 0.02 square miles (0.05 km²), or 0.54%, is water.^[5]

The racial mix of the population is: 65.60% Black, 23.3% Hispanic, 14.0% White, 3.10% Asian, 2.4% two or more races, 0.40% American Indian, and 01.10% other race.

References

1. U.S. Geological Survey Geographic Names Information System: Lanham, Maryland
2. "Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data (DP-1): Lanham CDP, Maryland". U.S. Census Bureau, American Factfinder. <http://factfinder2.census.gov>. Retrieved November 12, 2014.
3. "Doctors Community Hospital". *Doctors Community Hospital website*. Doctors Community Hospital. 2009-01-29. <http://www.dchweb.org/>.
4. "National Register Information System". *National Register of Historic Places*. National Park Service. 2010-07-09. http://nrhp.focus.nps.gov/natreg/docs/All_Data.html.
5. "Geographic Identifiers: 2010 Demographic Profile Data (G001): Lanham CDP, Maryland". U.S. Census Bureau, American Factfinder. <http://factfinder2.census.gov>. Retrieved November 12, 2014.

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- ***Cheverly, Maryland – Zip Code 20784***

In its over 80 years, the **Town of Cheverly** has grown from farmland to a small livable community just minutes from the Nation's Capital. Cheverly is 1.27 square miles in area, and the 2010 U.S. Census survey counted a population of 6,173 residents.

The Town is located in the western portion of Prince George's County, Maryland, just a mile from the northeastern Washington, D.C. border. Cheverly largely lies between two major road arteries -- the Baltimore-Washington Parkway and Maryland Route 50. Established as a planned residential community, Cheverly is convenient to Washington, D.C. by Metro bus and rail, and to retail shopping centers in the surrounding communities.

Demographics

Cheverly is home to the Prince George's Hospital Center and the Publick Playhouse for the Performing Arts.[3] Cheverly's ZIP codes are 20784 and 20785. As of the census[5] of 2000, there were 6,433 people, 2,258 households, and 1,637 families residing in the town. The population density was 4,769.9 people per square mile (1,839.8/km²). There were 2,348 housing units at an average density of 1,741.0 per square mile (671.5/km²). The racial makeup of the town was 33.86% White, 56.79% African American, 0.17% Native American, 2.50% Asian, 0.03% Pacific Islander, 3.22% from other races, and 3.44% from two or more races. Hispanic or Latino of any race were 6.76% of the population.

There were 2,258 households out of which 39.8% had children under the age of 18 living with them, 48.8% were married couples living together, 17.1% had a female householder with no husband present, and 27.5% were non-families. 20.4% of all households were made up of individuals and 4.7% had someone living alone who was 65 years of age or older. The average household size was 2.85 and the average family size was 3.30.

References

1. U.S. Geological Survey Geographic Names Information System: Cheverly, Maryland
2. "Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data (DP-1): Cheverly town, Maryland". U.S. Census Bureau, American Factfinder. <http://factfinder2.census.gov>. Retrieved December 9, 2011.
3. "Publick Playhouse". Maryland-National Capital Park and Planning Commission. <http://www.pgparcs.com/places/artsfac/publick.html>.]
4. "US Gazetteer files: 2010, 2000, and 1990". United States Census Bureau. 2011-02-12. <http://www.census.gov/geo/www/gazetteer/gazette.html>. Retrieved 2011-04-23.
5. "American FactFinder". United States Census Bureau. <http://factfinder.census.gov>. Retrieved 2008-01-31.

6. a b "Community Summary Sheet, Prince George's County". Cheverly, Maryland. Maryland State Highway Administration, 1999. 2008-05-10.

http://www.sha.maryland.gov/oppen/pg_co.pdf.

7. M-NCPPC Illustrated Inventory of Historic Sites (Prince George's County, Maryland), 2006.

Sources of Information Retrieved November 12, 2014

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- ***Landover, Maryland – Zip Code 20785***

Landover is an unincorporated community and census-designated place in Prince George's County, Maryland, United States.^[1] As of the 2010 census it had a population of 23,078.^[2] Landover was named for the town of Llandover, Wales.^[3] Landover is located at [38°55'28"N 76°53'15"W](#)[38.9244°N 76.8876°W](#). According to the U.S. Census Bureau, it has an area of 4.07 square miles (10.55 km²), of which 0.004 square miles (0.01 km²), or 0.13%, is water.^[4] The Prince Georges County Sports and Learning Complex is in Landover. Landover also had career based colleges such as Fortis College^[9] that offers programs including bio-technician, medical assisting, and medical coding and billing.

Demographics

Landover's health insurance coverage is 51.5% private, 33.2% public assistance and 17.2% uninsured. There are 12% of the families and 4.7% of married couples below the poverty levels. The racial makeup of the town was 9.90% White, 81.90% African American, 0.40% Native American, 0.70% Asian, 0.10% Pacific Islander, 14.60% Hispanic, and 2.40% from two or more races.

References

1. U.S. Geological Survey Geographic Names Information System: Landover, Maryland
2. "Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data (DP-1): Landover CDP, Maryland". U.S. Census Bureau, American Factfinder. <http://factfinder2.census.gov>. Retrieved December 20, 2011.
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5. "Facility Locations." Giant Food. Retrieved on September 6, 2011. 8301 Professional Place, Suite 115 Landover, MD 20785."
6. "National Register Information System". National Register of Historic Places. National Park Service. 2010-07-09. http://nrhp.focus.nps.gov/natreg/docs/All_Data.html.
7. "Harlem Renaissance Festival". Festival Media Corporation. <http://www.festivals.com/viewevent.aspx?eventid=2aWwZDqLM2w%3D>. Retrieved August 24, 2012.
8. "Prince George's County Public Schools". Prince George's County Public Schools. <http://www1.pgcps.org/>. Retrieved August 24, 2012.
9. Fortis College - Landover
10. U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, County

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pages/productview.xhtml?pid=ACS_11_3YR_DP03&prodType=table](http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_11_3YR_DP03&prodType=table)

- ***Greenbelt, Maryland – Zip Code 20770***

The **Greenbelt Historic District** is a national historic district located in Greenbelt, Prince George's County, Maryland, United States. The district preserves the center of one of the few examples of the Garden City Movement in the United States. With its sister cities of Greenhills, Ohio and Greendale, Wisconsin, Greenbelt was intended to be a "new town" that would start with a clean slate to do away with problems of urbanism in favor of a suburban ideal. Along with the never-commenced town of Greenbrook, New Jersey, the new towns were part of the New Deal public works programs.^[3]

Demographics

As of the census ^[9] of 2000, there were 21,456 people, 9,368 households, and 4,965 families residing in the city. The population density was 3,586.6 people per square mile (1,385.3/km²). There were 10,180 housing units at an average density of 1,701.7 per square mile (657.3/km²). As of 2010 Greenbelt had a population of 23,068. The racial and ethnic composition of the population was 30.10% White, 47.80% Black, 0.30% Native American, 9.70% Asian, 0.10% Pacific Islander, 3.30% from two or more races and 14.30% Hispanic or Latino.^[11]

There were 9,368 households out of which 26.9% had children under the age of 18 living with them, 33.1% were married couples living together, 15.0% had a female householder with no husband present, and 47.0% were non-families. 35.0% of all households were made up of individuals and 5.8% had someone living alone who was 65 years of age or older. The average household size was 2.29 and the average family size was 3.00.

In the city the population was spread out with 21.9% under the age of 18, 12.5% from 18 to 24, 39.1% from 25 to 44, 19.8% from 45 to 64, and 6.7% who were 65 years of age or older. The median age was 32 years. For every 100 females there were 91.8 males. For every 100 females age 18 and over, there were 88.2 males.

In the 2000 census, the median income for a household in the city was \$46,328, and the median income for a family was \$55,671. Males had a median income of \$39,133 versus \$35,885 for females. The per capita income for the city was \$25,236. About 6.0% of families and 10.2% of the population were below the poverty line, including 12.7% of those under age 18 and 7.2% of those ages 65 or over.

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- 2.a b "Greenbelt, Maryland Historic District". National Historic Landmark summary listing. National Park Service. <http://tps.cr.nps.gov/nhl/detail.cfm?ResourceId=2203&ResourceType=District>. Retrieved 2008-03-03.
3. "Greenbelt Historic District". National Historic Landmarks in Maryland listing. Maryland Historical Trust. <http://www.mht.maryland.gov/nr/NRDetail.aspx?HDID=658&FROM=NRNHLList.aspx>. Retrieved 2008-06-13.
4. National Register of Historic Places Inventory-Nomination: PDF (32 KB), National Park Service, , 19 and Accompanying photos, exterior and interior, from 19 PDF (32 KB)
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Retrieved from http://en.wikipedia.org/wiki/Greenbelt,_MD#Demographics

- ***Capitol Heights, Maryland – Zip Code 20743***

Capitol Heights is a town in Prince George's County, Maryland, United States.^[1] The population was 4,337 at the 2010 census.^[2] Development around the Capitol Heights Metro station has medical facilities and eateries to support the community. The Washington Redskins football stadium is just to the east of Capitol Heights, near the Capital Beltway (I-95/495) and Hampton Mall shopping center which has a new hotel and eateries. The town borders Washington, D.C.

Demographics

As of the census^[4] of 2000, there were 4,138 people, 1,441 households, and 1,014 families residing in the town. The population density was 5,047.3 people per square mile (1,948.4/km²). There were 1,603 housing units at an average density of 1,955.2 per square mile (754.8/km²). The racial makeup of the town was 92.85% Black or African American, 4.81% White, 0.27% Native American, 0.36% Asian, 0.36% from other races, and 1.35% from two or more races. Hispanic or Latino of any race were 0.87% of the population.

There were 1,441 households out of which 37.5% had children under the age of 18 living with them, 35.2% were married couples living together, 28.5% had a female householder with no husband present, and 29.6% were non-families. 25.7% of all households were made up of individuals and 8.0% had someone living alone who was 65 years of age or older. The average household size was 2.87 and the average family size was 3.41.

In the town the population was spread out with 30.8% under the age of 18, 6.9% from 18 to 24, 32.6% from 25 to 44, 21.4% from 45 to 64, and 8.3% who were 65 years of age or older. The median age was 34 years. For every 100 females there were 84.8 males. For every 100 females age 18 and over, there were 78.8 males.

The median income for a household in the town was \$46,667, and the median income for a family was \$53,826. Males had a median income of \$36,950 versus \$35,225 for females. The per capita income for the town was \$18,932. About 9.3% of families and 11.4% of the population were below the poverty line, including 15.8% of those under age 18 and 9.6% of those age 65 or over.

References

1. U.S. Geological Survey Geographic Names Information System: Capitol Heights, Maryland
2. "Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data (DP-1): Capitol Heights town, Maryland". U.S. Census Bureau, American Factfinder. <http://factfinder2.census.gov>. Retrieved December 8, 2011.

3. "US Gazetteer files: 2010, 2000, and 1990". United States Census Bureau. 2011-02-12. <http://www.census.gov/geo/www/gazetteer/gazette.html>. Retrieved 2011-04-23.
4. "American FactFinder". United States Census Bureau. <http://factfinder.census.gov>. Retrieved 2008-01-31.
5. "Chad Scott". databaseFootball.com.
<http://www.databasefootball.com/players/playerpage.htm?ilkid=SCOTTCHA01>. Retrieved November 6, 2012.

Sources of Information Retrieved November 12, 2014

Retrieved from http://en.wikipedia.org/wiki/Capitol_Heights,_Maryland

- ***Kettering, Maryland – Zip Code -20774***

Kettering is an unincorporated area and census-designated place (CDP) in Prince George's County, Maryland, United States.^[1] The population was 12,790 at the 2010 census,^[2] primarily African-American. The name Kettering was created by a suburban housing developer in the 1960s when development began. Kettering is adjacent to Prince George's Community College, the upscale gated community of Woodmore, Six Flags America, Evangel Temple megachurch, and the community of Largo at the end of the Washington Metro Blue Line. Watkins Regional Park in Kettering offers a large playground, a colorful carousel, miniature golf, a miniature train ride, and various animals.

Kettering is located at [38°53'42"N 76°47'47"W](#)^[3] [38.895012°N 76.796471°W](#).^[3] According to the United States Census Bureau, the CDP has a total area of 5.5 square miles (14 km²), all of it land.

Demographics

As of the census^[4] of 2000, there were 11,008 people, 3,814 households, and 2,955 families residing in the CDP. The population density was 2,016.5 people per square mile (778.4/km²). There were 3,958 housing units at an average density of 725.0/sq mi (279.9/km²). The racial makeup of the CDP was 5.78% White, 90.62% African American, 0.19% Native American, 1.24% Asian, 0.47% from other races, and 1.71% from two or more races. Hispanic or Latino of any race was 0.95% of the population.

There were 3,814 households out of which 36.3% had children under the age of 18 living with them, 50.0% were married couples living together, 23.3% had a female householder with no husband present, and 22.5% were non-families. 18.4% of all households were made up of individuals and 1.7% had someone living alone who was 65 years of age or older. The average household size was 2.86 and the average family size was 3.24.

In the CDP the population was spread out with 26.6% under the age of 18, 7.1% from 18 to 24, 30.6% from 25 to 44, 29.1% from 45 to 64, and 6.6% who were 65 years of age or older. The median age was 37 years. For every 100 females there were 81.3 males. For every 100 females age 18 and over, there were 75.8 males.

The median income for a household in the CDP was \$78,735, and the median income for a family was \$82,777. Males had a median income of \$47,059 versus \$45,243 for females. The per capita income for the CDP was \$30,398. About 0.8% of families and 1.9% of the population were below the poverty line, including 1.9% of those under age 18 and 2.0% of those ages 65 or over.

References

- 1.U.S. Geological Survey Geographic Names Information System: Kettering, Maryland
- 2."Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data (DP-1): Kettering CDP, Maryland". U.S. Census Bureau, American Factfinder. <http://factfinder2.census.gov>. Retrieved December 20, 2011.
- 3."US Gazetteer files: 2010, 2000, and 1990". United States Census Bureau. 2011-02-12. <http://www.census.gov/geo/www/gazetteer/gazette.html>. Retrieved 2011-04-23.
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Retrieved from http://en.wikipedia.org/wiki/Kettering,_Maryland

- ***Bowie, Maryland – Zip Code 20721& 20720***

Bowie is a city of 54,727 residents, according to the 2010 Census, located in Prince George's County, and convenient to Washington, DC, Annapolis, and Baltimore. The city consists of approximately 18-square miles. There are more than 1,100 acres set aside as parks or as preserved open space, including over 22 miles of paths and trails, and 75 ball fields. Bowie has a nonpartisan city government directed by a mayor and six council members. The City Council meets on the first and third Mondays of most months in sessions that are open to the public.

Bowie is a city in Prince George's County, Maryland, United States.^[1] The population was 54,727 at the 2010 census. Bowie has grown from a small railroad stop to the largest municipality in Prince George's County, and the fifth most populous city^[2] and third largest city by area in the state of Maryland.

Bowie is located at 38°57'53"N 76°44'40"W / 38.96472°N 76.74444°W / 38.96472; -76.74444 (38.964727, -76.744531).^[12] According to the city's 2009 State of the Environment report, the city has a total area of 18 square miles (47 km²), of which 0.04 square miles (0.10 km²), or 0.12%, is water.^[13]

Demographics

As of the 2010 Census, Bowie had a population of 54,727. 99.5% of the population lived in households with a total of 19,950 households. The racial and ethnic composition of the population was 38.9% non-Hispanic white, 47.9% non-Hispanic black, 0.3% Native American, 4.1% Asian, 0.1% Pacific Islander, 1.9% from some other race and 3.6% from two or more races. 5.6% of the population was Hispanic or Latino of any race.^[14]

As of the census^[15] of 2010, there were 54,727 people, 18,188 households, and 13,568 families residing in the city. The population density was 3,121.9 people per square mile (1,205.5/km²). There were 18,718 housing units at an average density of 1,162.5 per square mile (448.9/km²).

The racial makeup of the city was: 41.40% White, 48.70% Black or African American, 2.95% Asian, 2.92% Hispanic or Latino (of any race), 2.30% from two or more races, 0.93% Other races, 0.30% Native American and 0.03% Pacific Islander.

There were 19,950 households of which 37.0% had children under the age of 18 living with them, 53.2% were married couples living together, 14.0% had a female householder with no husband present, 4.3% had a male householder with no wife present, and 28.5% were non-families. 23.4% of all households were made up of individuals and 7.7% had someone living alone who was 65 years of age or older. The average household size was 2.73 and the average family size was 3.23.

According to a 2007 estimate, the median income for a household in the city was \$99,105, and the median income for a family was \$109,157.^[16] Males had a median income of \$52,284 versus \$40,471 for females. The per capita income for the city was \$30,703. About 0.7% of families and 1.6% of the population were below the poverty line, including 1.0% of those under age 18 and 1.8% of those age 65 or over.

Rank by Per Capita Income in Prince George's County: 7

Rank by Per Capita Income in Maryland: 65

References

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Retrieved from http://en.wikipedia.org/wiki/Bowie,_Maryland

- ***Riverdale, Maryland – Zip Code 20737***

Riverdale Park is a town in Prince George's County, Maryland, United States.^[1] The population was 6,956 at the 2010 census.^[2] Riverdale Park is located at [38°57'46"N 76°55'47"W](#)[38.96278°N 76.92972°W](#) (38.962810, -76.929699)^[3]. According to the United States Census Bureau, the town has a total area of 1.7 square miles (4.3 km²), of which 0.03 square miles (0.07 km²), or 1.50%, is water.^[4]

Demographics

As of the census ^[5] of 2000, there were 6,690 people, 2,172 households, and 1,437 families residing in the town. The population density was 4,212.7 people per square mile (1,624.5/km²). There were 2,321 housing units at an average density of 1,461.5 per square mile (563.6/km²). The racial makeup of the town was 39.91% White, 38.51% African American, 0.49% Native American, 4.25% Asian, 0.12% Pacific Islander, 12.99% from other races, and 3.74% from two or more races. Hispanic or Latino of any race was 28.27% of the population.

There were 2,172 households out of which 38.4% had children under the age of 18 living with them, 42.0% were married couples living together, 16.4% had a female householder with no husband present, and 33.8% were non-families. 23.9% of all households were made up of individuals and 4.1% had someone living alone who was 65 years of age or older. The average household size was 3.06 and the average family size was 3.60.

In the town the population was spread out with 28.7% under the age of 18, 12.2% from 18 to 24, 38.7% from 25 to 44, 15.6% from 45 to 64, and 4.9% who were 65 years of age or older. The median age was 29 years. For every 100 females there were 110.6 males. For every 100 females age 18 and over, there were 109.3 males.

The median income for a household in the town was \$44,041, and the median income for a family was \$49,904. Males had a median income of \$30,053 versus \$30,200 for females. The per capita income for the town was \$19,293. About 9.0% of families and 12.0% of the population were below the poverty line, including 16.0% of those under age 18 and 7.2% of those ages 65 or over.

References

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Sources of Information Retrieved November 12, 2014

Retrieved from http://en.wikipedia.org/wiki/Riverdale_Park,_Maryland

- *Districts Heights, Maryland – Zip Code 20747*

District Heights is an incorporated city in Prince George's County, Maryland, United States, located near Maryland Route 4.^[1] The population was 5,837 at the 2010 census. For more information, see the separate articles on Forestville, Maryland and Suitland.

District Heights is 9.85 miles (15.85 km) away from central Washington, D.C. District Heights is located at [38°51'34"N 76°53'21"W](#)[38.85944°N 76.88917°W](#) (38.859545, -76.889139)^[2]. According to the United States Census Bureau, the city has a total area of 0.9 square miles (2.3 km²), all of it land.

Demographics

As of the 2010 Census the population of District Heights was 5,837. The racial and ethnic composition of the population was 4.25% non-Hispanic white, 89.5% non-Hispanic black, 0.2% Native American, 0.6% Asian, 1.15 from some other race and 1.9% from two or more races. 3.7% of the population was Hispanic or Latino or any race.^[3]

As of the census^[4] of 2000, there were 5,958 people, 2,070 households, and 1,538 families residing in the city. The population density was 6,649.1 people per square mile (2,556.0/km²). There were 2,170 housing units at an average density of 2,421.7 per square mile (930.9/km²). The racial makeup of the city was 9.20% White, 87.95% African American, 0.12% Native American, 0.86% Asian, 0.20% from other races, and 1.68% from two or more races. Hispanic or Latino of any race was 0.49% of the population.

There were 2,070 households out of which 38.3% had children under the age of 18 living with them, 39.6% were married couples living together, 28.2% had a female householder with no husband present, and 25.7% were non-families. 22.1% of all households were made up of individuals and 5.0% had someone living alone who was 65 years of age or older. The average household size was 2.88 and the average family size was 3.36.

In the city the population was spread out with 30.8% under the age of 18, 8.3% from 18 to 24, 29.3% from 25 to 44, 23.6% from 45 to 64, and 8.0% who were 65 years of age or older. The median age was 34 years. For every 100 females there were 84.9 males. For every 100 females age 18 and over, there were 76.1 males.

The median income for a household in the city was \$52,331, and the median income for a family was \$61,220. Males had a median income of \$37,129 versus \$32,443 for females. The per capita income for the city was \$21,190. About 4.5% of families and 5.9% of the population were below the poverty line, including 9.0% of those under age 18 and 6.1% of those ages 65 or over.

References

1. U.S. Geological Survey Geographic Names Information System: District Heights, Maryland
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b. In Table II, describe significant demographic characteristics and social determinants that are relevant to the needs of the community and include the source of the information in each response.

For purposes of this section, social determinants are factors that contribute to a person’s current state of health. They may be biological, socioeconomic, psychosocial, behavioral, or social in nature. (Examples: gender, age, alcohol use, income, housing, access to quality health care, education and environment, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary).

Some statistics may be accessed from the Maryland State Health Improvement Process, (<http://dhmh.maryland.gov/ship/>) and its Area Health Profiles 2013, (<http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx>), the Maryland Vital Statistics Administration (<http://dhmh.maryland.gov/vsa/SitePages/reports.aspx>), The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) (http://dhmh.maryland.gov/mhhd/Documents/Maryland_Health_Disparities_Plan_of_Action_6.10.10.pdf), the Maryland ChartBook of Minority Health and Minority Health Disparities, 2nd Edition (<http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Health%20Disparities%20Data%20Char%20book%202012%20corrected%202013%2002%2022%2011%20AM.pdf>)

Table II: Prince George’s County

Characteristic or determinant	Response County/Value		Source
Community Benefit Service Area(CBSA) Target Population: <u>target population,</u> <u>by sex,</u> <u>by race,</u> <u>by ethnicity</u> and	Prince George’s County: <u>Target Population</u> <u>By Sex</u> Male Female <u>Race:</u> White African American Am Ind/AK Native Asian Other <u>Ethnicity</u> Hispanic/Latin Not Hispanic/Latin	891,838 428,505 (48.05%) 463,333 (51.95%) 179,560 (20.13%) 557,752 (62.54%) 4,584 (0.51%) 37,827 (4.24%) 112,115 (12.58%) 141,935 (15.91%) 749,903 (84.09%)	2014 Data provided by Healthy Communities Institute: http://admin.dchweb.thehcn.net/index.php?module=DemographicData&type=user&func=ddview&varset=1&ve=text&pct=2&levels=1 From secondary sources of: Demographics information provided by Claritas, under these <u>terms of use</u> .

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<u>by average age</u>	<u>Ages:</u> under 18 (not our patients) 18+ 25+ 65+ Average Median Age	207,454 (23.26%) 684,384 (76.74%) 587,677 (65.90%) 99,013 (11.10%) 35.30	
Median Household Income within the CBSA	20706 20715 20720 20721 20737 20740 20743 20747 20770 20772 20774 20784 20785 Prince George's Maryland	\$ 70,996 \$101,564 \$120,088 \$117,962 \$ 60,103 \$ 64,531 \$ 57,543 \$ 60,689 \$ 64,760 \$102,678 \$ 95,010 \$ 59,904 \$ 63,283 \$ 73,675 \$ 73,169	
Percentage of households with incomes below the federal poverty guidelines within the CBSA	Zip Code 20706 20715 20720 20721 20737 20740 20743 20747 20770 20772 20774 20784 20785 Prince George's (total families 13,322 or 6.83%)	Number 682 7.42% 116 1.71% 108 1.87% 136 1.84% 435 9.95% 214 5.19% 936 9.71% 964 9.68% 473 7.91% 215 1.88% 326 2.84% 557 8.84% 1,029 10.9% 6,191	

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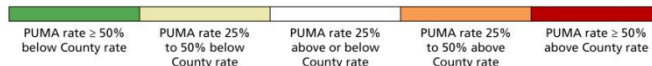
<p>Please estimate the percentage of uninsured people by County within the CBSA. This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2010ACS.shtml</p> <p>DCH used: The US Census Bureau's Small Area Health Insurance Estimates (SAHIE) program produces estimates of health insurance coverage for all states and counties. In July 2005, SAHIE released the first nationwide set of county-level estimates on the number of people without health insurance coverage for all ages and those under 18 years old. SAHIE releases estimates of health insurance coverage by age, sex, race, Hispanic origin, and income categories at the state-level and by age, sex, and income categories at the county-level.</p>	<p>Adults without Health Insurance by Race/Ethnicity</p>	<p>20%</p>	<p>URL of Source: http://www.countyhealthrankings.org/app/#!//maryland/2014/rankings/prince-georges/county/outcomes/overall/additional</p> <p>http://dchweb.thehcn.net/index.php?module=Trackers&func=display&tid=1</p>
<p>Percentage of Medicaid recipients by County within the CBSA.</p>	<p>Prince George's County</p>	<p>14.76%</p> <p>825,284 in Prince George's county versus 5,589,768 in Maryland</p>	<p>http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_09_1YR_B27007&prodType=table</p>
<p>Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/SitePages/Home.aspx</p>	<p>Prince George's County</p>	<p>Black=78.4 years</p> <p>White=80.3 years</p>	<p>Report dated 2010-2012 dates:</p> <p>http://dhmh.maryland.gov/ship/SitePages/Home.aspx</p>

Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).

Table 3.7 Unadjusted Mortality Rates per 100,000 for All Causes, Top Five Leading Causes of Death, and Remaining Other Causes Among Adult Prince George’s Residents Age 65 and Older in 2006

Region	All Causes	Heart Disease	Cancer	Cerebro-vascular Disease	Diabetes	Chronic Lower Respiratory Disease	Other Causes	Total Population, Age 65+	
Prince George's County	4380.7	1418.0	1005.0	213.4	174.8	155.6	1413.9	72,637	
Inside Beltway	North PUMA 1	4361.2	1453.7	985.3	129.2	242.3	145.4	1405.3	6,191
	North Central PUMA 3	4154.8	1446.0	916.5	173.1	152.8	142.6	1323.8	9,820
	South Central PUMA 4	4743.6	1570.5	1121.8	170.9	267.1	160.3	1453.0	9,360
	South PUMA 7	4429.4	1503.7	1119.0	221.5	244.8	128.2	1212.2	8,579
Outside Beltway	North PUMA 2	3854.1	1023.7	808.7	301.1	103.2	189.3	1428.1	11,624
	Central PUMA 5	4160.4	1215.2	1072.3	214.5	150.1	135.8	1372.5	13,989
	South PUMA 6	4948.8	1759.2	1024.9	229.5	137.7	175.9	1621.6	13,074
Total number of deaths in county, Age 65+	3182	1030	730	155	127	113	1027		

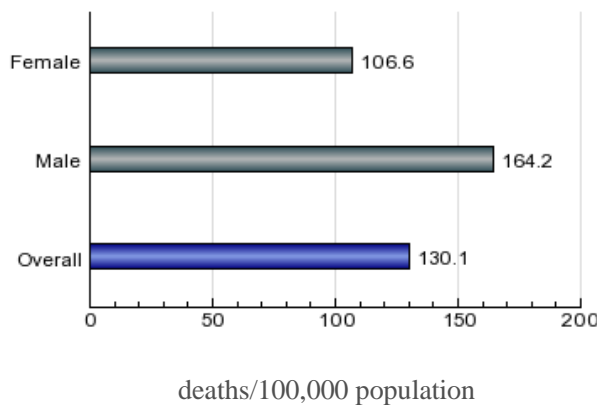
SOURCE: Deaths—Maryland Department of Health and Hygiene Vital Statistics Administration, <http://www.vsa.state.md.us/html/reports.html>; Population denominator for mortality rate calculation—2006 American Community Survey.



Key diagnosis that Doctors Community Hospital has initiatives to serve the community.

Coronary Heart Disease

a. Age-Adjusted Death Rate due to Coronary Heart Disease by Gender



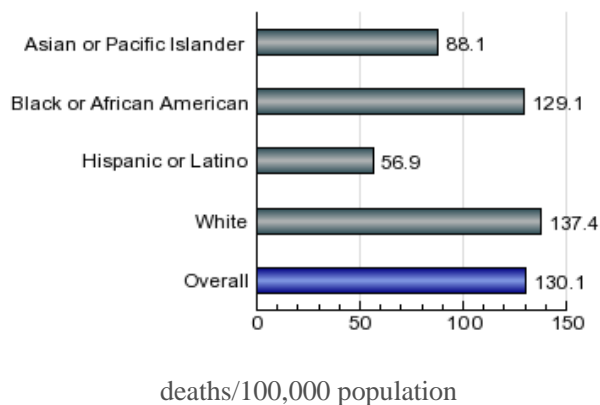
<http://www.princegeorgescountymd.gov/pgcha/pdfs/rand-assessing-health-care.pdf>

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URL of Data:

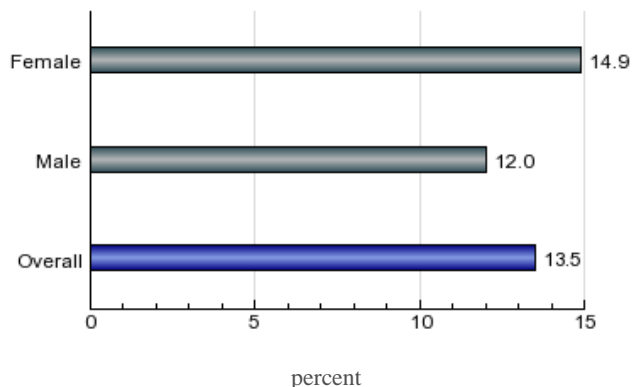
<http://dchweb.thehcn.net/modules.php?op=modload&name=NS-Indicator&file=indicator&indid=3000025000025&iid=13188027>

b. Age-Adjusted Death Rate due to Coronary Heart Disease by Race/Ethnicity

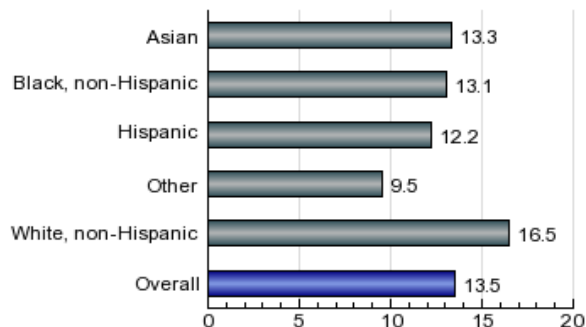


Diabetes

(1) Adults with Diabetes by Gender

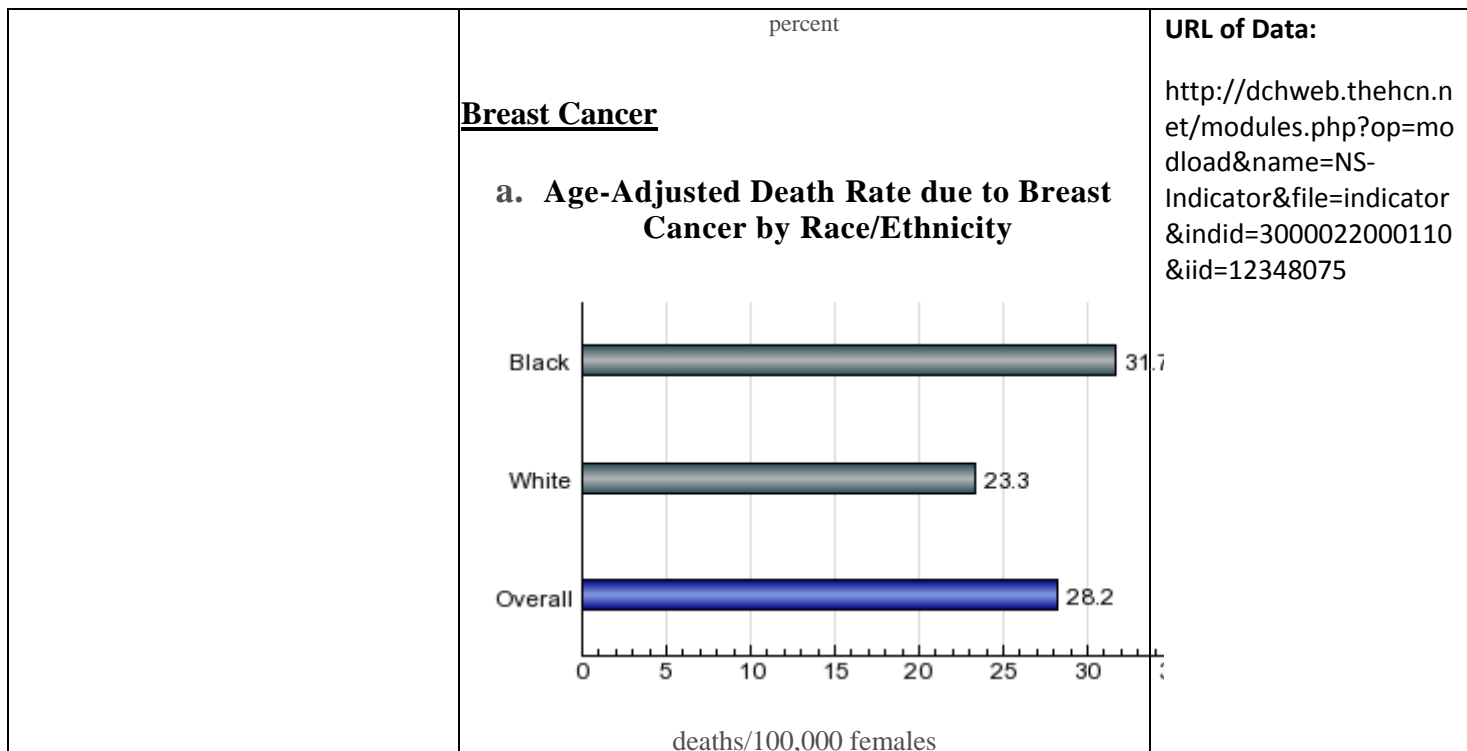


(2) Adults with Diabetes by Race/Ethnicity



URL of Data:

<http://dchweb.thehcn.net/modules.php?op=modload&name=NS-Indicator&file=index&topic=0&group=category&breakout=all>



URL of Data:
<http://dchweb.thehcn.net/modules.php?op=modload&name=NS-Indicator&file=indicator&indid=3000022000110&iid=12348075>

Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions.

	Prince George's County
Demographics	
Population	891,838
% below 18 years of age	23.26%
% 65 and older	11.10%
% White	20.13%
% African American	62.54%
% American Indian and Alaskan Native	0.51%
% Asian	4.24%
% Native Hawaiian/Other Pacific Islander	0.08%
% All Other	12.49%
% Hispanic	15.91%
% Non-Hispanic White	84.09%
% not proficient in English	3.13%

URL of Data:
<http://admin.dchweb.thehcn.net/index.php?module=DemographicData&type=user&func=ddview&varset=1&ve=text&pct=2&levels=1>

Other - Diabetes

Doctors Community Hospital serves diabetes patients. This county has 13.5%

URL of Data:
<http://dchweb.thehcn.net/modules.php?op=m>

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	13.5% of its population affected by diabetes, as compared to 8.3% in Maryland.		<p>odload&name=NS-Indicator&file=index&topic=110&group=category&breakout=all</p> <p>http://admin.dchweb.thehcn.net/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=11019531</p>
Other - Illiteracy	This county has a 14.62% illiteracy rate (less than high school graduation) as compared to 11.39% in Maryland.	14.62%	<p>URL of Data:</p> <p>http://admin.dchweb.thehcn.net/index.php?module=DemographicData&type=user&func=ddview&varset=1&view=text&pct=2&levels=1</p>

Table II Supplemental – County Health Rankings Reflects Prince George’s County at less than the 50% in most categories

	Prince George's County	Error Margin	Top U.S. Performers*	Maryland	Rank (of 24)
Health Outcomes					17
Length of Life					18
Premature death	7,720	7,514-7,925	5,317	6,865	
Quality of Life					14
Poor or fair health	13%	12-14%	10%	13%	
Poor physical health days	2.9	2.6-3.1	2.5	3.0	
Poor mental health days	3.0	2.7-3.3	2.4	3.2	
Low birthweight	10.4%	10.2-10.6%	6.0%	9.1%	
Health Factors					14
Health Behaviors					8
Adult smoking	14%	13-15%	14%	15%	
Adult obesity	34%	32-36%	25%	28%	
Food environment index	7.7		8.7	8.5	
Physical inactivity	24%	22-26%	21%	24%	
Access to exercise opportunities	98%		85%	91%	
Excessive drinking	10%	9-11%	10%	15%	
Alcohol-impaired driving deaths	31%		14%	33%	
Sexually transmitted infections	699		123	467	
Teen births	35	35-36	20	31	
Clinical Care					21
Uninsured	16%	15-17%	11%	12%	
Primary care physicians	1,804:1		1,051:1	1,134:1	
Dentists	1,762:1		1,392:1	1,438:1	
Mental health providers	1,483:1		521:1	666:1	
Preventable hospital stays	52	51-54	46	60	
Diabetic screening	80%	79-82%	90%	84%	
Mammography screening	61%	59-63%	71%	65%	
Social & Economic Factors					15
High school graduation	75%			83%	

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	Prince George's County	Error Margin	Top U.S. Performers*	Maryland	Rank (of 24)
Some college	59%	58-60%	70%	67%	
Unemployment	6.8%		4.4%	6.8%	

* 90th percentile, i.e., only 10% are better

** Please see <http://www.countyhealthrankings.org> for more information.

Note: Blank values reflect unreliable or missing data

<http://www.countyhealthrankings.org/app/#!/maryland/2014/county/snapshots/033>

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

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

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

1. The written document (CHNA) must include the following:

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

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

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

A prioritized description of all the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs; and
A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

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

- (1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP)(<http://dhmh.maryland.gov/ship/>);
- (2) SHIP's CountyHealth Profiles 2012 (<http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx>);
- (3) the Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
- (4) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
- (5) Local Health Departments;
- (6) County Health Rankings (<http://www.countyhealthrankings.org>);
- (7) Healthy Communities Network (<http://www.healthycommunitiesinstitute.com/index.html>);
- (8) Health Plan ratings from MHCC (<http://mhcc.maryland.gov/hmo>);
- (9) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
- (10) Behavioral Risk Factor Surveillance System (<http://www.cdc.gov/BRFSS>);
- (11) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
- (12) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNA involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
- (13) Survey of community residents; and
- (14) Use of data or statistics compiled by county, state, or federal governments.

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

The IMPLEMENTATION STRATEGY must:

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

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

Yes
 No

Provide date here. 6 / 29 / 13 (mm/dd/yy)

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

[Link to Doctors Community Hospital's Community Health Needs Assessment](#)

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

Yes
 No

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

[Link to Doctors Community Hospital's Community Health Needs Assessment Implementation Strategy:](#)

In addition to being accessible via the site's search tool, this information has been assessable three primary ways.

1. [Health & Wellness page](#)
2. [About Us > Commitment to the Community page](#)
3. [Community Benefits Report footer link that appears on the bottom of every page](#)

See Appendix IX for the Assessment and Implementation Strategy

III. COMMUNITY BENEFIT ADMINISTRATION

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

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

Yes
 No

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

i. Senior Leadership

1. CEO
2. CFO
3. Other (please specify)
 - a. Vice President, Foundation
 - b. COO,
 - c. CNO,
 - d. CMO,
 - e. CIO,
 - f. VP HR

ii. Clinical Leadership

1. Physician (CMO, Utilization Review)
2. Nurse (CNO, Director, Nursing)
3. Social Worker
4. Other (Director of Transitional Care)

iii. Community Benefit Department/Team

1. X Individual (Community Resource Coordinator 1 FTE, Director, Volunteers and Community Relations 1 FTE,)
2. X Committee (Executive Team: CEO, VP Foundation, COO, CFO, CNO, CMO, CIO, VP HR, Directors Marketing, Physician Integration, Transitional Care, Physician Liaison, Social Worker, Nursing Leadership, Utilization Review Committee)
3. X Other (Director of Decision Support and Reimbursement)

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

Spreadsheet _yes _____no

Narrative _yes _____no

Conducted by the Community Benefits Department and Team

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

Spreadsheet _yes _____no

Narrative _yes _____no

Review is done after submission at the first Board meeting in January 20XX.

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

1. Please use Table III (see attachment) to provide a clear and concise description of the primary needs identified in the CHNA.

The principal objective of each initiative and how the results will be measured, time allocated to each initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on the measured outcomes, and the current FY costs associated with each initiative. Use at least one page for each initiative (at 10 point type). Please be sure these initiatives occurred in the FY in which you are reporting.

Please see attached examples of how to report.

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

- a. Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups.
 - b. Name of Initiative: insert name of initiative.
 - c. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics that will be used to evaluate the results (Use several pages if necessary)
 - d. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?
 - e. Key Partners in Development/Implementation: Name the partners (community members and/or hospitals) involved in the development/implementation of the initiative. Be sure to include hospitals with which your hospital is collaborating on this initiative.
 - f. How were the outcomes of the initiative evaluated?
 - g. Outcome: What were the results of the initiative in addressing the identified community health need, such as a reduction or improvement in rate? (Use data to support the outcomes reported). How are these outcomes tied to the objectives identified in item C?
 - h. Continuation of Initiative: Will the initiative be continued based on the outcome?
 - i. Expense: What were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.
2. Were there any primary community health needs that were identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples include other social issues related to health status, such as unemployment, illiteracy, the fact that another nearby hospital is focusing on an identified community need, or lack of resources related to prioritization and planning.) This information may be copied directly from the CHNA that refers to community health needs identified but unmet.

Yes, illiteracy was identified in Prince George's County and Doctors Community Hospital will continue to work with the county officials and other non-profits to see how we can partner on this unmet need. A subset of illiteracy may be a result of the lack of understanding how to manage your care. Additional training and education is being considered.

FY2014 was the first year for the Global Budget Revenue Agreement (GBR). Its focus coincides with the issues identified in the CHNA and we expect to have financial stability while implementing the CHNA initiatives. Below is listed the opening paragraph of the GBR Agreement.

"The Global Budget Revenue ("GBR") model is a revenue constraint and quality improvement system designed by the Maryland Health Services Cost Review Commission ("HSCRC") to provide hospitals with strong financial incentives to manage their resources efficiently and effectively in order to slow the rate of increase in health care costs and improve health care delivery processes and outcomes. The GBR model is consistent with the Hospital's mission to provide the highest value of care possible to its patients and the communities it serves."

In FY 2014, the hospital opened a heart failure free clinic to educate DCH patients on this disease to be able to stay healthy at home without recurring readmissions. A second free clinic is opening in FY 2015, the Congestive Obstructive Pulmonary Disease COPD clinic. There are plans to consider opening these services to the general community.

V. PHYSICIANS

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

The Utilization Committee and Medical Staff Committee continue to identify gaps in the availability of specialist providers to serve the uninsured cared for by the hospital. Programs that are being evaluated and developed include the following:

- ❖ *Orthopedics (began the expansion in FY 2014).*
- ❖ *Thoracic services*
- ❖ *Limited health services for the homeless*
- ❖ *Limited health services for undocumented resident*
- ❖ *Limited health services for the elderly with family working outside the county*
- ❖ *Limited availability of primary care physicians for sickle cell (DCH opened a clinic in FY 2014)*
- ❖ *Limited availability of primary care physicians to provide heart failure patients education and the tools to get them into a healthy lifestyle regiment. (DCH opened an education clinic in FY 2014)*

Under GBR, the hospital is working on population health initiatives with community physicians, and hopes to start an ACO to serve the patients of Prince George's County.

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

- ❖ *DCH has 50+ Hospital-based physicians to care for inpatients, since the limited number of community physicians are not able to see outpatients and attend to their inpatients.*
- ❖ *DCH spent millions of dollars on emergency department on-call coverage since Prince George's County has a limited number of primary care physicians and patients flock to the emergency departments for care. DCH has over 30 contracts for the variety of specialties.*
- ❖ *DCH offered Medical Directorships to ensure that physicians participate in the leadership of the hospital and the services offered to the county's residents.*
- ❖ *DCH offered the payment to nursing homes and some physicians to care for patients who are uninsured in order to keep the patients out of the inpatient setting.*

VI. APPENDICES

To Be Attached as Appendices:

1. Appendix I: 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)

Doctors Community Hospital does the following to ensure patients are aware of our financial policies:

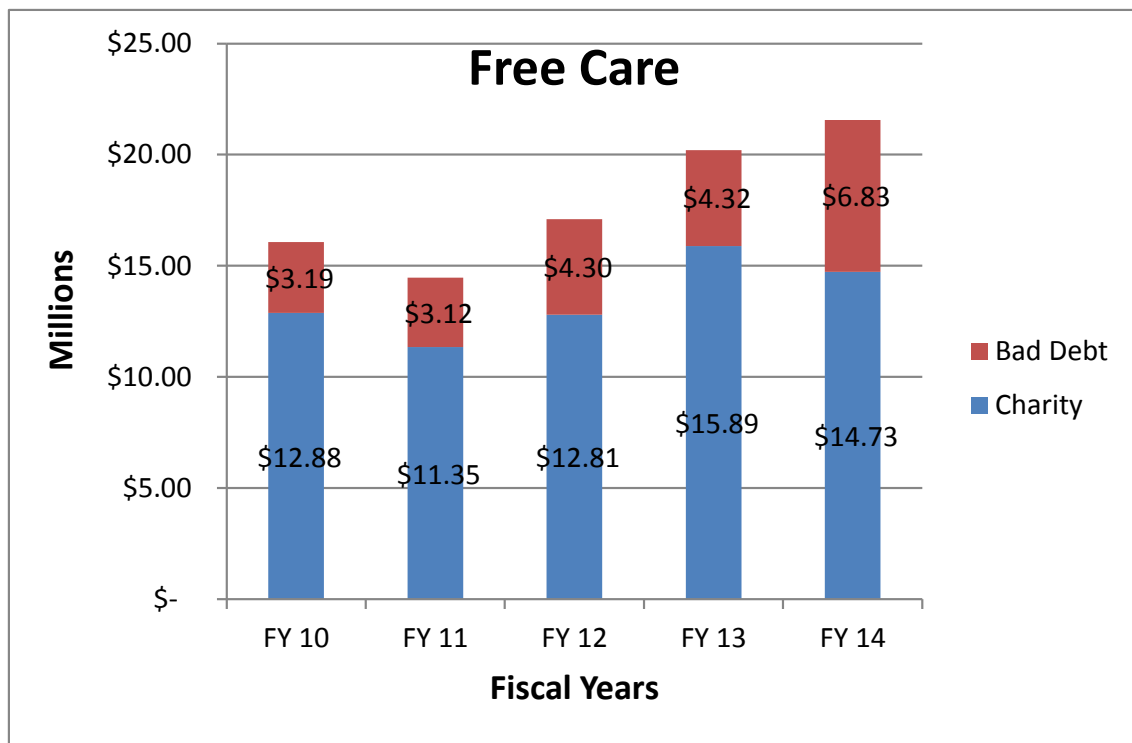
- ❖ *Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):*
 - *in a culturally sensitive manner,*
 - *at a reading comprehension level appropriate to the CBSA's population, and*
 - *in non-English languages that are prevalent in the CBSA.*
- ❖ *Posts its FAP, or a summary 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;*
- ❖ *Offers assistance in completing government and DCH financial assistance paperwork, at the cost of DCH, and*
- ❖ *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.*

Processes for Charity Care:

- ❖ *Notification Procedures regarding Charity care:*
- ❖ *There are signs posted in the Emergency Department, and all Admissions areas of the hospital.*
- ❖ *Each patient is given a brochure with the following information at time of admission and a copy is sent with any bills:*
- ❖ *There is a Spanish version of the brochure available as well.*
- ❖ *Financial Assistance*
- ❖ *Financial Assistance is available for patients who receive urgent or emergency services and do not have health insurance including Medicaid. Free care is provided for patients whose gross family income is at or below 200 percent of the Federal Poverty Guidelines. A 25-percent discount will be applied to qualified patients whose gross family income is above 200 percent of the Federal Poverty Guidelines.*
- ❖ *Financial Assistance applications may be obtained at the Emergency Registration or Outpatient Registration Departments or by calling the Business Office at 301-552-8186.*

- ❖ *Upon request, an application will be mailed to the patient. To qualify, the applicant must also provide proof of family income and expenses.*
- ❖ *Maryland Medical Assistance*
- ❖ *Doctors Community Hospital provides case workers to assist patients with Maryland Medical Assistance applications who have received Inpatient or Emergency Outpatient care. Patients who have received Inpatient care and do not have insurance may contact one of the phone numbers listed below:*
- ❖ *Annually we have an announcement posted in the local newspapers as well.*

History of Uncompensated Free Care- Chart



2. Appendix II: Include a copy of your hospital's FAP (label appendix II).

See Attached PDF

- 3. Appendix III: Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) (label appendix III).**

See Attached PDF

4. Appendix IV: Attach the hospital's mission, vision, and value statement(s)

Description of Doctors Community Hospital Mission, Vision & Values

The main purpose of our hospital is to provide quality healthcare to our surrounding community, we have dedicated ourselves to doing just that. We have pledged to always do that to the best of our ability by providing a quality healthcare team, with quality tools, equipment and education.

The **Mission** of Doctors Community Hospital is

"Dedicated to Caring for Your Health."

Our **Vision** is to

"Continuously strive for excellence in service and clinical quality to distinguish us with our patients and other customers."

Our **Values** are vested in the word SERVICE.

S - Safety
E - Excellence
R - Respect
V - Vision
I - Innovation
C - Compassion
E - Everyone

5. Appendix V: Prince George's County Health Action Plan

<http://www.princegeorgescountymd.gov/Government/AgencyIndex/Health/improvement.asp>

See Attached PDF

6. **Appendix VI: Blueprint for a Healthy Prince George's County, 2011 – 2014**
<http://www.princegeorgescountymd.gov/Government/AgencyIndex/Health/improvement.asp>

See Attached PDF

7. Appendix VII: Detailed Description, by Zip Code, of the communities that comprise the majority of Doctors Community Hospital's Community Benefit Service Areas

- **Lanham, Maryland – Zip Code 20706**

Lanham is an unincorporated community and census-designated place in Prince George's County, Maryland, in the United States.^[1] As of the 2010 census it had a population of 10,157.^[2] The terminal of the Washington Metro's Orange Line, as well as an Amtrak station, are across the Capital Beltway in New Carrollton, Maryland. Doctors Community Hospital is located in Lanham.^[3])

According to the U.S. Census Bureau, Lanham has a total area of 3.6 square miles (9.2 km²), of which 3.5 square miles (9.1 km²) is land and 0.02 square miles (0.05 km²), or 0.54%, is water.[5]

Demographics

The racial mix of the population is Black alone - 11,534 (59.4%), Hispanic - 3,310 (17.0%), White alone - 2,455 (12.6%), Asian alone - 1,547 (8.0%), two or more races - 549 (2.8%), American Indian alone - 15 (0.08%), and other race alone - 4 (0.02%).

Shoppers Food & Pharmacy, software company Vocus, media company Radio One and publisher Rowman & Littlefield are based in Lanham. Washington Bible College, Capital Bible Seminary, Equip Institute are located in this community.

References

1. U.S. Geological Survey Geographic Names Information System: Lanham, Maryland
2. "Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data (DP-1): Lanham CDP, Maryland". U.S. Census Bureau, American Factfinder. <http://factfinder2.census.gov>. Retrieved December 20, 2011.
3. "Doctors Community Hospital". *Doctors Community Hospital website*. Doctors Community Hospital. 2009-01-29. <http://www.dchweb.org/>.
4. "National Register Information System". *National Register of Historic Places*. National Park Service. 2010-07-09. http://nrhp.focus.nps.gov/natreg/docs/All_Data.html.
5. "Geographic Identifiers: 2010 Demographic Profile Data (G001): Lanham CDP, Maryland". U.S. Census Bureau, American Factfinder. <http://factfinder2.census.gov>. Retrieved December 20, 2011.

Sources of information reviewed November 12, 2014

Retrieved from http://en.wikipedia.org/wiki/Lanham,_Maryland

Retrieved from <http://www.city-data.com/city/Lanham-Seabrook-Maryland.html>

- ***Cheverly, Maryland – Zip Code 20784***

In its over 80 years, the **Town of Cheverly** has grown from farmland to a small livable community just minutes from the Nation's Capitol. Cheverly is 1.27 square miles in area, and the 2010 U.S. Census survey counted a population of 6,173 residents.

The Town is located in the western portion of Prince George's County, Maryland, just a mile from the northeastern Washington, D.C. border. Cheverly largely lies between two major road arteries -- the Baltimore-Washington Parkway and Maryland Route 50. Established as a planned residential community, Cheverly is convenient to Washington, D.C. by Metro bus and rail, and to retail shopping centers in the surrounding communities.

Cheverly was begun as a planned suburb in the early 1900s. The Cheverly area was first platted in 1904 for a 93-acre (380,000 m²) community called Cheverly Gardens. The land was subsequently purchased in 1918 by Robert Marshall, president of the Washington Suburban Realty Company. The Cheverly subdivision platted by Marshall was developed around the 1839 Magruder family homestead known as Mount Hope. Marshall became the first resident of Cheverly by taking up residence in the restored homestead in 1919. In 1923, the first road, now known as Cheverly Avenue, was completed and paved to connect the Pennsylvania Railroad line to Landover Road. 34 developer-built houses were constructed between 1921 and 1925. Most of the early houses were mail-order designs from Sears & Roebuck and the McClure Homes Company. Marshall lost control of the Washington Suburban Realty Company in 1927. Harry Wardman assumed the position until the company's bankruptcy in 1929 due to the stock market crash.[6]

Incorporation was granted in 1931 to address concerns for better roads and services. During the 1930s and 1940s, the streets were improved and lighting enhanced, and the number of residences increased from 135 to 650. Residential construction continued through the 1960s, creating a varied housing stock of early Cape Cod houses, with later ranch and split-level types. Two garden-style apartment complexes (Cheverly Terrace and Hanson Arms) were constructed in the early 1960s along Landover Road near the US Route 50 interchange. The community center, town hall, and park facility was built in 1978. Industrial property was established in 1958 on the west side of town and adjacent to Route 50.[6]

On April 29, 2006, the community held a 75th anniversary celebration at the town community center. The historic home Mount Hope has been the town's official symbol since 1931.

Demographics

Cheverly is home to the Prince George's Hospital Center and the Publick Playhouse for the Performing Arts.[3] Cheverly's ZIP codes are 20784 and 20785. As of the census[5] of 2000, there were 6,433 people, 2,258 households, and 1,637 families residing in the town. The population density was 4,769.9 people per square mile (1,839.8/km²). There were 2,348 housing units at an average density of 1,741.0 per square mile (671.5/km²). The racial makeup of the town was 33.86% White, 56.79% African American, 0.17% Native American, 2.50% Asian, 0.03% Pacific Islander, 3.22% from other races, and 3.44% from two or more races. Hispanic or Latino of any race were 6.76% of the population.

There were 2,258 households out of which 39.8% had children under the age of 18 living with them, 48.8% were married couples living together, 17.1% had a female householder with no husband present, and 27.5% were non-families. 20.4% of all households were made up of individuals and 4.7% had someone living alone who was 65 years of age or older. The average household size was 2.85 and the average family size was 3.30.

References

1. U.S. Geological Survey Geographic Names Information System: Cheverly, Maryland
2. "Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data (DP-1): Cheverly town, Maryland". U.S. Census Bureau, American Factfinder. <http://factfinder2.census.gov>. Retrieved December 9, 2011.
3. "Publick Playhouse". Maryland-National Capital Park and Planning Commission. <http://www.pgparcs.com/places/artsfac/publick.html>.]
4. "US Gazetteer files: 2010, 2000, and 1990". United States Census Bureau. 2011-02-12. <http://www.census.gov/geo/www/gazetteer/gazette.html>. Retrieved 2011-04-23.
5. "American FactFinder". United States Census Bureau. <http://factfinder.census.gov>. Retrieved 2008-01-31.
6. a b "Community Summary Sheet, Prince George's County". Cheverly, Maryland. Maryland State Highway Administration, 1999. 2008-05-10. http://www.sha.maryland.gov/oppn/pg_co.pdf.
7. M-NCPPC Illustrated Inventory of Historic Sites (Prince George's County, Maryland), 2006.

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Retrieved from <http://www.cheverly-md.gov/Pages/index>

Retrieved from http://en.wikipedia.org/wiki/Cheverly,_Maryland.

- **Landover, Maryland – Zip Code 20785**

Landover is an unincorporated community and census-designated place in Prince George's County, Maryland, United States.^[1] As of the 2010 census it had a population of 23,078.^[2] Landover was named for the town of Llandovery, Wales.^[3]

Landover is located at [38°55'28"N 76°53'15"W38.9244°N 76.8876°W](#). According to the U.S. Census Bureau, it has an area of 4.07 square miles (10.55 km²), of which 0.004 square miles (0.01 km²), or 0.13%, is water.^[4]

Though small, Landover houses many neighborhoods, which include Glenarden, Brightseat, Ardmore, Palmer Park, Kentland, Dodge Park, Columbia Park, Willow Hills(Hill Rd), Belle Haven, Lansdowne, and Village Green. Metrorail's Orange Line passes through the community. Landover Hills is a separate, incorporated community a few miles away. Landover is the birthplace of the late Len Bias. The Prince Georges County Sports and Learning Complex is in Landover.

Giant Food has its headquarters in a location in unincorporated Prince George's County near Landover.^[5] Landover also had career based colleges such as Fortis College^[9] that offers programs as a bio-technician, medical assisting and medical coding and billing.

Shopping and Crime

References

- 1.U.S. Geological Survey Geographic Names Information System: Landover, Maryland
2. "Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data (DP-1): Landover CDP, Maryland". U.S. Census Bureau, American Factfinder. <http://factfinder2.census.gov>. Retrieved December 20, 2011.
- 3."Profile for Landover, Maryland, MD". ePodunk. <http://www.epodunk.com/cgi-bin/genInfo.php?locIndex=2651>. Retrieved August 25, 2012.
4. "Geographic Identifiers: 2010 Demographic Profile Data (G001): Landover CDP, Maryland". U.S. Census Bureau, American Factfinder. <http://factfinder2.census.gov>. Retrieved December 20, 2011.
5. "Facility Locations." Giant Food. Retrieved on September 6, 2011. 8301 Professional Place, Suite 115 Landover, MD 20785."
6. "National Register Information System". National Register of Historic Places. National Park Service. 2010-07-09. http://nrhp.focus.nps.gov/natreg/docs/All_Data.html.
- 7."Harlem Renaissance Festival". Festival Media Corporation. <http://www.festivals.com/viewevent.aspx?eventid=2aWwZDqLM2w%3D>. Retrieved August 24, 2012.
- 8."Prince George's County Public Schools". Prince George's County Public Schools. <http://www1.pgcps.org/>. Retrieved August 24, 2012.

9. Fortis College - Landover

10.U.S. Census

Bureau.<http://www.census.gov/prod/www/abs/decennial/index.html>.Retrieved 2010-07-17.

Sources of Information reviewed November 12, 2014

Retrieved from http://en.wikipedia.org/wiki/Landover,_Maryland.

- ***Greenbelt, Maryland – Zip Code 20770***

The **Greenbelt Historic District** is a national historic district located in Greenbelt, Prince George's County, Maryland, United States. The district preserves the center of one of the few examples of the Garden City Movement in the United States. With its sister cities of Greenhills, Ohio and Greendale, Wisconsin, Greenbelt was intended to be a "new town" that would start with a clean slate to do away with problems of urbanism in favor of a suburban ideal. Along with the never-commenced town of Greenbrook, New Jersey, the new towns were part of the New Deal public works programs.^[3]

Greenbelt's center has survived with few alterations compared with its sister towns. It was designated a National Historic Landmark in 1997.^{[2][4]}

In April 1935 Congress passed the Emergency Relief Appropriation Act, intended to counter the effects of the Great Depression through the appropriation of \$5 billion for jobs programs. As a result, President Franklin Delano Roosevelt established the Resettlement Administration (RA) to coordinate federal efforts concerning housing and land, placing particular emphasis on rural poverty. While the focus of the RA remained primarily rural, it was also charged with resettling farm workers who were leaving agriculture in search of industrial work. New towns were seen as a solution to this problem, to be built outside urban areas and surrounded by healthful green belts of preserved land. As many as 3000 of these towns were initially envisioned. 100 cities were studied for new towns, eventually narrowing to 25. Four sites were picked for the first trials: Washington, D.C., Milwaukee, Wisconsin, Cincinnati, Ohio and New Brunswick, New Jersey. The Washington site was to be near Berwyn, Maryland, on land depleted by tobacco farming. 12,000 acres (49 km²) were purchased, and work began in late 1935, using 1000 laborers.^[5] Architects and planners were hired in June 1935, site construction began in December 1935, and Roosevelt was briefed on the plans in April 1936. Wallace Richards was the RA regional coordinator, Douglas Ellington was the principal architect, Reginald Wadsworth was associate principal architect, Hale Walker was the town planner, and Harold Bursley was the engineering designer. The design team described areas for group housing, single-family residences, light and heavy industry, businesses, schools and parks. beyond the original town area, planned for 4000 families, two more areas were reserved for 3000 families each, with capacity for 50% growth. Much of the land south of Greenbelt Road that was designated for town expansion has since been transferred to the National Park Service and is now Greenbelt Park, while other areas became the Henry A. Wallace Beltsville Agricultural Research Center.^[5]

Within the planned suburban development, 1000 units were designated for white residents, and 250 for African-American residents. A 1,750 acres (710 ha) tract was designated the Rossville Rural Development, and was apparently meant to be an area of 50 farms for African-Americans, based on the old African-American community of Rossville. Both Rossville and the suburban housing for African-Americans were eventually dropped from the plan.^[5]

Demographics

As of 2010 Greenbelt had a population of 23,068. The racial and ethnic composition of the population was 25.9% non-Hispanic white, 47.0% non-Hispanic black, 0.3% Native American, 2.6% Asian Indian, 7.1% other Asian, 0.1% Pacific Islander, 0.3% non-Hispanic of some other race, 3.3% from two or more races and 14.3% Hispanic or Latino of any race.[11]

As of the census[9] of 2000, there were 21,456 people, 9,368 households, and 4,965 families residing in the city. The population density was 3,586.6 people per square mile (1,385.3/km²). There were 10,180 housing units at an average density of 1,701.7 per square mile (657.3/km²). The racial makeup of the city was 39.74% White, 41.35% African American, 0.23% Native American, 12.05% Asian, 0.05% Pacific Islander, 3.11% from other races, and 3.47% from two or more races. Hispanic or Latino of any race were 6.45% of the population.

There were 9,368 households out of which 26.9% had children under the age of 18 living with them, 33.1% were married couples living together, 15.0% had a female householder with no husband present, and 47.0% were non-families. 35.0% of all households were made up of individuals and 5.8% had someone living alone who was 65 years of age or older. The average household size was 2.29 and the average family size was 3.00.

In the city the population was spread out with 21.9% under the age of 18, 12.5% from 18 to 24, 39.1% from 25 to 44, 19.8% from 45 to 64, and 6.7% who were 65 years of age or older. The median age was 32 years. For every 100 females there were 91.8 males. For every 100 females age 18 and over, there were 88.2 males.

The median income for a household in the city was \$46,328, and the median income for a family was \$55,671. Males had a median income of \$39,133 versus \$35,885 for females. The per capita income for the city was \$25,236. About 6.0% of families and 10.2% of the population were below the poverty line, including 12.7% of those under age 18 and 7.2% of those age 65 or over.

History of the City

Construction involved the transport of as many as 5000 men by rail to the Branchville railroad halt each day. Roosevelt visited on November 13, 1936. However, politics intervened, and amid criticism of the program, the RA was placed under the U.S. Department of Agriculture. In September 1937 it became the Farm Security Administration. By 1938 the greenbelt town was dissolved. The construction cost for Greenbelt was estimated at \$13,394,400.^[5]

The government began accepting applications for residence in Greenbelt, basing acceptance on income, health, family size, financial reliability, clean living habits and indications of community spirit. Prospective tenants were interviewed at their homes. Wives were not permitted to work,

and were expected to stay home and take care of children. The average age of the initial tenants was 29 years. Tenants paid \$18–25 per month for an apartment, and \$28–41 for a semidetached house.^[5]

The town was managed as a cooperative, with a citizens committee to run the commercial center. This arrangement was viewed with considerable skepticism, particularly within Congress. Eventually, by the 1950s, several members of Greenbelt's coops appeared before Congressional subcommittees on charges of communism and monopolistic practices as part of the McCarthy investigations.^[5]

After several abortive attempts to divest itself of the town, the Federal Government hired Hale Walker, the town's original planner, along with Harold Heller to develop a master plan for expansion of the town. The new plan envisioned a reduction of agricultural use and an increase in single-family housing. In 1947 the Greenbelt Mutual Home Owners Corporation was formed as a vehicle for the sale of the town. Congressional legislation was passed that allowed the government to sell the greenbelt towns to non-profit groups with at least 50% veteran members.

In December 1952 the Greenbelt Veterans Housing Corporation (GVHC) bought 1580 units and 240 acres (0.97 km²) of developed land for \$6,285,450. In 1953 the GVHC bought 709 acres (2.87 km²) of undeveloped land for \$670,219. Other areas were sold to private developers, and in 1956 the GVHC sold the undeveloped land to cover its loan. In 1957 Greenbelt Homes, Inc. was formed from the GVHC to manage the community, and retains title to 1600 units and 280 acres (1.1 km²) of land. The supermarket remains a co-op.^[5]

Greenbelt is laid out as a crescent of "superblocks" containing two rows of frame or concrete block multi-family dwellings. Houses are linked by footpaths and are grouped around central service courts, with the public sides facing the communal "garden" space. A central town common includes the original commercial district, community center and school, linked to the residential areas by pedestrian underpasses. A recreation area, 27 acres (11 ha) lake, and allotment gardens are located beyond the common. The architecture is modernist in style. The historic district includes more than 400 structures, as well as three pre-existing family cemeteries. The original center of Greenbelt has since been surrounded by newer development, causing it to be compared with a medieval fortress town, a walled center surrounded by contemporary neighborhoods.^[5]

Greenbelt borrowed techniques pioneered seven years previously at Radburn, New Jersey, which turned housing layouts "inside-out" to keep automobiles and service traffic hidden. The architectural design, while modern in tone, borrows details such as pitched slate roofs, plain walls and steel casement windows from the English garden cities at Letchworth and Welwyn Garden City. International Style influences are visible in the white walls and flat roofs of the concrete block buildings.

Landscaping was integrated into the design, with mature specimen trees saved or transplanted during site development. Each of the group housing units had a plot 30 feet (9.1 m) by 90 feet (27 m) between the house and the parklands, cared for by the tenant. On the service side space was provided for trash storage and clothes drying. Landscaping was used to create privacy, and the finished community was notable for the maturity of the plantings.¹

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- ***Capitol Heights, Maryland – Zip Code 20743***

Capitol Heights is a town in Prince George's County, Maryland, United States.^[1] The population was 4,337 at the 2010 census.^[2] Development around the Capitol Heights Metro station has medical facilities and eateries to support the community. The Washington Redskins football stadium is just to the east of Capitol Heights, near the Capital Beltway (I-95/495) and Hampton Mall shopping center which has a new hotel and eateries. The town borders Washington, D.C.

Demographics

As of the census^[4] of 2000, there were 4,138 people, 1,441 households, and 1,014 families residing in the town. The population density was 5,047.3 people per square mile (1,948.4/km²). There were 1,603 housing units at an average density of 1,955.2 per square mile (754.8/km²). The racial makeup of the town was 92.85% Black or African American, 4.81% White, 0.27% Native American, 0.36% Asian, 0.36% from other races, and 1.35% from two or more races. Hispanic or Latino of any race were 0.87% of the population.

There were 1,441 households out of which 37.5% had children under the age of 18 living with them, 35.2% were married couples living together, 28.5% had a female householder with no husband present, and 29.6% were non-families. 25.7% of all households were made up of individuals and 8.0% had someone living alone who was 65 years of age or older. The average household size was 2.87 and the average family size was 3.41.

In the town the population was spread out with 30.8% under the age of 18, 6.9% from 18 to 24, 32.6% from 25 to 44, 21.4% from 45 to 64, and 8.3% who were 65 years of age or older. The median age was 34 years. For every 100 females there were 84.8 males. For every 100 females age 18 and over, there were 78.8 males.

The median income for a household in the town was \$46,667, and the median income for a family was \$53,826. Males had a median income of \$36,950 versus \$35,225 for females. The per capita income for the town was \$18,932. About 9.3% of families and 11.4% of the population were below the poverty line, including 15.8% of those under age 18 and 9.6% of those age 65 or over.

Notable people include Chad Scott, American football cornerback in the NFL, played for Pittsburgh Steelers and the New England Patriots.^[5]

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- ***Kettering, Maryland – Zip Code -20774***

Kettering is an unincorporated area and census-designated place (CDP) in Prince George's County, Maryland, United States.^[1] The population was 12,790 at the 2010 census,^[2] primarily African-American. The name Kettering was created by a suburban housing developer in the 1960s when development began. Kettering is adjacent to Prince George's Community College, the upscale gated community of Woodmore, Six Flags America, Evangel Temple megachurch, and the community of Largo at the end of the Washington Metro Blue Line. Watkins Regional Park in Kettering offers a large playground, a colorful carousel, miniature golf, a miniature train ride, and various animals.

Kettering is located at [38°53'42"N 76°47'47"W](#)^[3] [38.895012°N 76.796471°W](#).^[3] According to the United States Census Bureau, the CDP has a total area of 5.5 square miles (14 km²), all of it land.

Demographics

As of the census^[4] of 2000, there were 11,008 people, 3,814 households, and 2,955 families residing in the CDP. The population density was 2,016.5 people per square mile (778.4/km²). There were 3,958 housing units at an average density of 725.0/sq mi (279.9/km²). The racial makeup of the CDP was 5.78% White, 90.62% African American, 0.19% Native American, 1.24% Asian, 0.47% from other races, and 1.71% from two or more races. Hispanic or Latino of any race were 0.95% of the population.

There were 3,814 households out of which 36.3% had children under the age of 18 living with them, 50.0% were married couples living together, 23.3% had a female householder with no husband present, and 22.5% were non-families. 18.4% of all households were made up of individuals and 1.7% had someone living alone who was 65 years of age or older. The average household size was 2.86 and the average family size was 3.24.

In the CDP the population was spread out with 26.6% under the age of 18, 7.1% from 18 to 24, 30.6% from 25 to 44, 29.1% from 45 to 64, and 6.6% who were 65 years of age or older. The median age was 37 years. For every 100 females there were 81.3 males. For every 100 females age 18 and over, there were 75.8 males.

The median income for a household in the CDP was \$78,735, and the median income for a family was \$82,777. Males had a median income of \$47,059 versus \$45,243 for females. The per capita income for the CDP was \$30,398. About 0.8% of families and 1.9% of the population were below the poverty line, including 1.9% of those under age 18 and 2.0% of those age 65 or over.

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- ***Bowie, Maryland – Zip Code 20721 & 20720***

Bowie is a city of 54,727 residents, according to the 2010 Census, located in Prince George's County, and convenient to Washington, DC, Annapolis, and Baltimore. The city consists of approximately 18-square miles. There are more than 1,100 acres set aside as parks or as preserved open space, including over 22 miles of paths and trails, and 75 ball fields. Bowie has a nonpartisan city government directed by a mayor and six council members. The City Council meets on the first and third Mondays of most months in sessions that are open to the public.

The following was retrieved from http://en.wikipedia.org/wiki/Bowie,_Maryland.

Bowie is a city in Prince George's County, Maryland, United States.^[1] The population was 54,727 at the 2010 census. Bowie has grown from a small railroad stop to the largest municipality in Prince George's County, and the fifth most populous city^[2] and third largest city by area in the state of Maryland.

19th century History

The city of Bowie owes its existence to the railway. In 1853, Col. William Duckett Bowie obtained a charter from the Maryland legislature to construct a rail line into Southern Maryland. In 1869, the Baltimore & Potomac Railroad Company began the construction of a railroad from Baltimore to Southern Maryland, terminating in Pope's Creek. The area had already been dotted with small farms and large tobacco plantations in an economy based on agriculture and slavery. In 1870, Ben Plumb, a land speculator and developer, sold building lots around the railroad junction and named the settlement Huntington City. By 1872, the line was completed, together with a "spur" to Washington DC and the entire line through Southern Maryland was completed in 1873.

Huntington City was renamed in honor of the son of William Duckett Bowie and his business partner, Oden Bowie,^{[3][4][5][6]} who was President of the Baltimore & Potomac Railroad at the time,^[7] and previously Governor of Maryland.^[8] The town was subsequently rechartered as Bowie in 1880. In the early days the land was subdivided by developers into more than 500 residential building lots, to create a large town site at a junction of the Baltimore and Potomac's main line to southern Maryland, and the branch line to Washington, DC.

20th century History

By 1902, the Baltimore & Potomac was purchased by the powerful Pennsylvania Railroad. A second railroad entered the community when the Washington, Baltimore and Annapolis Electric Railway electric trolley line commenced service in 1908. The large interurban cars brought rapid transit to the area, with trains running hourly. Bowie area stations included High Bridge, Hillmeade, and the Race Track.

The convergence of the two rail systems induced the Southern Maryland Agricultural Society to build the Bowie Race Track in 1914. The track enabled the Belair Stud to become one of Maryland's premier areas for thoroughbreds. Also in 1914, a teacher-training college, or normal school as it was referred to then, was built for African-Americans, just outside the town. This now has become Bowie State University. In 1916, the town of Bowie was incorporated. In 1957, the firm of Levitt and Sons acquired the nearby Belair Estate, the original colonial plantation of the Provincial Governor of Maryland, Samuel Ogle, and developed the residential community of Belair at Bowie. Two years later the town of Bowie annexed the Levitt properties, and then re-incorporated the now-larger area as a city in 1963. The overwhelming majority of Bowie residents today live in this 1960s Levitt planned community, whose street names are arranged in alphabetical sections.^[citation needed] Levitt & Sons had a long history of prohibiting the sale of houses (including resale by owners) to African Americans which led to civil rights protests in Bowie in 1963.^[9]

Bowie enjoys a rich and diverse historic and cultural heritage. The original Belair Estate contains the Belair Mansion (circa 1745), the beautiful five-part Georgian plantation house of Governor Samuel Ogle and his son Governor Benjamin Ogle. It was purchased in 1898 by the wealthy banker James T. Woodward who, on his passing in 1910, left it to his nephew, William Woodward, Sr., who became a famous horseman. Restored to reflect its 250-year-old legacy, the Mansion is listed on the National Register of Historic Places.

Belair Stable, on the Estate, was part of the famous Belair Stud, one of the premier racine stables in the 1930s, '40s, and '50s. Owned and operated by William Woodward, Sr. (1876–1953), it closed in 1957 following the death of his son, Billy Woodward. Belair had been the oldest continually operating thoroughbred horse farm in the country. It is said that the blood of Belair horses flows through the veins of every American race horse of distinction.^[citation needed]

Bowie today

Honoring the tradition of a rail town, the City of Bowie has preserved this piece of its history in the Huntington Railroad Museum, which includes historic materials displayed in the station's restored railroad buildings. In 2006, the City reopened the Bowie Building Association building as a Welcome Center for all to enjoy and learn about the history of Bowie. This building is a small brick and block structure constructed circa 1930. It originally housed the Bowie Building Association, which helped finance much of the development in the early days of the community. Bowie has grown from a small agricultural and railroad town to one of the largest and fastest growing cities in Maryland. It is a city of 16 square miles (41 km²) and approximately 50,000 residents. It has nearly 2,000 acres (8.1 km²) set aside as parks or open space. It has 72 ball fields, three community centers, an ice arena at Allen Pond Park, the Bowie Town Center, the 800-seat Bowie Center for the Performing Arts, a 150-seat theatrical playhouse, a golf course,

and three museums. Bowie is home to the Bowie Baysox, a Class AA Eastern League professional baseball team affiliated with the Baltimore Orioles. The Baysox currently play their home games at Prince George's Stadium. The city has recently added a state-of-the-art senior citizens center and a gymnasium for community programs. The city is a family-oriented community whose motto is "Growth, unity and progress".

Despite its low crime rate, Bowie has seen high profile criminal activity. Michael Bray was co-pastor at the Reformation Lutheran Church in Bowie when he conspired to bomb 10 clinics and offices of abortion supporters in three states and the District of Columbia from January 1984 through January 1985. He eventually served almost 4 years in prison for these crimes.^[10] On October 7, 2002, a 13-year old boy was critically wounded by a sniper soon after he was dropped off at Benjamin Tasker Middle School in Bowie. This shooting was one in a series of murders and attempted murders referred to collectively as the Beltway sniper attacks.

Bowie State University, located north of Bowie, has been open since 1865.

Bowie is located at [38°57'53"N 76°44'40"W](#)[38.96472°N 76.74444°W](#) (38.964727, - 76.744531).^[12] According to the city's 2009 State of the Environment report, the city has a total area of 18 square miles (47 km²), of which 0.04 square miles (0.10 km²), or 0.12%, is water.^[13]

Demographics

As of the 2010 Census, Bowie had a population of 54,727. 99.5% of the population lived in households with a total of 19,950 households. The racial and ethnic composition of the population was 38.9% non-Hispanic white, 47.9% non-Hispanic black, 0.3% Native American, 4.1% Asian, 0.1% Pacific Islander, 1.9% from some other race and 3.6% from two or more races. 5.6% of the population was Hispanic or Latino of any race.^[14]

As of the census^[15] of 2010, there were 54,727 people, 18,188 households, and 13,568 families residing in the city. The population density was 3,121.9 people per square mile (1,205.5/km²). There were 18,718 housing units at an average density of 1,162.5 per square mile (448.9/km²).

The racial makeup of the city was:

- 41.40% (Non-Hispanic) White
- 48.70% Black or African American
- 2.95% Asian
- 2.92% Hispanic or Latino (of any race)
- 2.30% from two or more races
- 0.93% Other races
- 0.30% Native American
- 0.03% Pacific Islander

There were 18,188 households out of which 37.7% had children under the age of 18 living with them, 60.0% were married couples living together, 11.0% had a female householder with no husband present, and 25.4% were non-families. 19.7% of all households were made up of individuals and 5.2% had someone living alone who was 65 years of age or older. The average household size was 2.74 and the average family size was 3.16.

In the city the population was spread out with 26.9% under the age of 18, 5.7% from 18 to 24, 34.9% from 25 to 44, 23.0% from 45 to 64, and 9.4% who were 65 years of age or older. The median age was 36 years. For every 100 females there were 91.5 males. For every 100 females age 18 and over, there were 87.3 males.

According to a 2007 estimate, the median income for a household in the city was \$99,105, and the median income for a family was \$109,157.^[16] Males had a median income of \$52,284 versus \$40,471 for females. The per capita income for the city was \$30,703. About 0.7% of families and 1.6% of the population were below the poverty line, including 1.0% of those under age 18 and 1.8% of those age 65 or over.

Rank by Per Capita Income in Prince George's County: 7

Rank by Per Capita Income in Maryland: 65

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- *Riverdale, Maryland – Zip Code 20737*

Riverdale Park is a town in Prince George's County, Maryland, United States.^[1] The population was 6,956 at the 2010 census.^[2] Riverdale Park is located at [38°57'46"N 76°55'47"W](#)[38.96278°N 76.92972°W](#) (38.962810, -76.929699)^[3]. According to the United States Census Bureau, the town has a total area of 1.7 square miles (4.3 km²), of which 0.03 square miles (0.07 km²), or 1.50%, is water.^[4]

Riverdale Park and the neighboring community of West Riverdale developed in the late nineteenth century as streetcar suburbs in central Prince George's County. The town is located approximately seven miles northeast of Washington, D.C., and is bounded to the north by East-West Highway and bisected by the heavily traveled US Route 1. The City of College Park is located to the north, and the City of Hyattsville is located to the south and southwest. The area was first developed in 1801 when a Belgian aristocrat, Henri Joseph Stier, purchased 800 acres situated between two tributaries of the Anacostia River known as the Paint and Northwest branches. Stier and his family moved to America several years earlier to escape the French Revolution (1788-1789). He named his holdings Riversdale (PG: 68-04-005) and began constructing his residence that same year. The mansion was modeled after the Stier family's Belgian home, Chateau du Mick, and when completed in 1807, the building stood as a two-story stuccoed-brick dwelling in the late Georgian style.

Just two years after purchasing and improving the property, in 1803, the political tension that had caused Stier to flee his native country subsided and he and his wife, Marie Louise, returned to Belgium. Riversdale was given to their daughter, Rosalie, who married George Calvert, the grandson of the fifth Lord Baltimore, in 1799. After Rosalie Stier Calvert died in 1821 and George Calvert in 1838, their son, Charles Benedict Calvert, took over the plantation. Charles Calvert was a renowned agriculturist and helped establish the Maryland Agricultural College, now the University of Maryland at College Park. In 1861, Calvert was elected to the United States Congress and fought for the establishment of the United States Department of Agriculture. During his life, Charles Calvert conducted a variety of agricultural experiments at Riversdale and expanded the original holdings to 2,200 acres. Calvert died in 1864; however, the property remained in the ownership of the Calvert family for another twenty years.

The 1861 Martenet map depicts the rural setting of Riversdale and identifies Charles B. Calvert as owner. The old Baltimore Turnpike, now known as US Route 1, is located to the west of the mansion house. To the east of the house is the Washington Branch of the Baltimore & Ohio Railway, which opened in 1833. The railway is located inside the boundaries of Riverdale Park, just west of the Paint Branch tributary. The 1878 Hopkins map shows little change and no significant development had occurred.

In 1887, the heirs of Charles Benedict Calvert conveyed 474 acres of land to New York City businessmen John Fox and Alexander Lutz in two separate transactions. The first deed involved the sale of 300 acres including the Riversdale mansion. The remaining 174 acres were transferred to Fox and Lutz shortly thereafter. The cost of the sales to Fox and Lutz totaled \$47,000. On March 23, 1889, Fox and Lutz formed the Riverdale Park Company, which was named in honor of the grand Federal-style mansion at the center of the proposed community. The company planned on creating an upper-middle-class residential suburb for residents working in Washington, D.C. and Baltimore.

The land was platted in 1889 by surveyor D.J. Howell and the new development was named Riverdale Park. In an attempt to differentiate the historic plantation known as Riversdale from the subdivision, the “s” was dropped. The new roads were named in honor of United States presidents and were arranged in a grid pattern that surrounded a central ellipse that served as the site of the commuter train station. The first of the stations was constructed in 1890. Laid out as a “villa park,” the community featured traffic circles and green space, using the mansion as a central amenity. The three original sections of the suburb utilized relatively uniform lot dimensions and building setbacks, thereby creating a cohesive development of middle- and upper-middle-class housing. The residential housing lots surrounded the high-style Riversdale mansion.

The construction of dwellings in Riverdale Park began in 1890. The buildings reflected popular trends of the time and were of wood-frame construction. Some structures were pyramidal-roof Foursquares, while others had front-gable or cross-gable roofs. Many houses from this period have projecting bays, corner towers, and wrap-around porches. By the turn of the twentieth century, Riverdale Park comprised 60 dwellings, a Presbyterian church, a schoolhouse, and a railroad station. The new community straddled the Washington line of the Baltimore & Ohio Railroad, which provided residents an easy commute to Washington, D.C.

Recognizing the financial potential of the new suburb, builders purchased groups of lots that were soon improved by high-style single-family dwellings. Joseph A. Blundon (ca.1847-1909) was one such late-nineteenth-century builder. Born in Georgetown, Blundon worked as a general contractor in Washington, D.C., before moving to Riverdale Park in 1889. He was instrumental in forming the Riverdale Park Company and served as its first manager. Blundon acted independently of the development company when he purchased several lots each year for the purpose of overseeing the construction of single-family dwellings. Between 1891 and 1909, he was responsible for the erection of roughly 90 buildings in Riverdale Park. Accordingly, he became known as the “Father of Riverdale.”

In 1920, a handful of owners in both Riverdale Park and the nearby West Riverdale petitioned the Maryland General Assembly requesting authority to incorporate the two neighborhoods as a municipality. On June 14, 1920, the community was incorporated as the Town of Riverdale. As a

result of the transfer of power from the Riverdale Park Company to the municipal government, the importance of the real estate company began to diminish, prompting a financial strain. Within ten years of the town's incorporation, the Riverdale Park Company went bankrupt. Numerous annexations in the mid-twentieth century have increased Riverdale's overall size. The municipal government continued to grow and change during this period. In 1941, the town changed the name of its roads to conform to the standards of the United States Postal Service and carried a similar pattern as those of Washington, D.C., and nearby College Park. The increasing population and commercial and governmental growth of metropolitan Washington, D.C., most notably during the last twenty years of the twentieth century, has resulted in further development of the town of Riverdale. This late-twentieth-century growth was predominantly commercial and centered along Baltimore Avenue, thereby physically and visually separating West Riverdale from Riverdale Park.

In 1998, the town was officially renamed Riverdale Park. Today, the town is made up of a mix of housing styles including 1960s apartment buildings, pre- and post-World War II era buildings, as well as dwellings from the turn of the twentieth century. The Riversdale mansion, now surrounded by eight acres is owned by The M-NCPPC, which purchased it in 1949. The Riversdale property is bounded roughly by 48th Avenue to the west, Riverdale Road to the north, Taylor Street to the east and Oglethorpe Street to the south.

Demographics

As of the [census^{\[5\]}](#) of 2000, there were 6,690 people, 2,172 households, and 1,437 families residing in the town. The population density was 4,212.7 people per square mile (1,624.5/km²). There were 2,321 housing units at an average density of 1,461.5 per square mile (563.6/km²). The racial makeup of the town was 39.91% White, 38.51% African American, 0.49% Native American, 4.25% Asian, 0.12% Pacific Islander, 12.99% from other races, and 3.74% from two or more races. Hispanic or Latino of any race were 28.27% of the population.

There were 2,172 households out of which 38.4% had children under the age of 18 living with them, 42.0% were married couples living together, 16.4% had a female householder with no husband present, and 33.8% were non-families. 23.9% of all households were made up of individuals and 4.1% had someone living alone who was 65 years of age or older. The average household size was 3.06 and the average family size was 3.60.

In the town the population was spread out with 28.7% under the age of 18, 12.2% from 18 to 24, 38.7% from 25 to 44, 15.6% from 45 to 64, and 4.9% who were 65 years of age or older. The median age was 29 years. For every 100 females there were 110.6 males. For every 100 females age 18 and over, there were 109.3 males.

The median income for a household in the town was \$44,041, and the median income for a family was \$49,904. Males had a median income of \$30,053 versus \$30,200 for females. The per capita income for the town was \$19,293. About 9.0% of families and 12.0% of the population were below the poverty line, including 16.0% of those under age 18 and 7.2% of those age 65 or over.

References

1. U.S. Geological Survey Geographic Names Information System: Riverdale Park, Maryland
2. "Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data (DP-1): Riverdale Park town, Maryland". U.S. Census Bureau, American Factfinder. <http://factfinder2.census.gov>. Retrieved December 14, 2011.
3. "US Gazetteer files: 2010, 2000, and 1990". United States Census Bureau. 2011-02-12. <http://www.census.gov/geo/www/gazetteer/gazette.html>. Retrieved 2011-04-23.
4. "Geographic Identifiers: 2010 Demographic Profile Data (G001): North Brentwood town, Maryland". U.S. Census Bureau, American Factfinder. <http://factfinder2.census.gov>. Retrieved December 14, 2011.
5. "American FactFinder". United States Census Bureau. <http://factfinder.census.gov>. Retrieved 2008-01-31.

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- ***Districts Heights, Maryland – Zip Code 20747***

District Heights is an incorporated city in Prince George's County, Maryland, United States, located near Maryland Route 4.^[1] The population was 5,837 at the 2010 census. For more information, see the separate articles on Forestville, Maryland and Suitland.

District Heights was originally farm land owned by Major Leander P. Williams, purchased as four patented Lord Baltimore tracts known as: "Good Luck", "Magruder's Plains Enlarged", "the Levels", and "Offutt's Adventure". Under grants issued to Lord Baltimore by King Charles I of England, the tracts belonged to Colonel Ninian Beall, Benjamin Berry, and Alexander Magruder. District heights evolved from one of the four patents. In 1925 land purchased and formed into District Heights Company by Joseph Tepper, David L. Blanken, Henry Oxenberg, Gilbert Leventhal, Simon Gordon, and Simon Gerber. The land was farmed by Walter and Al Dustin, whose farmhouse stood at 7116 Foster Street. By 1925 streets laid out first three blocks of Halleck Street and Aztec. By 1936, the city had approximately 25 homes built, two businesses, a grocery store and filling station, a pump house and water tower to furnish the water and pressure for the City, a sewage system and a free Model T bus service to 17th and Pennsylvania Avenue, S.E.

District Heights is 9.85 miles (15.85 km) away from central Washington, D.C. District Heights is located at [38°51'34"N 76°53'21"W](#)[38.85944°N 76.88917°W](#) (38.859545, -76.889139)^[2]. According to the United States Census Bureau, the city has a total area of 0.9 square miles (2.3 km²), all of it land.

Demographics

As of the 2010 Census the population of District Heights was 5,837. The racial and ethnic composition of the population was 4.25% non-Hispanic white, 89.5% non-Hispanic black, 0.2% Native American, 0.6% Asian, 1.15 from some other race and 1.9% from two or more races. 3.7% of the population was Hispanic or Latino or any race.^[3]

As of the census^[4] of 2000, there were 5,958 people, 2,070 households, and 1,538 families residing in the city. The population density was 6,649.1 people per square mile (2,556.0/km²). There were 2,170 housing units at an average density of 2,421.7 per square mile (930.9/km²). The racial makeup of the city was 9.20% White, 87.95% African American, 0.12% Native American, 0.86% Asian, 0.20% from other races, and 1.68% from two or more races. Hispanic or Latino of any race were 0.49% of the population.

There were 2,070 households out of which 38.3% had children under the age of 18 living with them, 39.6% were married couples living together, 28.2% had a female householder with no husband present, and 25.7% were non-families. 22.1% of all households were made up of

individuals and 5.0% had someone living alone who was 65 years of age or older. The average household size was 2.88 and the average family size was 3.36.

In the city the population was spread out with 30.8% under the age of 18, 8.3% from 18 to 24, 29.3% from 25 to 44, 23.6% from 45 to 64, and 8.0% who were 65 years of age or older. The median age was 34 years. For every 100 females there were 84.9 males. For every 100 females age 18 and over, there were 76.1 males.

The median income for a household in the city was \$52,331, and the median income for a family was \$61,220. Males had a median income of \$37,129 versus \$32,443 for females. The per capita income for the city was \$21,190. About 4.5% of families and 5.9% of the population were below the poverty line, including 9.0% of those under age 18 and 6.1% of those age 65 or over.

References

U.S. Geological Survey Geographic Names Information System: District Heights, Maryland

"US Gazetteer files: 2010, 2000, and 1990". United States Census Bureau. 2011-02-12. <http://www.census.gov/geo/www/gazetteer/gazette.html>. Retrieved 2011-04-23.

2010 general profile of population and housing characteristics of District Heights from the US Census

"American FactFinder". United States Census Bureau. <http://factfinder.census.gov>. Retrieved 2008-01-31.

Demographics

About Us

Sources of Information reviewed November 12, 2014

Retrieved from http://en.wikipedia.org/wiki/District_Heights,_Maryland.

VIII: The Community Benefit Reporting Tool

Also Attached Excel Sheet

Doctors Community Hospital HSCRC Community Benefits Narrative Report FY 2014

	A	B	C	D	E	F	G	H	I	J	K	L
1												
2												
3												
4												
5		Hospital Name:	Doctors Community Hospital									
6		HSCRC Hospital ID #:	21-0051									
7		# of Employees:	1,466									
8												
9		Contact Person:	Mary P. Dudley									
10		Contact Number:	301-552-8601									
11		Contact Email:	Mdudley@DCHweb.org									
12												
13												
14												
15												
16												
17	T00	Medicaid Costs										
18	T99	Medicaid Assessments				N/A	N/A	\$5,467,732.00		\$4,675,594.00	\$792,138.00	
19												
20	A00.	COMMUNITY HEALTH SERVICES										
21	A10	Community Health Education				839	4,192	\$51,267.00	\$32,298.21		\$83,565.21	
22	A11	Support Groups				325	1,670	\$55,667.00	\$35,070.21		\$90,737.21	
23	A12	Self-Help							\$0.00		\$0.00	
24	A20	Community-Based Clinical Services							\$0.00		\$0.00	
25	A21	Screenings				372	1,387	\$22,920.00	\$14,439.60		\$37,359.60	
26	A22	One-Time/Occasionally Held Clinics							\$0.00		\$0.00	
27	A23	Free Clinics							\$0.00		\$0.00	
28	A24	Mobile Units							\$0.00		\$0.00	
29	A30	Health Care Support Services							\$0.00		\$0.00	
30	A40								\$0.00		\$0.00	
31	A41								\$0.00		\$0.00	
32	A42								\$0.00		\$0.00	
33	A43								\$0.00		\$0.00	
34	A44								\$0.00		\$0.00	
35												
36	A99	Total Community Health Services			TOTAL	1,536	7,249	129,854	\$81,808.02	\$0.00	\$211,662.02	
37												

Doctors Community Hospital HSCRC Community Benefits Narrative Report FY 2014

	A	B	C	D	E	F	G	H	I	J	K	L
						# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST(\$)	INDIRECT COST(\$)	OFFSETTING REVENUE(\$)	NET COMMUNITY BENEFIT	
38												
39	B00	HEALTH PROFESSIONS EDUCATION										
40	B10	Physicians/Medical Students							\$0.00		\$0.00	
41	B20	Nurses/Nursing Students				32,264	454	\$1,129,240.00	\$0.00		\$1,129,240.00	
42	B30	Other Health Professionals				10,558	1,435	\$497,650.00	\$0.00		\$497,650.00	
43	B40	Scholarships/Funding for Professional Education							\$0.00		\$0.00	
44	B50								\$0.00		\$0.00	
45	B51								\$0.00		\$0.00	
46	B52								\$0.00		\$0.00	
47	B53								\$0.00		\$0.00	
48												
49	B99	Total Health Professions Education			TOTAL	42822	1889	\$1,626,890.00	\$0.00	\$0.00	\$1,626,890.00	
50												
51						# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST(\$)	INDIRECT COST(\$)	OFFSETTING REVENUE(\$)	NET COMMUNITY BENEFIT	
52	C00	MISSION DRIVEN HEALTH SERVICES (please list)										
53	C10								\$0.00		\$0.00	
54	C20								\$0.00		\$0.00	
55	C30								\$0.00		\$0.00	
56	C40								\$0.00		\$0.00	
57	C50								\$0.00		\$0.00	
58	C60								\$0.00		\$0.00	
59	C70								\$0.00		\$0.00	
60	C80								\$0.00		\$0.00	
61	C90								\$0.00		\$0.00	
62	C91								\$0.00		\$0.00	
63												
64	C99	Total Mission Driven Health Services			TOTAL	0	0	\$0.00	\$0.00	\$0.00	\$0.00	
65												
66						# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST(\$)	INDIRECT COST(\$)	OFFSETTING REVENUE(\$)	NET COMMUNITY BENEFIT	
67	D00	RESEARCH										
68	D10	Clinical Research							\$0.00		\$0.00	
69	D20	Community Health Research							\$0.00		\$0.00	
70	D30								\$0.00		\$0.00	
71	D31								\$0.00		\$0.00	
72	D32								\$0.00		\$0.00	
73												
74	D99	Total Research			TOTAL	0	0	0	\$0.00	0	\$0.00	

Doctors Community Hospital HSCRC Community Benefits Narrative Report FY 2014

	A	B	C	D	E	F	G	H	I	J	K	L
						# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST(\$)	INDIRECT COST(\$)	OFFSETTING REVENUE(\$)	NET COMMUNITY BENEFIT	
75												
76	E00	Cash and In-Kind Contributions										
77	E10	Cash Donations						\$302,899.19	\$0.00		\$302,899.19	
78	E20	Grants							\$0.00		\$0.00	
79	E30	In-Kind Donations				1,773	10,930	\$58,240.00	\$0.00		\$58,240.00	
80	E40	Cost of Fund Raising for Community Programs							\$0.00		\$0.00	
81												
82	E99	Total Cash and In-Kind Contributions			TOTAL	1773	10930	\$361,139.19	\$0.00	\$0.00	\$361,139.19	
83												
84						# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST(\$)	INDIRECT COST(\$)	OFFSETTING REVENUE(\$)	NET COMMUNITY BENEFIT	
85	F00	COMMUNITY BUILDING ACTIVITIES										
86	F10	Physical Improvements and Housing							\$0.00		\$0.00	
87	F20	Economic Development				102	2,509	\$41,353.00	\$26,052.39		\$67,405.39	
88	F30	Community Support				10,420	3,328	\$347,060.00	\$218,647.80		\$565,707.80	
89	F40	Environmental Improvements							\$0.00		\$0.00	
90	F50	Leadership Development/Training for Community Members							\$0.00		\$0.00	
91	F60	Coalition Building							\$0.00		\$0.00	
92	F70	Advocacy for Community Health Improvements							\$0.00		\$0.00	
93	F80	Workforce Development				3,146	8,350	\$79,403.00	\$50,023.89		\$129,426.89	
94	F90								\$0.00		\$0.00	
95	F91								\$0.00		\$0.00	
96	F92								\$0.00		\$0.00	
97												
98	F99	Total Community Building Activities			TOTAL	13,668	14,187	467,816	294,724	0	762,540	
99												
100						# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST(\$)	INDIRECT COST(\$)	OFFSETTING REVENUE(\$)	NET COMMUNITY BENEFIT	
101	G00	COMMUNITY BENEFIT OPERATIONS										
102	G10	Assigned Staff				2,080		\$62,400.00	\$39,312.00		\$101,712.00	
103	G20	Community health/health assets assessments				120		\$7,200.00	\$4,536.00		\$11,736.00	
104	G30	HCI Contract						\$20,000.00	\$12,600.00		\$32,600.00	
105	G31								\$0.00		\$0.00	
106	G32								\$0.00		\$0.00	
107												
108	G99	Total Community Benefit Operations			TOTAL	2,200	0	\$89,600.00	\$56,448.00	\$0.00	\$146,048.00	
109												

Doctors Community Hospital HSCRC Community Benefits Narrative Report FY 2014

	A	B	C	D	E	F	G	H	I	J	K	L
110	H00	CHARITY CARE (report total only)										
111	H99	Total Charity Care			TOTAL	\$14,726,686.00						
112												
113		FINANCIAL DATA										
114	I10	INDIRECT COST RATIO				63.00%						
115												
116	I00	OPERATING REVENUE										
117	I20	Net Patient Service Revenue				\$175,897,565.00						
118	I30	Other Revenue				\$4,687,403.00						
119	I40	Total Revenue				\$180,584,968.00						
120												
121	S99	TOTAL OPERATING EXPENSES				\$176,796,204.00						
122												
123	I50	NET REVENUE (LOSS) FROM OPERATIONS				\$3,788,764.00						
124												
125	I60	NON-OPERATING GAINS (LOSSES)				\$1,400,011.00						
126												
127	I70	NET REVENUE (LOSS)				\$5,188,775.00						
128												
129						# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST(\$)	INDIRECT COST(\$)	OFFSETTING REVENUE(\$)	NET COMMUNITY BENEFIT	
130	J00	FOUNDATION COMMUNITY BENEFIT										
131	J10	Community Services							\$0.00		\$0.00	
132	J20	Community Building							\$0.00		\$0.00	
133	J30								\$0.00		\$0.00	
134	J31								\$0.00		\$0.00	
135	J32								\$0.00		\$0.00	
136												
137	J99	TOTAL FOUNDATION COMMUNITY BENEFIT				0	0	\$0.00	\$0.00	\$0.00	\$0.00	
138												

Doctors Community Hospital HSCRC Community Benefits Narrative Report FY 2014

	A	B	C	D	E	F	G	H	I	J	K	L
						# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST(\$)	INDIRECT COST(\$)	OFFSETTING REVENUE(\$)	NET COMMUNITY BENEFIT	
139												
140	K00	TOTAL HOSPITAL COMMUNITY BENEFIT										
141	A99	Community Health Services				1,536	7,249	129,854	81,808	0	211,662	
142	B99	Health Professions Education				42,822	1,889	1,626,890	0	0	1,626,890	
143	C99	Mission Driven Health Care Services				0	0	0	0	0	0	
144	D99	Research				0	0	0	0	0	0	
145	E99	Financial Contributions				1,773	10,930	361,139	0	0	361,139	
146	F99	Community Building Activities				13,668	14,187	467,816	294,724	0	762,540	
147	G99	Community Benefit Operations				2,200	0	89,600	56,448	0	146,048	
148	H99	Charity Care				N/A	N/A	N/A	N/A	N/A	\$14,726,686.00	
149	J99	Foundation Funded Community Benefit				0	0	0	0	0	0	
150	T99	Medicaid Assesments				N/A	N/A	5,467,732	0	4,675,594	792,138	
151												
152	K99	TOTAL HOSPITAL COMMUNITY BENEFIT				61,999	34,255	8,143,031	432,980	4,675,594	18,627,103	
153												
154	U99	% OF OPERATING EXPENSES				10.54%						
155	V99	% of NET REVENUE				358.99%						
156												

IX: Community Health Needs Assessment and Implementation Strategy

See Attached PDF

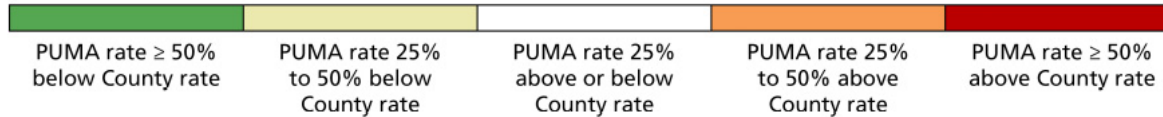
Table III – Initiatives

Initiative 1. Prevalence of Diabetes

Identified Need	Prevalence of Diabetes In Prince George’s County	
Hospital Initiative	<p>A. On the Road Diabetes Program- The Joslin Center in collaboration with Prince George's County Health Department provide in-depth education and free diabetes screening to county residents.</p> <p>B. Joslin Diabetes Center will offer Nutrition Seminars at Health Fairs.</p>	
Primary Objective	<p>To provide diabetes education and screening to 500 county residents.</p> <p>Educate community on better food choices</p>	
Single or Multi-Year Initiative Time Period	<p>A. 2012-2014</p> <p>b. Ongoing</p>	
Key Partners in Development and/or Implementation	<p>Prince George's County Health Department</p> <p>Local faith-based organizations</p>	
How were the outcomes evaluated?	<p>An evaluation of the number of screenings completed each year.</p> <p>Number of Educational programs presented each year.</p>	
Outcomes (Include process and impact measures)	<p>There were 307 people screened with the On the Road Program, with 25 seen for follow-up issues.</p> <p>23 lectures with 10-40 attendees each.</p>	
Continuation of Initiative	Yes, we will continue to partner with the Prince George’s Health Department.	
<p>A. Total Cost of Initiative for Current Fiscal Year</p> <p>B. What amount is Restricted Grants/Direct offsetting revenue</p>	<p>A. Total Cost of Initiative</p> <p>\$11,372.00</p>	<p>B. Direct offsetting revenue from Restricted Grants</p>

Region		All Causes	Heart Disease	Cancer	Cerebro-vascular Disease	Diabetes	Chronic Lower Respiratory Disease	Other Causes	Total Population, Age 65+
Prince George's County		4380.7	1418.0	1005.0	213.4	174.8	155.6	1413.9	72,637
Inside Beltway	North PUMA 1	4361.2	1453.7	985.3	129.2	242.3	145.4	1405.3	6,191
	North Central PUMA 3	4154.8	1446.0	916.5	173.1	152.8	142.6	1323.8	9,820
	South Central PUMA 4	4743.6	1570.5	1121.8	170.9	267.1	160.3	1453.0	9,360
	South PUMA 7	4429.4	1503.7	1119.0	221.5	244.8	128.2	1212.2	8,579
Outside Beltway	North PUMA 2	3854.1	1023.7	808.7	301.1	103.2	189.3	1428.1	11,624
	Central PUMA 5	4160.4	1215.2	1072.3	214.5	150.1	135.8	1372.5	13,989
	South PUMA 6	4948.8	1759.2	1024.9	229.5	137.7	175.9	1621.6	13,074
Total number of deaths in county, Age 65+		3182	1030	730	155	127	113	1027	

SOURCE: Deaths--Maryland Department of Health and Hygiene Vital Statistics Administration, <http://www.vsa.state.md.us/html/reports.html>; Population denominator for mortality rate calculation—2006 American Community Survey.



Age-Adjusted Death Rate per 100,000 due to Diabetes

Initiative 2. High Breast Cancer Incidence

Identified Need	High Breast Cancer incident with low results in Breast Cancer Screening
Hospital Initiative	Collaboration with Susan G. Komen Foundation for a grant titled: "The Prince George's County Continuum of Breast Care"
Primary Objective	<ol style="list-style-type: none"> 1) To reduce disparities in breast health care in Prince George's County residents. 2) To offer free screenings 3) To navigate those patients with abnormal findings 4) To assist residents in the screening process, up to an including medical or surgical treatment 5) To provide high quality outreach using existing community organizations. 6) To ensure early detection of breast disease and early treatment.
Single or Multi-Year Initiative Time Period	<p>4 Year Period:</p> <p>CY 2012-</p> <p>CY 2015</p>
Key Partners in Development and/or Implementation	<p>Dr. Regina Hampton</p> <p>Signature Breast Care Center (SBCC)</p> <p>African Women's Cancer Awareness Association (AWCAA)</p>
How were the outcomes evaluated?	Every 6 months starting June 30, 2012 through December 31, 2016
Outcomes (Include process and impact measures)	<p>Excerpt from Komen Report on Outcomes</p> <p>By the end of the project, we will create a community-based continuum that will increase utilization of breast screening by uninsured and underserved women.</p> <p>Objective 1: Establish staffing and infrastructure to support the community-based</p>

continuum of breast care.

-Examine % of staff positions filled every 6 months.

-Confirm navigator program launched.

-Staffing/Infrastructure includes: 100% filled.

1)Program Coordinator

2)Treatment Navigator (In-kind)

3)The navigator program has been designed and launched. Recent purchase of an integrated navigation system that requires minimal manual input.

4) Screening navigator hired

Objective 2: By the end of the first project year, a breast care navigation network will be established with the community providers.

-Ensure personnel in place

-Evaluate staff every six months

-Review and revise MOU with community partners

-Track referrals

-Memorandum's Of Understandings have been established with community partners to offer free screening mammograms and follow-up exams through outreach and transportations efforts. Our community partners include:

1) African Women's Cancer Awareness Assoc. Outreach activities are conducted at churches and health fairs

2) All Shades of Pink, Inc

3) Zaida Morris

4) Nueva Vida

5) The Mary's Center

6) The Ethiopian Development Association

7) First Baptist Church of Glenarden

	<p>8) Sisters Network of PG County</p> <p>Conduct Outreach with partners in Latino Community</p> <p>The Community Clinic, Casa of Maryland, Franklin Park Clinic and St. Bernardita Church and retail stores in the Latino community.</p> <p>8) First Baptist Church of Glenarden – Shabbach! Ministries</p> <p>This partnership provides transportation two times per month to and from the partner centers in Langley Park.</p> <p>9) Prince George’s Breast & Cervical Program: We partnered with PGBCC Program to offer free screening mammograms, bra fittings, and clinical breast exams to the women age 40 – 65 years of age. We saw over 93 patients and performed 175 screening mammograms; 40 diagnostic mammograms , 32 breast ultra sounds</p> <p>Flyer was created in both English and Spanish.and were distributed to our community partners, churches, government agencies, and grocery stores.</p> <p>Objective 3: Through the utilization of a community navigator, 1200 uninsured women per year will receive access to breast care screening through the collaborative network of community-based partners coordinated by DCH.</p> <p>-Track number of women referred for services</p> <p>-% of women screened :</p> <p>-100% of the women referred for screening were screened</p> <p>-7% needed navigation services.</p> <p>Total # of Komen Grant patients referred: 205</p> <p>Screening mammograms = average 82 per month</p>
Continuation of Initiative	Yes

Doctors Community Hospital HSCRC Community Benefits Narrative Report FY 2014

<p>C. Total Cost of Initiative for Current Fiscal Year</p> <p>D. What amount is Restricted Grants/Direct offsetting revenue</p>	<p>C. Total Cost of Initiative</p> <p>\$31,315</p> <p>plus forfeiture of revenue and inkind expenses estimated to be \$905,000 over 4 years of grant</p>	<p>D. Direct offsetting revenue from Restricted Grants</p>

Initiative 3. Cardiovascular Disease and Related Risk Factors

Identified Need	Cardiovascular Disease and related Risk Factors	
Hospital Initiative	Provide 3-4 Carotid Artery Screenings at health events, such as Health Fairs and other events	
Primary Objective	To screen residents for potential risk of vascular disease	
Single or Multi-Year Initiative Time Period	Ongoing	
Key Partners in Development and/or Implementation	City of Greenbelt, local faith based organizations	
How were the outcomes evaluated?	By the number of people served	
Outcomes (Include process and impact measures)	The number of screening increased this year with 6 people identified with possible vascular issues.	
Continuation of Initiative	Yes, with plans to increase screenings	
E. Total Cost of Initiative for Current Fiscal Year F. What amount is Restricted Grants/Direct offsetting revenue	E. Total Cost of Initiative \$1240.00	F. Direct offsetting revenue from Restricted Grants

Initiative 4. Overweight/Obesity Nutrition and Exercise

Identified Need	Overweight/Obesity Nutrition & Exercise	
Hospital Initiative	Free educational seminars offered by the Diabetes Center options including nutrition, exercise and surgery at Health Fairs, local municipalities and churches	
Primary Objective	Educate overweight Community on options to make personal changes and health risks of Obesity Educate community on better food choices	
Single or Multi-Year Initiative Time Period	Ongoing	
Key Partners in Development and/or Implementation	Doctors Community Hospital Associated Physicians Joslin Diabetes Center, Local Faith Based organizations and municipalities.	
How were the outcomes evaluated?	Attendance numbers	
Outcomes (Include process and impact measures)	On average 4-10 attendees per month. Gradual increase attendees	
Continuation of Initiative	Yes, ongoing	
G. Total Cost of Initiative for Current Fiscal Year H. What amount is Restricted Grants/Direct offsetting revenue	G. Total Cost of Initiative \$10,332.00	H. Direct offsetting revenue from Restricted Grants

Initiative 5. The Need to Increase Graduation Rate in County

Identified Need	Need to increase High Graduation rate in County	
Hospital Initiative	The hospital provides an opportunity for high students with identified learning needs to come to the hospital through a Job Sampling Program.	
Primary Objective	Provide students the opportunity to observe vocations that are within their reach after graduating high school.	
Single or Multi-Year Initiative Time Period	Ongoing	
Key Partners in Development and/or Implementation	Prince George's County Schools	
How were the outcomes evaluated?	By the number of participants	
Outcomes (Include process and impact measures)	Increased by one new program, hours increased slightly.	
Continuation of Initiative	Yes, with plans to increase number of school programs	
I. Total Cost of Initiative for Current Fiscal Year J. What amount is Restricted Grants/Direct offsetting revenue	I. Total Cost of Initiative \$94,500.00	J. Direct offsetting revenue from Restricted Grants

Initiative 6. Incidents of High Blood Pressure/Stroke

Identified Need	Incidence of High Blood Pressure/Stroke	
Hospital Initiative	<p>Provide Blood Pressure screening at municipal, church and businesses, health events with in the community.</p> <p>Provide education regarding stroke, signs, symptoms and emergency response to potential stroke. Utilize screening tool at health events.</p> <p>Provide Stroke Support Group for survivors and caregivers</p>	
Primary Objective	<p>To educate and screen the community for stroke risk</p> <p>To screen the community for potential risk of high blood pressure</p>	
Single or Multi-Year Initiative Time Period	Ongoing	
Key Partners in Development and/or Implementation	American Heart Association	
How were the outcomes evaluated?	Number of lectures and screenings offered	
Outcomes (Include process and impact measures)	Increased outreach programs by 30%	
Continuation of Initiative	Ongoing	
<p>K. Total Cost of Initiative for Current Fiscal Year</p> <p>L. What amount is Restricted Grants/Direct offsetting revenue</p>	<p>K. Total Cost of Initiative</p> <p>\$8,281.00</p>	<p>L. Direct offsetting revenue from Restricted Grants</p>

Initiative 7. Prostate and other cancers

Identified Need	Incidence of Prostate, colorectal and Other Cancers	
Hospital Initiative	Colorectal Screening with the Prince George's County Health Department Annual Prostate Screening	
Primary Objective	In partnership with Prince Georges County Health Department the hospital will provide endoscopic screenings for people identified by the Health Department as under or uninsured. Provide digital exam and PSA screening	
Single or Multi-Year Initiative Time Period	Ongoing	
Key Partners in Development and/or Implementation	Prince George's County Health Department, Local Urologist	
How were the outcomes evaluated?	By number of screenings and number of people needing follow-up	
Outcomes (Include process and impact measures)	CPEST Program Number of people screened 254 Number of people colonoscopy performed 230 Number of people with detected cancer 5 Number of people with cancers sent to surgery 5 Numbers of people with cancers sent for chemotherapy 2 Prostate screenings 30	
Continuation of Initiative	Two year program	
M. Total Cost of Initiative for Current Fiscal Year N. What amount is Restricted Grants/Direct offsetting revenue	M. Total Cost of Initiative \$31,520.00	N. Direct offsetting revenue from Restricted Grants

Initiative 8. Rehabilitation

Identified Need	Rehabilitation	
Hospital Initiative	County Continuum of Breast Care	
Primary Objective	lymphedema support group met quarterly Participants' schedules. It offers an open and friendly environment for patients, friends and family members to discuss ideas, give hope, provide support and share information. Each session has an education component	
Single or Multi-Year Initiative Time Period	Ongoing	
Key Partners in Development and/or Implementation	Local Physicians	
How were the outcomes evaluated?	Number of attendees at sessions	
Outcomes (Include process and impact measures)	Levels are the same with 10-15 participants each session.	
Continuation of Initiative	Ongoing	
O. Total Cost of Initiative for Current Fiscal Year P. What amount is Restricted Grants/Direct offsetting revenue	O. Total Cost of Initiative \$5,004	P. Direct offsetting revenue from Restricted Grants

Initiative 9. Sleep Disorders

Identified Need	Incidence of Sleep Disorders	
Hospital Initiative	<p>Provide educational programs and sleep assessments at health fairs and special events to help people identify potential sleep disorders</p> <p>Provide monthly support group meetings to give additional support to individuals struggling with harmful sleep disorders</p>	
Primary Objective	To educate and screen the community for harmful sleep disorders.	
Single or Multi-Year Initiative Time Period	Ongoing	
Key Partners in Development and/or Implementation	Sleep Centers of America	
How were the outcomes evaluated?	By number of attendees	
Outcomes (Include process and impact measures)	Increased sessions by 3 and increased attendees By 50	
Continuation of Initiative	Ongoing	
<p>Q. Total Cost of Initiative for Current Fiscal Year</p> <p>R. What amount is Restricted Grants/Direct offsetting revenue</p>	<p>Q. Total Cost of Initiative</p> <p>\$3,479</p>	<p>R. Direct offsetting revenue from Restricted Grants</p>

Appendix II Label: Copy of our hospital's FAP

Insert PDF

TO: Camille Bash, Vice President Finance
FROM: Stella Reed, Director Patient Financial Services
DATE: October 20, 2014
SUBJECT: HSCRC Annual Filing 2014



Attached, please find the following data:

- PDF File Letter dated May 30, 2014, stating Policies and Procedures have been reviewed by the Hospital Board of Directors.
- PDF File Credit and Collection Policy
- PDF File Financial Assistance Policy with Exhibits A- D
- PDF File Accounts Receivable Clearing House Agreement dated 7/13/2010
- PDF File Accounts Receivable Clearing House W-9 Form
- PDF File Accounts Receivable Outsourcing Agreement dated 1/31/2016
- PDF File Debt Collection Financial Assistance Report FYE 2014
- PDF File English and Spanish Brochure page for Financial Assistance



8118 Good Luck Road
Lanham, Maryland 20706-3596
301-552-8118

DATE: May 30, 2014

TO: Camille Bash, Vice President, Finance
Stella Reed, Director, Patient Financial Services

FROM: Heidi Riedlbauer, Secretary, Board of Directors

SUBJECT: Policies and Procedures for Patient Financial Services

This memorandum certifies that the Annual Collections Policy was reviewed and approved by the Hospital's Board of Directors at the May 29, 2014 Board of Directors Meeting.

A handwritten signature in blue ink, reading "Heidi L. Riedlbauer", is written over a horizontal line.

Heidi L. Riedlbauer
Secretary, Board of Directors

**Doctors Community Hospital
Hospital Policy**

Subject: Credit and Collection Policy

Policy Number: 030

Date: October 1, 1995

Last Revised Date: November 2010

Page 1 of 4

Philip B. Down, President

Approved by:

PURPOSE:

The purpose of this policy is to establish an organization that consolidates the financial management activities of the hospital so that controls meet accounting standards, ensures optimal cash flow, meets all compliance standards and minimizes bad debt. It is the goal of the hospital to enhance relations among the hospital, the patient, the physicians and the community by performing all activities in a professional, courteous and timely manner.

GENERAL POLICY: The Director of Patient Financial Services is responsible to ensure that subordinate staff seeks collection of hospital debt at the earliest possible opportunity, unless patients have applied for financial assistance. (See Financial Assistance Policy Number 050)

Patient's Request for Estimate of Charges:

The patient may make a request for an estimate of charges for all services excluding emergency services, to the Hospital's Business Office during normal working hours of Monday through Friday from 8:00 a.m. to 4:30 p.m. The hospital's business office will provide the patient an estimate of charges in writing by one of the following written methods, US mail, e-mail, or fax.

Insurance

Insurance benefits are verified and authorizations are sought at time of patient scheduling for elective procedures or within 24 hours of an unplanned admission. Hospital staff bill insurance accounts on an electronic billing system and perform billing follow-up of accounts. Insurance follow-up is consistently completed until the claim is paid or acknowledged by the insurance. Denied claims are analyzed to determine if appeal should be initiated. Claims are appealed when there is evidence that technical denials or medical necessity denials should be challenged.

Self-Pay Collection

Collection efforts are made during the registration process seeking payment for self-pay accounts and or co-payments. The hospital sends an initial summary bill to all patients, which lists major service categories. Attached to summary bills is a Patient Financial Services Brochure, which provides information on billing and how to apply for Patient Financial Assistance (See Financial Assistance Policy 050).

Self-pay and residual self-pay balances are outsourced to a contracted agent who sends statements and letters seeking collection of hospital debt. The billing agent is directed to seek full payment at the earliest possible date and can accept monthly payment arrangements until the account is paid in full. The

billing/collection agent's collection activity to include statements and letters has been reviewed and approved by the hospital's Director of Patient Financial Services.

Sale of Debts: Neither the hospital nor its billing/collection agent will sell patient debts to businesses for the purpose of hospital profit for patient debt collection.

Credit Bureau Reporting

Credit bureau reporting is done in the name of the hospital's collection agent who analyses the account to ensure the balance due is the patient's liability and not due from an insurance company. All accounts placed with the Credit Bureau are sent to the Director of Patient Financial Services of the Hospital prior to placement reporting to review the data and respond to the hospital's collection agent, with approval or denial to report. Accounts are not reported until collection efforts were made with the patient by sending letters or making collection calls through the call center process for debt collection, which normally takes 6 months from placement date. The collection agent does not report accounts to the credit bureau when legal placement is made in order to ensure that the same debt is not reported twice to the credit bureau.

When patient debts are paid in full, the hospital's collection agent will notify the credit bureau, within 60 days that the debt has been satisfied and paid.

If a patient was reported to a credit bureau and it is determined that the patient qualified under a presumptive mean-test or qualifies for financial assistance, the hospital would report the debt as closed.

Bad Debt

The hospital classifies accounts as bad debt beyond 120 days from discharge date regardless of patient/guarantor payment activity since collection action is completed through the hospital billing/collection agent. The billing/collector agent, based upon payment history of the patient, may not have classified the debt as a bad debt in their system at the same time as the hospital. However, classification of the debt as a bad debt will not occur until the contracted billing/collection agent has exhausted collection efforts and the account is older than 120 days from discharge date, There could be circumstances when the debt would be placed earlier if return mail has been received and skip tracing is not successful. (See Bad Debt policy number 090).

Court Action

When collection efforts are not successful or the patient fails to meet payment commitments, legal action may be filed with the court. Prior to court filing, accounts are reviewed by the hospital's Patient Services Team Leader who oversees credit and collection duties.

Judgments and Liens:

The hospital will not force the sale or foreclosure of a patient's primary residence to collect a debt owed on a hospital bill. If a hospital holds a lien on a patient's primary residence, the hospital will maintain its position as a secured creditor with respect to other creditors to whom the patient may owe a debt.

Vacate Judgment

If it is determined that the patient qualifies for Financial Assistance for the period of time for the debt, the hospital will refund to the patient any payment amounts exceeding \$25.00 within a 2 year period from the date of service was found to be eligible for Financial Assistance. (See Financial Assistance Policy 050). An exception will be if the patient did not cooperate in providing the data for the financial assistance application and in such cases the refund period will be limited to 30 days from the patient's request for Financial Assistance.

Interest

Neither the hospital nor its billing/collection agent charges pre-judgment interest to patients.

Patient Complaints:

All patient complaints received by hospital staff or the hospital's billing/collection agent are referred to the Director of Patient Financial Services. The Director of Patient Financial Services will refer any clinical complaints to the hospital's Risk Manager and place a bill hold on the account until resolution is determined. Other billing complaints are reviewed and response is sent to the patient as instructed by the Director of Patient Financial Services.

Discounts

Patients who pay the full amount at time of service are given a 2% discount, which is applied against total charges. The hospital does not provide any special discounts to payers, or contractual allowances outside the designated allowance as determined by the Health Services Cost Review Commission.

Doctors Community Hospital

Financial Assistance Policy

SUBJECT: Financial Assistance Policy

Policy Number 050

Prepared by: Patient Financial Services

Date: May 5, 2003

Revised: December 17, 2007
January 2008, May 2009,
Oct 2009, Feb 2010,
April 2010, May 2010, Aug 2010,
Nov 2010, June 2013, Mar 2014

Philip B. Down, President
Page 1 of 3

Approved by

PURPOSE

To provide general information and guidelines to identify indigent persons who have no means of paying for medical services or treatments.

POLICY

General Statement:

The Patient Financial Services Department of the hospital is responsible for determining the eligibility for Financial Assistance patients. Referral for Financial Assistance is made by Registration, Billing, and Financial Counseling Staff within the department or by other departments such as, Nursing, Quality Assurance, Social Services, Physician Offices or the patient or a patient's family member with legal authority to act on behalf of the patient. Referral for Financial Assistance is also made by Medicaid Advocates and Collection Agents. The hospital will consider all medical debts for services provided within the hospital excluding purely cosmetic services.

1. Patient Education

Doctors Community Hospital recognizes its charitable mission to provide reasonable care to those patients who cannot afford Lealthcare and has provided the following methods to communicate the Financial Assistance Program.

- a. Published notices of available Financial Assistance are printed in local newspapers annually,
- b. Signs are posted at emergency registration, outpatient registration and the hospital's business office in patient waiting areas,

-
- c. Financial policy brochures written in English and Spanish, specifying who to call for Financial Assistance, medical assistance and billing questions, is available in patient lobby waiting areas of the hospital,
 - d. Financial policy brochures are provided to every inpatient at time of admission. The information is a hand-out as part of the Hospital's admission package,
 - e. Financial policy is provided to every patient with their initial summary bill,
 - f. Financial policy is provided to every patient upon patient request by the business office,
 - g. An overview of Financial Assistance is provided to all hospital employees as part of the annual employee orientation in order to provide direction or assistance to patients.

2. Eligibility Criteria

Patients will be considered for Financial Assistance regardless of race, sex, national origin or creed. To qualify for Financial Assistance, the following areas of eligibility must apply:

- a. **Free Care** will be given to patients whose gross income is at or below 200 percent of the Federal Poverty Guidelines when considering number of family members in the household.
- b. **Reduced Cost Program** is available with a 25% balance bill reduction when the family unit income is between 200 to 300 percent of the Federal Poverty Guidelines. Reduced cost program includes patient liability after third party payment such as deductible, coinsurance and co-payments amounts.
- c. **Medical Hardship** is available for patients whose gross family income is between 200 and 500 percent of the Federal Poverty Guidelines, when hospital debt exceeds 25% of the family gross income for the family unit, and such eligibility will remain active during a 12 month period beginning on the date which the reduced cost medically necessary care was initiated. All immediate family members within the family household who have medical debts at Doctors Community Hospital will be considered. However, debts for other providers or account balances for patient deductible, coinsurance or co-payments will be excluded under the Medical Hardship Program.

3. Other Eligibility Consideration:

- a. Self-pay patients enrolled in certain means-tested programs will qualify as presumptive Financial Assistance eligibility for free care by submitting proof of enrollment in a social service program within 30 days of request for free care. If the patient fails to submit the means-tested documentation within 30 days, upon patient request an additional 30 days will be granted for documentation. Programs that should be considered for presumptive assistance are as follows:
 - i. Household with children in the free or reduced lunch program,
 - ii. Supplemental Nutritional Assistance Program (SNAP),
 - iii. Low income household energy assistance program,
 - iv. Primary Adult Care Program,
 - v. Women's, Infants and Children program (WIC),
- b. In addition to programs listed in means-test for presumptive charity, the hospital will consider all accounts as free care without patient application or further proof when such patients' insurance eligibility through the hospital eligibility verification system indicate that the patient qualifies for a program such as pharmacy only or physician only coverage. Other state programs not mentioned where the patient is eligibility for assistance programs where there is no medical insurance coverage will also be considered.

-
- c. Patients who qualify against credit bureau Propensity to Pay scoring when considering income estimates, household size and up to 200 % of federal poverty levels will have patient liability written off in full to presumptive charity.
 - d. The hospital may apply discretion and approve patients beyond the 12 month medical bill period when the patient's health status is severe or other financial circumstances prevent payment from the patient.

4. Ineligible Patients

The following is a list of situations where patients will not qualify for Financial Assistance.

- a. Patients who have health insurance and services are payable by other third-party insurance,
- b. Patients who refuse to complete the hospital's Financial Screening Application, when presumptive free care is not warranted,
- c. A non U S citizen who traveled to the US primarily for the purpose of receiving medical services at no cost,
- d. Patients whose credit bureau report validates the patient's application was false or misleading,
- e. Patients who fail to provide supporting information to validate information contained on the Financial Assistance Application,
- f. Patients whose monetary assets exceed \$10,000 excluding up to \$150,000 in a primary residence and retirement benefits where the IRS has granted preferential treatment.

5. Application Requests

Self pay patients, who do not meet the presumption means-test, are requested to complete an application when they apply for Financial Assistance. A Financial Screening Application (see Exhibit A) is given to the patient when one of the following situations occurs:

- a. Patient requests Financial Assistance,
- b. Patients or family member expresses inability to pay for medical debts,
- c. Other hospital departments staff request Financial Assistance for the patient,
- d. Medicaid Advocates or Collection Agents request Financial Assistance Application.

6. Application Process

Applicants are requested to complete the Financial Screening form and a cover letter listing documents to support program eligibility will be attached (see Exhibit B). Listed below is the required information, which must be received and verified prior to consideration for Financial Assistance, when presumptive meant test programs do not apply

- a. All gross income for all family members of the household unit,
- b. Other income such as, Alimony, Child support and stipends,
- c. Assets as listed in Section Item 4, "Ineligible Patients" under section F of this document,
- d. Monthly expenses for immediate family members of the household,
- e. List of outstanding debtors,
- f. List of medical debts owed or paid for the past 12 months for services at Doctors Community Hospital.

7. Approval Process

Excluding presumption programs, prior to approving patient applications, information is reviewed and additional verification of eligibility may be made by obtaining a credit bureau application. The patient generally is notified by letter, (see Exhibit C) unless the patient calls the office or makes a visit to the business office to determine eligibility. Patients are advised of the amount of eligibility and if there is any patient liability and who to call to make payment arrangements. Approval for write-off for Financial Services is made by the Director of Patient Financial Services with additional approval of the Vice President of Finance for account balances greater than \$5,000.

8. Denial Process

Upon final review of the application and patient income and expense documents, patient's who do not qualify for the program are notified by letter indicating the reason for denial and how to request reconsideration if the patient disagrees with the hospital decision (see Exhibit D).



...tion for caring.

DOCTOR'S COMMUNITY HOSPITAL
8118 Good Luck Road
Lanham, Maryland 20706-3596

Financial Screening Form
Please Print Legibly

Exhibit A (1)

Patient Name _____ SS # _____

Patient Address _____

City _____ State _____ Zip Code _____

Birth Date ____/____/____ Home Phone No. () _____ Work Phone No. () _____

Spouse Name (if applicable) _____ SS # _____

Spouse Address (if different from Patient) _____

City _____ State _____ Zip Code _____

Birth Date ____/____/____ Home Phone No. () _____ Work Phone No. () _____

LIST ALL CHILDREN UNDER 21 YEARS OF AGE

Child's Name _____ Birth Date ____/____/____

Child's Name _____ Birth Date ____/____/____

Child's Name _____ Birth Date ____/____/____

Child's Name _____ Birth Date ____/____/____

Child's Name _____ Birth Date ____/____/____

RESPONSIBLE PARTY INFORMATION (Do NOT Complete if Patient is Responsible Party)

Responsible Party Name _____ SS # _____

Address _____

City _____ State _____ Zip Code _____

Birth Date ____/____/____ Home Phone No. () _____ Work Phone No. () _____

EMPLOYMENT INFORMATION

Place of Employment _____

Address _____

City _____ State _____ Zip Code _____

Telephone No. () _____ Extension _____ Supervisor Name _____

INSURANCE INFORMATION

Do you have health insurance? Yes No
If YES, Name of Company _____ Policy # _____

Have you ever applied to a State Medical Assistance Program? Yes No
If YES, Name of State _____ Birth Date ____/____/____

Do you receive assistance from the state? Yes No

Exhibit A (2)

Please provide proof of income and expenses with this application:
Such as: Last 2 pay stubs, W-2 Forms, Bank Statements, Utility Bills, Mortgage Statements

MONTHLY INCOME

	GROSS	NET
Patient Salary	_____	_____
Spouse / Other	_____	_____
Soc. Sec. Income	_____	_____
Disab. Income	_____	_____
Pension Income	_____	_____
Interest Income	_____	_____
Unemployment	_____	_____
TOTAL	_____	_____

OTHER MONEY RECEIVED

Allmony	_____	_____
Child Support	_____	_____
Other	_____	_____
TOTAL	_____	_____

OTHER ASSETS

Name of Bank (Checking) _____
 Account # _____
 Name of Bank (Savings) _____
 Account # _____
 Name of Bank (Checking) _____
 Account # _____
 Name of Credit Union _____
 Account # _____
 Other Bank Account(s) _____

Do you own stocks? Yes No
 Do you own bonds? Yes No
 Do you own property? Yes No

I have answered the questions in this application correctly to the best of my recollection and based on my records. I understand that the Account Review Committee of Doctors Community Hospital may request additional information from credit reporting agencies, employers and other third parties.

Applicant Signature _____
 Date of Application _____

MONTHLY EXPENSES

Rent / Mortgage _____
 To Whom Paid _____
 Telephone No. () _____ Ext. _____
 Auto Payment _____
 Year _____ Make _____ Model _____
 Financed By _____
 Phone No. () _____ Ext. _____
 Electricity _____
 Gas Utility _____
 Telephone _____
 Allmony _____
 Child Support _____
 Credit Cards (See Below) _____
 Medical / Dental (See Below) _____
TOTAL _____

DOCUMENT CREDIT CARDS & MEDICAL / DENTAL

List Credit Cards
 Account # _____
 Account # _____
 Account # _____

List Medical / Dental

Other Expenses

Exhibit B

(Dear Patient:

It is believed that you may qualify for the hospital's Financial Assistance Program. Hospital Financial Assistance is only considered when there are no other financial assistance programs, which pay medical debts or insurance coverage.

Financial Assistance help is limited to medical expenses for services at Doctors Community Hospital. The program does not cover services elsewhere or physician bills. If you qualify for the program, all or part of your medical expenses may be considered.

If you qualify for one of the following programs, please complete the attached application form and only provide with your application proof of eligibility in any one of the social service programs such as;

- Children with reduced or free lunch program,
- Supplemental Nutritional Assistance Program (SNAP),
- Low-income household energy assistance program,
- Primary Adult Care Program (PAC),
- Women, Infants and Children (WIC).

If you do not qualify for one of the social service programs as listed above, you must complete the attached application screening form and provide with your application sufficient documents to prove your total income and expenses. In addition, the hospital may perform a credit check at the hospital's expense, validating your eligibility for the program. Documents required to be considered for Financial Assistance are as follows:

- Wage statements for all household members such as pay stubs,
- Other income such as, alimony, child support and stipends,
- Your W-2 forms for current and prior year,
- Bank statements, which show income and expenses,
- Statement of any other income received in your household,
- Copies of monthly statements and expenses paid to creditors,
- List of outstanding medical expenses, owed or paid to Doctors Community Hospital for the past 12 months.

Please provide documents supporting assets excluding retirement programs where benefits are listed as exclusions under the IRS.

If you are unemployed and receive help or other support for daily living, you may provide a letter from another source indicating what kind of help you are receiving such as free room and board, utilities payments etc.

Failure to provide information to support your need for Financial Assistance may disqualify your eligibility. Please send all information within 30 days of this letter to:

Leslie Mende, Lead Patient Accounts Coordinator
Doctors Community Hospital
8118 Good Luck Road
Lanham, MD 20706-3596
(301) 552-8186

RUN DATE: 11/11/10 Doctors Community Hospital B/AR **LIVE**
RUN TIME: 1521 E/AR LETTER DICTIONARY
RUN USER: BOLEMO

PAGE 1

MNEMONIC: CHARITY1 ACTIVE: Y NAME: FINANCIAL APPLICATION APPROVED
PAGE SIZE: 66 LINE LENGTH: 75 LEFT MARGIN: 20
AUTO SPOOL: AUTO SORT:

Exhibit C

DOCTORS COMMUNITY HOSPITAL
8118 GOODLUCK ROAD
LANHAM, MARYLAND 20706

[DATE]

[GUARANTOR NAME]
[GUARANTOR ADDRESS LINE]
[GUARANTOR CITY, STATE ZIP]

RE: [ACCOUNT #]
[PATIENT NAME]

Dear [GUARANTOR NAME]:

Your application has been approved for financial assistance for the following account(s):

ACCOUNT #	AMOUNT APPROVED	REMAINING BALANCE PAYABLE BY PATIENT
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----

If there is a remaining balance on your account(s), please call the hospital's Business Office at 301-552-8092 to establish a payment plan.

Yours truly,

Leslie Meade
Collections Team Leader

Exhibit D

Dear Patient:

We regret to inform you that your application for financial assistance has been denied for the following reason (s).

_____ Your application was missing sufficient documentation to prove income and expenses,

_____ Your income exceeds eligibility criteria under the Federal Poverty Guidelines. Please contact our office at (301) 552-8092 to establish a payment plan,

_____ There is a conflict in the Credit Report and data reported with your application,

_____ Our records indicate that you have third-party insurance or you may qualify for a state program for Medical Assistance.

_____ Other reason (s) _____

If you disagree with this decision, please provide missing information or contact me to provide reasons why your debts should be reconsidered for Financial Assistance by calling (301) 552-8186 within the next fifteen day (15) from the date of this letter to reopen your case.

Thank you,

Leslie Meade, Team Leader
Patient Accounts Coordinator



ADDENDUM TO MANAGEMENT SERVICES AGREEMENT

July 13, 2010

Ms. Stella Reed
Director, Patient Financial Services
Doctors Community Hospital
8118 Good Luck Road
Lanham, Maryland 20706

Dear Stella,

This shall serve as an Addendum to the Accounts Receivable Outsourcing Agreement dated January 31, 2006, by and between Doctors Community Hospital (DCH) and Accounts Clearing House, LLC (ACH).

- All Early-Out Services will be proved by Accounts Receivable Clearing House, LLC and all bad debt collections services will be under the auspices of Accounts Clearing House, LLC.

All other terms and conditions as set forth in the Accounts Receivable Outsourcing Agreement shall remain in force and are not affected by this Addendum.

If you are in agreement with these changes and clarifications, please sign where indicated below.

Doctors Community Hospital

Accounts Clearing House, LLC/Accounts

By: Stella Reed
Stella Reed
Director, Patient Financial Services

By: Ronald Watkins
Ronald Watkins
President

Date: 7-14-2010

Date: 7-13-10

DOCTORS COMMUNITY HOSPITAL BUSINESS ASSOCIATES AGREEMENT

Specific definitions:

- a. Business Associate. "Business Associate" shall mean Accounts Receivable Clearing House, LLC.
- b. Covered Entity. "Covered Entity" shall mean Doctors Community Hospital.
- c. Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR § 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
- d. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.
- e. Protected Health Information. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR § 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
- f. Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.501.
- g. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

Obligations and Activities of Business Associate

- a. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required By Law.
- b. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
- c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement. [This provision may be included if it is appropriate for the Covered Entity to pass on its duty to mitigate damages to a Business Associate.]
- d. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.
- e. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

- f. Business Associate agrees to provide access, at the request of Covered Entity, and in the time (in less than 45 days after receiving written request) and manner, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524. [Not necessary if business associate does not have protected health information in a designated record set.]
- g. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner [Insert negotiated terms]. [Not necessary if business associate does not have protected health information in a designated record set.]
- h. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available [to the Covered Entity, or] to the Secretary, in a time and manner [Insert negotiated terms] or designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
- i. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.
- j. Business Associate agrees to provide to Covered Entity or an Individual, in time and manner [Insert negotiated terms], information collected in accordance with Section [Insert Section Number in Contract Where Provision (i) Appears] of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.
- k. The Covered Entity and Business Associate agree to negotiate to amend the Agreement as necessary to comply with any amendment to any provision of HIPAA or its implementing regulations set forth at 45 C.F.R. parts 160 and 164, including but not limited to, the Privacy Regulation, which materially alters either Party or both Parties' obligations under the Agreement. Both Parties agree to negotiate in good faith mutually acceptable and appropriate amendment(s) to the Agreement to give effect to such revised obligations. If the Parties are unable to agree to mutually acceptable amendment(s) within 30 days of the relevant change in law or regulations, either Party may terminate the Agreement consistent with its terms.
- l. In the event that any provision of this Agreement violates any applicable statute, ordinance or rule of law in any jurisdiction that governs this Agreement, such provision shall be ineffective to the extent of such violation without invalidating any other provision of this Agreement.

- m. Business Associate agrees to indemnify, defend and hold harmless the Covered Entity, its directors, officers, agents, shareholders, and employees against all claims, demands, or causes of action that may arise from Business Associate's employees, agents, or independent contractors improper disclosure of the protected health information and from any intentional or negligent acts or omissions.
- n. The Agreement shall be governed by the laws of the State of Maryland and shall be construed in accordance therewith.

Permitted Uses and Disclosures by Business Associate

a. Specify purposes:

Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information on behalf of, or to provide services to, Covered Entity for the following purposes, if such use or disclosure of Protected Health Information would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity:
Purposes: CAP SURVEY

Specific Use and Disclosure Provisions [only necessary if parties wish to allow Business Associate to engage in such activities]

- a. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
- b. Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
- c. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(f)(B).
- d. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with § 164.502(j)(1).

Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions [provisions dependent on business arrangement]

- a. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.
- b. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.
- c. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity. [Include an exception if the Business Associate will use or disclose protected health information for, and the contract includes provisions for, data aggregation or management and administrative activities of Business Associate].

Term and Termination

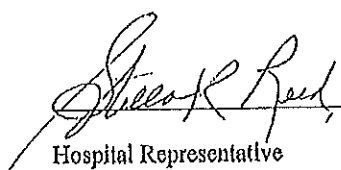

- a. Term. The Term of this Agreement shall be effective as of November 13, 2008, and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section. [Term may differ.]
- b. Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:
 1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement.
 2. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or
 3. If neither termination nor cure are feasible, Covered Entity shall report the violation to the Secretary.

c. Effect of Termination.

1. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy (in a manner that protects the confidentiality and privacy of the material) all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
2. In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon [Insert negotiated terms] that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

Miscellaneous

- a. Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.
- b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.
- c. Survival. The respective rights and obligations of Business Associate under Section [Insert Section Number Related to "Effect of Termination"] of this Agreement shall survive the termination of this Agreement.
- d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

	7-14-2010		7-13-10
Hospital Representative	Date	Business Associate	Date

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See Specific instructions on page 2

Name (as shown on your income tax return)
ACCOUNTS RECEIVABLE CLEARING HOUSE, LLC

Business name, if different from above

Check appropriate box: Individual/sole proprietor Corporation Partnership
 Limited liability company. Enter the tax classification (O=disregarded entity, C=corporation, P=partnership) ▶ Exempt payee
 Other (see instructions) ▶

Address (number, street, and apt. or suite no.)
PO BOX 2373

City, state, and ZIP code
GLEN BURNIE, MD 21060-2373

Requester's name and address (optional)

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I Instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3. Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number	
or	
Employer identification number	
26	2238344

Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- I am a U.S. citizen or other U.S. person (defined below).

Certification Instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the Instructions on page 4.

Sign Here: Signature of U.S. person ▶ Date ▶ **7-13-10**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify that you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

Accounts Clearing House, LLC

ACCOUNTS RECEIVABLE OUTSOURCING AGREEMENT

THIS AGREEMENT is made by and between Doctor's Community Hospital, with its principal offices at 8118 Good Luck Road, Lanham, Maryland 20706 ("Client") and Accounts Clearing House, LLC, a Maryland corporation with its principal offices at 300 Hospital Drive, Suite 30, Glen Burnie, Maryland, 21061 (ACH) as of the date of execution by a duly authorized representative of ACH. The effective date of this Agreement shall be _____.

In consideration of the mutual promises, covenants and agreements contained in this Agreement, the parties agree as follows:

1. SERVICES.

1.1 Accounts Receivable Outsourcing. ACH will seek to obtain reimbursement for Client's charges for "Accounts" (see Exhibit 1) placed with ACH through the follow-up, rebilling and collection activities relating to such Accounts (the "Accounts Receivable Outsourcing"). All activities undertaken on behalf of Client shall be done in the name of the Client. During the term of this Agreement, ACH will be the sole provider of Accounts Receivable Outsourcing services to the Client for the Accounts. As part of ACH's Accounts Receivable Outsourcing Services, ACH will:

- (a) provide follow-up, tracking, re-billing and collection efforts and related activities for the Accounts;
- (b) staff and manage an off-site receivables management center to handle the re-billing, follow-up, tracking and collection activities for the Accounts to include providing an off-site manager for the supervision of the management of the Accounts and other personnel as deemed necessary by ACH to perform the Accounts Receivable Outsourcing Services required by this Agreement;
- (c) If necessary, provide on-site staff support at no additional cost to Client;
- (d) prepare and send to Client, ACH's standard monthly management reports;
- (e) develop work flows and follow-up letters for collection of the Accounts, with said work flows and letters to be mutually agreed upon as to process, content and format;
- (f) direct all payments on the Accounts to Client. Any payments received by ACH will be logged and forwarded to Client within two (2) business days;
- (g) establish a mutually agreed upon procedure for handling unpaid Accounts and for the request, use, maintenance and return of Client's patient files. ACH will prepare monthly and send to Client a hard copy of all returned Accounts.

All Accounts placed with ACH must be placed for a minimum of 120 days. ACH reserves the right to establish and amend its follow-up and collection efforts and activities as ACH, in its opinion, subject to Client approval, deems to be appropriate for the management of the Accounts. All follow-up and collection efforts and activities shall be in accordance with patient relation's policies and procedures consistent with those employed by Client. ACH and Client will establish a mutually agreed upon procedure for handling unreimbursed Accounts and for the request, use, maintenance, and return of Client's patient files.

1.2 Third-Party Agreements. Client acknowledges that in order for ACH to perform the Accounts Receivable Outsourcing Services, ACH will be required to enter into agreements with third-party payers and fiscal intermediaries regarding the provision of electronic claims submission, eligibility verification, claims status and other similar services (the "Third-Party Agreements"). Client agrees to indemnify and hold ACH harmless from and against any and all claims, actions, suits, proceedings, costs, expenses, damages, and liabilities incurred by ACH, including court costs and attorney's fees, related to any claim by any other party to a Third-Party Agreement, arising out of or relating to Client's provision of inaccurate or incomplete information to ACH or Client's negligence or willful misconduct.

Accounts Clearing House, LLC

2. CLIENT RESPONSIBILITIES AND OBLIGATIONS.

- 2.1 General. Client will cooperate and cause its employees to cooperate with ACH in every reasonable respect as mutually agreed by Client and ACH to allow ACH to perform its duties under the Agreement.
- 2.2 Provision of Account Information. Client will furnish ACH with all appropriate information necessary to enable ACH to perform the Accounts Receivable Outsourcing Services under this Agreement. As part of said responsibility Client will provide ACH:
- (a) All patient and billing information mutually deemed appropriate and necessary by ACH and Client regarding the *Accounts*;
 - (b) Access to requested patient files, UB92 and /or HCFA 1500 forms, face sheets, itemized bills and other relevant *Account* documentation; and
 - (c) Cash receipt and application information.

Client is responsible for providing the information identified above relating to the accounts to ACH in the required format as agreed upon by Client and ACH. ACH will have no responsibility for the accuracy of the information received or problems arising out of erroneous or incomplete information received from Client. Further Client warrants that all *Accounts* are valid and legally recoverable debts.

- 2.3 Installation of Telephone Lines. At ACH' request and cost, Client will make available within 10 days following the Effective Date, a private dedicated "voice grade" telephone line to be used for the transmission of Account information to ACH. In the event that this Agreement is terminated within twelve (12) months from its inception, all installation and monthly charges for this telephone line shall be the sole responsibility of Client.
- 2.4 Special Instructions. Client will notify ACH in advance of any special instructions to be used by ACH in providing Accounts Receivable Outsourcing Services (such as listing of specific patients who are to be excluded from follow-up and collection activities due to their "VIP" status or for any other reasons).

3. FEES

- 3.1 Monthly Fee. The fees payable to ACH for providing Accounts Receivable Outsourcing Services to Client will be based on terms as specified in Exhibit I.
- 3.2 Payment Terms. Client will pay to ACH, within forty-five (45) days from the date an invoice is delivered to Client, all payments due under this Agreement. Any amount payable under this Agreement and not paid within forty-five (45) days will be delinquent and shall bear interest at the lesser of one and one-half percent (1 1/2%) per month or the maximum monthly rate allowed by the applicable state.
- 3.3 Fee Change. ACH shall have the right to adjust the monthly fee in the event that Client fails to disclose to ACH at or prior to this Agreement is executed, accurate and complete information relating to Client's accounts receivable profile, which information, if disclosed, would have led ACH to propose a higher or lower Monthly Fee. In the event that ACH increases or decreases the Monthly Fee, ACH will provide Client with ninety- (90) day's prior written notice of this change. If any proposed fee increase is unacceptable to Client, Client may terminate this Agreement upon ninety (90) day's prior written notice to ACH.
- 3.4 Statement. ACH each month will render to Client a written statement setting forth all payments on the *Accounts* made to ACH directly and all deductions.
- 3.5 Taxes. All taxes and other levies in the nature of sales, use or excise taxes as they apply to the State of Maryland resulting from the services provided to the Client by ACH hereunder shall be the responsibility of the Client and shall be paid by the Client directly.

Accounts Clearing House, LLC

4. INITIAL TERM, RENEWALS AND TERMINATION.

The initial term of this Agreement will be two (2) years commencing as of the executed date of the Agreement. This Agreement shall be self-renewing for additional one (1) year terms unless either party delivers to the other, written notice of termination at least thirty (30) days prior to the expiration of the then current term. This Agreement may be terminated by either party, for any reason, upon thirty (30) days prior written notice to the other without penalty from the date of inception of signed Agreement unless otherwise specified in the Agreement. Upon any termination of this Agreement, (a) ACH will continue its efforts with respect to the Accounts assigned prior to and existing as of the date of termination for a period of ninety (90) days; (b) ACH will continue its efforts with respect to all Accounts where payment arrangements are being met according to agreed upon terms, until conclusion of the payment arrangements; and (c) Client will pay ACH the Monthly Fee with respect to the collections referenced in (a) and (b) above regardless of when collections are received and whether received by Client or ACH.

5. CONFIDENTIALITY

- 5.1 Confidentiality of ACH Information. Client acknowledges that the System employed by ACH in providing Accounts Receivable Outsourcing Services is confidential and the sole property of ACH. Client agrees not to disclose to any persons or entities other than ACH, any information it receives concerning ACH business practices or other secrets deemed to be confidential by ACH.
- 5.2 Confidentiality of Client Information. ACH agrees not to disclose to any persons or entities not affiliated with ACH, any information about Client or any of Client's patients received by ACH in the course of providing the Accounts Receivable Outsourcing Services except as required to provide the Accounts Receivable Outsourcing Services or as otherwise legally required. Notwithstanding the preceding sentence, Client agrees that ACH may use Client information for statistical compilation purposes so long as Client and patient identifying information is kept confidential in accordance with applicable laws, rules and regulations. (See Exhibit II)
- 5.3 Confidentiality of Contract Terms. Without ACH's prior written consent, Client will not in any manner or form, disclose, provide or otherwise make available to any third parties, in whole or in part, this Agreement or any terms hereof.

6. DISCLAIMER OF WARRANTIES

Client acknowledges that ACH has the incentive to perform Accounts Receivable Outsourcing Services in a timely and efficient manner. Client acknowledges however, that the timing and amounts of collections generated through the Live Treat Services are subject to numerous variables beyond ACH's control. **THEREFORE, EXCEPT FOR THE EXPRESS REPRESENTATIONS AND WARRANTIES SET FORTH IN THIS AGREEMENT, ACH DISCLAIMS ANY AND ALL REPRESENTATIONS AND WARRANTIES, EXPRESS, IMPLIED, OR STATUTORY, PERTAINING TO THE PERFORMANCE OF THE ACCOUNTS RECEIVABLE OUTSOURCING SERVICES HEREUNDER.**

7. LIMITATION OF LIABILITY

In no event will ACH be liable for lost profits or be responsible for the uncollectibility of any Account.

8. INDEMNIFICATION

Each party agrees to indemnify, defend and hold harmless the other party, their directors, officers, employees and agents from and against any claim, liability, loss or expense (including without limitation attorney's fees) arising directly or indirectly out of an act by a party or its directors, officers, employees or agents in connection with either party's duties or performance under this Agreement.

Accounts Clearing House, LLC

9. NON-INDUCEMENT

During the term of this Agreement and for a period of one (1) year thereafter, neither ACH nor Client will, without the prior written consent of the other, either directly or indirectly, on its own behalf or in the service of others, solicit, divert, or hire away, or attempt to solicit, divert, or hire away, any person employed by the other, whether or not such employee is a full-time, part-time, or temporary employee and whether or not such employee is pursuant to a written agreement, is for a determined period, or is at-will without the prior written consent of the parties.

10. ACCESS TO BOOKS, DOCUMENTS, AND RECORDS

The provisions of this Section 9 are included in this Agreement because of possible application to Section 1861(v)(1)(I) of the Social Security Act. If such section is not applicable to this Agreement, whether now or in the future, then this Section 9 will be deemed not part of this Agreement and will, or will thereafter, be considered null and void. If such provision is applicable to this Agreement, ACH agrees with the Client that until the expiration of four (4) years after furnishing the Accounts Receivable Outsourcing Services under this Agreement, ACH will make available to the Secretary of the United States Department of Health and Human Services (the "Secretary"), and the United States Comptroller General, and their duly authorized representatives, this contract and all books, documents and records necessary to certify the nature and extent of the costs of these services. If ACH carries out the duties of this Agreement through a subcontract worth \$10,000 or more over a 12 month period with a related organization, the subcontract will also contain and access clause to permit access by the Secretary, the United States Comptroller General and their representatives to the related organization's books and records.

11. MISCELLANEOUS

11.1 Entire Agreement. This Agreement and the Exhibits referenced herein describe the entire agreement between the parties and will be binding upon and inure to the benefit of their successors and permitted assigns only with the express written consent of Client. This Agreement supercedes all prior written and oral agreements and understandings between ACH and Client pertaining to Accounts Receivable Outsourcing Services and can only be changed in writing executed by the parties against whom such change is sought to be enforced.

11.2 Notices. Any notice to be given under this Agreement will be in writing and will be effective on date of receipt if sent or delivered to:

If to ACH:

Boyce Rollterer
President
Accounts Clearing House, LLC
300 Hospital Drive, Suite 30
Glen Burnie, Maryland 21061

If to Client:

Dennis Scanlon
Vice President, Finance
Doctor's Community Hospital
8118 Good Luck Road
Lanham, Maryland 20706

or in either case to such other address or individual as the party to be notified, by proper notice hereunder have directed.

11.3 Severability. If any provision of this Agreement, or portion thereof, is declared invalid, the remaining provisions will remain in full force and effect.

11.4 Assignment. This Agreement is binding upon and inures to the benefit of and is enforceable by ACH, Client and their respective legal representatives, permitted assigns and successors of interest. This Agreement will not be assigned or transferred, in whole or in part, by Client and may only be assigned by ACH with the express written consent of Client.

11.5 Governing Law. This Agreement is made and entered into and will be construed and interpreted in accordance with the laws of the State of Maryland.

Accounts Clearing House, LLC

11.6 Authority to Sign. ACH and Client acknowledge that they are duly authorized by appropriate corporate action to enter into this Agreement and that the Agreement is being signed by duly authorized agents authorized to act for their respective parties.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date executed by the duly authorized representative of ACH.

CLIENT: DOCTOR'S COMMUNITY
HOSPITAL

By: 

Title: Vice President, Finance

Date: 1/31/06

ACCOUNTS CLEARING HOUSE, LLC

By: 

Title: President

Date: 1/31/06

Accounts Clearing House, LLC

EXHIBIT I

ACCOUNTS:

Phase I Accounts-

Those prefont accounts and balances that are identified by financial class as Self Pay, Commercial, HMO, MCO, Worker's Compensation or any other insurance accounts identified by Client.

Client represents that monthly Self Pay accounts are profiled as of 12/15/05 as follows:

Aging:	# of Accounts	Gross Assignments	Contractuals/Writeoff %
0-30 days	3,700	\$1,100,000	N/A
31-60 days	_____	_____	_____
61-90 days	_____	_____	_____
91-120 days	_____	_____	_____
121-150 days	_____	_____	_____
151-180 days	_____	_____	_____
181 + days	_____	_____	_____

Client represents that monthly Commercial accounts are profiled as of 12/15/05 as follows:

Aging:	# of Accounts	Gross Assignments	Contractuals/Writeoff %
0-30 days	_____	_____	_____
31-60 days	_____	_____	_____
61-90 days	_____	_____	_____
91-120 days	300	\$250,000	N/A
121-150 days	_____	_____	_____
151-180 days	_____	_____	_____
181 + days	_____	_____	_____

Client represents that monthly Secondary accounts are profiled as of 12/15/05 as follows:

Aging:	# of Accounts	Gross Assignments	Contractuals/Writeoff %
0-30 days	_____	_____	_____
31-60 days	TBD	TBD	_____
61-90 days	_____	_____	_____
91-120 days	_____	_____	_____
121-150 days	_____	_____	_____
151-180 days	_____	_____	_____
181 + days	_____	_____	_____

The above-referenced amounts are an estimate and represent an accumulated backlog of insurance accounts. Client may, at its discretion make additional placements at time intervals to be determined.

FEE SCHEDULE:

Self Pay Accounts. Client agrees to assign to ACH, for a minimum of at least the first six months from the effective date of the Agreement, 100 % of all Self Pay Accounts. Client agrees to pay ACH a monthly fee of nine and one-quarter percent (9.25%) of all monies collected from the accounts identified as Self Pay. After the first six months, should Client only assign to ACH fifty-percent of the Self Pay Accounts, the fee shall be nine and one-half (9.5 %) of all monies collected from the accounts identified as Self Pay. It is further agreed that the determination for changing the assignment percentage from 100% to 50% shall be predicated on a mutually agreed upon performance baseline as agreed upon by Client and ACH. Any payments received within five calendar days from the date of placement shall not be subject to any fee.

Commercial Accounts. Client agrees to pay ACH a monthly fee of six percent (6%) of all monies collected from the accounts identified as Commercial Accounts. Any payments received within seven calendar days from the date of placement shall not be subject to any fee.

Accounts Clearing House, LLC

Secondary Accounts. Client agrees to pay ACH a monthly fee of five percent (5%) of all monies collected from the accounts identified as Secondary Accounts. Any payments received within seven calendar days from the date of placement shall not be subject to any fee.

ADDITIONAL SERVICES

ACH will provide for the licensed use of the AegisEDI remit management and follow-up systems (ARIS) as described in attached AegisEDI Subscription Agreement.

Upon termination client shall reserve the right to continue use of ARIS. Fees for use will be the same as described in attached AegisEDI Subscription Agreement.

Should client decide to enforce the fifty percent assignment protocol on Self Pay Accounts as described in the Fee Schedule referenced above, ACH agrees to allow Client to retain the ARIS system at no charge. The only event that shall occur that will allow AegisEDI to implement the Fee Schedule in the Aegis EDI Subscription Agreement will be the termination of the Accounts Receivable Outsourcing Agreement or an assignment level on Self Pay Accounts lower than fifty percent of the total Self Pay Accounts.

ACH agrees to assume the ARIS Setup Costs as described in Exhibit A of the AegisEDI Subscription Agreement.

CLIENT: DOCTOR'S COMMUNITY HOSPITAL

ACCOUNTS CLEARING HOUSE, LLC

By: [Signature]

By: [Signature]

Title: VP Finance

Title: President

Date: 1/3/06

Date: 1/31/06

Accounts Clearing House, LLC

EXHIBIT II

INDEPENDENT CERTIFICATION AND AGREEMENT OF COMPLIANCE

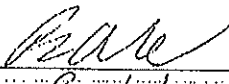
I hereby certify that I am a duly authorized officer of the independent contractor named below ("Contractor). On behalf of Contractor and its officers, directors, employees, and agents, I certify that I have received and read the "Compliance Program Policy Manual" dated _____ of *Doctor's Community Hospital* and fully understand the requirements set forth in that document. I certify that Contractor shall act in full accordance with all rules and policies of *Doctor's Community Hospital*. These rules and policies include *Doctor's Community Hospital's* commitment to comply with all applicable federal and state laws, and *Doctor's Community Hospital's* commitment to conduct its business in compliance with the highest ethical standards.

To this end, Contractor expressly agrees that the *Doctor's Community Hospital* "Compliance Program Policy Manual" shall be incorporated within and made a part of the Contractor's Agreement with *Doctor's Community Hospital* and shall survive termination of this Agreement for any reason. Any failure of Contractor to comply with the rules and policies set forth in *Doctor's Community Hospital* "Compliance Program Policy Manual" or to report violations of these rules and policies may result in immediate termination by *Doctor's Community Hospital* of its Agreement with Contractor.

CLIENT: DOCTOR'S COMMUNITY HOSPITAL

ACCOUNTS CLEARING HOUSE, LLC

By: 

By: 

Title: VP Finance

Title: President

Date: 1/31/85

Date: 1/31/00

Debt Collection/financial Assistance Report

FYE 2014

Hospital Name Doctors Community Hospital
Hospital Numt 210051

1. Collection Agency Name

- a. Accounts Receivable Clearing House
- b. _____
- c. _____
- d. _____
- e. _____
- f. _____
- g. _____
- h. _____

2. Number of liens

i. 0

3. Number of extended payment plans

j. 1,823

FINANCIAL ASSISTANCE

4. Number of applications for financial assistance received

k. 231

5. Number of applications for financial assistance approved

218

Note: represents number of applications not number of accounts

attach: DCH Policies and Procedures for assigning a debt to a collection agent for collection and for compensating such a collection agent for services rendered. (PDF format)

HSCRC

General Billing Information

About four days after receiving medical services, you will receive a Summary Bill in the mail. To request an itemized bill or if you have any questions, contact the Business Office:

7404 Executive Place, Suite 300 A
Seabrook, MD 20706
301-552-8093

While you are still at the hospital, you may pose your questions to the following:

- **Outpatient Registration Department**
Main Hospital, 2nd Floor
Monday to Friday, 8:00 a.m. to 4:30 p.m.
- **Emergency Department Registration Office**
Main Hospital, 1st Floor
24 hours a day

Patient Obligation

- Pay your bills timely
- Provide your correct insurance information
- Notify the Business Office if your financial status changes and will impact your ability to pay the bill

Patient Rights

- Doctors Community Hospital or Medicaid may provide assistance to patients who meet the financial assistance criteria
- Patients who believe they were wrongly referred to a collections agency have the right to contact the Business Office to discuss this matter



Financial Assistance

Financial assistance is available for patients who receive services at Doctors Community Hospital. Patients may qualify for free care or partial care based on their family's gross income as applied to the Federal Poverty Guideline.

Applications for financial assistance may be obtained at emergency registration or outpatient registration at the hospital. You can also call the Business Office at 301-552-8186 to have an application mailed to you.

Mail the completed application as well as proof of family income and expenses to the following:

Doctors Community Hospital
Patient Financial Services
8118 Good Luck Road
Lanham, MD 20706

Maryland Medical Assistance

Doctors Community Hospital provides case workers to assist patients who received inpatient or emergency outpatient care with Maryland Medical Assistance applications. Patients who received inpatient care, and do not have insurance, may contact one of the telephone numbers listed below.

LAST NAME BEGINNING WITH:

A-J DECO 301-552-8116
K-Z MEDLAW 301-552-8682

Additional Assistance

Emergency Outpatient Services

• Contact DECO at 301-552-8116

• Medical Medicaid Applications for Other Outpatient Services

• Contact the Maryland Department of Social Services at 800-332-6347, TTY 800-925-4434

How Does Health Insurance Billing Work?

After receiving services, we will bill your health insurance. To ensure that the claim was properly submitted, we will make a copy of your current identification and insurance cards.

Insurance companies require that we supply them with complete information on the person who carries the coverage. This information includes name, address, telephone number, date of birth, employment and social security number.

Incomplete information could cause a denial by your insurance provider, and you could be responsible for the balance.

If you are unable to provide complete insurance and subscriber information, we will not be able to bill your insurance.

Servicios no facturados por Doctors Community Hospital

Es posible que su tratamiento en Doctors Community Hospital requiera los servicios de proveedores que facturan por separado. Estos proveedores le facturarán a su proveedor de seguros. Sin embargo, si por algún motivo la compañía de seguros no paga por los servicios, es posible que usted reciba una factura. Si tiene preguntas respecto de las facturas de estos proveedores, comuníquese directamente con ellos. A continuación, se proporciona la información de contacto de algunos de los proveedores.

Para servicios profesionales:

- Clinical Laboratory Associates
- Diagnostic Imaging Associates
- Doctors Emergency Physicians
- Elliott & Wargotz Pathology
- Matrix House Physicians

Contacto:

- Meridian Financial Management
301-498-2922

Para servicios profesionales:

- Joslin Diabetes Center
- The Center for Wound Healing

Contacto:

Asistencia financiera

Se encuentra disponible asistencia financiera para los pacientes que reciben atención para servicios de urgencias o emergencias. Se proporciona atención gratuita para los pacientes cuyo ingreso bruto familiar sea del 200% de las Pautas federales de pobreza, o menos.

Las solicitudes de Asistencia financiera pueden obtenerse en el Departamento de registro de emergencias o en el Departamento de registro de pacientes ambulatorios, o llamando a la Oficina comercial al 301-552-8186.

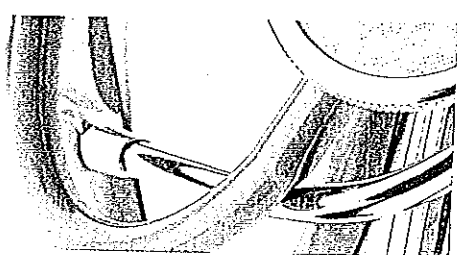
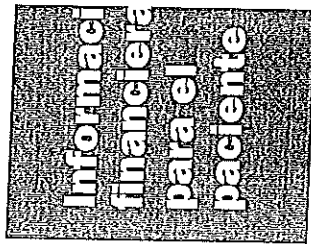
Si se solicita, se enviará al paciente una solicitud por correo. A fin de reunir los requisitos, el solicitante también debe presentar comprobantes del ingreso y de los gastos familiares.

Asistencia médica de Maryland

Para los pacientes que han recibido atención para pacientes hospitalizados o atención ambulatoria de emergencia, Doctors Community Hospital ofrece trabajadores de casos que ayudan a estos pacientes con las solicitudes de Asistencia médica de Maryland. Los pacientes que hayan recibido atención para pacientes hospitalizados y no cuenten con un seguro pueden llamar a uno de los siguientes números de teléfono:

Si su apellido comienza con:

	Contacto	Núm. de teléfono
A-J	DECO	301-552-8116
K-Z	MFDI AW	301-552-8662



Appendix III Label: Copy of the Patient Information Sheet provided to the patients in accordance with Health-General §19-214.1(e)

Insert PDF

Paying Your Bill

Bills for services rendered are to be paid upon receipt. **Co-payments are set by your insurance provider and are due at the time of service.**

Services Not Billed by Doctors Community Hospital

Your treatment at Doctors Community Hospital may require services of healthcare professionals who will bill your insurance provider separately. However, if for some reason the insurance company does not pay for the services, you may receive the bill. If you have questions about such bills, contact those professionals directly. Below is the contact information for some of these services.

Professional Services

- + Clinical Laboratory Associates
- + Diagnostic Imaging Associates
- + Doctors Emergency Physicians
- + Elliott & Wargotz Pathology

 **Contact Meridian Financial Management at 301-498-2922**

- + Joslin Diabetes Center
- + Center for Wound Healing and Hyperbaric Medicine

 **Contact Universal Health Network at 888-846-5527**

- + Southern Maryland Anesthesia & Associates, LLC

 **Contact Southern Maryland Anesthesia & Associates at 800-583-1360**

Your private physician may also bill you. Please contact him/her directly to discuss those bills.

APPENDIX III: PATIENT INFORMATION SHEET

What If My Visit Is Due To A Motor Vehicle Accident?

We will ask for your automobile and health insurance information. Your automobile insurance will be billed first. If your automobile insurance does not pay the bill, your medical insurance will be billed next. We will bill you for any non-covered balances.

What If I Am Injured On The Job?

We will bill the workers' compensation insurance provider of your employer. If payment is not received from this provider, you are responsible for the bill.

What Does Medicare Cover?

Medicare Part A covers inpatient charges, and Medicare Part B covers outpatient charges that are considered "medically necessary."

If your doctor orders a service that is not considered "medically necessary" by Medicare, you will be asked to sign an Advance Beneficiary Notice (ABN). The ABN is Medicare's way of informing you of the possibility that it might not pay for the service ordered. By signing the ABN, you agree to accept responsibility for payment if Medicare does not pay.

You can sign the ABN and agree to pay for service, or you can refuse the service. If you refuse, we encourage you to talk with your doctor about alternative options that would be covered by Medicare.



8118 Good Luck Road
Lanham, Maryland 20706

PHONE 301-552-8118

Patient Financial Information



General Billing Information

About four days after receiving medical services, you will receive a Summary Bill in the mail. To request an itemized bill or if you have any questions, contact the Business Office:

7404 Executive Place, Suite 300 A
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301-552-8093

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Main Hospital, 2nd Floor
Monday to Friday, 8:00 a.m. to 4:30 p.m.
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Main Hospital, 1st Floor
24 hours a day

Patient Obligation

- + Pay your bills timely
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Patient Rights

- + Doctors Community Hospital or Medicaid may provide assistance to patients who meet the financial assistance criteria
- + Patients who believe they were wrongly referred to a collections agency have the right to contact the Business Office to discuss this matter



How Does Health Insurance Billing Work?

After receiving services, we will bill your health insurance. To ensure that the claim was properly submitted, we will make a copy of your current identification and insurance cards.

Insurance companies require that we supply them with complete information on the person who carries the coverage. This information includes name, address, telephone number, date of birth, employment and social security number.

Incomplete information could cause a denial by your insurance provider, and you could be responsible for the balance.

If you are unable to provide complete insurance and subscriber information, we will not be able to bill your insurance.

Financial Assistance

Financial assistance is available for patients who receive services at Doctors Community Hospital. Patients may qualify for free care or partial care based on their family's gross income as applied to the Federal Poverty Guideline.

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Patient Financial Services
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Lanham, MD 20706

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LAST NAME BEGINNING WITH:

A-J	DECO	301-552-8116
K-Z	MEDLAW	301-552-8682

Additional Assistance

Emergency Outpatient Services

👉 **Contact DECO at 301-552-8116**

Medical Medicaid Applications for Other Outpatient Services

👉 **Contact the Maryland Department of Social Services at 800-332-6347, TTY 800-925-4434**

Appendix V: Prince George's County Health Action Plan

<http://www.princegeorgescountymd.gov/Government/AgencyIndex/Health/improvement.asp>

Insert PDF



Prince George's County Health Action Plan 2012

Pamela B. Creekmur, Acting Health Officer
301-883-7834 | pbcreekmur@co.pg.md.us

Fran Preneta, Consultant
301-883-3153 | fpreneta@co.pg.md.us

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Prince George's County Health Action Plan 2012

1. Local Health Planning Coalition Description

The Local Health Planning Coalition Description, provided previously to Maryland Department of Health and Mental Hygiene (DHMH), can be viewed online at:

Overview:

http://www.princegeorgescountymd.gov/Government/AgencyIndex/Health/pdf/PGHAC_Overview_1-12.pdf

Coalition Members:

<http://www.princegeorgescountymd.gov/Government/AgencyIndex/Health/pdf/membership.pdf>

Adjunct Coalitions, Organizations and Committees:

http://www.princegeorgescountymd.gov/Government/AgencyIndex/Health/pdf/PGHAC_Adj%20Coals%20Orgs%20Ctees_1-12.pdf

2. Local Health Data Profile

Selection of the Priorities, Objectives, and Strategies included in Prince George's County's Health Improvement Plan (PGCHIP) took into consideration:

- The Health Department's federal, state, and local mandates for provision of services and programs and its available resources (funding and personnel) to implement strategies.
- The capacity of existing and potential community partners to share responsibility for meeting our health objectives
- The commitment of local political leaders (i.e. Board of Health) to monitor progress towards meeting our objectives and to consider health implications when making policy decisions and adopting legislation.
- Evidence-based best practices that address our objectives.
- National and statewide public health strategies for reducing HIV infection.

The first six Priorities with their corresponding Objectives and Strategies are in alignment with the Maryland State SHIP Vision Areas 1-6; however, we have re-arranged the Priorities in descending order of importance according to the extent to which the health concerns they address impact the population as a whole, demonstrate major disparities, and/or pose longstanding, complex challenges to their prevention and control in Prince George's County. Consequently, Access to Care is listed as our first priority, followed by Chronic Diseases, Infant Mortality/Reproductive Health, Infectious Diseases (HIV/AIDS, Sexually Transmitted Infections and TB), Safe Physical Environments, and Safe Social Environments.

The “County-Specific Health Priorities” address broader issues related to health care infrastructure, workforce, and systems issues of particular concern to County stakeholders.

For the purposes of the 2012 Local Health Action Plan, the Prince George’s Health Action Coalition selected strategies within four of our six Priority Areas - Access to Care, Chronic Diseases, Infant Mortality, and HIV/AIDS and Sexually Transmitted Diseases - as the priorities for Coalition and partner activity during calendar year 2012, as outlined in Section 4 (Local Health Improvement Priorities 2011- 2014) of this document.

A. SHIP Measures – Regional/County Profile (provided by DHMH)

The online County Profile can be viewed at:

http://eh.dhmd.gov/ship/SHIP_Profile_Prince_Georges.pdf

B. Additional Data Collected through Local Assessments, Surveys, and Other Methods

Additional data used to make decisions about the County’s priority health concerns was collected from a variety of sources, including input from local political and community leaders, key health care stakeholders, and County residents. This included:

- A review of **County-specific statistics** from the Maryland Department of Health and Mental Hygiene Vital Statistics Administration (DHMH VSA) reports, Behavioral Risk Factor Surveillance System (BRFSS) data, U.S. Census Bureau information, and other commonly used data sources. A summary of the County’s greatest health concerns based on this data is provided in the PGCHIP (Section entitled “The Health of Our Population and Health Care System - Where We Stand”).
- A review of the **2009 RAND Report**, a comprehensive study sponsored by the Prince George’s County Council of the health needs of County residents and the capacity of the County’s health care system to respond. A **summary** of the RAND data is provided in the online Prince George’s County Health Improvement Plan, and can be viewed at:
<http://www.princegeorgescountymd.gov/Government/AgencyIndex/Health/pdf/LocalhealthPlanPrefinal.pdf>
- A **comprehensive and detailed presentation** of the health data and study conclusions by the RAND researchers can be viewed in the RAND report entitled “Assessing Health and Health Care in Prince George’s County” located on the Prince George’s County Government’s Web site, and can be viewed at:

<http://www.princegeorgescountymd.gov/pgcha/PDFS/rand-assessing-health-care.pdf>

- A review of the “**Baker 2010 Transition Team Transition Report**, March 11, 2011”. A Transition team was assembled by County Executive Rushern Baker to study the workings of all County Government agencies in order to seek ways to streamline operations and improve service delivery. The full online report is can be viewed at:
<http://www.princegeorgescountymd.gov/Government/ExecutiveBranch/PDF/Baker2010TransitionTeamTransitionReport.pdf>
- Summary information from **nine “town hall” style forums** held by the Prince George’s County Health Officer in July and August of 2009.
- A **consensus report** from a meeting of major State and local health officials and health care stakeholders, political and community leaders, health experts and community advocates in December 2010, sponsored by the Prince George’s County Executive. The findings and recommendations of this group are published in a report entitled “Conversation on Building an Integrated Community-oriented Healthcare System in Prince George’s County, Executive Summary, Prince George’s Community College, December 14, 2010”.
- Input from **meetings with the Prince George’s County Council/Board of Health** between May and September 2011 that included a presentation by the Maryland Secretary of Health on the State Health Improvement Process (SHIP). In addition, the County Health Improvement Plan was presented between October-December 2011 at separate meetings with the County stakeholders for additional input and feedback.
- Results of a **survey of 126 County residents** attending an annual “Holiday Food and Fitness Expo” in November 2009, sponsored by Prince George’s County Health Department (PGCHD), Maryland-National Capital Park and Planning Commission (M-NCPPC), and Prince George’s County Public Schools (PGCPS).
- Input from **key County coalitions and community groups** at a meeting held on September 9, 2011, sponsored by the Maryland Department of Health and Mental Hygiene (DHMH) and PGCHD.
- Comments from participants at a **symposium entitled “Health √ (Check), The Prognosis for Prince George’s County”**, held at Prince George’s Community College on October 1, 2011 and sponsored by the National Harbor Chapter of Jack and Jill of America, Inc., Prince George’s County Council Chair Ingrid M. Turner, and M-NCPPC Parks and Recreation.

- **Feedback from the community** during the public comment period when the draft Plan was posted on PGCHD Web site in October and November 2011.

In addition, between November 2011 and January 2012, the Prince George's County Health Department contracted with Abt SRBI to conduct a Behavioral Risk Factor Surveillance System (BRFSS) telephone survey in Prince George's County. Altogether, 1,125 households throughout the County were interviewed, with an additional 375 households "oversampled" in four Port Town communities, which have a large percentage of minority residents (predominantly African American/Black and Hispanics). The results of this survey will be available in March 2012.

Finally, a map of the County entitled "Number of Elevated Indicators by Zip Code, Prince George's County", provided by Maryland Department of Health and Mental Hygiene, will be used by the PGHAC to identify areas of the County where strategies and action steps outlined in this document (Section 4) will specifically be targeted (primarily inside the Capital Beltway 495/95). The online map can be viewed at:

http://www.princegeorgescountymd.gov/Government/AgencyIndex/Health/pdf/Elev+Hlth+Indic+by+Zip_11-11.pdf

3. Local Health Context

In addition to the formation of the Prince George's Health Action Coalition (PGHAC), a number of existing Coalitions have been included as partners in developing, implementing, and evaluating the Prince George's County Health Improvement Plan (PGCHIP) and Health Action Plan 2012. These Coalitions, listed in Section 1 (Local Health Planning Coalition Description) of this document, are considered to be Adjunct PGHAC members. As such, they will continue to independently meet according to their established meeting schedules as well as attend meetings of the PGHAC Coalition and its Workgroups in order to inform the health planning process.

4. Local Health Improvement Priorities 2012 (See Attachment A)

5. Local Health Planning Resources and Sustainability Plan

In a future meeting of the PGHAC, the Coalition will conduct an inventory of all the existing and anticipated assets and resources available among Coalition members, Coalition Workgroup members, Coalition Adjunct members and other key stakeholders to support implementation of the specific strategies outlined in the Health Action Plan 2012. These resources, both in-kind and direct funding, may include:

- Personnel (i.e. professional, administrative, clerical)
- Services (i.e. medical, social, educational, lab, language and deaf interpreter, other agency-specific)

- Training, meeting, and office space
- Equipment and Supplies (i.e. office, medical, lab, educational)
- Communication methods (websites, television, radio, publications, newsletters, other)
- Printing, reproduction, and postage
- Subscriptions to professional publications, grant directories, other sources that support research into best practices, funding
- Computers and computer software
- Training/conference funds and stipends for trainers
- Mileage reimbursement funds
- Agency mini-grants and other available direct funds

Each Coalition Workgroup and their designated Research Intern will also have an on-going responsibility to identify potential funding sources that can support the Prince George's County Health Action Plan 2012 and PGCHIP. If needed, a special Funding Workgroup will be established to oversee fund seeking activities. Administrative support staff will assist the Workgroups in responding to Requests for Proposals.

Prince George’s County Health Action Plan 2012: Action Plan for Priority 1

Implementation Period: January 1 – December 31, 2012
Name and Title of Person Completing Action Plan: Gloria Brown, Co-Chair; Ben Ijomah, Co-Chair
PGHAC Workgroup: Access to Care Workgroup (Priority 1)

Priority 1: Ensure that Prince George’s County Residents Receive the Health Care They Need, Particularly Low Income, Uninsured/Underinsured Individuals				
County Outcome Objective		Current County Baseline Data		2014 County Goal
Increase the proportion of persons with health insurance		82.2% (percentage of civilian non-institutionalized ages 18-64 with any type of health insurance, BRFSS 2008-2010)		91.1% using midpoint to Healthy People (HP) 2020
Reduce the proportion of individuals who are unable to obtain, or delay obtaining, necessary medical care, dental care, or prescription medications		15.8% (percentage of people who reported that there was a time in the past 12 months when they could not afford to see a doctor, BRFSS 2008-2010)		15% using 5% decrease
Increase the proportion of low income children and adolescents who receive dental care		57.8% (percentage of low income children ages 4-20 enrolled in Medicaid that received a dental service in the past year, Medicaid Calendar Year 2009)		60.7% using 5% increase
Increasing Enrollment of Adults and Children in Medicaid, HealthChoice/MCHP, Other Health Programs				
Strategy (What?)	Responsible Agencies (Who?)	Target Date for Completion (When?)	Action Steps (How?)	Performance Indicators
#6: Place Medical Assistance eligibility/enrollment workers at strategic clinic sites (i.e. FQHCs).	Prince George’s County Department of Social Services Maryland Department of Human Resources Maryland Department of Health and Mental	June 2012	1. Develop Medical Assistance (MA) Co Pay Contracts to place DSS Eligibility Workers at 3 FQHCs to process MA applications.	Eligibility Workers (3) placed at 3 FQHC sites Number of MA applications submitted for processing by Eligibility Workers and number actually approved. Percent increase over previous reporting period in the total

APPENDIX V: HEALTH ACTION PLAN

	Hygiene HealthChoice Program			number of MA applications processed by responsible agencies
	Community Clinic, Inc. (FQHC)			Percent increase from previous reporting period in the total number of County women and children enrolled in MA
	Greater Baden Medical Services (FQHC)			
	Mary's Center (FQHC)			

Increasing Linkage to Care				
Strategy (What?)	Responsible Agencies (Who?)	Target Date for Completion (When?)	Action Steps (How?)	Performance Indicators
#6: Work with the Medical Society, Board of Physicians, Board of Pharmacy, and other medical associations to identify ways to increase access to dental, vision, and medical care (including specialty care), and to low cost prescriptions medication.	Prince George's County Health Department Medical Society Board of Physicians Board of Pharmacy Other medical professional associations (i.e. for Physician Assistants, Nurses, Nurse Practitioners, Dentists, Dental Hygienists, Ophthalmologists and Optometrists) Greater Baden Medical Services (FQHC) Mary's Center (FQHC)	Throughout 2012	1. Designate at least 2 Prince George's Health Action Coalition (PGHAC) meetings to include representatives of identified medical professional associations for the purpose of identifying areas of the County and populations with access to care issues, the specific services that are needed to fill service gaps, and ways to increase access to care. 2. Convene monthly meetings of the PGHAC Access to Care Workgroup to follow-up on actions identified in the above-mentioned meetings. 3. Continue promoting existing services to the public on the part of all partners,	Meetings held; number and types of professional associations participating Geographic areas and populations with access to care issues identified Needed services identified Recommendations on ways to increase access to care identified, along with resources needed to implement recommendations Workgroup meetings held; actions undertaken and barriers to implementing actions identified Outreach and public information activities implemented; number

APPENDIX V: HEALTH ACTION PLAN

	<p>Community Clinic, Inc. (FQHC)</p> <p>PGHAC members</p>		<p>using established and non-traditional outreach and public information methods/materials. Focus efforts on specifically reaching hard-to-reach, minority, non-English-speaking, and uninsured or underinsured County residents.</p>	<p>and types of materials distributed</p> <p>Percent increase over previous reporting period in the number of calls to the Health Department's Healthline Program, a widely publicized free telephone information and referral service, from individuals seeking care</p> <p>Percent increase over the previous reporting period in the number of calls to other agency customer service or information desks from individuals seeking care</p> <p>Percent increase over the previous reporting period in the number of individuals served (by all partners)</p>
<p>#8: Provide up-to-date information to the public about the services available through existing providers including FQHCs and other safety net clinics.</p>	<p>Prince George's County Department of Family Services</p> <p>Prince George's County Department of Social Services</p> <p>Prince George's County Health Department</p> <p>Greater Baden Medical Services FQHC)</p>	<p>June 2012</p>	<p>1. Develop and/or revise safety net providers' informational flyers, brochures, and other materials describing their services and service locations for distribution to the public through established outreach activities, including website postings, health fairs, community events, etc.</p> <p>2. Identify and use non-traditional outreach methods, materials and outlets to broaden distribution of safety net provider informational materials to</p>	<p>Informational materials updated and translated into relevant languages</p> <p>Number and types of materials distributed</p> <p>Number and types of distribution sources used</p> <p>Number, types, and locations of non-traditional outreach methods/outlets identified and used to distribute information to</p>

APPENDIX V: HEALTH ACTION PLAN

	<p>Community Clinic, inc. (FQHC)</p> <p>Mary's Center (FQHC)</p> <p>Pregnancy Aid Center</p> <p>Forestville Pregnancy Center</p> <p>Mobile vans (Governor's Wellmobile, Deamonte Driver Dental van, Mary's Center van, Children's Hospital van)</p> <p>Other community safety net providers</p> <p>Dimensions Healthcare and other hospitals serving County residents</p> <p>PGHAC members and other partners</p> <p>Prince George's County Memorial Library System</p> <p>Local churches, businesses, low income housing complexes and other non-traditional sites for distributing informational materials</p>		<p>the public, especially to hard-to-reach, non-English-speaking, low income, and uninsured/underinsured individuals.</p> <p>3. Revise the widely used Health Department "Community Services Guide-at-a-Glance", a resource directory, for distribution to and use by all partners and provider agencies in referring individuals to needed care. Create an on-line version of the Guide-at-a-Glance that can be updated regularly and downloaded.</p>	<p>the public; number of materials distributed</p> <p>Community Services Guide-at-a-Glance revised and available on-line.</p> <p>Number of Guides distributed</p> <p>Number of partners using Guides for referring clients in need of services</p> <p>Percent increase over previous reporting period in the number of calls to the Health Department's Health<i>line</i> Program from individuals seeking care</p> <p>Percent increase over previous reporting period in the number of calls to other partner agencies' customer service or public information desks from individuals seeking care</p> <p>Percent increase over the previous reporting period in the number of individuals served (by all partners)</p>
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Prince George’s County Health Action Plan 2012: Action Plan for Priority 2

Implementation Period: January 1 – December 31, 2012
Name and Title of Person Completing Action Plan: John O’Brien, Chair; Karen Bates, Co-Chair; James Chesley, Co-Chair
PGHAC Workgroup: Chronic Diseases Workgroup (Priority 2)

Priority 2: Prevent and Control Chronic Disease in Prince George’s County, Particularly Among Minorities.				
County Outcome Objective		Current County Baseline Data		2014 County Goal
Increase the proportion of adults who are at a healthy weight		28.6% (percentage of adults at a healthy weight {not overweight or obese}, BRFSS 2008-2010) White Non-Hispanic – 39.6% Black – 13.0% Hispanic – 23.0% Asian – Not Available		30% using 5% increase White Non-Hispanic – 41.6% using 5% increase Black – 13.7% Hispanic – 24.2% Asian – Not Available
Reduce the proportion of children and adolescents who are considered obese		16.1% (percentage of youth ages 12-19 who are obese, MYTS 2008)		15.3% using 5% decrease
Increasing Access to Healthier Foods				
Strategy (What?)	Responsible Agencies (Who?)	Target Date for Completion (When?)	Action Steps (How?)	Performance Indicators
#1: Adopt local policies requiring chain restaurants to provide menu labeling that gives consumers information on nutritional values of in-store menu selections.	Prince George’s County Health Department PGHAC members Prince George’s County Office of the County Executive Prince George’s County Council/Board of	April 2012 (Bills to be heard April 2013)	1. Research the strategies that neighboring jurisdictions used to successfully established menu labeling in their restaurants. Identify strategies that can be replicated in Prince George’s County. 2. Prepare an educational packet and presentation that will be used to educate the County Council/Board of Health, County Executive’s Office	Research completed; strategies identified for implementation in the County Educational packet and presentation prepared and presented to County Council/Board of Health,

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	<p>Health/County Executive's Office</p> <p>Restaurant owners and other menu labeling supporters</p>		<p>about the importance of menu labeling.</p> <p>3. Using other jurisdictions' legislation as models, develop a draft of proposed legislation for presentation to the Prince George's County Council/ Board of Health and County Executive's Office.</p> <p>4. Solicit owners of restaurants that have already adopted menu labeling in their stores, as well as other advocates of menu labeling, to provide support for the menu labeling proposed legislation.</p>	<p>County Executive's Office</p> <p>Proposed legislation drafted and presented to County Council/Board of Health, County Executive's Office</p> <p>Restaurant owners and other advocates identified and involved in educating County Council/Board of Health, County Executive's Office, about menu labeling</p> <p>Menu labeling legislation adopted</p> <p>Chain restaurants providing menu labeling in compliance with the legislation requirements (per Health Department restaurant inspections)</p>
<p>#2: Educate local leaders, restaurant owners, and the public about menu labeling and its impact on selection of healthy food choices, using media outlets, community events, educational materials, and</p>	<p>Prince George's County Health Department</p> <p>PGHAC members</p> <p>Restaurant owners and other menu labeling supported</p> <p>Local political, religious, academic, and other community leaders</p>	<p>Throughout 2012</p>	<p>1. Research the strategies that neighboring jurisdictions used to successfully established menu labeling in their restaurants. Identify strategies that can be replicated in Prince George's County.</p> <p>2. Prepare an educational packet and presentation that will be used to educate local leaders, restaurant owners, the media, and the public about the importance of menu labeling. Include educational materials and</p>	<p>Research completed; strategies identified for implementation in the County</p> <p>Educational packet and presentation prepared</p> <p>Number and types of educational programs conducted; number of</p>

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<p>other venues/methods.</p>	<p>Media</p>		<p>venues that reach minorities, non-English-speaking populations.</p> <p>3. Identify the food deserts and high-risk geographic areas of the County with a concentration of fast-food chain restaurants to target educational efforts.</p> <p>4. Solicit owners of restaurants that have already adopted menu labeling in their stores, as well as other advocates of menu labeling, to provide assistance in educating local leaders, restaurant owners, the media, and the public.</p>	<p>participants</p> <p>Number and types of venues (including media outlets) used to impart menu labeling information to leaders, restaurant owners, the public; number of individuals reached</p> <p>Number and locations of food deserts and high risk areas identified; number of educational programs presented in these areas; number of participants</p> <p>Restaurant owners and other advocates identified and involved in educating local leaders, restaurant owners, the media, and the public about menu labeling</p> <p>Menu labeling legislation adopted</p> <p>Chain restaurants providing menu labeling in compliance with the legislation requirements (per Health Department restaurant inspections)</p>
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<p>#3: Increase public demand for healthier food choices at restaurants and food markets through education and advocacy; partner with the Food Supplemental Nutrition Education Program to assist with community education to low income and other at-risk communities.</p>	<p>Prince George's County Health and Human Services Agencies</p> <p>Food Supplemental Nutrition Education Program</p> <p>PGHAC members</p> <p>Restaurant owners</p> <p>Grocery store managers and owners</p> <p>Local farmers and farmers' markets</p> <p>Community sites where health fairs, community events, educational programs can be conducted (i.e Park and Planning Recreation Centers, schools, churches, local businesses, County government agencies, low income apartment complexes)</p>	<p>Throughout 2012</p>	<ol style="list-style-type: none"> 1. Prepare a public education program in conjunction with the Food Supplemental Nutrition Education Program that specifically reaches low income, minority, non-English-speaking, and other populations at risk for chronic diseases. 2. Identify the food deserts and high-risk geographic areas of the County where populations at greatest risk for chronic diseases reside, for targeted education, advocacy for farmers' markets, and implementation of other strategies that promote purchase of healthier foods 3. Explore with Verizon the possibility of offering free texting services to partners for the purpose of sending text messages to County residents regarding healthier food choices. 4. Identify free media, Website and internet internet outlets that can be used to educate the public about healthier food choices, including County government agency Websites. 5. Identify and implement strategies to promote greater consumer participation in local farmers' markets, greater consumer support for additional farmers' markets, and increased purchasing of locally grown foods. 	<p>Educational program prepared</p> <p>Number of educational programs presented; number of participants</p> <p>Number and locations of food deserts and high risk areas identified</p> <p>Number of educational programs presented in these areas; number of participants</p> <p>Number and types of activities that promote the purchase of healthier foods implemented</p> <p>Verizon contacted; if successful, text messages prepared and sent to County residents; number of text messages Verizon receives in response</p> <p>Media, Website, and internet outlets identified and used to deliver messages about healthier food choices; number of page views or visits to sites</p> <p>Strategies identified and implemented</p> <p>Number of new farmers' markets established</p> <p>Number of individuals using</p>
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			<p>6. Identify grocery stores willing to offer healthier food choices and incentives for consumers to purchase healthier foods. Develop a plan to implement healthier food selection strategies in these locations.</p>	<p>farmers' markets (estimates)</p> <p>Number of WIC food vouchers used at farmers' markets (or number of women on WIC using food vouchers at farmers' markets)</p> <p>Grocery stores identified</p> <p>Plan developed; strategies and incentives that promote consumer purchase of healthier foods offered (i.e. increased use of locally grown food products, larger choice of fresh fruits and vegetables, in-store signage identifying healthier foods)</p> <p>Grocery store data on healthier food purchases</p>
<p>#5. Increase marketing of healthier foods, using the Get Fresh Baltimore model.</p>	<p>Prince George's County Health Department (WIC Farmers' Market Nutrition Program)</p> <p>Kaiser Permanente</p> <p>Get Fresh Baltimore Program</p> <p>Prince George's County Public Schools</p> <p>Maryland-National Capital Park and Planning Commission (Planning Department and Parks and</p>	<p>December 2012</p>	<p>1. Meet with Get Fresh Baltimore Program staff to identify elements of the Program that can be replicated in Prince George's County, i(i.e. establishment of a Get Fresh Prince George's Website, a virtual supermarket, community gardens)</p> <p>2. Identify specific partners to be involved in establishing the Get Fresh Prince George's County Program.</p> <p>3. Develop a plan for implementing the Get Fresh Program in the County, including strategies that reach minorities, non-English-speakers, low income, and other populations at</p>	<p>Meeting(s) held; strategies to be replicated in the County identified</p> <p>Partners identified</p> <p>Plan developed</p>

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	Recreation) Maryland Department of Agriculture University of Maryland Extension Grocery stores Farmers and farmers' markets Food Supplemental Nutrition Education Program Media Supplemental Nutrition Assistance Program (SNAP) Local municipalities with community gardens		risk for chronic diseases. 4. Identify geographic areas of the County and populations at greatest risk for poor eating habits and chronic diseases, for targeted 5. Identify funding and other resources needed to support the implementation of the Get Fresh Prince George's County Program.	Target areas and populations identified Funding and other resources identified and procured Get Fresh Prince George's Program phased in as funding permits (fully operational by March 2013)
Promoting Physical and Recreational Activity				
Strategy (What?)	Responsible Agencies (Who?)	Target Date for Completion (When?)	Action Steps (How?)	Performance Indicators
#1: Support the implementation of the PGCPs new Fitness-Gram Program in grades K-12. (FitnessGram includes an	Prince George's County Public Schools PGHAC members	Throughout the 2012 school year	1. Provide ongoing school staff training to ensure the program is being uniformly implemented. 2. Review data collected from the assessment tools and compare with	Fitness-Gram Program implemented in grades k-12 Number of students participating in Program Student level of fitness (associated with being healthy)

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<p>assessment tool that obtains personal data to determine a student's fitness level).</p>			<p>previous year's data to determine program effectiveness.</p>	<p>measured by data collected in assessment tools</p>
<p>#2: Work with the PGCPs including the School Wellness Councils to sustain the Healthy Schools Program and ensure compliance with the school system Wellness Policy that identifies increased physical activity for students, promotes healthier food and beverage choices in schools, and contributes to a healthier school environment in general.</p>	<p>Prince George's County Public Schools (School Wellness Councils) Kaiser Permanente PGHAC members</p>	<p>Throughout the 2012 school year</p>	<ol style="list-style-type: none"> 1. Secure grant funding to support/sustain the Healthy Schools Program. 2. Initiate the development of a strategic plan with interested partners to expand the Healthy Schools Program. 3. Increase the number of healthy food selections on the school menus. 4. Collect and analyzing BMI data from the Healthy Schools Program on an on-going basis. 	<p>Funding procured</p> <p>Plan developed</p> <p>Partners have a written agreement indicating support of the Healthy Schools Program</p> <p>Number of schools actively participating in the HSP (as evidenced by completion of the annual school health inventory); number of students participating</p> <p>Number and types of new menu items that meet new dietary guidelines</p> <p>Data on student purchases of healthy food items from school menus</p> <p>BMI data collected and analyzed</p>
<p>#3: Seek funding to pilot the implementation of the M-NCPPC and PGCHD's</p>	<p>Maryland-National Capital Park and Planning Commission Prince George's County</p>	<p>January 2013</p>	<ol style="list-style-type: none"> 1. Identify funding to support implementation of the Prescription-REC Program as a pilot project. 	<p>Funding identified</p> <p>Prescription-REC Program implemented</p>

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<p>Prescription-REC Program for County residents with high blood pressure and/or high cholesterol who have a “prescription” from their health care provider to start an exercise regimen.</p>	<p>Health Department Local health care providers PGHAC members</p>		<ol style="list-style-type: none"> 2. Identify at least 3 physicians that will make 5 or more client referrals to the Prescription-REC Program and participate in the pilot to measure the Program’s effectiveness in reducing high blood pressure and high cholesterol among clients. 3. Advertise the Prescription –REC Program, targeting geographic areas and populations at greatest risk for high blood pressure and/or high cholesterol. 	<p>Physicians identified and making referrals</p> <p>Number of clients referred, enrolled, and completing the Prescription-REC Program</p> <p>Number, types, and locations of advertising venues/formats used to promote the Prescription-REC Program</p> <p>Improvements in selected client health indicators (i.e. BMI, weight reduction, BP, Hemoglobin A1c, blood glucose)</p> <p>Client satisfaction surveys</p>
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Prince George’s County Health Action Plan 2012: Action Plan for Priority 3

Implementation Period: January 1 – December 31, 2012
Name and Title of Person Completing Action Plan: Elliot Segal, Co-Chair; Evelyn Reed, Co-Chair
PGHAC Workgroup: Infant Mortality Workgroup (Priority 3)

Priority 3: Improve Reproductive Health Care and Birth Outcomes for Women in Prince George’s County, Particularly Among African American Women.		
County Outcome Objective	Current County Baseline Data	2014 County Goal
Reduce infant deaths	Overall rate - 10.4 (number of infant deaths/1,000 live births, VSA 2007- 2009) White/Non-Hispanic rate - 10.6 Black rate - 13.3 Hispanic rate - 4.6 Asian rate - 2.7	Overall rate - 8.2 using midpoint to HP 2020 White/Non-Hispanic rate - 10.1 using 5% decrease Black rate - 12.6 using 5% decrease Hispanic rate - 4.4 using 5% decrease Asian rate - 2.6 using 5% decrease By 2012 reduce to 9.6/1,000 By 2013 reduce to 9.0/1,000 By 2014 reduce to 8.2/1,000
Reduce low birth weights (LBW) and very low birth weights	Overall - 10.6% (percentage of births that are LBW, VSA 2007-2009) White/Non-Hispanic - 7.6% Black - 12.5% Hispanic - 7.5% Asian - 7.7%	Overall - 9.2% using midpoint to HP 2020 White - 7.2% using 5% decrease Black - 11.9% using 5% decrease Hispanic - 7.1% using 5% decrease Asian - 7.3% using 5% decrease
Increase the proportion of pregnant women who receive prenatal care beginning in the first trimester	Overall - 67% (percentage of births where mother received first trimester prenatal care, VSA 2007-2009) White/Non-Hispanic - 82.3%	Overall - 70.4 % using 5% increase White - 86.4% using 5% increase Black - 72.9% using 5% increase

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		Black - 69.4% Hispanic - 52.7% Asian - 66.6%		Hispanic - 55.3% using 5% increase Asian - 69.9% using 5% increase
Linking Women to Prenatal Care and Women’s Wellness Services				
Strategy (What?)	Responsible Agencies (Who?)	Target Date for Completion (When?)	Action Steps (How?)	Performance Indicators
<p>#1: Expand existing prenatal care and women’s health services to include screening and counseling for diabetes prevention and management (including gestational diabetes), weight management and nutrition counseling, substance abuse and smoking cessation services, referral to dental health services, mental health services and domestic violence prevention, and screenings and referrals for Medicaid.</p>	<p>MD Dept. of Health and Mental Hygiene – FIMR and SIDS data Fetal and Infant Mortality Review Team</p> <p>Greater Baden Medical Services (FQHC)</p> <p>Mary’s Center (FQHC)</p> <p>Community Clinic, Inc. (FQHC)</p> <p>Mobile Vans (Governor’s Wellmobile, Mary’s Center van, March of Dimes)</p> <p>Dimensions Healthcare System</p> <p>Doctor’s Community Hospital</p> <p>Southern Maryland Hospital</p> <p>Other hospitals serving County women</p>	<p>April 2012</p>	<p>1. Identify all areas with high infant mortality (i.e. 20785, 20743, 20706) at the level of neighborhood/zipcode.</p> <p>a. Use IPO/FIMR and SIDS death certificate data to identify addresses and race/ethnicity.</p> <p>b. Use addresses and zipcodes to identify neighborhoods for more specificity in determining target areas for outreach purposes (see Action Step #10).</p>	<p>Zipcodes and neighborhoods identified</p> <p>Addresses and racial/ethnic data identified</p> <p>Number of fetal and infant deaths by zipcode/neighborhood ascertained</p>
		<p>December 2012</p>	<p>2. Work with providers of prenatal, preconception, inter-conception, and women’s wellness services to inventory services currently provided (including family planning, patient navigator, and other services listed in the strategy statement) and to determine service gaps.</p> <p>3. Identify barriers that may prevent women from seeking early and continual access to care and potential solutions.</p> <p>4. Create referral mechanisms with new</p>	<p>Inventory of existing services completed; gaps in service identified</p> <p>Barriers identified</p> <p>Short-term solutions identified and implemented</p> <p>Long-term solutions identified</p> <p>Referral mechanisms in place</p>

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	<p>Pregnancy Aid Center</p> <p>Forestville Pregnancy Center</p> <p>Prince George’s County Medical Society</p> <p>Improved Pregnancy Outcome Committee</p> <p>Local FIMR Team</p> <p>Prince George’s County Department of Social Services</p> <p>TMAN (Treatment of Mothers of Addicted Newborns) Program</p> <p>Prince George’s County Health Department (Maternity and Family Planning, Children and Parents, Dental Health, Healthline, School Health, and Infants At Risk Programs)</p> <p>Prince George County Department of Family Services</p> <p>Healthy Families Prince George’s Program</p> <p>Prince George’s County Public Schools</p>	<p>December 2012</p> <p>March 2013</p>	<p>providers/partners and streamline the referral processes among existing providers/partner agencies to facilitate access to early and on-going care by pregnant women and women of childbearing age.</p> <p>5. Work with providers and partners to develop a plan to expand/improve existing services and add new services in future years.</p> <p>6. Work with partners to increase the proportion of women delivering a live birth who received preconception or inter-conception care services and practiced key CDC-recommended preconception and inter-conception health behaviors:</p> <p>a. Develop a form to be used by all county OB-GYN providers to collect needed information.</p> <p>b. Enlist all county OB/GYNs to use the new form to collect information regarding woman’s wellness or preconception/inter-conception health visits at the first prenatal care visit for all pregnant women.</p>	<p>Preliminary plan developed that identifies new services that need to be created, existing services that need to be expanded (i.e. increased number of appointment slots, increased number of service locations and hours, added bi-lingual capacity)</p> <p>Services that can be created or expanded/improved right away and without additional resources in place; number of women served</p> <p>Form developed and in use by providers; data tabulated and analyzed</p> <p>Number of women who deliver an infant at term and of normal birth weight and who have received woman’s wellness and preconception or interconception care services.</p>
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		December 2012	c. Expand wrap-around services to pregnant women such as housing, counseling, employment, assistance with domestic violence issues, that also reach women seeking care at private physician offices. Provide written information regarding these services at the time they renew their driver's license.	Types and numbers of wrap-around services provided; number of women who received these services Number of written materials distributed to women at Motor Vehicle Administration sites
		February 2013	9. Once a year, convene a symposium to educate public and private providers and community health centers on the importance of preconception/interconception care to establish wellness before pregnancy for improvement of pregnancy outcomes, to share information on best practices, strengthen collaborations, etc.	Symposium conducted; number of participants
		December 2014	10. Create a central data base for all pregnant women for the purposes of offering home visitation services and linking them and their families to a medical home and family planning services.	Number of pregnant women entered into data base. Number of pregnant women who received home visits and who were linked to a medical home and family planning
		Throughout 2012	11. Continue providing outreach on the part of all partners to at-risk pregnant women and women of childbearing age, particularly those who reside in zipcodes and neighborhoods identified in Action Step #1, to inform them of the importance of early and on-going prenatal,	Number, types, and locations of outreach activities undertaken by all agencies; number and types of materials distributed through outreach (including materials in Spanish and other languages)

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			preconception/inter-conception, and women's wellness services. Focus on using strategies, outlets, and materials that reach minorities, non-English-speaking, and low income uninsured and underinsured women.	
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Prince George’s County Health Action Plan 2012: Action Plan for Priority 4

Implementation Period: January 1 - December 31, 2012
Name and Title of Person Completing Action Plan: Reverend Tony Lee, Chair; Charlene Dukes
PGHAC Workgroup: HIV/STIs Workgroup (Priority 4)

Priority 4: Prevent and Control Infectious Disease in Prince George’s County, Particularly Among African Americans and Other Minorities.				
County Outcome Objective		Current County Baseline Data		2014 County Goal
Reduce new HIV infections among adults and adolescents		Overall rate - 56.4 (rate of new {incident} cases of HIV in persons age 13 and older per 100,000 population, IDEHA 2009) In progress for race specific data		Overall rate - 53.6 using 5% decrease
Reduce chlamydia trachomatis infections among young people		Overall rate - 631 (rate of chlamydia infections for all ages per 100,000 population, IDEHA 2009) White rate - 32.4 Black rate - 206.4 Hispanic rate - 74.8 Asian rate - Not Available (all ages)		Overall rate - 599.5 using 5% decrease White rate - 30.8 using 5% decrease Black rate - 196.1 using 5% decrease Hispanic rate - 71.1 using 5% decrease Asian rate - Not Available
Addressing HIV/AIDS				
Strategy (What?)	Responsible Agencies (Who?)	Target Date for Completion (When?)	Action Steps (How?)	Performance Indicators
#8: Expand outreach and prevention education efforts to include the use of innovative media and information	Prince George’s County Public Schools Prince George’s County Health Department Heart-to-Hand	December 2012	1. Identify target populations in zip codes identified by DHMH with increased incidence of Sexually Transmitted Infections. 2. Contact partnering agencies and identify new partners within target zip	Target populations identified New and existing partners identified; capacity to provide

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<p>technology methods such as online and social network services (i.e. Web sites, blogs, Facebook, Twitter, YouTube and Internet-Based Partner Services).</p>	<p>(community-based organization serving predominantly minority populations)</p> <p>Dimensions Healthcare System</p> <p>Prince George's County Department of Corrections</p> <p>University of Maryland (College Park) School of Public Health</p> <p>Bowie State University (HBCU - Historically Black University)</p> <p>Prince George's Community College</p> <p>Other academic institutions</p> <p>Faith-Based Organizations, particularly those serving minority and non-English speaking populations</p> <p>Apartment Management Companies, particularly those in target zip codes and serving low-income populations</p>		<p>codes defined above and assess their capacity to provide education and outreach (particularly to minority and non-English-speaking communities) to stem transmission rates.</p> <p>3. Institute capacity-building opportunities for responsible agencies.</p> <p>4. Develop and carry out coordinated outreach strategies with responsible agencies.</p> <p>5. Develop partnerships with academic institutions to develop and undertake new media projects and a social media campaign.</p>	<p>education and outreach, particularly to minority and non-English-speaking communities, assessed</p> <p>Number and types of capacity building activities undertaken; number of participants</p> <p>Number and types of outreach strategies implemented; number of individuals reached</p> <p>Partnerships established</p> <p>Media campaign implemented; number of individuals reached</p> <p>Percent increase over previous reporting period in number of visits to Be STD Free Website: BeSTDFree.com</p> <p>Number and types of online and social media outlets used; number of page views to internet sites</p> <p>Percent increase over previous reporting period in the number of contacts made by the Health Department's STD Program (via Internet Partner Services) with anonymous sex partners of HIV/STI positive individuals who they met on social media sites/internet; percent increase over previous reporting period in</p>
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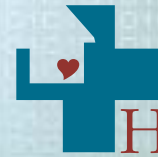
	<p>Sexually Transmitted Infections Community Coalition</p> <p>PGHAC members</p> <p>Local and regional radio, newspaper, and television media outlets, particularly those reaching minority and non-English-speaking audiences</p> <p>On-line social media outlets, particularly those reaching minority and non-English-speaking audiences</p>			<p>the number of these individuals who are tested for HIV/STIs.</p> <p>Percent increase over previous reporting period in the overall number of individuals tested for HIV</p> <p>Number of new testing sites established and percent increase over previous reporting period in the number of first-time tested.</p>
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Appendix VI: Blueprint for a Healthy Prince George's County, 2011 – 2014
<http://www.princegeorgescountymd.gov/Government/AgencyIndex/Health/improvement.asp>

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Rushern L. Baker, III
County Executive



**HEALTH
DEPARTMENT**
Prince George's County

Prince George's County Health Improvement Plan 2011 to 2014

Blueprint For A Healthier County

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Office of the Health Officer

Dear Fellow County Residents,

The arrival of 2012 marks an exciting time for Prince George's County. With the anticipated launching of nationwide health care reform in the near future and the elevation of health care as a priority under the leadership of County Executive Rushern L. Baker, III, we now have an unprecedented opportunity, unlike any time in the past, to make significant improvements in the health of all citizens and residents of our County.

To this end, I am pleased to announce the release of the Prince George's County Health Improvement Plan for 2012-2014 and beyond. This Plan provides a blueprint for creating new and innovative health programs, enhancing existing services, and making health systems changes at the local level that will help us to address our County's most pressing health concerns such as infant mortality, chronic conditions like diabetes and heart disease, HIV and other infectious diseases, access to care, substance abuse and domestic violence.

With support from our local hospitals, the public schools and other academic institutions, County agencies, the Maryland-National Capital Park and Planning Commission, and numerous other key health care providers and stakeholders, we are poised and ready to accept the challenge of transforming Prince George's County from one whose history of poor health outcomes overshadowed our many strengths to a County whose communities and residents serve as models for achieving health and well-being through partnerships, strategic planning, and effective resource management. In addition, our Plan includes strategies that are designed to help individuals adopt behaviors that lead to healthier lifestyles and greater quality of life for themselves, their families, and their neighbors.

As we embark on this new initiative, I invite you to join us in making Prince George's County one of the healthiest places in the world to live, work, and play. Health for all by the year 2020 need not be just a dream – together, and in collaboration with our many partners, we can make it happen!

Sincerely,

Pamela B. Creekmur
Acting Health Officer



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Rushern L. Baker, III
County Executive

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Introduction

At the heart of any community's success and prosperity is the health of its residents. When people have affordable health care, safe neighborhoods, a clean environment, and access to physical activity, recreation, nutritious foods, and other resources that contribute to a healthy lifestyle, they are more equipped to excel in school, thrive in the workforce, and fulfill their civic responsibilities.

This County Health Improvement Plan was prepared by the Prince George's County Health Department with the assistance of numerous stakeholders. These include the County Council serving as the Board of Health, the Maryland Department of Health and Mental Hygiene, existing community coalitions, and key stakeholders concerned about the health status and health needs of our County's population.

The Plan addresses our County's most pressing and immediate health needs as well as overarching concerns of the health stakeholder community as a whole. Collectively, the priorities, objectives, and strategies are ambitious and cover a broad array of health issues. Included are initiatives and programs specific to individual agencies as well as strategies that address policy and systems changes and that reflect social determinants of health. We also considered the key concepts that underscore the "Place Matters Initiative" launched by the Joint Center for Political and Economic Studies Health Policy Institute.

The County Health Improvement Plan has a ten-year timeframe (through 2020); however, the year 2014 was selected as the initial target year for reviewing most of our objectives for three reasons: 1) to be in alignment with the Maryland State Health Improvement Process (SHIP) target dates, 2) to allow us the opportunity to evaluate progress towards reaching our health objectives and make adjustments to the Plan at the halfway point towards meeting Healthy People 2020 goals and 3) to enable us to assess our priorities as they relate to planned health care reform for the nation.

Since no organization alone can perform all of the activities listed, the Plan relies extensively on existing partnerships and the forging of new alliances among many community groups and agencies. In addition, a robust and on-going search for funding and other resources will be required.

There is already tremendous enthusiasm, optimism and resolve among our key health stakeholders and local political leaders to make this Plan succeed in creating a healthier Prince George's County. While the work will be challenging, the benefits will be great.

Purpose of the County Health Improvement Plan

The County Health Improvement Plan for Prince George's County is a statement of policy and strategies which provide a planning framework for improving the health status of County residents.

The intent of the Plan is to promote a high level of communication among a diverse constituency involved in health-related activities and to serve as a central focal point for all health planning activities in the County.

In addition, it is intended to serve as a guide to decision makers for the effective allocation of health resources in that it contains specific priorities, health outcome objectives, and strategies that will be addressed over the next four to ten years.

Prince George's County—Who We Are

Prince George's County, Maryland, is located immediately north, east, and south of Washington, D.C and 18 miles south of the City of Baltimore. Our County has 485 square miles and 863,420 residents, which makes us the second most populous jurisdiction in the State of Maryland. Prince George's County has a number of unique characteristics which factored significantly into the development of our County Health Improvement Plan:

- **We are one of the most culturally diverse counties in Maryland.** Our residents include individuals from 149 countries who collectively speak 165 languages and dialects.
- **The majority of our residents are people of color.** Over 79% of the population are minorities - African Americans represent 65% of the total population followed by Hispanics/Latinos (15%), Asian-American/Pacific Islanders (4%), and Native American Indians (less than 1%). White Caucasians comprise 19% of the population.
- **Our County is comprised of a mix of urban, suburban, and rural communities.** However, the majority of our residents live inside the Capital Beltway adjacent to the District of Columbia.
- **The educational attainment of our population is comparable to that of the nation.** 85% percent of our population versus 84% for the U.S. as a whole have a high school degree or higher. U.S. Census Bureau figures for 2008 show that 27% of County residents over age 25 have a bachelor's degree or higher.
- **Our population is relatively affluent.** The U.S. Census Bureau Community Survey for 2010 shows that the median household income of County residents was \$69,545, considerably higher than the U.S. average of \$50,740. However, the County has a substantial number of low income "working poor" who reside primarily in densely populated communities located inside the Capital Beltway. Almost 10% of the County's children live in poverty.
- **Unlike neighboring jurisdictions, our County's ability to generate revenue to provide public services is severely restricted** because of a 1978 amendment to the County Charter called TRIM (Tax Reform Initiative by Marylanders) that places a cap on the collection of real property taxes. Our current assessable tax base, especially with regard to commercial properties, is insufficient to address all of the County's needs.

- **A large percent of our population is in the workforce, more than the national average.** 74% of our population ages 16 and over are gainfully employed versus 65% for the nation; however, this is lower than the Maryland average.
- **We have a significant number of uninsured County residents.** Estimates vary among data sources, ranging from 80,000 (RAND Report) to 150,000 uninsured, with possibly another 150,000 to 200,000 who are underinsured. The 2006 Small Area Health Insurance Estimate reveals that the County has the highest percentage and absolute number of uninsured persons in Maryland. The 2008 Behavioral Risk Factor Surveillance System self-reported data reveals that 19% of the County's population is uninsured (16% of African Americans versus 12% of White adults).
- **Despite our shortage of primary care physicians and inadequate primary care safety net,** our County has only one Medically Underserved Area (MUA) designation and only one federally qualified health center (FQHC) whose headquarters are located in the County.
- **The County-owned Prince George's Hospital Center operated by Dimensions Healthcare System provides a substantial amount of uncompensated care to our County's sizeable uninsured/underinsured population, and essentially serves as the primary safety net provider for the indigent.** This has contributed to serious financial challenges for the Hospital system, which is now in the process of being restructured. Dimensions also operates the Laurel Regional Hospital and the Bowie Health Center.
- **Other hospitals in the County provide a variety of premier services relevant to our health priorities.** Southern Maryland Hospital Center operates two women's health centers and recently opened a newly expanded Women and Newborns Center. Doctor's Community Hospital houses the Joslin Diabetes Center and the Center for Women's Wellness. Ft. Washington Medical Center is a small facility that provides a range of services and Malcolm Grow Medical Center serves the Andrews Air Force Base community.
- **Our County has an extensive array of park and recreation facilities operated by the Maryland-National Capital Park and Planning Commission (M-NCPPC)** that includes over 40 miles of trails, over 27,000 acres of park land, 43 community recreation centers, 10 aquatic facilities, and a state-of-the-art sports complex offering programs that promote healthy lifestyles.
- **Our County is home to the University of Maryland School of Public Health (UMDSPH), Bowie State University School of Nursing, and Prince George's Community College Center for Health Studies and Academy of Health Sciences,** and is in close proximity to other academic and medical institutions that can lend resources to address our health needs.

Assessing Our Health Needs

To determine our County's priority health needs, we reviewed data from a variety of sources and sought input from local political and community leaders, key health care stakeholders, and County residents. This included:

- **A review of County-specific statistics** from the Maryland Department of Health and Mental Hygiene Vital Statistics Administration (DHMH VSA) reports, Behavioral Risk Factor Surveillance System (BRFSS) data, U.S. Census Bureau information, and other commonly used data sources.
- **A review of the 2009 RAND Report**, a comprehensive study sponsored by the Prince George's County Council, of the health needs of County residents and the capacity of the County's health care system to respond. The RAND Report concluded that...

"The County's capacity to provide safety-net care beyond hospital and emergency care appears severely limited"... and that ... "strengthening the Prince George's ambulatory care safety net is an urgent concern".

Key findings of the RAND Report are presented in this Plan; however, a more comprehensive and detailed presentation of the health data and study conclusions by the RAND researchers can be viewed in the RAND report entitled "Assessing Health and Health Care in Prince George's County" located on the Prince George's County Government's Web site at:

<http://www.princegeorgescountymd.gov/pgcha/PDFS/rand-assessing-health-care.pdf>

- **A review of the "Baker 2010 Transition Team Transition Report, March 11, 2011"**. A Transition team was assembled by County Executive Rushern Baker to study the workings of all County Government agencies in order to seek ways to streamline operations and improve service delivery. Among the various subcommittees' recommendations were the following: making improvements to the County's health information technology infrastructure, establishing a health care system that is more patient-centered and community-based, and making improvements in the Prince George's County Health Department's (PGCHD) leadership and organizational structure. The full report is available at:

<http://www.princegeorgescountymd.gov/Government/ExecutiveBranch/PDF/Baker2010TransitionTeamTransitionReport.pdf>

- **Summary information from nine "town hall" style forums** held by the Prince George's County Health Officer in July and August of 2009. In open discussions and

small groups, over 200 participants expressed the need for safer neighborhoods, clean water, healthier food choices in their communities, more open spaces and walking/bike trails to promote physical activity, and greater access to health information, screenings, and primary health care, especially for the uninsured.

- **A consensus report from a meeting of major State and local health officials and health care stakeholders, political and community leaders, health experts and community advocates** in December 2010, sponsored by the Prince George's County Executive. Using the findings of the RAND Report and the Washington AIDS Partnership Profiles Report as a backdrop, the participants concluded that there is a need for further dialogue and action leading to the establishment of a more comprehensive, inter-connected and community-oriented system of health care for Prince George's County. The strategies included in the "County-Specific Health Priorities" section of this health plan reflect the findings and recommendations of this group, which are published in a report entitled "Conversation on Building an Integrated Community-oriented Healthcare System in Prince George's County, Executive Summary, Prince George's Community College, December 14, 2010".
- **Input from meetings with the Prince George's County Council/Board of Health** between May and September 2011 that included a presentation by the Maryland Secretary of Health on the State Health Improvement Process (SHIP). Access to care, reducing infant mortality, decreasing the burden of HIV, and meeting the health needs of County women were specifically named as areas of greatest concern. In addition, the County Health Improvement Plan was presented between October-December 2011 at separate **meetings with the County Executive and his staff as well as the Directors of the County Government's Health and Human Services agencies** for additional input and feedback.
- **Results of a survey of 126 County residents attending an annual "Holiday Food and Fitness Expo"** in November 2009, sponsored by Prince George's County Health Department (PGCHD), Maryland-National Capital Park and Planning Commission (M-NCPPC), and Prince George's County Public Schools (PGCPC). Top health concerns identified by respondents included healthy eating, low cost health care, diabetes, high cholesterol, exercise, asthma, and overweight/obesity.
- **Input from key County coalitions and community groups** at a meeting held on September 9, 2011, sponsored by the Maryland Department of Health and Mental Hygiene (DHMH) and PGCHD. This meeting produced a substantial number of the strategies listed in this Plan and helped to solidify critical partnerships among agencies, providers, and community groups. Participants included:

- **Community Health Transformation Coalition and Leadership Team**, assembled in June 2011 to apply for a Centers for Disease Control (CDC) and Prevention Community Transformation Grant.
 - **Health Action Forum**, a community advocacy group that promotes health systems changes to improve access to care.
 - **Health Disparities Coalition**, originally assembled as a Tobacco Coalition when Cigarette Restitution grant funds were first awarded to the County.
 - **Improved Pregnancy Outcome Coalition (IPOC)**, established in 2008 as part of a Minority Infant Mortality Reduction Project.
 - **Minority Outreach and Technical Assistance (MOTA) Group** at Bowie State University, formed when the Cigarette Restitution Funds were first awarded to the County and dedicated to meeting the needs of minority populations.
 - **Port Towns Community Health Partnership**, formed as part of a new initiative funded by Kaiser Permanente to improve the health of residents living in four historic port communities in the County.
 - **Sexually Transmitted Infections Community Coalition (STICC of Metropolitan Washington, DC)**, a partnership of over thirty public and private stakeholders with a common interest to reduce the impact of HIV and other sexually transmitted infections (STIs) in the community.
- **Comments from participants at a symposium entitled “Health √ (Check), The Prognosis for Prince George’s County”**, held at Prince George’s Community College on October 1, 2011 and sponsored by the National Harbor Chapter of Jack and Jill of America, Inc., Prince George’s County Council Chair Ingrid M. Turner, and M-NCPPC Parks and Recreation. Over 100 people attended the symposium, where a draft of the County Health Improvement Plan was presented for public comment.
 - **Feedback from the public** during the period when this Plan was posted on PGCHD Web site in October and November 2011.

The Health of Our Population and Health Care System—Where We Stand

A review of available County-specific health statistics shows that Prince George's County faces many challenges across a broad spectrum of health issues. Two significant themes are evident from the data analysis: disparities between minority and non-minority populations for many health conditions, and huge challenges related to access to care.

Key RAND REPORT Findings

Demographic

- Prince George's County is relatively affluent and highly diverse. The County has a large number of upper income Black residents and, compared to neighboring jurisdictions, the largest proportion of Hispanic and non-English speaking residents (second to Montgomery County).
- Many County residents commute outside the County (three in five work outside the County and one in five commutes more than 60 minutes to work). Compared to neighboring jurisdictions, County residents are least likely to live and work in the same county and most likely to work outside the state.
- In 2006, Prince George's County had a higher unemployment rate than any other neighboring jurisdiction except the District of Columbia.
- Among the County's seven Public Use Microdata Areas, communities varied widely for a number of socio-demographic characteristics; however, communities inside the Capital Beltway are more likely to be majority Black or Hispanic and lower income.

Health

- Compared to residents of the State and neighboring jurisdictions (except Baltimore City), Prince George's County residents were more likely to die from all reported causes of death combined, from five of the ten leading causes of death (heart disease, diabetes, accidents, septicemia, and kidney diseases), and from homicides and HIV/AIDS.
- County residents were significantly more likely to report that a health care provider told them they had a chronic condition than residents of Howard and Montgomery Counties and Maryland State.
- County residents were more likely to be overweight or obese than those in the District, Maryland State, and Baltimore, Montgomery and Howard Counties.

- Site specific (i.e. pancreas, ovaries, lungs) mortality rates from cancer are relatively high for Blacks in the County, while incidence rates are relatively low. This may indicate possible poor screening and detection rates for, and poor quality treatment of, identified cancers for Blacks as compared to Whites.
- The County has relatively high rates of asthma, obesity, HIV/AIDS, and homicide.
- Compared to surrounding jurisdictions, Prince George's County and the District of Columbia had the highest rates of infant mortality and low birth weight babies between the years 2000-2005.

Health Behaviors

- Compared to residents of neighboring jurisdictions, Prince George's County residents are less likely to drink heavily, less likely to exercise, more likely to smoke, and more likely to be overweight or obese. Within the County, however, those who are poor and less educated are more likely to drink heavily, smoke, not exercise, and not use seatbelts.
- In general, residents with more than a high school education reported more favorable health status on every measure except hypertension and overweight/obesity.
- Black County residents are less likely than Whites to report being vaccinated against flu and pneumonia, but more likely to report being tested for HIV, having received a mammogram within the last two years, and having had a cholesterol test within the past five years.
- Uninsured County residents use preventive care at sharply lower rates than insured residents.

Capacity and Access to Care

- An estimated 80,000 Prince George's County adult residents are uninsured, more than twice that of neighboring Howard County and approximately one-third more than in Montgomery County.
- Residents who lack health insurance are more likely than those with insurance to have no regular source of care, to miss care because of cost, and to have gone more than five years since their last dental exam (especially among Blacks).
- There is a shortage of primary care physicians (PCPs) in the County. Relatively few pediatricians practice in poor areas of the County, and adult PCPs and specialists are

concentrated in more affluent areas of the County located outside the Capital Beltway and near hospitals.

- Prince George's County appears to have an adequate hospital capacity relative to population growth; however, the County has a lower per capita supply of medical/surgical, obstetric, pediatric, and psychiatric beds as well as a lower per capita supply of emergency department (ED) treatment slots as compared to other jurisdictions.
- County residents use ED capacity more intensively than residents of other jurisdictions.
- The County lacks an adequate and comprehensive primary care safety net. Only one federally qualified health center (Greater Baden Medical Services) is headquartered in the County.

Patterns of Hospital and Emergency Department Use

- The County has higher rates of ambulatory care-sensitive hospitalizations and ED visits than surrounding jurisdictions.
- Prince George's County residents are more likely to leave the County for hospital and emergency care than are residents of Montgomery County and the District of Columbia.
- Prince George's Hospital Center discharges a disproportionate share of Medicaid patients, suggesting that it serves as a de facto safety net provider.

Other Pertinent Health Statistics (Highlights)*

- **Overall Health Ranking and Health Disparities:** Data from the County Health Rankings Report ranks Prince George's County 17 out of 24 among Maryland counties (24 being the lowest score). The 2010 report gives the County an overall comparative poor health ranking for the following:
 - death rates before the age of 75
 - the percentage of people who reported being in fair or poor health
 - the number of days people reported being in poor physical health
 - smoking, obesity, and binge drinking
 - receipt of clinical care
 - violent crime and liquor store density
 - unemployment rates and the number of children living in poverty
 - air pollution levels and access to healthy foods.

According to the *Maryland Department of Health and Mental Hygiene (DHMH) Vital Statistics Administration (VSA) Report*, the leading causes of death in 2009 for Prince George's County included:

Cause of Death	Ranking (Leading Causes of Death)
Diseases of the Heart	1 st
Malignant Neoplasms	2 nd
Cerebrovascular Diseases	3 rd
Diabetes Mellitus	4 th
Accidents	5 th
Assaults (Homicides)	8 th
Influenza and Pneumonia	11 th
HIV	12 th
Essential Primary Hypertension and Hypertensive Renal Disease	15 th

The *2009 Maryland Chartbook of Minority Health and Minority Health Disparities* combined 2002-2006 data showed that Blacks or African Americans in Prince George's County had higher mortality rates than Whites for all-cause mortality and for six of the top eight causes of death (exceptions were chronic lung disease and liver disease). The mortality ratio disparity was greatest for HIV and kidney disease where Blacks or African Americans had 4.3 times the HIV death rate and 2.4 times the kidney disease death rate of Whites.

- **Chronic Diseases and Related Conditions:**

Overweight/Obesity: The percentage of overweight or obese County residents is among the highest in the State of Maryland and nation and has steadily increased since 1995 for both adults and children. From 1995-2007, the number of County residents that were obese increased by 13%. Prince George's County and one other county had the highest obesity rates in the state (69%) in 2007, and *Behavioral Risk Factor Surveillance System (BRFSS)* data for 2010 shows this to have slightly increased to 70%. Among children up to age 18, 48% are at risk for obesity and are currently overweight. African Americans are disproportionately affected by obesity. The 2008 BRFSS data shows that 76% of Africans Americans were either overweight or obese, as compared to 62% of Whites.

Diabetes: According to the *Maryland VSA Reports*, 12% of County residents are diabetic. Significant disparities exist in the County regarding death rates due to diabetes. The age-adjusted death rate for diabetes in County African Americans is 47.1 per 100,000 versus 21.9 per 100,000 for Whites. This is significantly higher

than the Maryland age-adjusted diabetes death rates of 34.3 per 100,000 for African Americans and 21.7 per 100,000 for Whites. The 2009 Vital Statistics report indicates that Prince George's County had the highest number of diabetes deaths in the State (197), followed by Baltimore City (196) and Baltimore County (192).

According to the *2009 Maryland Pregnancy Risk Assessment Monitoring System Report*, 10% of women self-reported that diabetes was a complication during pregnancy. Within the Prince George's County Health Department maternity clinics, in 2010, 100 clients (17%) were diagnosed with gestational diabetes. Women who have had gestational diabetes have a 35 to 60 percent chance of developing diabetes in the next 10 to 20 years, and 5 to 10% of women with gestational diabetes are found to have Type 2 diabetes immediately after pregnancy.

Cardiovascular Disease and Related Risk Factors: Cardiovascular disease is the leading cause of death in Prince George's County and a key contributor to the County's racial gap in life expectancy. Twenty-eight percent of County residents have cardiovascular disease. According to DHMH's Vital Statistics Administration and Family Health Administration, the County's 2008 age-adjusted death rate from heart disease was disproportionately higher than the Maryland rate (280.4 versus 252.8 per 100,000). For African Americans, the age-adjusted death rate was 338.4 per 100,000 compared to 228.7 per 100,000 for Whites.

A comparison of BRFSS data from 2009 and 2010 shows that rates for selected chronic disease risk factors had an increasing trend in the County:

Risk Factor	2009	2010
Ever told you had a stroke?	1.2%	1.6%
Ever told you had diabetes?	10.9%	11.9%
Did not meet the Healthy People 2010 objective for moderate or vigorous physical activity.	56.5%	62.0%

Cancer: Malignant neoplasms (cancers) are the second leading cause of death among County residents. The County's 2008 age-adjusted mortality rate for all malignant neoplasms was 175.9/100,000 population, with disparities again appearing among African Americans. Their age-adjusted mortality rate was 202.2/100,000 compared to 151.6 deaths/100,000 for non-Hispanic Whites. African American women also have higher breast cancer mortality than White women – 38.3 deaths/100,000 versus 17.3/100,000. The prostate cancer death rate for African American men was higher (43.2/100,000) than that for White men (23.7/100,000). Disparities also exist for African Americans with regard to colorectal cancer, pancreatic cancer, and liver and biliary cancer.

The 2010 BRFSS survey shows that 22.7% of County residents ages 50+ have not had a sigmoidoscopy or colonoscopy, 25% of males ages 50+ have not had a Prostate Specific Antigen (PSA) test or digital rectal exam, 49.8% of people have never use sunscreen lotion with sun protection factor (SPF) 15 or higher when outdoors, and 15.4% of women ages 40+ have not had a mammogram or breast exam.

Tobacco Use: In Prince George's County, 12% of youth ages 18 and younger smoke, as do 16% of adults ages 19 and older according to the 2010 County Health Rankings Report. The percentage of African Americans in the County who currently report smoking cigarettes daily is 4% compared to 16% of Whites.

Asthma: The *September 2009 DHMH Asthma Profile* indicates that between the years 2004-2006, approximately 15% of County adults had been diagnosed with asthma and approximately 8% reported currently having asthma. In 2006, over 6,000 asthma-related ED visits and over 1,300 hospitalizations occurred among County residents. The asthma ED visit rate was four times higher among Black residents than among White residents and the hospitalization rate was approximately three times higher among Blacks than Whites.

- **Infant Mortality:** The current infant mortality rates for the County demonstrate that racial disparities still exist. The 2009 infant mortality rate for Blacks in the County was 11.1 per 1,000 live births, twice that for Whites (6.0) and Hispanics (6.0). Of note, the Hispanic infant mortality rate of 6.0 increased from 3.3 in year 2008. The County's overall infant mortality rate significantly declined between 2000-2004 and 2005-2009, and the infant mortality rate for Blacks significantly declined between 2008-2009; however, the infant mortality rate for Blacks has remained consistently higher than for Whites for a number of years.
- **Low Birth Weights:** Between the years 2000-2005, Blacks had the highest percentage of low birth weight babies in the County. In 2009, Blacks continued to have more low birth weight infants as compared to Whites and Hispanics: 8.0% for non-Hispanic Whites, 12.3% for Blacks, and 7.3% for Hispanics.
- **Late or No Prenatal Care:** In 2009 Prince George's County had the highest percent in Maryland of women of all ethnic backgrounds who received late or no prenatal care, and again, the data shows disparities: 7.7% of non-Hispanic Whites, 11.2% of Blacks, and 11.7% of Hispanics.
- **Substance Abuse:** It is estimated that 8% of the County's population has a chronic alcohol or other drug use problem. The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that roughly 7% of County residents used an illicit drug in the past month. Year 2009 BRFSS data indicates that over 45% of residents used alcohol within the past 30 days, with 6% reporting binge

drinking. Among youth, substance abuse is a cause for concern. The Center for Substance Abuse Research (CESAR) 2008 data shows that 3.5% of County crashes and 5% of County fatal crashes involved alcohol or drug impaired drivers ages 16-20, and over 12% of youth ages 12-20 reported binge drinking in the past month. Between July 2008 and June 2009, over 3,700 County residents were enrolled in substance abuse treatment.

- **Domestic Violence:** In 2009, 1,073 domestic violence cases were reported in Prince George's County, the fifth highest number among all Maryland counties. While the number of domestic violence related deaths in the County have steadily declined every year since July 2006, between July 1, 2007-June 30, 2010, 21 individuals died as a result of domestic violence. In a four year period of time, the Domestic Violence Advocate Unit at the Prince George's County Sheriff's Department saw a significant increase in the number of domestic violence victims referred to them for services, from 274 in 2007 to 3,675 in 2010.
- **HIV/AIDS:** According to data from the Infectious Diseases Environmental Health Administration (IDEHA) of DHMH, Prince George's County Maryland is ranked second in the State for the number of AIDS and HIV cases. As of December 31, 2009, there were 5,463 total living HIV and AIDS cases in the County. The County's 2008 HIV prevalence rate was 666 per 100,000 as compared to compared to 515 per 100,000 for the State of Maryland. At the end of 2009, Prince George's County accounted for approximately 65% of all AIDS cases in Suburban Maryland.

African Americans and other minorities in Prince George's County are disproportionately affected by HIV infection. Data through December 31, 2009 indicates that African Americans account for almost 88% of total living HIV cases, Hispanics account for 4.7% of total living HIV cases, and Whites represent 6.6% of total living HIV cases. The majority of the HIV cases occur in communities (zip codes) adjacent to the District of Columbia inside the Capital Beltway.

- **Other Sexually Transmitted Infections (STIs):** IDEHA data shows that in 2010, Prince George's consistently reported the highest number of cases in Maryland (excluding Baltimore City) of chlamydia, gonorrhea, and primary and secondary syphilis. Rates for these diseases were reportedly almost twice that of rates for the State of Maryland. Chlamydia and gonorrhea cases in the County were highest for those in age group 15-19 in 2008 (DHMH). This data has implications for HIV prevention based on the fact that persons infected with an STI are up to five (5) times more likely to get infected with HIV, if exposed. Conversely, those infected with HIV can transmit HIV more easily when having an STI.
- **Tuberculosis (TB):** According to the *2009 Maryland VSA Report*, there were 7 deaths in the State due to tuberculosis, 3 of whom were among Prince George's County residents. In 2010, Prince George's County was second in the state of

Maryland for TB Cases behind Montgomery County. Seventy-two percent (72%) of TB cases in Prince George's County occur in foreign-born clients. The TB Control Program exceeds the State of Maryland TB control objective of providing Directly Observed Therapy (DOT) services to at least 90% of TB cases.

- **Immunizations and Seasonal Flu Shots:** From 2007 to 2009, Prince George's County's vaccine coverage estimates among children 19-35 months of age were generally higher than those for the rest of the State of Maryland and Baltimore City in the National Immunization Survey. The County's vaccine coverage rates also increased in the most recent survey of the last two years, with over 95% of children ages 19-35 months being protected against diphtheria, tetanus, pertussis, haemophilus influenzae, hepatitis B, varicella and pneumococcal diseases. Prince George's County Health Department (PGCHD) Immunization Clinics serve approximately 5,000 children each year.

Reliable PGCHD data on the administration of seasonal/H1N1 flu shots is not available due to problems with establishing an electronic data base in the 2009-2010 County-wide flu campaigns and subsequent loss of some data; however, the BRFSS data for 2009 shows that only 33.5% of County residents stated they had received a flu shot in the past year. This number only slightly improved in 2010 to 36.6%. Neighboring counties and the State of Maryland had markedly higher percents of their populations stating they had received a flu shot in the 2010 BRFSS survey - Montgomery County (48.6%), Howard County (47.7%), Anne Arundel County (43.3%) and the State of Maryland (43.0%). In sampling 58 out of 200 schools and 3 public clinics where flu shots were administered in Prince George's County during the 2009-2010 campaign, (a total of 1533 vaccinations given), the demographic data showed that 42.5% of vaccinations given were to African Americans, followed by 35% to Hispanics, 11% to Whites, 4% to Asians, and 1.6% to Native Americans in the County.

- **Motor Vehicle Accidents, Assaults (Homicides), and Intentional Self-Harm (Suicides):** The *2009 Maryland VSA Report* shows that Prince George's County had the highest number of deaths due to motor vehicle accidents in the State (94) and the second highest number of deaths (behind Baltimore City) due to homicides (99). Thirteen deaths by accident were among adolescents ages 10-19, ten of whom were Black adolescents and three were White. Twelve of the homicides were among adolescents ages 10-19, and ten of these deaths were among Black adolescents. The County also had the third highest number of suicides (57), after Baltimore County (88) and Montgomery County (66). Of the deaths by intentional self-harm, 2 were among adolescents ages 10-19, and both were White. Between 2000-2004, 374 young people committed suicide in Maryland, 51 of whom were Prince George's County residents (approximately 6/100,000).

- **Fall-Related Injuries and Drownings:** According to the 2008 statistical report on injuries in Maryland, Prince George's County ranked 3rd in the State for the number of injury-related emergency department visits (over 60,000), of which 12,501 were fall-related, and 5th in the State for the number of hospitalizations (1,728 fall-related). There were 55 fall-related deaths in 2008, 51 of which were among individuals ages 45 and over. According to the 2010 BRFSS Survey, 5.4% of County residents ages 45 and over fell once, and 2.1% fell twice in the past three months; of these falls, 27% of respondents said one fall caused an injury and 1.1% said two falls caused an injury. There were 14 drownings in 2008, four among individuals ages 0-24 and ten among individuals ages 35 and over.
- **Alzheimer's Disease:** According to the Maryland VSA 2007-2009 data, the County's age-adjusted death rate due to Alzheimer's disease was 19.2/100,000 population, higher than the State's death rate of 16.9/100,000, and 6th highest in the State. In 2009, there were 87 deaths due to Alzheimer's disease.
- **Dental Health:** 2010 BRFSS Survey data shows that 14.1% of County residents went two years or more since last visiting a dentist for any reason. Over 65% of County residents indicated they had never had a test or exam for oral cancer or mouth cancer and over 14% of County residents went two years or more since their last teeth cleaning.
- **Access to Care – Health Care Resources:** Only one federally qualified health center (FQHC), Greater Baden Medical Services (GBMS), has its headquarters in the County. It provides comprehensive primary care medical services at five locations. One of these sites, Suitland Health and Wellness Center, represents a partnership between PGCHD and GBMS. In 2007, GBMS provided care to approximately 5,200 uninsured patients.

In recent years, Community Clinics, Inc. (CCI), a federally qualified health center based in Montgomery County, established a Women, Infants, and Children (WIC) distribution center and a family planning clinic at its Greenbelt location in Prince George's County. In addition, Mary's Center, Unity Health Clinics, and several non-FQHC safety net clinics located in neighboring jurisdictions provide care to County residents. However, these clinics combined can provide care to only a fraction of the County's uninsured. Access to care is further exacerbated by the growing number of County private physicians unwilling to accept Medicaid/Medicare patients.

Prince George's County is not a Health Profession Shortage Area, although small portions of the County are federally designated as medically underserved areas or underserved populations. When comparing Prince George's County's health resources to those of neighboring jurisdictions, the differences are remarkable:

Jurisdiction	Number of Uninsured Under Age 65*	Number of Safety Net Clinics	Number of Primary Care Physicians per 100,000 Population (2010)**
Prince George's County	149,038	5	95
Montgomery County	123,741	11	217
Baltimore City	77,570	44 ***	191
Washington, D.C.	61,680	38 - 40	241.6****

* Small Area Health Insurance Estimates for Counties, 2007

** County Health Rankings Report, 2010

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

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

- Individuals with Special Needs:** A substantial number of Prince George's County residents are individuals with special health needs. This includes individuals with intellectual and developmental disabilities (i.e. autism, cerebral palsy, Down Syndrome), individuals who develop or acquire disabilities after the age of 21 (i.e. multiple sclerosis, traumatic brain injury), individuals with mental illnesses, veterans with health conditions acquired as a result of their service in Iraq, Afghanistan, the Persian Gulf War and other wars/conflicts), blind/visually impaired individuals, deaf/hearing impaired individuals, and the homeless.

Currently there are approximately 1,850 Prince George's County residents with intellectual and developmental disabilities who are receiving State funded services from the Developmental Disabilities Administration (DDA). As of October 2011, there were 1,104 individuals on the waiting list for services from DDA. In fiscal year 2010, 835 families in Prince George's County applied for services from the Low Intensity Support Services Program, which provides up to \$3,000 during a fiscal year to assist families with smaller needs; between these two programs, Prince George's County was able to serve 522 individuals and families.

In fiscal year 2011, PGCHD's Infants and Toddlers Program served 1656 children ages 0-4 with developmental disabilities, and the PGCPs' September 30, 2010 enrollment data indicated that 14,381 students, or 11.4% of the student population, were children with disabilities (Maryland State Department of Education [MSDE], Maryland Special Education/Early Intervention Services Census Data and Related Tables, October 29, 2010). In school year 2009-10, there were 1,192 placements of students with disabilities in non-public school settings.

The number of County residents with mental illnesses and the number of homeless individuals in Prince George's County are both difficult to quantify. However,

according to the SAMHSA 2008-2009 data, 16.71% of Marylanders ages 18+ reported a diagnosed mental illness in the past year; this translates to 144,277 Prince George's County residents with mental illnesses. The Prince George's County Department of Family Services (PGCDFS) Mental Health and Disabilities Administration reported that 10,792 individuals in Prince George's County were served in the Public Mental Health System in fiscal year 2011.

A "Point-in-Time" survey (one-day street count) of sheltered and unsheltered homeless individuals and families completed in partnership with the Council of Governments and eight other counties and cities in the Washington Metropolitan area indicated that in fiscal year 2011, 773 individuals in the County were homeless. Data from the Canadian Post-M.D. Education Registry shows that in fiscal year 2011, 6008 individuals and families in Prince George's County requested shelter assistance, and 1932 received shelter. The County currently funds three emergency shelters and one hypothermia overnight shelter for homeless people.

According to the Columbia Lighthouse for the Blind and Visually Impaired, there are approximately 11,000 County residents who are blind or visually impaired. This data reflects the number of individuals with self-declared eye issues related to all the leading causes of blindness and visual impairment. The National Institutes of Health and Johns Hopkins University estimate that between one in five and one in seven individuals in the U.S. are deaf or hearing impaired; these estimates translate to 123,346-172,684 deaf or hearing impaired Prince George's County residents.

According to the *U.S. Census Bureau State and County QuickFacts* for 2005-2009, there were 66,256 veterans residing in Prince George's County. The number of these veterans with special health care needs related to their service is unknown; however, the physical, mental, and emotional injuries and disabilities among veterans, particularly those who served in the Vietnam and Persian Gulf wars, Iraq, and Afghanistan, are well documented. Homelessness among veterans is also a problem; in fiscal year 2011, the County served 82 homeless veterans.

- Additional County-specific health data can be found at the DHMH Web site (see State Health Improvement Process [SHIP]) at:

<http://dhmh.maryland.gov/ship/measures.html> .

Plan Development, Monitoring, and Evaluation

Selection of the Priorities, Objectives, and Strategies included in this Plan took into consideration:

- PGCHD's federal, state, and local mandates for provision of services and programs and its available resources (funding and personnel) to implement strategies.
- The capacity of existing and potential community partners to share responsibility for meeting our health objectives
- The commitment of local political leaders (i.e. Board of Health) to monitor progress towards meeting our objectives and to consider health implications when making policy decisions and adopting legislation.
- Evidence-based best practices that address our objectives.
- National and statewide public health strategies for reducing HIV infection.

The first six Priorities with their corresponding Objectives and Strategies are in alignment with the Maryland State SHIP Vision Areas 1-6; however, we have re-arranged the Priorities in descending order according to the extent to which the health concerns they address impact the broader community, demonstrate major disparities, and/or pose longstanding, complex challenges to their prevention and control in our County. The "County-Specific Health Priorities" address broader issues related to health care infrastructure, workforce, and systems issues of particular concern to County stakeholders. In no way do the Strategy statements reflect the totality of work that the Health Department and stakeholders listed in this Plan perform; rather, they represent substantive efforts, collaborative arrangements, and new approaches. It is important to note that for a number of Strategies to be implemented, a considerable infusion of new funding will be required, as well as the establishment of new and non-traditional partnerships.

To ensure that the County Health Improvement Plan is implemented and evaluated in terms of progress towards meeting the Plan's Health Objectives, the Health Department will establish a Prince George's Healthcare Action Coalition (PGHAC) lead by the Health Officer and comprised of critical stakeholders and consumers representing all major segments of the health care delivery system. Existing coalitions will be invited to serve as adjunct members of the PGHAC, lending their "content expertise" as it relates to each Priority.

The purpose of the PGHAC will be to assist the Health Officer as follows:

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- developing an action plan for carrying out and evaluating the County Health Improvement Plan that includes a timeline, responsible agencies/individuals, and success measures
- developing a framework (methods, materials, and timeframe) for gathering pertinent data from each partner involved in implementing the Plan's strategies, for evaluation and reporting purposes
- monitoring all activities related to the County Health Improvement Plan to ensure that all aspects of the Plan are carried out in a coordinated fashion among the responsible agencies and individuals
- maintaining communications among partner agencies, adjunct coalitions, and individuals regarding all matters related to the County Health Improvement Plan and the local health planning process
- identifying when new partnerships are needed to carry out the Plan and assisting in establishing those partnerships
- advising the Health Officer when barriers to the Plan's implementation and evaluation arise and resolutions are needed, or when new health issues emerge that may impact the Plan.
- preparing information for the media, local political and community leaders, researchers, and the public regarding progress made towards improving the health status of the County
- coordinating public meetings or forums when needed to obtain input from County residents and health care consumers into the Plan and the health planning process
- coordinating the adoption of health information technology among all partners to enhance provider communication and improve the delivery of care to County residents.

Priority 1: Ensure that Prince George’s County Residents Receive the Health Care They Need, Particularly Low Income, Uninsured/Underinsured Adults and Children.

(Corresponds with SHIP Vision Area 6: Ensure that Marylanders Receive the Health Care They Need)

County Outcome Objective	Current Baseline	2014 Target
Increase life expectancy in Prince George’s County	77.5 years (life expectancy at birth, VSA 2009)	81.4 years using 5% increase
Increase the proportion of persons with health insurance	82.2% (percentage of civilian non-institutionalized ages 18-64 with any type of health insurance, BRFSS 2008-2010)	91.1% using midpoint to Healthy People (HP) 2020
Reduce the proportion of individuals who are unable to obtain, or delay obtaining, necessary medical care, dental care, or prescription medications	15.8% (percentage of people who reported that there was a time in the past 12 months when they could not afford to see a doctor, BRFSS 2008-2010)	15% using 5% decrease
Increase the proportion of low income children and adolescents who receive dental care	57.8% (percentage of low income children ages 4-20 enrolled in Medicaid that received a dental service in the past year, Medicaid Calendar Year 2009)	60.7% using 5% increase
Increase the percentage of adults who visited a dentist within the past year	70.7% (percentage who visited a dentist for any reason in the past year, BRFSS 2010)	74.2% using 5% increase
Reduce the proportion of preventable hospitalizations related to Alzheimer’s disease and other dementias	11.5 (rate of hospital admissions [inpatient + outpatient] related to dementia/Alzheimer’s per 100,000 population, Health Services Cost Review Commission [HSCRC] 2010)	10.9 - rate using 5% decrease

Note: A number of these strategies also address Priority 3.

Increasing Enrollment of Adults and Children in Medicaid, HealthChoice/Maryland Children’s Health Program (MCHP), and Other Health Programs

Strategy 1: Improve the timely processing of HealthChoice/MCHP applications for pregnant women and children, enhance customer service to clients at the PGCHD's Regional Access Center, and continue to follow up on incomplete applications.

Strategy 2: Establish quick screening and prequalification processes that expedite eligible clients' enrollment in HealthChoice/MCHP and other government-sponsored health programs.

Strategy 3: Educate the public and providers about the eligibility requirements for the HealthChoice/MCHP, Medicaid Families and Children, Primary Adult Care, and Maryland Family Planning Programs, using methods and venues that target hard-to-reach women and children.

Strategy 4: Continue collaboration among the PGCHD's MCHP Program and other programs serving women and children (Healthy Start, Health//ine, Healthy Women/Healthy Lives, etc.) to identify potentially eligible clients and streamline their entry into HealthChoice/MCHP.

Strategy 5: Maintain communications between the PGCHD's MCHP Eligibility unit and the Prince George's County Department of Social Services (PGCDSS) to ensure that pregnant women and children receive a timely determination of eligibility.

Strategy 6: Place Medical Assistance eligibility/enrollment workers at strategic clinic sites (i.e. FQHCs).

Strategy 7: Increase awareness among the public and agencies serving children about the Kaiser Care for Kids Program that serves children ages 0-18 who are ineligible for MCHP; focus on reaching the Spanish-speaking community and families with undocumented children.

Strategy 8: Identify funding to adequately staff the Kaiser Bridge Program, and increase public awareness of the Program through widespread dissemination of informational materials and expansion of outreach efforts into non-traditional settings (i.e. unemployment offices, churches, non-profit organizations) where potentially eligible and hard-to-reach individuals seek services.

Increasing Linkage to Care

Strategy 1: Continue widespread dissemination of informational materials promoting the Health//ine Program that links pregnant women and children into care and expansion of outreach efforts into non-traditional settings (i.e. thrift stores, pawn shops, small strip mall businesses) to identify hard-to-reach individuals needing Health//ine services.

Strategy 2: Seek additional funding to enhance HealthLine's capacity to assist clients having problems with their HealthChoice/MCHP providers and difficulty complying with appointment keeping, and to maintain communications with providers to improve the provision of health services and resolve barriers to care for enrollees.

Strategy 3: Work towards establishing a single-point-of-entry health and human services center that provides "one-stop shopping" (per the 2013 Capital Improvement Plan) for individuals needing primary health care and other services.

Strategy 4: Seek funding to create community patient navigators who facilitate access to a medical home and specialty care for individuals facing barriers to care.

Strategy 5: Explore funding to support the addition of public health nurses and/or social workers at low-income housing complexes to expedite residents' access to services.

Strategy 6: Work with the Medical Society, Board of Physicians, Board of Pharmacy and other medical associations to identify ways to increase access to dental, vision, and medical care (including specialty care), and to low cost prescription medication.

Strategy 7: Explore ways to increase the number of urgent care centers in the County to reduce inappropriate use of hospital emergency departments.

Strategy 8: Provide up-to-date information to the public about the services available through existing FQHCs and other safety net clinics.

Increasing Health Literacy

Strategy 1: Educate health care providers and the public about available health literacy tools that enable individuals to access and understand health information, navigate the health care delivery system, and participate in decision-making about their own health care.

Strategy 2: Expand the use of modern technology such as social media outlets and mobile phones to communicate health information to the public and clients, particularly to individuals without internet access.

Strategy 3: Partner with the University of Maryland School of Public Health (UMDSPH) to conduct research on ways to advance the health literacy of County residents.

Enhancing School-Based Health Care and Dental Health Services

Strategy 1: Assess all students seen at the County's four School-Based Wellness Centers (SBWCs) funded through Prince George's County Department of Family

Services (PGCDFS) for their health insurance status and history of annual physical exams; provide students who lack a primary care provider/insurance with an annual physical exam (and risk assessment), and refer them to MCHP, Kaiser Care for Kids Program, and dental providers willing to accept uninsured children.

Strategy 2: Seek funding to establish dental case management services in the four SBWCs and in existing community dental health programs to ensure that children and adults without a dental provider are linked to dental care.

Strategy 3: Work with Kaiser Permanente to pilot a project to provide on-site dental care to the students attending Bladensburg High School and its three feeder elementary and middle schools.

Strategy 4: Continue educating parents, the public, school officials, and others about the importance of early intervention in preventing dental problems and the low cost dental services available in the community, including the Deamonte Driver Dental Project (mobile van) and the dental care pilot project at Bladensburg High School.

Strategy 5: Develop and disseminate oral health messages for adults that stress the link between chronic diseases, infant mortality and oral health.

Strategy 6: Work with community partners to enhance the network of dental providers willing to treat Medicaid insured and uninsured children and adults in the County.

Strategy 7: Seek funding for existing safety net clinics to provide dental services to uninsured/underinsured adults and children.

Strategy 8: Continue serving on the Maryland Dental Action Coalition to advocate for increased Medicaid reimbursements for dental services, and to identify ways to improve the oral health of County residents through increased prevention, education, advocacy, and access to oral health care.

Addressing Alzheimer's Disease

Strategy 1: Partner with the National Capital Area Chapter of the Alzheimer's Association to provide widespread public information about the ten warning signs of Alzheimer's, the importance of early detection and intervention, and the steps individuals with Alzheimer's and their families/caretakers can take to enhance the quality of their care and safety of their environment.

Strategy 2: Work with the PGCDFS Aging Services Division to identify additional strategies for providing seniors who have Alzheimer's or other dementias with

information and services that enable them to better manage their disease and maintain maximum independence.

Improving Health Care for Individuals with Special Needs*

* Also see Priority 2, Enhancing Access to Mental Health Services

Strategy 1: Continue collaboration between the PGCHD's Infants and Toddlers Program, The Arc, the PGCDPS, the Prince George's County Public Schools (PGCPS) Special Education Program, the Family Service Foundation, and other agencies serving County residents with intellectual and developmental disabilities to develop a consolidated multi-agency plan that outlines strategies and partnerships needed to address gaps in the delivery of health care to individuals with special needs.

Strategy 2: Continue assisting families of children enrolled in the Infants and Toddlers Program to ensure that children ages birth to three with special needs have updated immunizations and a medical home.

Strategy 3: Work with partner agencies serving individuals with disabilities to educate the public about the challenges they face in receiving health care, to increase public acceptance and support of persons with disabilities, and to eliminate the stigma associated with disabilities; enlist the faith community, local businesses that employ persons with disabilities, and other traditional and non-traditional partners in this effort.

Strategy 4: Identify a cadre of health care professionals (i.e. OB-GYNs and other physicians, nurses, dentists, physical therapists, nutritionists, social workers) willing to participate in training to increase their understanding of the unique needs of individuals with disabilities and to adapt their medical practices to better serve this population.

Strategy 5: Train health care providers to look for signs and symptoms of stress among their patients who are family members and caregivers of persons with special needs and to refer them to appropriate support services.

Strategy 6: Work with residential care providers to identify ways to make the environment healthier for and more supportive of the adoption of healthy lifestyles among individuals with special needs; offer educational programs that address the health care needs of direct care staff.

Strategy 7: Update the PGCHD's Community Services Guide-at-a-Glance to include agencies and programs that serve individuals with special needs; disseminate the Guide to community providers and agencies for use as a tool in linking clients with special needs and their families to available resources; ensure that these resources are made known to families by posting the information on agency Web sites and in their publications.

Strategy 8: Ensure that the Prince George's Healthcare Action Coalition (PGHAC) includes providers that serve populations with special needs and community advocates; establish a work group that focuses on improving care to individuals with special needs to reduce their risk for chronic diseases, dental problems, unintended pregnancy, sexually transmitted and other communicable diseases, sexual abuse, and substance abuse.

Strategy 9: Partner with PGCDFS Commission for Veterans, PGCDSS, the Homeless Services Partnership, the Salvation Army, and other organizations and agencies serving veterans and the homeless to identify ways to improve health service delivery to these populations.

Strategy 10: Increase public awareness of the County's Homeless Hotline which links individuals who are homeless or at risk of homelessness to needed services, as well as the 211 (Homelessness Prevention) Hotline, which assists individuals before they become homeless by providing mortgage/rental assistance and referral to other support services.

Strategy 11: Partner with the Columbia Lighthouse for the Blind and Visually Impaired, the Family Service Foundation, Gallaudet University, and other organizations serving blind/visually impaired and deaf/hearing impaired individuals to identify ways to improve health service delivery to these populations.

Strategy 12: Continue supporting the PGCDFS Mental Health and Disabilities Division's programs that serve individuals with mental illnesses and individuals in psychiatric crisis, particularly where collaborative agreements among community service providers are essential.

Strategy 13: Partner with PGCDFS, the Mental Health Association of Prince George's County, the National Alliance for the Mentally Ill, On Our Own, and other organizations serving individuals with mental illnesses to identify ways to improve health service delivery to this population.

Key Partners: The Arc, Board of Pharmacy, Board of Physicians, Columbia Lighthouse for the Blind and Visually Impaired, Community Clinics, Inc., community medical and dental providers, Deamonte Driver Dental Project, Dimensions Healthcare System, Doctors Community Hospital, Family Service Foundation, Forestville Pregnancy Center, Gallaudet University, Greater Baden Medical Services, Homeless Services Partnership, Improved Pregnancy Outcome Coalition, Kaiser Permanente, low-income housing complexes, managed care organizations, Maryland Dental Action Coalition, Mary's Center, Medical Society, Mental Health Association of Prince George's County, National Alliance for the Mentally II, National Capital Area Chapter of the Alzheimer's Association, On Our Own, Pregnancy Aid Center, Prince George's County Commission for Persons with Disabilities, Prince George's County Department of Family Services, Prince George's County Department of Social Services, Prince George's County Health Department, Prince George's County Public Schools, residential care providers, Salvation Army, Southern Maryland Hospital Center, University of Maryland School of Public Health.

Priority 2: Prevent and Control Chronic Disease in Prince George’s County, Particularly Among Minorities.

(Corresponds with SHIP Vision Area 5: Prevent and Control Chronic Disease)

County Outcome Objective	Current Baseline	2014 Target
Reduce deaths from heart disease	Overall rate - 224.2 (rate of heart disease deaths per 100,000 population (age-adjusted), VSA 2007-2009) White rate - 195.5 Black rate - 221.0 Hispanic rate - 66.4 Asian rate - 96.0	Overall rate - 188.5 using midpoint to HP 2020 White rate - 174.1 using midpoint to HP 2020 Black rate - 186.9 using midpoint to HP 2020 Hispanic rate - 63.1 using 5% decrease Asian rate - 91.2 using 5% decrease
Reduce the overall cancer death rate	Overall rate - 173.8 (rate of cancer deaths per 100,000 population [age-adjusted], VSA 2009) White rate - 199.0 Black rate - 181.9 Hispanic rate - 70.9 Asian rate - 87.0	Overall rate -167.2 using midpoint to HP 2020 White rate - 179.8 using midpoint to HP 2020 Black rate - 171.3 using midpoint to HP 2020 Hispanic rate - 67.4 using 5% decrease Asian rate - 82.7 using 5% decrease
Increase the proportion of adults who are at a healthy weight	28.6% (percentage of adults at a healthy weight [not overweight or obese], BRFSS 2008-2010) White Non-Hispanic - 39.6% Black - 13.0% Hispanic - 23.0% Asian - Not Available	30% using 5% increase White Non-Hispanic - 41.6% using 5% increase Black - 13.7% Hispanic - 24.2%
Reduce the proportion of children and	16.1% (percentage of youth ages 12-19 who are obese, MYTS 2008)	15.3% using 5% decrease

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adolescents who are considered obese		
Reduce hypertension-related emergency department visits	<p>Overall rate - 257.7 (rate of ED visits for hypertension [inpatient + outpatient] per 100,000 population, HSCRC 2010)</p> <p>White rate - 101.8 Black rate - 341.7 Hispanic rate - 54.3 Asian rate - 67.6</p>	<p>Overall rate - 244.8 using 5% decrease</p> <p>White rate - 96.7 using 5% decrease Black rate - 324.6 using 5% decrease Hispanic rate - 51.6 using 5% decrease Asian rate - 64.2 using 5% decrease</p>
Reduce diabetes-related emergency department visits	<p>Overall rate - 308.4 (rate of ED visits for diabetes [inpatient + outpatient] per 100,000 population, HSCRC 2010)</p> <p>White rate - 179.5 Black rate - 388.2 Hispanic rate - 101.6 Asian rate - Not Available</p>	<p>Overall rate - 293 using 5% decrease</p> <p>White rate - 170.5 using 5% decrease Black rate - 368.8 using 5% decrease Hispanic rate - 96.5 using 5% decrease Asian rate - Not Available</p>
Reduce drug induced deaths	6.1 (rate of drug-induced deaths per 100,000 population, VSA 2007-2009)	5.8 - rate using 5% decrease
Reduce tobacco use by adults	<p>13.3% (percentage of adults who currently smoke, BRFSS 2008-2010)</p> <p>White Non-Hispanic - 16.8%</p> <p>Black - 17.8%</p> <p>Hispanic - 5.7%</p> <p>Asian - Not Available</p>	<p>12.7% using midpoint to HP 2020</p> <p>White Non-Hispanic - 14.4% using midpoint to HP 2020 Black - 14.9% using midpoint to HP 2020 Hispanic - 5.4% using 5%</p>

		decrease Asian - Not Available
Reduce the proportion of youth who use any kind of tobacco product	23.3% (percentage of high school students grades 9-12 that have used any tobacco product in the past 30 days, Maryland Youth Tobacco Survey 2010)	22.2% using midpoint to HP 2020
Reduce the number of ED visits related to behavioral health conditions	713.1 (rate of ED visits for behavioral health conditions [inpatient + outpatient] per 100,000 population, HSCRC 2010) White rate - 740.7 Black rate - 778.3 Hispanic rate - 2243.9 Asian rate - 151.4	677.4- rate using 5% decrease White rate - 703.7 using 5% decrease Black rate - 739.4 using 5% decrease Hispanic rate - 2131.7 using 5% decrease Asian rate - 143.8 using 5 % decrease

Increasing Access to Healthier Foods *

* Also see Improving Our Environment under Priority #5

Strategy 1: Adopt local policies requiring chain restaurants to provide menu labeling that gives consumers information on nutritional values of in-store menu selections.

Strategy 2: Educate local leaders, restaurant owners, and the public about menu labeling and its impact on selection of healthy food choices, using media outlets, community events, educational materials, and other venues/methods.

Strategy 3: Increase public demand for healthier food choices at restaurants and food markets through education and advocacy; partner with the Food Supplement Nutrition Education Program to assist with community education to low income and other at-risk communities.

Strategy 4: Seek funding for educational programs that link healthy nutrition to other desirable outcomes (i.e. healthy pregnancy, reduced incidence of chronic disease).

Strategy 5: Increase marketing of healthier foods, using the Get Fresh Baltimore model.

Strategy 6: Develop and disseminate culturally and linguistically appropriate informational materials to educate the public about healthy nutrition and its impact on the body, healthy food selection and preparation; enlist the support of local chefs and restaurateurs in this effort.

Strategy 7: Adopt local policies providing incentives (tax credits, grants, loan programs, etc.) to supermarkets that lower prices on healthier food products and to attract new supermarkets to underserved areas.

Strategy 8: Identify funding to provide incentives to stores that offer healthier food choices at low cost, and advertise these incentives to the public; help connect local farmers with food outlets so that locally grown foods can be offered everywhere.

Strategy 9: Collaborate with supermarket corporate offices and local store managers to explore ways to provide incentives to customers that encourage the purchase of healthier foods.

Strategy 10: Adopt local policies to discourage consumption of calorie dense, nutrient poor foods through the use of incentives, land use and zoning regulations that place restrictions on the number and location of fast food restaurants, particularly in high-risk communities.

Strategy 11: Promote local farmers' markets and seek to add farmers' markets in food desert areas; appeal to local farmers to come to inner-Beltway locations by promoting their safety and the ability to accept food stamps and Women, Infants, and Children (WIC) Program vouchers for payment.

Strategy 12: Increase the number of needy families that participate in federal, state, and local government nutrition programs such as WIC, the Food Stamps Program, School Breakfast and Lunch Programs, the Child and Adult Care Food Program, the Senior Nutrition Program, the Afterschool Snacks and Supper Program, and the Summer Food Service Program.

Strategy 13: Enlist the faith-based community in providing education about healthy eating and chronic disease prevention, and explore funding to install computers in local churches where parishioners can access health information from Web sites.

Strategy 14: Encourage County residents to eat locally grown foods and educate them on methods for growing their own food, including gardening techniques (i.e. composting) and establishing community gardens; involve schools, local farmers, and municipalities in this effort.

Strategy 15: Encourage prenatal care providers to include nutrition education that teaches pregnant women how to purchase and prepare healthier foods to improve their health and that of their families.

Promoting Physical and Recreational Activity

Strategy 1: Support the implementation of the PGCPs new Fitness-Gram Program in grades K-12, which provides an individualized physical fitness plan for each participating student.

Strategy 2: Work with the PGCPs School Wellness Councils and the Healthy Schools Program to advocate for the adoption of school policies that increase physical activity for students, promote healthier food and beverage choices in schools, and contribute to a healthier school environment in general.

Strategy 3: Seek funding to pilot the implementation of the M-NCPPC and PGCHD's Prescription-REC Program for County residents with high blood pressure and/or high cholesterol who have a "prescription" from their health care provider to start an exercise regimen.

Strategy 4: Explore innovative ways to increase opportunities for physical and recreational activity in communities, schools, workplaces including:

- offering incentives to developers to build safe, attractive parks, playgrounds and recreation centers
- establishing joint use of school and community facility agreements allowing playing fields, playgrounds, and recreation centers to be used by the public when schools are closed
- promoting youth athletic leagues and worksite walking and other physical activity programs
- adopting a policing strategy to improve safety and security at parks
- promoting a culture of "everyday" physical activity (i.e. taking stairs, walking during breaks and lunchtime)
- offering discounts to consumers as incentives to use existing public and private health clubs and recreational facilities.

Promoting Clinical, Self-Management, and Other Services That Address Chronic Conditions

Strategy 1: Promote innovative community programs that address chronic diseases such as the Gaston and Porter Health Improvement Center's Women's Health Institute and Prime Time Sister Circles Program, the Children's National Medical Center's Obesity Institute, Southern Maryland Hospital Center's Fit 'N Fun Program, Cardiac Risk Reduction Center, and the Diabetes Self-Management Education Program, and the Doctor's Community Hospital's Joslin Diabetes Center; establish a mechanism for community providers to refer their at-risk clients.

Strategy 2: Identify best practices for diagnosis and management of high blood pressure and encourage physicians to incorporate them into their practices, including the use of electronic health record (EHR) prompts (i.e. Veteran's Administration model).

Strategy 3: Identify funding for a public education campaign to reinforce the risks of high blood pressure and to promote measures to reduce/control high blood pressure, including diet, physical activity, and medical management.

Strategy 4: Seek partnerships with hospitals, physician groups, and interested community groups to provide diabetes self-management education to those who are uninsured/underinsured; utilize services of diabetes educators.

Strategy 5: Seek funding to establish diabetes case management services that link uninsured/underinsured individuals to medical care, education, and supplies; include a hotline for those who have short-term needs.

Strategy 6: Offer diabetes prevention programs in non-clinical settings (i.e. M-NCPPC programs, schools).

Strategy 7: Work with physician groups to identify those at risk for diabetes and provide prevention education, including use of EHR prompts.

Strategy 8: Work with the American Association of Diabetes Educators to seek funding to recruit and train more minority diabetes educators; develop culturally and linguistically appropriate diabetes educational materials for our diverse population.

Strategy 9: Provide an assessment and physical exam to all students seen at the four SBWCs that include screening for obesity/overweight, and referral for further clinical and/or self-management programs as needed.

Strategy 10: Update the PGCHD's *Community Services Guide At-A-Glance* to feature providers and programs that address obesity, diabetes, hypertension, smoking cessation, weight management, and physical activity; disseminate the Guide (via Web sites and mailings) to community providers and agencies (including libraries) for use as a tool in linking individuals with chronic conditions to needed clinical care and self-management programs.

Strategy 11: Explore with PGCDFs and Prince George's Community College expanding their joint Living Well Chronic Disease Self-Management Program (from Stanford University) to serve a greater number of County residents diagnosed with chronic diseases.

Strategy 12: Partner with holistic health practitioners and other complementary and alternative medicine (CAM) providers to identify ways to integrate CAM into conventional health care practices and to promote chronic disease prevention and wellness models that will assist County residents adopt positive lifestyle changes and increase their level of personal responsibility for improving their health status.

Enhancing Health Care Providers' Skills in Treating and Preventing Chronic Diseases

Strategy 1: Seek funding to expand the PGCHD's Center for Healthy Lifestyles Initiative (CHLI) and to establish a Healthy Futures Training Institute (HFTI) through the UMDSPH. CHLI and HFTI will provide training and technical assistance to health care institutions, organizations, and providers to incorporate into their routine patient care practices evidence-based interventions for the following: reducing/managing overweight and obesity through physical activity and nutrition; controlling hypertension, diabetes, and high cholesterol; reducing cardiovascular disease; and preventing/reducing tobacco use.

Strategy 2: Expand the PGHAC to include members representing communities experiencing high rates of heart disease and other chronic conditions; establish work groups within the Coalition to continually research best practices and ways to incorporate them into standards of care for high blood pressure, high cholesterol, cardiovascular disease, etc.

Preventing and Treating Cancer

Strategy 1: Continue providing breast and cervical cancer screening (and referral for treatment) to women ages 40 and over who are uninsured/underinsured and whose incomes are at or below the 250% poverty level through the PGCHD's Breast and Cervical Cancer Screening Program (BCCP); fully implement the Expanded BCCP Program which will also serve men.

Strategy 2: Continue providing colorectal cancer screening and referral to appropriate entitlement programs for follow-up treatment to individuals ages 50 and over and who are uninsured/underinsured through the PGCHD's Colorectal Cancer Prevention, Education, Screening, and Treatment Program (CPEST).

Strategy 3: Partner with the American Cancer Society, Susan G. Komen For the Cure, and other agencies addressing cancer to provide public education on cancer prevention

and to encourage individuals to get recommended screenings (i.e. mammograms, colonoscopies, PSA tests); focus efforts on reaching African Americans and other minorities.

Strategy 4: Use the Maryland Comprehensive Cancer Control Plan as a guide for developing additional strategies to address cancer prevention, early detection and treatment, and disparities.

Strategy 5: Continue offering in the PGCHD's Immunization Clinics the Gardasil vaccine to males and females starting at age 11 to prevent genital warts caused by the human papilloma virus (HPV) and HPV-associated cancers (cancer of the cervix, vulva, vagina, penis, anus as well as head and neck cancer); continue educating the public about Gardasil's role in preventing genital warts and cancer.

Strategy 6: Seek funding to hire patient navigators who facilitate access to resources, financial assistance, transportation, and other needed services for individuals with breast and other cancers.

Increasing Public Awareness

Strategy 1: Work with community partners, the American Diabetes Association, American Heart Association, American Lung Association and other organizations to implement special initiatives that increase public awareness of measures to prevent chronic diseases and encourage adoption of healthier lifestyles.

Strategy 2: Develop and disseminate culturally and linguistically appropriate materials and messages about chronic disease prevention targeting the County's diverse populations, minorities and non-English speaking individuals.

Strategy 3: Place information on County agency and partner Web sites and in publications that provides tips for achieving a healthier lifestyle.

Creating Breastfeeding-Friendly Communities

Strategy 1: Establish a network of local hospitals interested in adopting practices to become baby-friendly; establish a network of OB/GYNs, family practice practitioners, and midwives who are supportive of breastfeeding and willing to promote it among clients and the community.

Strategy 2: Encourage local employers, health care institutions, and child care settings to establish policies and programs that support worksite breastfeeding.

Strategy 3: Identify funds to conduct a multi-media campaign to improve public attitudes towards breastfeeding.

Strategy 4: Identify new venues where mothers seeking health and other services can be educated about the health benefits of breastfeeding for their infants and children and breastfeeding as a potential obesity prevention strategy.

Strategy 5: Establish a work group within the PGHAC that continually researches best practices for promoting breastfeeding in maternal health care settings (i.e. WIC, Family Planning, Nutrition, Early, Periodic, Screening, Diagnosis, and Treatment Programs) and the community.

Enhancing Access to Substance Abuse Treatment

Strategy 1: Continue implementing the Safety NET (Network for Entry into Treatment) Project that provides substance abuse treatment and education to adults and youth. This Program addresses substance abuse as a factor in criminal justice system entry and recidivism, and youth violence prevention.

Strategy 2: Continue implementing PLAN (Partnership for Learning Among Neighbors), an intensive assessment and re-integration program for detainees with co-occurring mental health and substance use disorders that place them at high risk for recidivism and poor health outcomes.

Strategy 3: Update agreements with the extensive network of public and private substance abuse treatment providers to ensure multiple pathways to care and to facilitate the seamless provision of screening, intake, referral, assessment, and treatment services for County residents.

Strategy 4: Increase the number of individuals in substance abuse treatment who belong to priority (highest risk, highest cost) populations that put other members of the general population at risk, including:

- parenting women and women of childbearing age, to reduce the risk for infant mortality, fetal alcohol syndrome, failure to thrive, and early initiation of alcohol, tobacco and other drug use (ATOD)
- injection drug users, to reduce the spread of HIV and hepatitis
- first-time marijuana users and DUI/DWI offenders, to reduce crash and non-crash injuries (i.e. falls and domestic violence) and ATOD-related deaths.

Strategy 5: Increase the number of individuals in substance abuse treatment who are at greatest risk for ATOD use by demographics or health status, including:

- Latinos, by offering more English-Spanish addiction treatment capability

- youth ages 12–16, who are retained in treatment 90 days or more, to enable parents/guardians to participate in the treatment process
- individuals with co-occurring disorders, to reduce jail recidivism.

Strategy 6: Sustain jail-based substance abuse treatment, and Juvenile and Adult Drug Court interventions to increase the number of other individuals at high risk who are enrolled in treatment.

Strategy 7: Increase the number of individuals connected to substance abuse treatment through Screening, Brief Intervention and Referral to Treatment (SBIRT) efforts at local hospitals, to reduce repeat emergency room use by individuals addicted to ATOD.

Strategy 8: Increase advertisement of the wide range of substance abuse prevention, treatment, and community support services available to County residents through a radio campaign and outreach to schools, communities, businesses, and faith-based organizations.

Promoting Smoke-Free Communities

Strategy 1: Support M-NCPPC’s plan to expand its smoking ban to include the outdoor (open) spaces at all of its facilities.

Strategy 2: Work with partners to increase the number of smoke-free multi-unit housing properties in the County, particularly in areas most at risk for tobacco-related disease and disability (based on disease burden, socioeconomic status of residents, and size of the housing complex).

Strategy 3: Educate building managers, tenants, and tenant associations about the hazards of tobacco use and the steps to implement a smoke-free policy at their dwellings.

Strategy 4: Work toward the establishment of a smoke-free County by adopting legislation that bans smoking at all County and municipal government-owned properties (including outdoor spaces).

Strategy 5: Work with the University of Maryland Legal Resource Center for Tobacco Regulation, Litigation, and Advocacy to identify additional strategies leading to a smoke-free County.

Strategy 6: Work with partners to promote smoke-free college campuses.

Strategy 7: Work with partners to identify funds to conduct a County-wide campaign to educate at-risk adults and adolescents about the hazards of tobacco use and resources available for tobacco use cessation, using mass and social media outlets that appeal especially to youth; focus efforts on reaching County residents in the southern part of the County where tobacco use is more prevalent.

Strategy 8: Collaborate with existing school-based tobacco prevention programs to promote additional anti-tobacco messages to students.

Strategy 9: Explore with partners ways to train physicians, dentists, nurses, and other health care providers to deliver brief messages on the dangers of tobacco use and to refer their clients to available cessation programs.

Enhancing Access to Mental Health Services

Strategy 1: Support the implementation of PGDFS Mental Health and Disabilities Administration, Fiscal Year 2012 Annual Plan* to develop and maintain a comprehensive, efficient, and cost effective system of community-based mental health care in Prince George's County, particularly as it relates to collaborative agreements among community service providers.

* A complete description of this Plan is available in the *Prince George's County Department of Family Services, Mental Health and Disabilities Administration, Fiscal Year 2010 Annual Report and Fiscal Year 2012 Annual Plan Update*.

Strategy 2: Continue to provide behavioral health condition screenings to County residents at various points of service entry where potentially at-risk individuals may be identified (i.e. women's wellness centers, SBWCs, Prince George's County Department of Corrections (PGCDOC), Youth Service Bureaus, PGDFS, PGCDSS, and Adam's House).

Key Partners: Affiliated Santé, Alcohol and Drug Abuse Administration, American Association of Diabetes Educators, American Cancer Society, American Diabetes Association, American Heart Association, American Lung Association, Children's National Medical Center, community substance abuse treatment providers, complementary and alternative medicine and holistic health providers, Dimensions Healthcare System, Doctors Community Hospital, faith-based and non-profit community-based organizations, Food Supplement Nutrition Education (University of Maryland), Gaston and Porter Health Improvement Center, local businesses, local chefs, restaurateurs, farmers, and farmers' markets, Maryland-National Capital Park and Planning Commission multi-unit housing managers and tenant associations, Prince George's County Council/Board of Health, Prince George's County Executive, Prince George's County Courts, Prince George's County Criminal Justice Coordinating Council and Drug and Alcohol Advisory Committee, Prince George's County Department of Corrections, Prince George's County Department of Family Services, Prince George's County Department of Juvenile Services, Prince George's County Department of Social Services, Prince George's County Health Department, Prince George's County Memorial Library System, Prince George's County Parole and Probation Office, Prince George's County Police Department, Prince George's County Public Schools, Prince George's County State's Attorneys Office, private sector health care providers, Southern Maryland Hospital Center, supermarket corporate offices and grocery stores, Susan G. Komen For the Cure, University of Maryland Legal Resource Center for Tobacco Regulation, Litigation, and Advocacy, Youth Service Bureaus, University of Maryland School of Public Health.

Priority 3: Improve Reproductive Health Care and Birth Outcomes for Women in Prince George’s County, Particularly Among African American Women.

(Corresponds with SHIP Vision Area 1: Improve Reproductive Health Care and Birth Outcomes)

County Outcome Objective	Current Baseline	2014 Target
Reduce infant deaths	Overall rate - 10.4 (number of infant deaths/1,000 live births, VSA 2007- 2009) White/Non-Hispanic rate - 10.6 Black rate - 13.3 Hispanic rate - 4.6 Asian rate - 2.7	Overall rate - 8.2 using midpoint to HP 2020 White/Non-Hispanic rate - 10.1 using 5% decrease Black rate - 12.6 using 5% decrease Hispanic rate - 4.4 using 5% decrease Asian rate - 2.6 using 5% decrease
Reduce low birth weights (LBW) and very low birth weights	Overall - 10.6% (percentage of births that are LBW, VSA 2007-2009) White/Non-Hispanic - 7.6% Black - 12.5% Hispanic - 7.5% Asian - 7.7%	Overall - 9.2% using midpoint to HP 2020 White - 7.2% using 5% decrease Black - 11.9% using 5% decrease Hispanic - 7.1% using 5% decrease Asian - 7.3% using 5% decrease
Increase the proportion of pregnant women who receive prenatal care beginning in the first trimester	Overall - 67% (percentage of births where mother received first trimester prenatal care, VSA 2007-2009) White/Non-Hispanic - 82.3% Black - 69.4% Hispanic - 52.7% Asian - 66.6%	Overall - 70.4 % using 5% increase White - 86.4% using 5% increase Black - 72.9% using 5% increase Hispanic - 55.3% using 5%

		increase Asian - 69.9% using 5% increase
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Note – A number of these strategies also address Priority 1.

Linking Women to Prenatal Care and Women’s Wellness Services

Strategy 1: Expand existing prenatal care and women’s health services to include screening and counseling for diabetes prevention and management (including gestational diabetes), weight management and nutrition counseling, substance abuse and smoking cessation services, referral to dental health services, mental health services and domestic violence prevention, and screenings and referrals for Medicaid.

Strategy 2: Continue working with key partners to secure funding for existing County prenatal care programs that serve high risk and very high risk uninsured pregnant women needing specialty perinatology, midwifery and other services.

Strategy 3: Work with the PGCDOC to ensure that incarcerated pregnant women receive prenatal care and are linked to community services upon release.

Strategy 4: Continue working with the PGCPHS to ensure that pregnant adolescents receive prenatal care and are referred to family planning services after delivery.

Strategy 5: Identify resources to expand existing Healthy Start and perinatal navigator services that provide home visits and intensive follow-up for high risk pregnant women.

Strategy 6: Continue collaboration between PGCHD, PGCDFS, PGCDSS, and the Healthy Families Prince George’s County Program to ensure that pregnant women receive needed prenatal, pediatric, mental health, health education, and other support services in a coordinated manner.

Strategy 7: Identify funding for and implement an advertising campaign to promote all of the women’s wellness and prenatal care services available in the County and to encourage pregnant women to get into care early, focusing on reaching minority women.

Strategy 8: Work with local hospitals to identify ways to increase access to perinatology and fetology services for high risk pregnant women, as well as tubal ligation and vaginal births after c-section (VBACs).

Strategy 9: Increase availability of post-abortion counseling services.

Identifying Innovative Strategies to Address Infant Mortality

Strategy 1: Continue convening meetings of the Prince George's County Improved Pregnancy Outcome Coalition (IPOC) to identify best practices and seek resources for reducing infant mortality, and to advocate for policy, legislative, and systems changes that have an impact on infant mortality reduction; follow-up with providers to ensure they are initiating IPOC recommendations.

Strategy 2: Continue convening meetings of the Fetal and Infant Mortality Review (FIMR) Team to review infant mortality cases and to make recommendations to the Health Department regarding strategies to address the Team's specific findings.

Strategy 3: Recruit more hospital providers and primary care physicians to join the IPOC and FIMR.

Strategy 4: Provide information to pregnant women and women of childbearing age (including women with health insurance and higher incomes) about the risk factors that affect birth outcomes, especially focusing on African American women.

Promoting Family Planning Services

Strategy 1: Identify funding to implement an advertising campaign promoting existing community family planning services; focus on reaching minority women and adolescents through novel approaches.

Strategy 2: Continue partnerships between family planning providers in the County to ensure that available family planning appointment slots are filled through appropriate referral arrangements.

Strategy 3: Ensure that students seen at the four SBWCs are linked to family planning services in the community.

Strategy 4: Explore ways to engage male partners of sexually active women in seeking family planning services and supporting partner compliance with family planning methods.

Strategy 5: Ensure that obstetrics patients are provided with family planning education during prenatal care and referred to family planning services after delivery.

Strategy 6: Ensure that women who are ineligible for Title X family planning services, are uninsured/underinsured, have aged out or are over income limits, have access to women's wellness services.

APPENDIX VI: BLUEPRINT PLAN

Key Partners: Access to Wholistic and Productive Living Institute, Inc., Community Clinics, Inc., Dimensions Healthcare System, Doctors Community Hospital, Greater Baden Medical Services, Healthy Families Prince George's Program, FIMR Team, Forestville Pregnancy Center, Improved Pregnancy Outcome Coalition, Maryland Community Health Resources Commission, Maryland Department of Health and Mental Hygiene [DHMH] Family Health Administration and Office of Minority Health and Health Disparities, Mary's Center, Pregnancy Aid Center, Prince George's County Department of Corrections, Prince George's County Department of Family Services, Prince George's County Department of Social Services, Prince George's County Health Department, Prince George's County Public Schools, Southern Maryland Hospital Center, University of Maryland School of Medicine.

Priority 4: Prevent and Control Infectious Disease in Prince George’s County, Particularly Among African Americans and Other Minorities.

(Corresponds with SHIP Vision Area 4: Prevent and Control Infectious Disease)

County Outcome Objective	Current Baseline	2014 Target
Reduce new HIV infections among adults and adolescents	Overall rate - 56.4 (rate of new [incident] cases of HIV in persons age 13 and older per 100,000 population, IDEHA 2009) In progress for race specific data	Overall rate - 53.6 using 5% decrease
Reduce chlamydia trachomatis infections among young people	Overall rate - 631 (rate of chlamydia infections for all ages per 100,000 population, IDEHA 2009) White rate - 32.4 Black rate - 206.4 Hispanic rate - 74.8 Asian rate - Not Available (all ages)	Overall rate - 599.5 using 5% decrease White rate - 30.8 using 5% decrease Black rate - 196.1 using 5% decrease Hispanic rate - 71.1 using 5% decrease Asian rate - Not Available
For patients with newly diagnosed TB for whom 12 months or less of treatment is indicated, increase the proportion of patients who complete treatment within 12 months	91.7% of new TB cases have completed treatment (National TB Indicators Project, Centers for Disease Control and Prevention [CDC])	93.0% by 2015 to meet National TB Indicators Project goal
Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among young children	Varies according to specific vaccine administered - refer to National Immunization Survey for vaccine-specific data	Maintain high coverage levels

Increase the seasonal flu vaccine rates	33.9% (percentage of adults who have had a flu shot in the last year, BRFSS 2008-2010) White Non-Hispanic - 43.8% Black - 32.5% Hispanic - 24.9%	57% using midpoint to HP 2020 White Non-Hispanic - 61.9% using midpoint to HP 2020 Black - 56.3% using midpoint to HP 2020 Hispanic - 52.3% using midpoint to HP 2020
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Addressing HIV/AIDS

Strategy 1: Increase routine HIV screening in clinical settings and targeted screening in non-clinical settings, including the PGCDCOC, public substance abuse treatment programs, and the SBWCs (all located in areas with the highest morbidity rates); link HIV positives immediately to care, and high risk HIV negatives to other medical care and HIV prevention programs.

Strategy 2: Provide behavioral risk screening and evidence-based risk reduction education to persons living with HIV (PLWH) and HIV negative persons at highest risk, including men who have sex with men, high risk heterosexuals, at-risk youth, PGCDCOC detainees, etc.

Strategy 3: Implement prevention education and outreach strategies that specifically target heterosexual women, especially minority women.

Strategy 4: Explore ways to integrate evidence-based risk reduction education into the curriculum at the schools where the four SBWCs are located.

Strategy 5: Continue to provide on-going partner services for PLWH, including newly infected and their partners and PLWH diagnosed with a new sexually transmitted infection (STI).

Strategy 6: Continue to refer or link PLWH identified through partner services to medical care and support, and assign Linkage to Care workers to assist PLWH not currently in care.

Strategy 7: Work with a behavioral specialist to develop criteria for providing on-going behavioral counseling to at-risk persons; provide behavioral counseling to PLWH who engage in high risk behaviors, high risk negatives with repeat STIs, high risk men who have sex with men, and high risk heterosexuals.

Strategy 8: Expand outreach and prevention education efforts to include the use of innovative media and information technology methods such as online and social network services (i.e. Web sites, blogs, Facebook, Twitter, YouTube and Internet-Based Partner Services).

Strategy 9: Increase awareness among medical providers of the HIV medical care and support services available to HIV infected residents, and encourage providers to make HIV testing a routine part of care.

Strategy 10: Use case finding activities and partner surveillance data to identify the most effective settings and geographic areas to conduct targeted outreach and education.

Strategy 11: Train the medical community to be more comfortable and proficient in discussing substance use, sexual history and sexual habits with their patients, and in addressing cultural and linguistic barriers to their care.

Strategy 12: Increase the involvement of the faith-based community and churches in providing culturally sensitive HIV/STI prevention education and in serving as sites for free HIV testing; explore funding to establish a position within the PGCHD dedicated to working with the faith-based community.

Strategy 13: Work with medical associations, pharmaceutical representatives, and local academic institutions to provide continuing education to medical providers to ensure that their clinical skills in treating HIV/AIDS patients are up-to-date.

Addressing Other Sexually Transmitted and Communicable Diseases

Strategy 1: Identify funding to support a new chlamydia initiative including its prevention, expanded treatment capabilities, and partner services to identify individuals in need of treatment.

Strategy 2: Work with the Sexually Transmitted Infections Community Coalition (STICC) and other community partners to explore the development of a regional plan to address HIV and other STIs.

Strategy 3: Develop and disseminate, through media outlets and innovative outreach approaches, culturally and linguistically appropriate educational materials and messages on the most common STIs and their prevention.

Strategy 4: Continue to work with the medical community in managing and co-managing all active tuberculosis (TB) cases to ensure appropriate treatment of all TB cases.

Strategy 5: Continue to provide directly observed therapy (DOT) services to all TB cases in order that treatment is completed for the prevention of spread of TB.

Ensuring that Children Receive Recommended Immunizations

Strategy 1: Continue collaborating with the PGCPs nurses to ensure that all enrolled children are in compliance with required immunizations; provide updates about immunization requirements and available services to public school system nurses during the yearly health services orientation.

Strategy 2: Continue to provide outreach to private and non-public schools regarding immunization requirements and review their student immunization records.

Strategy 3: Continue collaborating with WIC offices, PGCDfS, the Healthy Families Prince George's County Program, and other programs that serve County children to ensure that these children receive recommended immunizations.

Strategy 4: Expand outreach efforts through community health fairs, Web site listings, and other venues to increase public awareness of the importance of childhood vaccines and the availability of County immunization clinics for uninsured/underinsured children; develop educational materials and messages that specifically target immigrants and new refugees.

Strategy 5: Maintain high vaccination coverage levels of County children by continuing to provide free immunizations to children at PGCHD Immunization Clinics and the SBWCs.

Increasing Community Acceptance of Seasonal Flu Shots

Strategy 1: Carry out an aggressive public information campaign about the importance of getting a seasonal flu shot; include messages and media outlets targeting minority and non-English speaking populations.

Strategy 2: Continue providing free flu shots in existing PGCHD clinics (Maternity, Family Planning, Sexually Transmitted Disease (STD), TB, HIV Clinics, etc.).

Strategy 3: Collaborate with school officials, mayors of municipalities, public officials representing local councilmanic districts, community clinics, PGCDfS and other County agencies to identify venues accessible to the public where free flu shots can be provided, especially for elderly and other at-risk populations; partner with community groups and businesses to provide low cost flu shots.

Strategy 4: Use the County's Medical Reserve Corps and Citizen Emergency Response Team volunteers to help staff public flu clinics.

Strategy 5: Collaborate with community medical providers interested in providing flu shots to ensure they have sufficient vaccine and other resources to provide flu shots to the public.

Strategy 6: Promote universal acceptance of flu vaccinations among all healthcare workers.

Key Partners: Academic institutions, Citizen Emergency Response Teams and Medical Reserve Corps, Community Clinics, Inc., councilmanic district public officials, Dimensions Healthcare System, Greater Baden Medical Service, Healthy Families Prince George's County Program, Heart-to-Hand and other HIV/STD community partners, faith-based community and local churches, local businesses and community-based organizations, Mary's Center, mayors of local municipalities, medical associations and pharmaceutical representatives, Prince George's County Courts, Prince George's County Department of Corrections, Prince George's County Department of Family Services, Prince George's County Department of Social Services, Prince George's County Health Department, Prince George's County Public Schools, private medical providers, private and non-public schools, Reality House and Salvation Army Rehabilitation Program (community substance abuse treatment centers), Sexually Transmitted Infection Community Coalition.

Priority 5: Ensure that Prince George’s County Physical Environments are Safe and Support Health, Particularly in At-Risk Communities.

(Corresponds with SHIP Vision Area 3: Ensure that Maryland Physical Environments are Safe and Support Health)

County Outcome Objective	Current Baseline	2014 Target
Reduce the rate of fall-related deaths	4.6 (rate of deaths associated with falls per 100,000 population, VSA 2007-2009)	4.37 - rate using 5% decrease
Reduce pedestrian injuries on public roads	47.8 (rate of pedestrian injuries, State Highway Administration 2007-2009)	34.1 - rate using midpoint to HP 2020
Reduce the number of drownings among children and adults	14 (count only, VSA 2008)	7 count only using 50% decrease
Reduce blood lead levels in children	74.6 (rate of new [incident] cases of elevated blood lead level in children under 6 per 100,000, Maryland State Department of Education [MSDE] 2009)	37.3 - rate using 50% decrease
Reduce the number of infant deaths from sudden unexpected infant deaths (SUIDs), including Sudden Infant Death Syndrome (SIDS), unknown cause, accidental suffocation and strangulation in bed	.9 (rate of SUIDs (including deaths attributed to SIDS, accidental suffocation and strangulation in bed [ASSB], and deaths of unknown cause per 1,000 live births, VSA 2005-2009)	.85 - rate using midpoint to HP 2020
Reduce salmonella infections transmitted through food	11.7 (rate of salmonella infections per 100,000 population, IDEHA 2010)	7.96 - rate using 32% decrease
Reduce hospital emergency department (ED) visits from asthma	Overall rate - 71.7 (rate of ED visits for asthma [inpatient and outpatient] per 10,000 population, HSCRC 2010) White rate - 25.8	Overall rate - 57.4 using 20% decrease White rate - 20.6 using 20% decrease

	Black rate - 90.9 Hispanic rate - 30.5 Asian rate - 17.7	Black rate - 72.7 using 20% decrease Hispanic rate - 24.4 using 25% decrease Asian rate - 14.2 using 20% decrease
Increase access to healthy food and venues for physical and recreational activity	13.6% (percentage of census tracts with food deserts, U.S. Department of Agriculture [USDA] 2000)	12.9% using 5% decrease

Preventing Fall-Related Deaths* and Pedestrian Injuries

* Note: See Addressing Alzheimer’s Disease under Priority # 1 for additional strategies.

Strategy 1: Collaborate with Prince George’s County’s Interagency Committee to obtain a mini-grant to pilot test Safe Steps: A Falls Prevention Program for Seniors with an at-risk senior population.

Strategy 2: Support the Prince George’s County Department of Public Works and Transportation and the PGCPD to implement a Safe Routes to Schools Program to increase the number of children safely walking and biking to school.

Strategy 3: Support the PGCDFA Aging Services Division’s Health Promotion and Disease Prevention Program that educates senior citizens about healthy lifestyles, including falls prevention.

Strategy 4: Support more widespread enforcement of pedestrian and driving laws by the County and municipal Police Departments.

Strategy 5: Support implementation of the Maryland State Highway Administration’s highway and traffic safety programs like the Click It or Ticket Program that promotes the proper use of child safety seats and seat belts and the Smooth Operator Program that addresses aggressive driving.

Strategy 6: Increase public education about pedestrian safety through use of multi-media venues and development and dissemination of culturally and linguistically appropriate educational materials.

Preventing Deaths from Drownings

Strategy 1: Partner with M-NCPPC to increase the number of free or low-cost swimming lessons available to low-income County residents.

Strategy 2: Provide written information on pool and water safety to apartment complex managers during PGCHD pool inspection visits for distribution to their residents.

Strategy 3: Post seasonal pool and water safety tips (including the role of alcohol as a risk factor) on County Web sites as well as tips for remaining safe during periods of flooding.

Eliminating Lead Poisoning

Strategy 1: Use Geographic Information System (GIS) technology to pinpoint where children with elevated blood lead levels live in the County in order to identify at-risk families and communities in need of intervention.

Strategy 2: Expand efforts to educate the public about sources of environmental lead, using novel outreach approaches and culturally and linguistically appropriate materials to specifically reach non-English speaking residents, immigrants, and other at-risk populations.

Strategy 3: Provide the medical community and organizations serving vulnerable populations with periodic lead poisoning prevention updates, including Web site listings, e-mail notices, and workshops.

Strategy 4: Expand collaboration with County medical providers to assure their awareness of current protocols for medical intervention/case management of children with elevated blood lead levels.

Strategy 5: Work with local remodeling contractors and their professional associations to enhance their understanding of ways to prevent lead-containing materials from contaminating the environment during renovations of older homes and buildings.

Strategy 6: Continue providing aggressive intervention and case management to children with elevated blood lead levels, education to their families to further reduce their environmental exposure to lead, and collaboration with their medical providers to assure healthy outcomes.

Strategy 7: Maintain County lead testing for uninsured and underinsured children who live in high risk areas and assure any needed medical follow-up.

Promoting Safe Sleep Practices for Infants

Strategy 1: Continue to provide parents of newborns who are at risk for having an unsafe sleeping environment education about safe sleep practices and a Pac n' Play crib.

Strategy 2: Explore ways to continue funding the PGCHD's Tomorrow's Children Initiative and seek other grants (from local businesses, community organizations, other sources) for providing safe cribs to needy County infants.

Strategy 3: Identify and train new IPOC members and other appropriate providers to be distributors of safe sleep education and cribs to families in need.

Strategy 4: Work with local hospitals to ensure infants being discharged at birth have access to a safe sleep environment and that all educational messages about safe sleep are consistent among providers of SIDS and safe sleep education.

Strategy 5: Collaborate with the PGCDFs and the Healthy Families Prince George's County Program to identify additional ways to educate parents about SIDS prevention.

Ensuring the Safety of Our Food

Strategy 1: Increase the number of high priority food service facility inspections and conduct intensive education and follow-up inspections targeting facilities that chronically fail to comply with critical item (food safety) standards.

Strategy 2: Provide handouts and educational materials for non-English speaking food facility owners and their employees, and enhance information pertinent to food service facilities on the PGCHD's Web site.

Strategy 3: Publish a list of chronic or egregious violators of food safety standards in the newspaper and on the PGCHD's Web site.

Reducing Asthma-Related Incidents

Strategy 1: Institute a Healthy Homes Program that assists families with asthmatic children to reduce or manage environmental triggers; explore ways to expand the program to include provision of asthma medications and supplies (and education on their proper use) for families in need.

Strategy 2: Use GIS and hospital data to identify zip codes with the highest number of asthma-related incidents among children, and develop and implement an educational program targeting families in these areas that focuses on helping them reduce or eliminate asthma triggers.

Strategy 3: Conduct home visits to families with asthmatic children to help them identify potential asthma triggers and to educate them about preventing or reducing future asthma incidents among their children.

Improving Our Environment *

*Also see Increasing Access to Healthier Foods under Priority #2

Strategy 1: Adopt local policies that incorporate principles of smart growth and population health determinants to evaluate and issue permits for new land use, housing development, transportation, and urban renovation/revitalization projects for the purposes of improving the built environment (access to walking/biking trails, crosswalks, etc.).

Strategy 2: Identify geographic health priority areas in the County, using GIS mapping and a scoring system that includes health-related factors such as presence of full-service grocery stores, sidewalks, bike trails, etc., where greatest need exists for improved community design.

Strategy 3: Work with the Port Towns Healthy Eating/Active Living (HEAL) Partnership to promote the HEAL Project as a model for other communities to replicate that demonstrates the use of smart growth principles in community design.

Strategy 4: Educate local political and community leaders (i.e. Prince George's County Council/Board of Health), developers, building managers, tenant associations and the public about smart growth principles, population health determinants, and built environment best practices.

Strategy 5: Collaborate with M-NCPPC to implement their ACHIEVE Project that focuses on policies, systems, and environmental change to promote healthier lifestyles through improved community design.

Strategy 6: Explore ways to offer incentives to developers for creating remote parking and drop-off zones near schools, public facilities, and shopping malls, and for making improvements in stairway access in new construction and renovations.

Strategy 7: Use GIS technology to identify areas of the County that are food deserts and that are disproportionately affected by unhealthy food vending to determine communities at risk for unhealthy dietary behaviors and in greatest need of more healthy food sources.

Strategy 8: Educate community residents in identified high-risk areas about the impact of unhealthy food choices and the need to advocate for more accessible, healthy food sources.

Strategy 9: Work with the PGCPs and M-NCPPC to explore ways to establish community gardens at public schools in at-risk communities in order to increase access to fruits and vegetables by students and their families.

Strategy 10: Work with the PGCPs to explore ways to develop and implement a Healthier School Environment Action Plan in selected schools that promotes physical activity and healthy eating among students and staff.

Strategy 11: Encourage after-school programs, licensed child care facilities and family child care providers to adopt policies and practices that promote safe and healthy child care environments, to include healthy eating and physical activity.

Strategy 12: Continue monitoring public mental health services for compliance with Americans with Disabilities Act requirements through the PGCDfS Mental Health and Disabilities Division, to ensure a safe environment for individuals with mental illnesses.

Key Partners: Building managers, Care First Blue Cross/Blue Shield, community medical providers, contractors and their professional associations, Dimensions Healthcare System, Doctors Community Hospital, Food Supplement Nutrition Education (University of Maryland) Program, Healthy Families Prince George's County, Improved Pregnancy Outcome Coalition, licensed child care facilities and family child care providers, local businesses, Maryland-National Capital Park and Planning Commission (Planning Department), Maryland State Highway Administration, Port Town Healthy Eating/Active Living community leaders, Prince George's County Council/Board of Health, Prince George's County Department of Family Services, Prince George's County Department of Public Works and Transportation, Prince George's County Executive, Prince George's County Health Department, Prince George's County Interagency Committee, Prince George's County Police Department and municipal police departments, Prince George's County Public Schools, Prince George's County Transportation Planning Board, SIDS MidAtlantic, Southern Maryland Hospital Center, tenant associations.

Priority 6: Ensure that Prince George’s County Social Environments are Safe and Support Health.

(Corresponds with SHIP Vision Area 2: Ensure that Maryland Social Environments are Safe and Support Health)

County Outcome Objective	Current Baseline	2014 Target
Decrease the rate of alcohol-impaired driving (.08+ blood-alcohol content [BAC] fatalities	0.3 (rate of deaths associated with fatal crashes where driver had alcohol involvement per 100 million Vehicle Miles of Travel, State Highway Administration 2009)	.29 - rate using 5% decrease
Reduce the suicide rate	6.3 (rate of suicides per 100,000 population, VSA 2007-2009)	5.99 - rate using 5% decrease
Increase the proportion of students who graduate with a regular diploma 4 years after starting 9th grade	73.3% (percentage of students who graduate high school four years after entering 9 th grade, MSDE 2010)	77% using 5% increase
Reduce fatal and non-fatal child maltreatment	3.6 (rate of non-fatal maltreatment cases reported to social services per 1,000 children under age 18, Department of Human Resources, FY 2010)	3.4 - rate using 5% decrease
Reduce domestic violence or reduce non-fatal physical assault injuries	62.7 (rate of ED visits related to domestic violence/abuse related per 100,000 population, HSCRC 2010)	59.6 - rate using 5% decrease

Addressing Underage and Adult Alcohol Use

Strategy 1: Work with partners to continue implementing the Communities Mobilizing Change on Alcohol (CMCA) Program, a project that involves a broad range of community support to discourage underage alcohol use by changing conditions in the physical, social, and cultural environment.

Strategy 2: Expand to other communities the Strategic Community Services, Inc. Communities That Care model, a program that addresses under-age drinking through the establishment of Prevention Councils that implement evidence-based strategies to educate and engage parents.

Strategy 3: Implement with partners other nationally recognized evidence-based substance abuse prevention programs at selected community sites, such as All Stars, Strengthening Families Adolescent Program, and Dare to Be You.

Strategy 4: Support the establishment of formal and informal neighborhood watch programs that enlist local residents to assist County and municipal Police Departments by identifying and reporting incidents of underage drinking, alcohol-impaired driving and other community hazards.

Strategy 5: Work with County and municipal Police Departments to develop strategies that encourage County residents to seek recreation opportunities that are safer alternatives to after-hour clubs.

Strategy 6: Promote the use of designated drivers, especially during holiday seasons and special events where alcohol use may increase.

Preventing Suicides

Strategy 1: Partner with Community Crisis Services, Inc. (which runs the Youth Suicide Prevention Hotline), the Prince George's County Response System, PGCDPS, and other health and human service providers about the availability of 24/7 counseling, support, and other services for individuals at risk of suicide, suicide attempters, their families and friends, and loss survivors.

Strategy 2: Partner with Community Crisis Services, Inc, to recruit and train lay individuals, professionals and other interested community residents in suicide prevention and intervention methods, using evidence-based programs such as the Substance Abuse and Mental Health Services Administration's (SAMHSA) SafeTALK (Suicide Alertness For Everyone), QPR (Quality Persuade and Refer), and ASIST (Applied Suicide Intervention Skills Training).

Strategy 3: Educate the public and health and human service providers about how to refer individuals in imminent danger of suicide to crisis services such as the Suicide Hotline or, when appropriate, to a crisis intervention team or the emergency room.

Strategy 4: Continue to provide a suicide risk assessment on every young person who presents for substance abuse services; refer cases to a crisis intervention service for follow-up or to the PGCDSS Child Protective Services (CPS) when cases meet criteria for medical neglect on the part of the parents or legal guardian.

Strategy 5: Work with the PGCPD to ensure that faculty and staff are trained on adolescent suicide risk factors and warning signs, and to help the school system develop a safety plan that includes clear protocols, lines of communication, and a crisis

team to be activated when risk of a suicide is identified or when a suicide attempt or completion by a student occurs.

Strategy 6: Ensure that every student at risk of suspension or expulsion for violent or illegal behavior receives immediate counseling for him/herself and family.

Strategy 7: Educate parents, adolescents, community leaders, faith leaders, and others about the risk factors that make adults and young people vulnerable to suicide (including the role of alcohol, other drugs, and handguns) and the services available to individuals at risk of suicide.

Increasing the High School Graduation Rate

Strategy 1: Continue to link students at risk of suspension or expulsion to needed community services and resources, including alternative educational programs (i.e. General Equivalency Diploma [GED]).

Strategy 2: Provide social work counseling and other appropriate interventions to every student seen at the County's four SBWCs who is truant or at risk for dropping out.

Strategy 3: Increase awareness among community providers and the public of the PGDFS Gang and Truancy Prevention Initiatives, After-School Programs, Youth Service Bureau programs, and other programs that serve vulnerable and at-risk youth.

Addressing Child Maltreatment and Domestic Violence

Strategy 1: Assess students seen at the four SBWCs who self-identify or are identified by school personnel as being at risk for an unsafe school, home, or community environment and make referrals for further intervention, including referral to CPS.

Strategy 2: Encourage schools and parent groups to establish formal and informal school and neighborhood "watch" programs that specifically monitor and report incidents of bullying, and to form intervention teams to address the problem.

Strategy 3: Assess every student seen by a Social Worker at the four SBWCs for his/her risk for child abuse, sexual abuse, or maltreatment; refer suspicious cases to CPS for follow-up.

Strategy 4: Continue convening meetings of the Prince George's County Child Fatality Review Team (CFRT) to review child fatality cases and to make recommendations for preventing child abuse and neglect to the local partner agencies and DHMH.

Strategy 5: Conduct outreach to medical providers to ensure they are aware of their responsibility and have the necessary information to report cases of child abuse and neglect.

Strategy 6: Continue providing domestic violence and healthy relationship counseling to clients of the PGCHD, Shepherd's Cove Shelter, and the PGCDOC who self-identify or are identified by a health provider as a victim or potential victim of domestic violence.

Strategy 7: Continue convening meetings of the Domestic Violence Coordinating Council for the purpose of reviewing domestic violence cases, sharing information, and building resources to address domestic violence.

Strategy 8: Collaborate with the Maryland Network Against Domestic Violence (MNADV) for professional training of County health care workers who serve at-risk clients.

Strategy 9: Continue convening meetings of the Domestic Violence Fatality Review Team to review records of domestic violence related fatalities and to make recommendations to the MNADV for future interventions.

Strategy 10: Continue providing relationship counseling, anger management and effective communications training, and parenting classes through the County's Adam's House Program to individuals at risk for domestic violence who are identified by the State's Attorney's Office, Parole and Probation Office, Family and Child Support Courts, PGCDSS, and other agencies.

Strategy 11: Enlist the faith-based community and other groups to establish support groups for victims and potential perpetrators of domestic violence.

Strategy 12: Collaborate with key stakeholders serving on the Prince George's County Justice Center Task Force to establish a model center where victims of domestic violence can obtain a multitude of services in one location such as restraining orders, substance abuse treatment, videotaped testimony for court (in lieu of personal appearance), child care, etc.

Strategy 13: Work with local law enforcement agencies to educate the public about firearms safety practices.

Key Partners: Community-based organizations, Community Crisis Services, Inc., community liquor stores, Dimensions Healthcare System, Doctors Community Hospital, Family Crisis Center, insurance companies, local communities and municipalities, local driver education schools, Maryland Department of Health and Mental Hygiene Alcohol and Drug Abuse Administration, Maryland 4-H Program, Maryland-National Capital Park and Planning Commission, Maryland Network Against Domestic Violence, Maryland State Liquor Board, Prince George's County Alcohol and Other Drugs Coalition and Youth Councils, Prince George's County Child Fatality Review Team, Prince George's County Courts, Prince George's County Crisis Response System, Prince George's County Department of Corrections, Prince George's County

APPENDIX VI: BLUEPRINT PLAN

Department of Family Services, Prince George's County Department of Social Services, Prince George's County Domestic Violence Coordinating Council and Domestic Violence Fatality Review Team, Prince George's County Fire Department and Emergency Services, Prince George's County Health Department, Prince George's County Highway Safety Task Force, Prince George's County Justice Center Task Force, Prince George's County Parole and Probation Office, Prince George's County Police Department and municipal police departments, Prince George's County Public Schools, Prince George's County Sheriff's Department, Prince George's County State's Attorney's Office, Shepherd's Cove homeless shelter, Southern Management, Southern Maryland Hospital Center, Strategic Community Services, Inc.

County-Specific Health Priorities*

*Note: Specific partners are not listed in this section because it is assumed that all partners identified previously under Priorities 1-6 will work collectively with the LHAPC to address the County-Specific Health Priorities.

Priority 1: **By 2015, enhance the health information technology infrastructure of Prince George's County in order to increase reimbursements for health services provided, improve patient care, and address disparities.**

Strategy 1: Establish an agency-wide third party electronic billing system in the PGCHD that meets federal and state Health Information Portability and Accountability Act (HIPAA) and other requirements.

Strategy 2: Work with the Chesapeake Health Information System for our Patients (CRISP - Maryland Statewide Health Information Exchange [HIE]) and the Management Service Organization to adopt Meaningful Use of Electronic Health Record (EHR) technology. The benefits of EHR, called eHealth for Prince George's County, will include:

- improvements in the quality and coordination of care delivered
- decreased health care costs and greater provider accountability
- reductions in the provision of unnecessary services
- engagement of health care consumers in the decision-making process and self-care management
- improvements in the overall management of population health.

Strategy 3: Work with DHMH to develop strategies for collecting health statistics at the sub-County level (i.e. census tracts, zip codes) in order to target health initiatives in areas of the County with greatest need.

Strategy 4: Fully integrate the County Stat data reporting system into PGCHD and other County agency operations for the purpose of evaluating progress towards meeting County Health Improvement Plan health objectives, identifying deficiencies in service delivery and possible remedies, and providing reports on the health status of the County to the public.

Priority 2: By 2020, obtain public health national accreditation of the Prince George's County Health Department.

Strategy 1: Work with DHMH to determine the requirements, steps and a timeline for seeking public health national accreditation.

Priority 3: By 2020, build a comprehensive integrated community-oriented health care system that meets the needs of all County residents.

Strategy 1: Forge long-lasting public and private partnerships with critical community stakeholders for the purposes of conducting joint long and short-term strategic health planning, increasing addressing existing and emerging health issues of mutual concern, and managing resources to support essential services and new initiatives.

Strategy 2: Complete the process outlined in the Memorandum of Understanding (MOU) between the County, State of Maryland, University of Maryland Medical System, University System of Maryland and Dimensions Health Corporation to have the Prince George's County hospital system join the University of Maryland Medical System. This process includes the construction of a new regional medical center (RMC) in Prince George's County supported by a comprehensive ambulatory care network and a University of Maryland Baltimore health sciences presence within the County. The RMC would serve Prince George's County and southern Maryland.

The MOU also calls for:

- **Physician/Provider Needs:** Development of a strategy to address physician and other allied health care provider needs
- **Strategic Plan for Discharging Liabilities:** Development of a feasible plan and timeline for satisfaction of the Dimensions' liabilities
- **Public Funding:** The County and State shall execute a Letter of Intent that reflects their commitment to provide a total of \$30 million of funding (\$15 million each) through FY 2015 to support the Dimensions' operations and discharge of liabilities
- **Reducing and Eliminating Operating Losses:** Development of a plan and timeline for implementing cost-containment, quality enhancement, and clinical integration measures necessary to reduce and ultimately eliminate the Dimensions' operating losses.

*Note: See "Prince George's County Hospital Authority Final Report and Recommendations, May 21, 2010" for a complete description of findings and recommendations.

Strategy 3: Move forward with implementing recommendations of the Prince George's County Executive's 2010 Transition Team to improve service delivery by Prince George's County health and human service agencies and other County agencies providing services that impact the health of County residents.

Strategy 4: Work with federal and state authorities to explore ways to achieve additional Medically Underserved Area (MUA), Medically Underserved Population (MUP) and Governor Exceptional MUP designations for the County, in an effort to increase the number of FQHCs and other safety net clinics in areas of the County where health resources are scarce.

Strategy 5: Leverage the existing resources of GBMC, CCI, Mary's Center, Dimensions Healthcare System, Children's National Medical Center, and other community providers to address the immediate need for additional well child, women's wellness, immunization, sick care, prenatal care, family planning, health education, dental, and other primary care services.

Strategy 6: Work towards the establishment of a primary care coalition that focuses on improving the quality and provision of primary care in the County through adoption of best practices, technology, and systems changes.

Strategy 7: Establish a Health Care Coordinating Council comprised of key health stakeholders that will inform the Prince George's County Council on issues requiring health policy and financing decisions, advise the Council in its role as the Board of Health, and participate in designing a comprehensive and integrated healthcare system for the County.

Strategy 8: Develop the County's grantsmanship capacity by establishing a unit within County government dedicated to the pursuit of federal, state, local, and private foundation resources.

Strategy 9: Explore opportunities to provide additional funding to community-based non-profit organizations and to critical programs that serve vulnerable populations but are severely underfunded and/or understaffed, such as the SBWCs and Health*line*.

Strategy 10: Partner with UMDSPH, Bowie State University, other academic institutions, private and non-profit organizations to determine opportunities for collaboration in the following areas: seeking funding for existing and new health initiatives, conducting community needs assessments and program evaluations, and carrying out research and demonstration projects that help to determine best practices needed to address our critical health concerns and to eliminate disparities.

Strategy 11: Tap the expertise and resources of the National Institutes of Health, Food and Drug Administration, other federal health agencies in the Washington Metropolitan area, Kaiser Permanente, other managed care organizations, health insurance companies, local businesses, faith-based organizations, and pharmaceutical and biomedical technology companies to identify ways to collaborate on special initiatives that enhance access to care.

Strategy 12: Partner with community groups such as Health Action Forum, the River Jordan Project, and Progressive Cheverly to identify ways to increase public input into long and short-range health planning for the County that reflects the concerns of all of the County's diverse populations.

Strategy 13: Develop and implement an educational campaign to significantly increase awareness among community providers, key stakeholders, partners, and the public about the comprehensive array of services available to vulnerable, at-risk, and special needs populations through the County Government's Health and Human Services agencies.

Strategy 14: Increase awareness among community providers, key stakeholders, partners, and the public about the various County agency programs that serve as expedited or single points of entry into care for specific populations, including PGCHD's Health*line* Program for pregnant women and children, PGCDFS's Local Access Mechanism for families seeking youth services, and PGCDFS's Maryland Access Point for family caregivers and persons with disabilities seeking services.

Priority 4: Throughout 2011 - 2015, work with partners to implement strategies that attract more licensed medical professionals and other health care workers to the County in order to address the severe health care workforce shortage.

Strategy 1: Explore ways to offer sign-on bonuses and/or other incentives to licensed health professionals considering positions in County Government.

Strategy 2: Partner with the UMDSPPH, Bowie State University and Prince George's Community College to promote careers in public health among their students and to create student internships, preceptorships, and other programs that address the staffing needs of community health providers.

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- Community Health Transformation Coalition and Leadership Team
- Domestic Violence Coordinating Council
- Domestic Violence Fatality Review Team
- Fetal and Infant Mortality Review Team
- The Gaston and Porter Health Improvement Center
- Health Action Forum
- Health Disparities Coalition
- Improved Pregnancy Outcome Coalition
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Document Abbreviations

ACHIEVE	Action Communities for Health, Innovation, and Environmental Change
ASIST	Applied Suicide Intervention Skills Training
ATOD	Alcohol, Tobacco, and Other Drugs
BCCP	Breast and Cervical Cancer Program
BRFSS	Behavioral Risk Factor Surveillance System
CAM	Complementary and Alternative Medicine
CCI	Community Clinics, Inc.
CDC	Centers for Disease Control (and Prevention)
CESAR	Center for Substance Abuse Research
CHLI	Center for Healthy Lifestyle Initiatives
CMCA	Communities Mobilizing Change on Alcohol
CPEST	(Colorectal) Cancer Prevention, Education, Screening, and Treatment
CPS	Child Protective Services
DDA	Developmental Disabilities Administration
DHMH	(Maryland) Department of Health and Mental Hygiene
DOT	Directly Observed Therapy
DUI/DWI	Driving Under the Influence/Driving While Intoxicated
ED	Emergency Department
EHR	Electronic Health Record
FIMR	Fetal and Infant Mortality Review
FQHC	Federally Qualified Health Center
GBMS	Greater Baden Medical Services
GED	General Equivalency Diploma
GIS	Geographic Information Systems
HEAL	Healthy Eating/Active Living
HFTI	Healthy Futures Training Institute
HIE	Health Information Exchange
HIPAA	Health Information Portability and Accountability Act
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HP	Health People
HSCRC	Health Services Cost Review Commission
IDEHA	Infectious Diseases and Environmental Health Administration
IPOC	Improved Pregnancy Outcome Coalition
LBW	Low Birth Weight

MCHP	Maryland Children’s Health Program
MCO	Managed Care Organization
MNADV	Maryland Network Against Domestic Violence
M-NCPPC	Maryland-National Capital Park and Planning Commission
MOU	Memorandum of Understanding
MSDE	Maryland State Department of Education
MUA	Medically Underserved Area
MUP	Medically Underserved Population
OB/GYN	Obstetrician/Gynecologist
PCP	Primary Care Physician
PGCDFS	Prince George’s County Department of Family Services
PGCDOC	Prince George’s County Department of Corrections
PGCDSS	Prince George’s County Department of Social Services
PGCHD	Prince George’s County Health Department
PGCPS	Prince George’s County Public Schools
PGHAC	Prince George’s Healthcare Action Coalition
PLAN	Partnership for Learning Among Neighbors
PLWH	Persons Living With HIV/AIDS
PSA	Prostate Specific Antigen
QPR	Quality Persuade and Refer
SafeTALK	Suicide Alertness for Everyone TALK
SafetyNET	Safety Network for Entry into Treatment
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention and Referral to Treatment
SBWCs	School-Based Wellness Centers
SIDS	Sudden Infant Death Syndrome
SIDS/MA	Sudden Infant Death Syndrome/MidAtlantic
SPF	Sun Protection Factor
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
STICC	Sexually Transmitted Infections Community Coalition
SUID	Sudden Unexpected Infant Death
TB	Tuberculosis
UMDSPH	University of Maryland School of Public Health
USDA	United States Department of Agriculture
VBAC	Vaginal Birth After C-Section
WIC	Women, Infants, and Children

For More Information

Electronic copies of this document are available at www.princegeorgescountymd.gov/health.

If you wish to become a partner in carrying out the County Health Improvement Plan, or if you have questions or comments about this Plan, please call 301-883-7834.

Appendix IX: Community Health Needs Assessment and Implementation Strategy

Insert PDF

Doctors Community Hospital Community Health Needs Assessment Report

June 27, 2013

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UPDATED JUNE 30, 2014: TO INCLUDE IMPROVEMENTS IN FORMAT AND EXPLANATION OF METHODOLOGY, ONLY. NO SURVEY DATA WAS CHANGED

EXECUTIVE SUMMARY

Doctors Community Hospital has a 37-year tradition of providing quality medical and surgical care to the residents of Prince George's County. To address the dominant healthcare needs of this community, the hospital recently performed both primary and secondary research to gauge the general market environment as well as the healthcare realities and perceptions of county members. With such information, tactics can be reinforced or developed to address the findings.

Among its 863,420 residents, Prince George's County's population includes predominately minorities – African Americans (65 percent) and Latinos (15 percent). About 74 percent of those who are ages 16 or older are employed – contributing to a medium income of \$69,545, which is higher than the national average. Additionally, approximately 81 percent of residents are insured.

Even with these statistics, there are significant health disparities among Prince George's County residents. In fact, according to the Department of Health and Mental Hygiene's vital statistics report, the county is ranked 18 out of 24 among Maryland counties and leads in deaths caused by heart disease, cancer, cerebrovascular diseases, diabetes, accidents, assaults, influenza/pneumonia, HIV and hypertension/hypertensive renal disease. Moreover, the county has high incidences of obesity, diabetes, cardiovascular disease, breast cancer, tobacco use and asthma. (Appendix A has been included in this report, which further reflects disparities in Prince George's County relating to health and education as compared with residents of the District of Columbia and Virginia.)

In addition to the above data, the hospital conducted its own survey from December 2012 to April 2013. With a goal of identifying the dominant healthcare concerns of residents, respondents' top five issues were high blood pressure, weight loss/obesity, diabetes, nutrition/exercise and heart disease.

Dedicated to passionately caring for its patients and the community, Doctors Community Hospital has established tactics that addressed many of these health issues and concerns. These tactics included initiatives conducted by its specialty programs, support groups, community outreach coordinators and partnerships. This report will detail these programs as well as provide details regarding the aforementioned data.

HOSPITAL OVERVIEW

Doctors Community Hospital (DCH) is a not-for-profit corporation that was founded in 1975 by leading physicians who were committed to ensuring that county residents had convenient access to a wide range of medical and surgical services. In addition to the main hospital located in Lanham, it also has offices in Greenbelt, Bowie and Largo in Maryland.

In fiscal year 2012, the hospital employed about 1,462 employees with more than half being Prince George's County residents. Also, Doctors Community Hospital had a medical staff of 505 physicians.

Within a patient-centered environment, the hospital has focused on continuously elevating its high standards of quality. Accredited by the Joint Commission, the hospital has earned the Delmarva Excellence Award for Quality and Press Ganey Top Improver Award. Moreover, the hospital was ranked #1 for quality by Prince George's County residents in a University of Maryland survey.

THE COMMUNITY DCH SERVES

There is an estimated 834,000 residents in Prince George's County, which represents 15 percent of all Marylanders. This county represents 93 percent of the hospital's service market.

In fiscal year 2012, the hospital had 12,052 total admissions and performed 13,098 surgical services procedures. Also, in Doctors Community Hospital's Emergency Department, it had 54,312 visits. Generally, the major health conditions encountered in typical emergency departments include:

- Diabetes
- Cardiac
- Asthma and other pulmonary
- Cancer
- Renal failure
- Septicemia, influenza and other infections

THE COMMUNITY HEALTH NEEDS ASSESSMENT BACKGROUND

The purpose of the Community Health Needs Assessment (CHNA) was to gather information about the health needs, behaviors and conditions of Prince George's County residents.

The CHNA was comprised of both quantitative health information and qualitative feedback from the community. This multi-faceted approach ensured a profile of the county's health that examined various perspectives and data sources. The three research components included secondary data, community surveys and focus group testing.

With insight about the overall health status of Prince George's County, DCH can investigate strategies to address some of those concerns.

PROCESS AND METHODS USED TO CONDUCT THE ASSESSMENT

In this section we will describe the process and method to conduct the assessment including a description of the sources and dates of the data, analytical methods applied, gaps in information, and prioritization methods.

Secondary Data

One of the initial steps in developing the CHNA was collecting secondary data from reputable sources such as the United States Census Bureau and the Maryland Department of Health and Mental Hygiene (DHMH).

This report integrated not only more traditional physical health statistics including cancer rates, it also included demographic and household information. When reviewed collectively, this data revealed that social determinants such as income and education impacted health status, behaviors and outcomes. In fact, research showed that lower educational levels, poverty levels and race/ethnicity are risk factors for certain health conditions.

Demographic Statistics

Prince George's County is located in Maryland. Specifically, it is immediately north, east and south of Washington, D.C., and 18 miles from Baltimore City. The county is 485 square miles in size with 863,420 residents – making it the second most populous county in Maryland.

Some of the demographic information about this county includes:

- *Diversity* - Prince George's County is one of the most diverse of Maryland counties. With residents who speak more than 150 languages, residents come from all parts of the world, especially Mexico, Central America, Africa, South America, Haiti and other Caribbean nations.
- *Race/Ethnicity** – Minorities represent more than 80 percent of residents – African Americans (64.9 percent) and Hispanics/Latinos (16.9 percent). Also, this population consists of Caucasians (17.4 percent), Asian-American/Pacific Islanders (4 percent) and Native Americans (less than 1 percent).
- *Education* - The educational backgrounds of residents are comparable to national averages. This county's residents include 85 percent who have high school diplomas. Also, an estimated 27- 30 percent of residents who are ages 25 and older have a bachelor's degree or higher. In the United States, the educational background of citizens include 84 percent who have high school diplomas with about 29 percent of those ages 25 and older having a bachelor's degree or higher.
- *Income* - The population in the county is relatively affluent with a medium household income of \$69,545 in comparison to the average of \$50,740 in the United States.

However, the county has a substantial number of low income “working poor” who reside primarily in the densely populated communities of District Heights, Capital Heights and Hyattsville located inside the Capital Beltway. About 10 percent of county children live in poverty with about 43 percent of their families qualifying for the free lunch program. Also, approximately 17.5 percent of adults who live in the county are unable to afford to seek treatment from a doctor, which results in a lack of routine medical care and higher than average emergency department visits for treatment.

- *Employment* – A large percentage of the population is in the workforce with 74 percent of residents ages 16 and older being gainfully employed versus the 65 percent national average.
- *Insurance* – The Small Area Health Insurance Estimate revealed that the county has the highest percentage and absolute number of uninsured people in Maryland. Data from the 2008 Behavioral Risk Factor Surveillance System (BRFFS) showed that 19 percent of the county’s population was uninsured (16 percent of African American and 12 percent of Caucasian adults).
- *Community Type* - The county had a mix of urban, suburban and rural communities. However, the majority of residents lived inside the Capital Beltway adjacent to the District of Columbia.
- *Recreational Facilities* – The county had an extensive array of parks and recreational facilities operated by the Maryland-National Capital Park and Planning Commission. They included more than 40 miles of trails, 27,000 acres of parklands, 43 community recreational centers, 10 aquatic facilities and a state-of-the-art sports complex.
- *Educational Facilities* – The county was home to the University of Maryland School of Public Health, Bowie State University School of Nursing and Prince George’s County College’s Nursing Program. It was also within close proximity to other academic and medical institutions that could provide resources to address community health needs.

Source: *Blueprint for a Healthy Prince George’s County 2011-2014*

*** 2013 Population by Single Race and Ethnicity**

<i>Single Race/Ethnicity</i>	<i>Population</i>	<i>Percentage</i>
Black/African American	571,380	64.91 percent
White	153,542	17.44 percent
Hispanics/Latinos	149,109	16.94 percent

Some Other Race	84,722	9.63 percent
Asian	36,153	4.11 percent
2+ Races	29,284	3.33
American Indians/Alaskan Natives	4,565	.52 percent
Native Hawaiian/Pacific Islanders	577	.07 percent

Source: Health Communities Institute Dashboard

Health Status Indicators

- *Overall Health Rankings and Health Disparities* – A health report ranked Prince George’s County 18 out of 24 among other Maryland counties. (The lowest score was 24.) This report gave the county an overall comparative poor health ranking for death rates occurring before the age of 75; percentage of people who reported being in fair or poor health; the number of days people reported being in poor physical health, smoking, obesity, binge drinking and receipt of clinical care; violent crime; liquor store density; unemployment rates; the number of children living in poverty; air pollution levels; and access to healthy foods.

According to the DHMH Vital Statistics Annual Report, the leading causes of death in Prince George’s County in 2009 included:

Cause of Death	Ranking by Cause Death
Diseases of the heart	1 st
Malignant neoplasms (cancer)	2 nd
Cerebrovascular diseases	3 rd
Diabetes mellitus	4 th
Accidents	5 th
Assaults (homicides)	8 th
Influenza and pneumonia	11 th
HIV	12 th

Data from the 2009 Maryland Chartbook of Minority Health and Minority Health Disparities showed significant differences in mortality rates among specific groups. For example, from 2002 to 2006, African Americans in the county had higher mortality rates than Caucasians for all causes including for six of the top eight causes of death (excluding chronic lung disease and liver disease).

The mortality ratio disparity was greatest for HIV and kidney disease. African Americans experienced 4.3 times the HIV death rate than Caucasians. Also, African Americans experienced 2.4 times the kidney disease death rate than Caucasians.

Chronic Diseases and Related Conditions

- *Overweight/Obesity* – The percentage of overweight or obese county residents was among the highest in Maryland and the nation. This rate has steadily increased since 1995 for both adults and children. From 1995 to 2007, the number of overweight/obese county residents increased by 13 percent.

Among children ages 18 or younger, about 48 percent were at risk for becoming obese or were currently overweight. African Americans were disproportionately affected by obesity. In fact, data from the 2008 BRFSS study showed that 76 percent of African Americans versus 62 percent of Caucasians were either overweight or obese.

- *Diabetes* – Twelve percent of county residents were diabetic. According to DHMH's Vital Statistics Administration, significant disparities existed in the county regarding diabetes-related deaths. The age-adjusted death rate for diabetes among African Americans was 47.1 per 100,000 and 21.9 per 100,000 for Caucasians. This rate was significantly higher than the Maryland age-adjusted diabetes death rates of 34.3 per 100,000 for African Americans and 21.7 per 100,000 for Caucasians. (Age-adjustment is a methodology used to compare rates among populations with differing age distributions.)

The 2009 Vital Statistics Administration report indicated that Prince George's County had the highest number of actual diabetes deaths in the state (197), which was followed by Baltimore City (196) and Baltimore County (192).

- *Cardiovascular Disease and Related Risk Factors* – Cardiovascular disease was the leading cause of death in Prince George's County, and it was a key contributor to the county's disparity in life expectancy. About 28 percent of county residents had cardiovascular disease with related age-adjusted death rates that were significantly higher than the Maryland average (280.4 versus 252.8 per 100,000).

For African Americans, the age-adjusted death rate was 338.4 per 100,000 compared to 228.7 per 100,000 for Caucasians.

A comparison of BRFSS data from 2009 and 2010 showed that rates for certain chronic disease risk factors had an increasing trend in the county.

<i>Risk Factors</i>	<i>2009</i>	<i>2010</i>
Ever told you had a stroke?	1.2 percent	1.6 percent
Ever told you had diabetes?	10.9 percent	11.9 percent
Did not meet the Healthy People 2010 objective for moderate or vigorous physical activity?	56.5 percent	62.0 percent

- *Cancer* – Malignant neoplasms (cancers) were the second leading cause of death among county residents. In 2008, the county’s age-adjusted mortality rate for all malignant neoplasms was 175.9 per 100,000. Among African Americans, the age-adjusted mortality rate was 202.2 per 100,000 compared to 151.6 per 100,000 for Caucasians.

African-American women had higher breast cancer mortality (38.3 per 100,000) than Caucasian women (17.3 per 100,000). Regarding prostate cancer, African-American men had higher mortality rates (43.2 per 100,000) than those of Caucasian men (23.7 per 100,000). Such disparities were mirrored relating to African Americans with colorectal, pancreatic, and liver and biliary cancers.

- *Tobacco Use* – Approximately 12 percent of children ages 18 and younger smoked. Among adults ages 19 and older, about 16 percent smoked according to the 2010 County Health Rankings report. The percentage of African Americans in the county who currently smoked cigarettes daily was 4 percent compared to 16 percent of Caucasians.
- *Asthma* – Between 2004 and 2006, approximately 15 percent of county adults were diagnosed with asthma and 8 percent reported currently having asthma according to a DHMH profile. In 2006, this condition caused more than 6,000 asthma-related emergency department visits and 1,300 hospitalizations among county residents. The asthma-related emergency department visits were four times higher among African-American residents than among Caucasians. Accordingly, the hospitalization rate was approximately three times higher among African Americans than Caucasians.

Community Health Assessment Surveys

From December 2012 to April 2013, a community health assessment survey was distributed among community members, faith-based organizations, business leaders as well as current patients and their families.

With more than 500 surveys completed, respondents provided demographic information and selected their top four healthcare concerns. As shown in the below table, the five concerns that were most frequently selected were high blood pressure, weight loss/obesity, diabetes, nutrition/exercise and heart disease.

<i>Health Issues</i>	<i>Percentage Selected by Respondents in Their Top Four</i>
High blood pressure	16 percent
Weight loss/obesity	15 percent
Diabetes	14 percent
Nutrition and Exercise	13 percent
Heart disease	11 percent
Cancer – breast	10 percent
Sleep disorder	5 percent
Asthma	4 percent
Stroke	4 percent
Cancer – prostate	3 percent
Cancer – other	2 percent
Rehabilitation	2 percent
Sickle cell	1 percent

Wound care	.80 percent
Other	.20 percent

Focus Group Testing

Approximately 15 community members participated in a four-hour focus group. The participants identified five healthcare issues of most concern to them:

- Expanded community outreach and programs
- Mental health services
- Fitness and wellness programs
- Health promotion and nutrition classes
- Support groups for diabetes education and stress management

Methodology for prioritizing data collected

Members of the Community Health Needs Assessment committee used a criteria-based scoring system to prioritize the data collected into initiatives.

The Criteria-Based scoring System Tool:

	Triple Aim (30 Points)	Prince George's County Health Plan (20 Points)	Community Partner (15 Points)	Internal Human and Financial Resources (15 Points)	Survey Responses (10 Points)	Direct Community Request (10 Points)	TOTAL POINTS
Cancer (Breast)	30	20	15	15	10	10	100
Diabetes	30	20	15	15	10	10	100
Cancer (Colorectal)	30	20	15	15	0	10	90
Cardiovascular Disease and Related Risk Factors	30	20	5	5	10	10	80

High Blood Pressure	30	20	5	5	10	10	80
Nutrition and Exercise	30	20	5	5	10	10	80
Overweight/Obesity	30	20	0	5	10	10	75
Stroke	30	20	5	5	5	10	75
Cancer (Prostate)	30	20	5	5	5	10	75
Education	30	20	5	5	5	10	75
Sleep Disorders	30	0	0	5	5	10	50
Rehabilitation	30	0	0	5	5	10	50

EXISTING HEALTH CARE FACILITIES AND OTHER RESOURCES

Appendix B is a listing of the existing health care facilities and other resources, other than our hospital, within the community that could help meet the health needs identified in the CHNA.

IMPLEMENTATION STRATEGY

The implementation strategy was approved by the CHNA Committee on June 27, 2013. The authorizing governing body of the hospital also approved the strategy.

Health Needs Addressed by the Hospital

Many of the chronic illnesses and healthcare concerns mentioned in this report have been addressed as part of Doctors Community Hospital's ongoing commitment to care for the residents of Prince George's County. As part of our strategic planning process, the hospital will continue to assess the continuation of current as well as addition of new programs to favorably impact the health of the community.

The following chart is as a result of the prioritization of the data received from our community assessment survey processes following our methodology

<i>Issue</i>	<i>Total</i>
Diabetes	100
Cancer (Breast)	90
Cardiovascular Disease and Related Risk Factors	81.6
Overweight/Obesity	81.6
Nutrition and Exercise	80
Education	80
Cancer (Colorectal)	75
High Blood Pressure	75
Stroke	68.3

Cancer (Prostate)	51.6
Rehabilitation	48.3
Sleep Disorders	40

Below is a summary of each of the initiatives.

- *Diabetes* – The hospital’s Joslin Diabetes Center in collaboration with the Prince George’s County Health Department launched the On the Road Diabetes Program in April 2013. Participants received free diabetes screenings and in-depth education classes at various locations throughout the county. The program’s goals were to serve at least 500 residents during 25 to 30 sessions in calendar year 2013.
- *Cancer (Breast)* – *The first of its kind in Prince George’s County, the hospital’s Center for Comprehensive Breast Care provided free digital mammograms to underinsured and uninsured women in the county. With a one million dollar grant from Susan G. Komen, the center’s goal was to provide free mammograms to 100 female residents monthly. Additionally, the center provided monthly support groups – one for women who were newly diagnosed with or receiving breast cancer, and the other for male caregivers of those who have breast cancer*
- *Cardiovascular Disease and Related Risk Factors* – Each quarter, the hospital offered a cardiac rehab support group to help people regain their strength and mobility after treatment for a cardiovascular condition.
- *Overweight/Obesity* – It’s Bariatric and Weight Loss Center offered free seminars throughout the year. Participants learned about various weight loss options including nutrition, exercise and surgery. Also, given the relationship between obesity and diabetes, the hospital’s Joslin Diabetes Center had a nutritionist who helped patients learn how to make healthy dietary decisions.
- *Nutrition and Exercise* – Nutrition and exercise were important components of various outreach and educational programs provided by the hospital’s Joslin Diabetes Center, Bariatric and Weight Loss Center and Cardiovascular Rehabilitation Program.
- *Education* – The hospital’s Job Sampling Program provided opportunities for high school students to observe various vocations and work on skills-enriching projects. Along with evaluations that were part of each student’s academic grades, this program focused on exposing students to career opportunities while helping those who had learning or socialization challenges.

- *High Blood Pressure* – The hospital participated in about five blood pressure screening events yearly; and it is investigating approaches to provide more screenings to better meet the growing requests from surrounding community churches, local businesses and government agencies.
- *Stroke* – The hospital offered a monthly stroke support group. Participants included stroke survivors and caregivers who were empowered to share their experiences while reinforcing their optimism, resiliency, determination and independence.
- *Cancer (Prostate)* – The hospital offered free prostate screenings. Conducted by board-certified urologists, these screenings included general education about prostate and urologic health.
- *Cancer (Colorectal)* – In partnership with Prince George’s County’s Health Department, the hospital provided free colonoscopies to low income county residents who were ages 50 or older; or younger than age 50 with a family history of colorectal cancer. This initiative resulted in 86 screenings with gastroenterologists identifying two cases of cancer.
- *Rehabilitation* –The hospital’s lymphedema support group met quarterly at various times and dates to better accommodate participant’s schedules. It offered an open and friendly environment for patients, friends and family members to discuss ideas, give hope, provide support and share information. Also, guest speakers presented on various lymphedema-related topics.
- *Sleep Disorders* –The hospital’s Sleep Center performed several community screenings throughout the year. Also, it provided two educational opportunities. A support group focused on encouraging interactive discussions among people suffering from sleep apnea. A lecture series included speakers who addressed the health risks of various sleep disorders. At each educational group, participants learned how proper sleep and sleep disorder treatments reduced health-related problems such as diabetes, high blood pressure, heart disease and stroke.

Unmet Health Needs

Illiteracy-Illiteracy was identified in Prince George’s County and Doctors Community Hospital will continue to work with the county officials to see how we can assist.

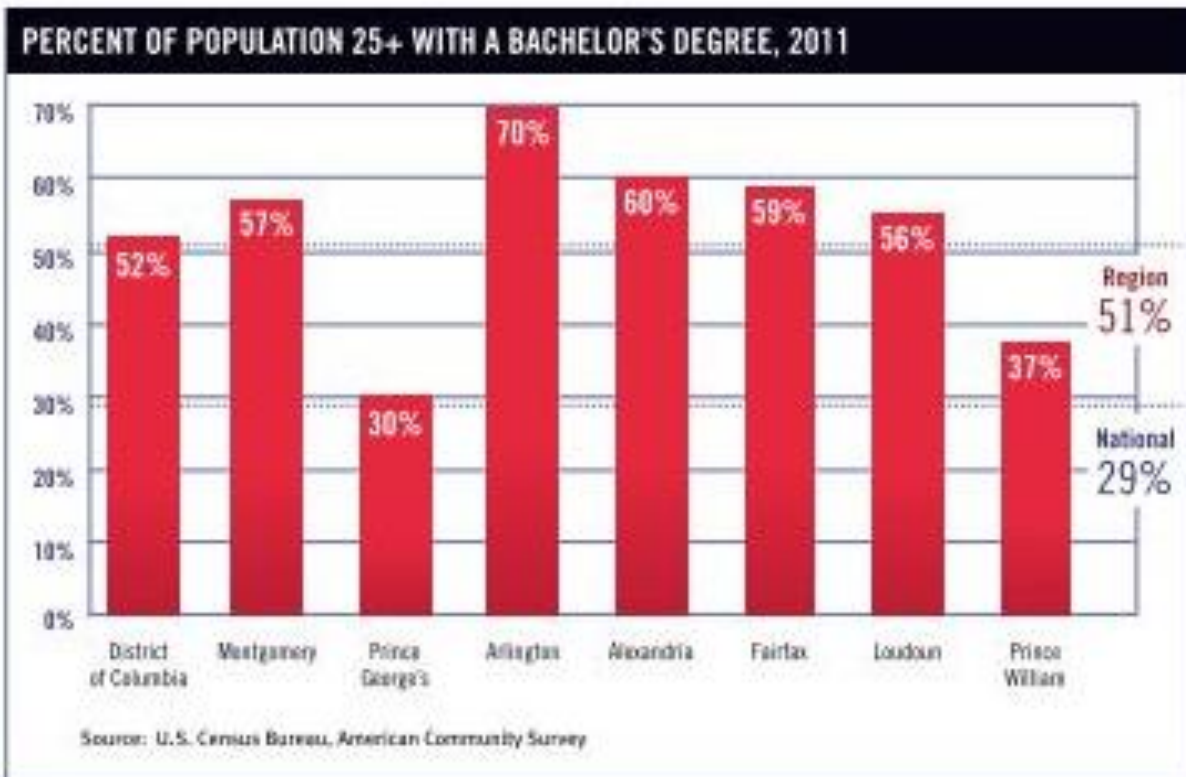
The hospital does not have the specialized resources needed to provide a program.

APPENDIX A: GEOGRAPHIC DISPARITIES

United Way of the National Capital Area Report

When compared to jurisdictions within a wider geographic area, numerous health and educational disparities that increasingly impact Prince George's County are further highlighted. In a May 2013 report, the United Way of the National Capital Area published a "Community Snapshot" with such information.

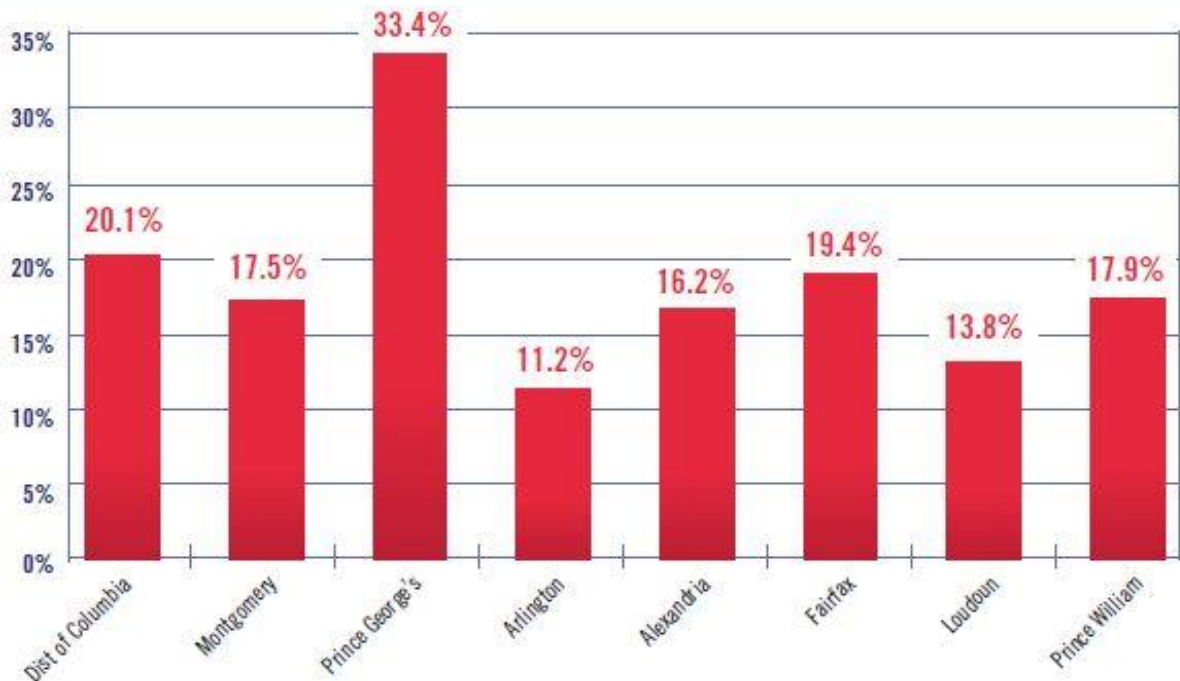
- Education – Approximately 30 percent of Prince George's County adults ages 25 and older had bachelor's degrees. In the District of Columbia, Montgomery County and four Virginia jurisdictions, a range of 37 to 70 percent of adults ages 25 and older had bachelor's degrees. These statistics represented a 7 to 40 percent gap.



Source: United Way of National Capital Area's May 2013 Community Snapshot

- Health – Approximately 33.4 percent of Prince George's County adults were obese. In the District of Columbia, Montgomery County and four Virginia jurisdictions, a range of 11.2 to 20.1 percent of adults were obese. These statistics represented a 13.3 to 22.2 percent gap.

PERCENT OF ADULTS WITH A BODY MASS INDEX > 30 (OBESE), 2009*



* No data were reported for Alexandria or Loudoun in 2009; Alexandria figure is from 2007 & Loudoun is from 2008.
Sources: Centers for Disease Control, National Center for Health Statistics

Source: United Way of National Capital Area's May 2013 Community Snapshot

APPENDIX B: PRINCE GEORGE'S
HEALTH FACILITIES

HEALTH SERVICES *for You!*



<http://www.princegeorgescountymd.gov/health>

Healthline: 1.888.561.4049 Call Toll Free

TTY/STS Dial 711 for Maryland Relay



Rushern L. Baker, III
County Executive





HEALTH SERVICES FOR YOU

If you live in Prince George's County, Maryland, our health services are for you!

Your County Health Department is here to help protect you from injury, disease and disability by assuring that you have access to quality health care.

Our staff is equipped to provide you with an array of specialized services—from immunizations to health insurance. We educate individuals and communities about disease prevention and assure that public facilities are safer through inspection, licensing and complaint investigations.

We encourage you to take charge of your health; to adopt a healthier lifestyle by educating yourself about healthy behaviors, getting routine screenings, and seeking help when you need it.

Keep this directory handy for reference, and take special note of emergency public health phone numbers.

If you need help or have any questions, just give us a call. We care about you!

PROTECTING AND IMPROVING THE HEALTH OF OUR COMMUNITY

The Prince George's County Health Department, by law and/or policy, does not permit discrimination in the delivery of services and employment on the basis of handicapped status, race, color or national origin; additionally, discrimination in any phase of employment practices, policies and procedures on the basis of religion, age, sex or political affiliation is prohibited. This encompasses all facilities and programs directly operated by Prince George's County Health Department, grant-in-aid programs, providers of health services receiving Federal funds through Prince George's County Health Department, contractors and subcontractors.

LOCATIONS

ADELPHI

Judy Hoyer Center
8908 Riggs Road
Adelphi, MD 20783

ANDREWS AIR FORCE BASE

1191 Menoher Drive
Room 116
Andrews AFB, MD 20769

CAPITOL HEIGHTS

CAP
501 Hampton Park Blvd.
Capitol Heights, MD 20743

CHEVERLY

Cheverly Health Center
3003 Hospital Drive
Cheverly, MD 20785

CLINTON

**D. Leonard Dyer
Regional Health Center**
9314 Piscataway Road
Clinton, MD 20735

HYATTSVILLE

Metro Building 1
525 Belcrest Road
Suite 660
Hyattsville, MD 20782

1401 E. University Blvd.
Suite 201
Hyattsville, MD 20783

LANDOVER

Largo West Building
425 Brightseat Road
Landover, MD 20785

7824 Central Avenue
Landover, MD 20785

7836 Central Avenue
Landover, MD 20785

LARGO

Headquarters Building
1701 McCormick Drive
Largo, MD 20774

Largo Government Center

9201 Basil Court
Suite 318
Largo, MD 20774

LAUREL

13900 Laurel Lakes Avenue
Suite 220
Laurel, MD 20707

Oasis Youth Services Bureau

13900 Laurel Lakes Avenue
Suite 225
Laurel, MD 20707

SUITLAND

**Suitland Health
and Wellness Center**
5001 Silver Hill Road
Second Floor
Suitland, MD 20746

NOTE: Not all of the following services are available at all locations. Call the service listing in advance for more information.

VOLUNTEER OPPORTUNITIES

Recruitment and training of Medical Reserve Corps (MRC) Volunteers, both medical and non-medical.

301-883-7802

IMPORTANT PHONE NUMBERS

Rabies exposure or incidence of other communicable/infectious disease outbreaks or emergency

301-583-3750
Mon-Fri 8:00 a.m.-4:30 p.m.

240-508-5774
All other hours

Fire, loss of water, or sewage overflow in any food service facility

301-883-7690
Mon-Fri 7:30 a.m.-4:00 p.m.

240-508-5868
All other hours

Special medical waste improper disposal

301-883-7606
Mon-Fri 7:30 a.m.-4:00 p.m.

240-508-5868
All other hours

Well water or septic system problems (lack of water or overflow) at private residences and commercial businesses

301-883-7681
Mon-Fri 7:30 a.m.-4:00 p.m.

240-508-5868
All other hours

General information—Voice

301-883-7879
All hours

General information—TTY/STS via Maryland Relay

Dial 711
All hours



WOMEN AND CHILDREN

FOR ALL WOMEN AND CHILDREN

Addiction, mental health, rehabilitation and case management services for adult women, including pregnant women and women with children. 301-324-2872

Addictions and mental health services for adult County residents age 18 years and older with substance abuse and related mental health problems including assessments, treatment, and case management; urinalysis and breathalyzer testing; individual, family and group counseling. 301-583-5920
301-856-9400

Breast and cervical cancer screening, including mammograms and PAP tests, for women age 40 and over who meet financial criteria; **breast cancer support groups** in English and Spanish. 301-883-3525

Coordination of health care services (case management) including hospital and home nursing visits for high-risk mothers and infants, especially substance abusers, HIV-positives, premature infants, pregnant and parenting teens. 301-618-2464

Early intervention services for children 0-3 years with special needs or developmental delays and are County residents: developmental evaluations, service coordination, family support and training, referrals to community programs, educational and therapy services. 301-856-9465

Family planning including contraceptive counseling and devices, emergency contraception, pregnancy options information, Pap tests and abnormal Pap follow-up. 301-583-3340
301-856-9520

FREE health insurance for pregnant women and children up to age 19 with low-to-average incomes. Healthline
1-888-561-4049

Health insurance for children up to 19 years old who do not qualify for Medical Assistance for routine physical exams, laboratory tests, well-child health care, immunizations and X-rays. 301-883-7858

Health screenings for women of childbearing age to ensure optimal health prior to pregnancy, including family planning information; cholesterol, diabetes and high blood pressure screenings; nutritional counseling; folic acid supplements and referrals to other services. 301-583-3313

HIV services including counseling, testing, treatment and prevention. 301-583-3700

Immunizations against childhood diseases are provided free through scheduled appointments to children age 6 weeks to 20 years. 301-583-3300

Lead poisoning prevention including coordination of care for children with elevated blood lead levels from exposure to lead paint or lead products; community education. 301-883-7230

Medical services for uninsured children under 19 years of age who are County residents, and who cannot afford private insurance and do not qualify for any government health insurance program. 301-883-7858

Nutrition and breastfeeding education and support to low-income pregnant, breastfeeding and postpartum women, and children age birth to 5 years who are at nutritional risk. 301-856-9600

Pregnancy case management services for women at risk of poor birth outcomes including counseling, parenting information and referrals to other services. 301-883-7230

Reproductive health services for young women age 10 to 24 years, including comprehensive reproductive health services; education and counseling promoting cooperative relationships, good nutrition and healthy behaviors. 301-324-5141

Re-entry assistance services for ex-offenders transitioning back to the community including family planning, health education, relationship counseling, child support counseling, parenting groups, career development, job preparation and placement. 301-817-1900

Sexually-transmitted infection (STI) and HIV services including testing, counseling and treatment services for any age County resident (parental consent not required). 301-583-3150
301-583-7752

Tobacco use prevention and cessation including free nicotine patches for County residents age 18 years and older. 301-324-2989

FOR PREGNANT WOMEN AND THEIR CHILDREN

Case management services and home visits for pregnant women at risk of poor birth outcomes and at-risk children up to age 2 years including counseling, parenting information and referrals to other health services. 301-883-7230

General dental services including dental treatment and referrals to specialty care for maternity patients referred from the Health Department's Maternal Health and Family Planning Program, uninsured children age 0-18 years, and children age 0-21 years enrolled in the Maryland Medicaid Healthy Smiles Program. 301-583-5900

Prenatal care and reproductive health services for uninsured and underinsured women including pregnancy testing, pre- and post-natal care, hospital delivery arrangements, referral to childbirth classes, family planning and emergency contraception, nutrition counseling, sexually-transmitted infection (STI) testing and counseling. Healthline
1-888-561-4049



ADOLESCENTS

FOR ALL TEENS

Case management and support services for juvenile offenders who qualify to reduce their risk of becoming perpetrators or victims of violence. 301-817-1900

Educational programs for teens and their families addressing injury prevention due to underage drinking and distracted driving. 301-324-2989

FREE health insurance for children up to age 19 with low-to-average incomes. Healthline 1-888-561-4049

High school-based health and social services for students attending Bladensburg, Fairmont Heights, Northwestern and Oxon Hill High Schools. 301-883-7887

HIV services including counseling, testing, treatment and prevention. 301-583-3700

Immunizations against childhood diseases are provided free through scheduled appointments to teens up to age 20 years. 301-583-3300

Medical services for uninsured children under 19 years of age who are County residents, and who cannot afford private insurance and do not qualify for any government health insurance program. 301-883-7858

Mental health and family counseling for children under age 18 and their families. 301-498-4500

Sexually-transmitted infection (STI) and HIV services including testing, counseling and treatment services for any age County resident (parental consent not required); referrals for adolescent HIV care. 301-583-3150 301-583-7752

Substance abuse treatment services (outpatient) for County residents age 11 to 18 years including assessments; crisis counseling; individual, family and group counseling; urinalysis and breathalyzer testing. 301-583-5941 301-434-4890 301-856-9400

FOR FEMALES

Reproductive health services for young women age 10 to 24 years, including comprehensive reproductive health services; education and counseling promoting cooperative relationships, good nutrition and healthy behaviors. 301-324-5141

FOR MALES

Health services for male adolescents and young fathers including male family planning and health education, child support counseling, relationship counseling and parenting groups, G.E.D. preparation, career development and skill-building, job preparation and placement. 301-817-1900

MEN

Addictions and mental health services for substance abuse and related mental health problems for adult County residents age 18 years and older including assessments, treatment, and case management; urinalysis and breathalyzer testing; individual, family and group counseling. 301-583-5920 301-856-9400

Health and social services for men and fathers, including male family planning and health education, relationship counseling, child support counseling, parenting groups, sports physicals, G.E.D. preparation, career development, job preparation and placement. 301-817-1900

HIV services including counseling, testing, treatment and prevention. 301-583-3700

Re-entry assistance services for ex-offenders transitioning back to the community including crisis intervention, assistance with domestic violence, and anger management. 301-817-1900

Sexually-transmitted infection (STI) and HIV services including testing, counseling and treatment services for any age County resident (parental consent not required). 301-583-3150 301-583-7752

Tobacco use prevention and cessation including free nicotine patches for County residents age 18 years and older. 301-324-2989



SENIORS

Colorectal cancer screening for County residents over age 50 who meet financial criteria. 301-883-3526

Comprehensive evaluation of the chronically-ill or older adults who are at risk for nursing home placement. 301-856-4730

EVERYONE

DOCUMENTS

Birth and death certificate certified copies. 301-324-2940

Maryland Public Information Act requests for Prince George's County Health Department Records. 301-883-7832

Medical record consent and release for patients. 301-324-2940

Review of fetal/infant death records by a professional panel to identify possible underlying causes of death. 301-583-3380

HEALTH INSURANCE

Health insurance for families who live in Maryland and who meet income criteria; includes psychosocial assessments, referrals and certification to other programs. HealthLine
1-888-561-4049

Temporary health care coverage for individuals who cannot afford it and are not eligible for any other health care coverage, through Kaiser Bridge. 301-856-9427

MEDICAL ASSISTANCE (MA)-RELATED

Personal in-home care for chronically-ill or disabled persons on Medical Assistance who qualify. 301-856-4732

Transportation of individuals on Medical Assistance to scheduled medical appointments. 301-856-9555



DISEASE CONTROL

Animal bite and animal exposure investigation and follow-up. 301-583-3750

Communicable disease outbreak investigation and follow-up on hepatitis A and B, salmonellosis and other food/water-borne illnesses, meningitis, vaccine-preventable diseases, anthrax and other unusual disease outbreaks; assistance with disease reporting procedures. 301-583-3750

Influenza (flu) and pneumococcal (pneumonia) vaccination clinics. 301-583-3750

Lyme disease information. 301-583-3750

Rabies vaccination clinics for cats, dogs and ferrets, and rabies pre- and post-exposure immunizations for individuals at-risk. 301-583-3750

Tuberculosis (TB) services, including chest X-rays and treatment for County residents of all ages who have suspected or confirmed TB disease, been in contact with a person with suspected or confirmed TB disease, a positive TB test or may be at high risk for TB disease. 301-583-3110

ENVIRONMENTAL HEALTH

Air quality complaint investigations. 301-883-7681

Food service facility inspections of restaurants, grocery stores, carry outs, convenience stores, processing plants, warehouses, mobile units, carnivals and fairs, farmers markets, vending locations; temporary food service facility permits; facility-related complaints or illegal operations investigations. 301-883-7690

Food service manager training for food handlers working in non-profit, charitable organizations and temporary event operations. 301-883-7650

Environmental lead assessments in the homes of children with confirmed elevated blood lead levels. 301-883-7662

Permits and plan review for licensed food facilities, public pools and spas and new well/septic system installations; ID cards for Certified Food Service Managers and Licensed Pool Operators. 301-883-7630

Public health emergency preparedness and response community education and training. 301-883-7838

Public swimming pool and spa inspections, permits and complaint investigations. 301-883-7606

Rodent and other disease vector education. 301-883-7681

Solid and hazardous waste inspections, permits and complaint investigations. 301-883-7606

Tanning facility complaint investigations. 301-883-7681

Well and septic system inspections, permits and complaint investigations. 301-883-7681

COLLABORATIONS AND SOURCES

Local Government and Health Departments

- Pamela B. Creekmur, Health Officer, Prince George's County Health Department
- Judith Davis, Mayor, City of Greenbelt
- Anne Healy, Maryland State Delegate
- Sarah Potter Robbins, City of New Carrollton

Minority Outreach

- Charlene Dukes, PhD, President Prince George's Community College
- Dwayne Leslie, General Conference of Seventh Day Adventist, Silver Spring, Maryland

Community Leaders and Programs

- Brian Mentzer, Pastor, Riverdale Baptist Church, Largo, MD
- Mary's Center, Hyattsville, MD

Breast Center Initiatives – Community Leaders

- Dr. Regina Hampton – professional fees for reading mammogram screenings as part of Susan G. Komen grant
- Center for Comprehensive Breast Care – share of the cost for a community navigator, van access and van
- African Women's Cancer Awareness Association – shares the cost for a community navigator
- Denise Whalen-White, Executive Director, All Shades of Pink Inc.

Surgical Services Improvements – Physician Leaders

- Dr. Richardo Scartascini, OB-GYN, Greenbelt, Maryland
- Dr. Jonah Murdock, Urologist, Greenbelt, Maryland
- Capital Orthopaedics Specialists, Lanham, Maryland

Technical Assistance

- Jennifer Belforte, MPH, Account Manager, Healthy Communities Institute
- The Advisory Board staff – Crimson Quality and Utilization products
- Intellimed Software – utilization reports
- County Health Rankings – services offered to county residents

Websites Visited and Resources Used for Secondary Data:

- Blueprint for a Healthy Prince George's County
- Centers for Disease Control and Prevention
- Healthy Communities Institute
- Maryland Vital Statistics Administration
- Rand Report on Prince George's County
- U.S. Health and Human Services
- University of Maryland's Prince George's County Health Environment Report

Website for Existing Health Care Facilities and other resources

- <http://www.princegeorgescountymd.gov/sites/Health/Services/HealthServices/Pages/default.aspx>

Community Benefit Committee – Doctors Community Hospital Representatives

- Robyn Webb-Williams, Vice President, Doctors Community Hospital Foundation
- Mary P. Dudley, Director, Community Relations and Volunteer Services
- Sabra Wilson, Community Resources Coordinator, Community Relations
- Sherri Moore, Development Officer, Doctors Community Hospital Foundation
- Angela Wilson, Director, Marketing and Communications
- Keith Mitchell, Web Support Specialist

Approved: Doctors Community Hospital Executive Staff June 27, 2013

Community Health Needs Assessment Implementation Plan

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Initiative Time Period	Key Partners	Evaluation dates
Diabetes	On the Road Diabetes Program- The Joslin Center in collaboration with Prince George's County Health Department provide in-depth education and free diabetes screening to county residents.	To provide diabetes education and screening to 500 county residents	2012-2014	Prince George's County Health Department Local faith-based organizations	Annually in November
	Joslin Diabetes Center will offer Nutrition Seminars at Health Fairs.	Educate community on better food choices	ongoing		Annually in November
Breast Cancer	Collaboration with Susan G. Komen Foundation for a grant titled: "The Prince George's County Continuum of Breast Care	<ol style="list-style-type: none"> 1) To reduce disparities in breast health care in Prince George's County residents. 2) To offer free screenings 3) To navigate those patients with abnormal findings 4) To assist residents in the screening process, up to an including medical or surgical treatment 5) To provide high quality outreach using existing community organizations. 6) To ensure early detection of breast disease and early treatment. 	4 Year Period: CY 2012 - 2015	Dr Regina Hampton Capital Breast Care Center (CBCC) African Women's Cancer Awareness Association (AWCAA)	Every 6 months 6/30/12-12/31/16
Cardiovascular Disease and related Risk Factors	Provide 3-4 Carotid Artery Screenings at health events, such as Health Fairs, Womens Health Conference and other events	To screen residents for potential risk of vascular diseases	ongoing	City of Greenbelt, local faith based organizations	Annually in November
	Sponsor Cardiac Rehab and Women Heart support groups for individuals who have had a cardiac episode	To help individuals regain strength and return to an enhanced physical condition, after cardiac issues.	ongoing	Women Heart Organization American Heart Association	annually in November

Community Health Needs Assessment Implementation Plan

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Initiative Time Period	Key Partners	Evaluation dates
Overweight/Obesity Nutrition & Exercise	Free educational seminars offered by the Bariatric and Weight Loss Center teaching weight loss options including nutrition, exercise and surgery	Educate overweight Community on options to make personal changes and health risks of Obesity	ongoing		Annually in November
Need to increase High Graduation rate in County	The hospital provides an opportunity for high students with identified learning needs to come to the hospital through a Job Sampling Program.	Provide students the opportunity to observe vocations that are within their reach after graduating high school.	ongoing during the school year	Prince George's County Schools	Annually in May
Prostate & other Cancer s	Colorectal Screening with the Prince George's County Health Department	In partnership with Prince Georges County Health Department the hospital will provide endoscopic screenings for people identified by the Health Department as under or uninsured.	2012-2014	Prince George's County Health Department & local gastroendrologist	
	Prostate Screening	Provide a digital and PSA screening for prostate cancer for the community	annually each Fall	local Urologist	Annually in November
High Blood Pressure/Stroke	Provide Blood Pressure screening at municipal, church and business health events within the community.	To screen community for potential health risk of high blood pressure	Ongoing		Annually in Novmeber
	Provide education regarding stroke, signs, symptoms and risk	to educate and screen the community for stroke	ongoing		Annually in November
	Provide Stroke Support Group for survivors and caregivers		ongoing		Annually in November
Rehabilitation	lymphedema support group met quarterly participant's schedules. It offers an open and friendly environment for patients, friends and family members to discuss ideas, give hope, provide support and share information. Each session has an education component on lymphedema-related topics	Provide education and support to individuals dealing with lymphedema issues. Most men and women have these issues due to post-surgical side effects or trauma.	ongoing	local physicians	Annually in November

Community Health Needs Assessment Implementation Plan

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Initiative Time Period	Key Partners	Evaluation dates
Sleep Disorders	Provide educational programs/screenings at health fairs and special events to help people identify potential sleep disorders	to educate and screen the community for harmful sleep disorders.	ongoing	Sleep Centers of America	annually in November
	Provide monthly support group meeting to give additional support to individuals struggling with harmful sleep disorders.		ongoing		annually in November