Dimensions Healthcare System

COMMUNITY HEALTH NEEDS ASSESSMENT

PRINCE GEORGE'S HOSPITAL CENTER

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OVERVIEW
PRINCE GEORGE'S HOSPITAL CENTER

Prince George's Hospital Center (PGHC) was founded in 1944, and is a 224-bed, 60-bassinet acute care teaching hospital and regional referral center located in Cheverly, Maryland. PGHC is a member of Dimensions Healthcare System (DHS), and is the largest not-for-profit hospital in Prince George's County. The hospital offers a comprehensive range of inpatient and outpatient medical and surgical services, including trauma and critical care, cardiac care, open-heart surgery and therapeutic catheterization, maternal and child health services, obstetrics/gynecology, senior health care, behavioral health, domestic violence, diabetes, and other services. Approximately 50% of the patient population is either uninsured or covered by Medicaid, which makes PGHC a vital safety net hospital.

In fiscal year (FY) 2012, PGHC admitted over 13,500 patients (including 2,150 births), and had nearly 95,000 outpatient visits in FY 2012. The hospital has the second busiest trauma center in the state of Maryland, and sees over 3,000 trauma patients per year. Its Emergency Department is a state designated Level II Trauma Center. PGHC offers a designated ST-Elevation Myocardial Infarction (STEMI) center with a comprehensive Cardiac Care Program, providing 24-hour cardiac catheterization and open-heart surgery capabilities for all acute heart emergencies, and is the only hospital in Prince George's County that provides these services. The hospital offers a state of the art Intensive Services Pavilion,

and a Level III Neonatal Intensive Care Unit. In addition, PGHC has the only 24-hour hospital based comprehensive sexual assault center in Maryland. The hospital also operates a free-standing 24-hour emergency department located in Bowie, Maryland.

Prince George's Hospital Center provides a wide scope of community programs, including those that focus on diabetes management and education, breast health, domestic violence, HIV testing, smoking cessation, senior health, and childbirth. PGHC has implemented a community-based care transition program aimed at reducing readmissions, lowering emergency department utilization, reducing health care costs and the incidence of childhood obesity. The hospital also offers support groups geared toward patients with medical issues involving brain injury, cardiac rehabilitation, as well as survivors of rape and sexual abuse, and those with alcoholism.

BACKGROUND AND LEGISLATION

IRS requirement: Community benefit. A non-profit hospital qualifies for federal tax exemption from the IRS if it meets certain requirements, which includes utilizing a percentage of its resources to fund activities and services that benefit the community. The community benefit requirement is based on the principle that the government's loss of tax revenues is offset by the hospital's allocation of a percentage of its financial resources to benefit the public welfare, which the government would otherwise have to expend. Community benefit (CB) services and activities include:

- Charity care
- Health education and screening to vulnerable populations
- Mission driven health services, and
- Medical research and education for health professionals that benefit the greater good.

Federal intervention: IRS requirement to file Schedule H. In 2005, the Government Accountability Office (GAO) found that non-profit hospitals were not defining community benefit in a consistent manner that would enable policymakers to hold them accountable for providing benefits commensurate with their federal tax-exempt status. Thereafter, the IRS issued a requirement that non-profit hospitals file Schedule H (Form 990), which:

- Summarizes charity care policies
- Documents the hospital's community benefit programs

- Identifies how the hospital is meeting community health care needs
- Describes other activities associated with tax-exempt status, and
- Distinguishes between charity care and bad debt.

Maryland State Intervention: Health Services Cost Review Commission (HSCRC) – mandatory community benefit reporting. In 2005, the HSCRC began to require non-profit hospitals to report annually on community benefit activities and services. The HSCRC CB report covers the fiscal period of July 1 to June 30 and is due each year on December 15. Pursuant to HSCRC regulations, a "community benefit" is defined as an activity that is intended to address community needs and priorities through disease prevention and improvement of health status, including:

- Services to vulnerable and underserved populations
- Financial and in-kind support of public health programs
- Donations of funds, property and other resources
- Health care education, screening and prevention, and
- Health care cost containment activities.

In 2011, Maryland hospitals reported providing $1.203 billion in community benefits, and the CB spending for each hospital was 9.2% of its total operating expenses on average.

- Prince George's Hospital Center's FY 2011 CB expenditure was 18.8% of its total operating expenses. The rate was more than 2 times higher than the state average, primarily due to the hospital's substantial expenditures on charity care and mission-driven physician subsidies.

Federal community health needs assessment legislation: Patient Protection and Affordable Care Act of 2010 (PPACA). Under the PPACA, and IRC 501 (r), hospitals are required to conduct a CHNA every three years to identify the significant health needs in the communities they serve, and create a strategic plan to meet at least some of those needs. PGHC must complete a community health needs assessment by June 30, 2013. The hospital must develop and adopt an Implementation Strategy Plan (ISP) by November 15, 2013, which aims at meeting some of the health needs identified in the assessment.

The CHNA should be based on the findings of multiple types of data collection and analysis, and must include input from individuals who represent the broad interests of the community served by the hospital.

Community Health Needs Assessment Requirements

Part 1: Community Health Needs Assessment

- Purpose: identification of significant health needs within the hospital service area.
    - Significant health needs are determined based on
        - Burden, scope, urgency, importance to the community, and health disparities issues.
    - Hospital must address some of the health needs identified from CHNA.

- Hospital is not required to address all identified health needs, but it must explain why the needs are not being addressed (i.e. lack of resources, not feasible to address)

Part 2: Implementation Strategy

- Purpose: design and implement community benefits activities that effectively address selected significant health needs, through hospital programs, activities and partnerships with local community and public health organizations.
- Outcome: a written plan that is submitted with Schedule H (Form 990) and made widely available to the public.
- Date of plan adoption: the ISP is considered "adopted" on the date it is approved by the hospital's and/or Dimensions Healthcare System's Board of Directors.
- Requirements:
  - Describe how the hospital plans to meet the selected need(s) and conduct an impact evaluation for each strategy.
  - Explain why the hospital does not intend to address other needs.
  - Evaluate the ongoing progress of strategies set forth in the ISP.
  - Describe mechanism for ongoing assessment of the ISP and set forth the data sources being used to monitor the plan.
  - Identify all programs and resources the hospital is committing to address the selected needs.

- Describe any planned collaboration with other hospitals, community health organizations, county health department, etc.
- Submit an annual progress report regarding the ISP, along with Schedule H (Form 990).

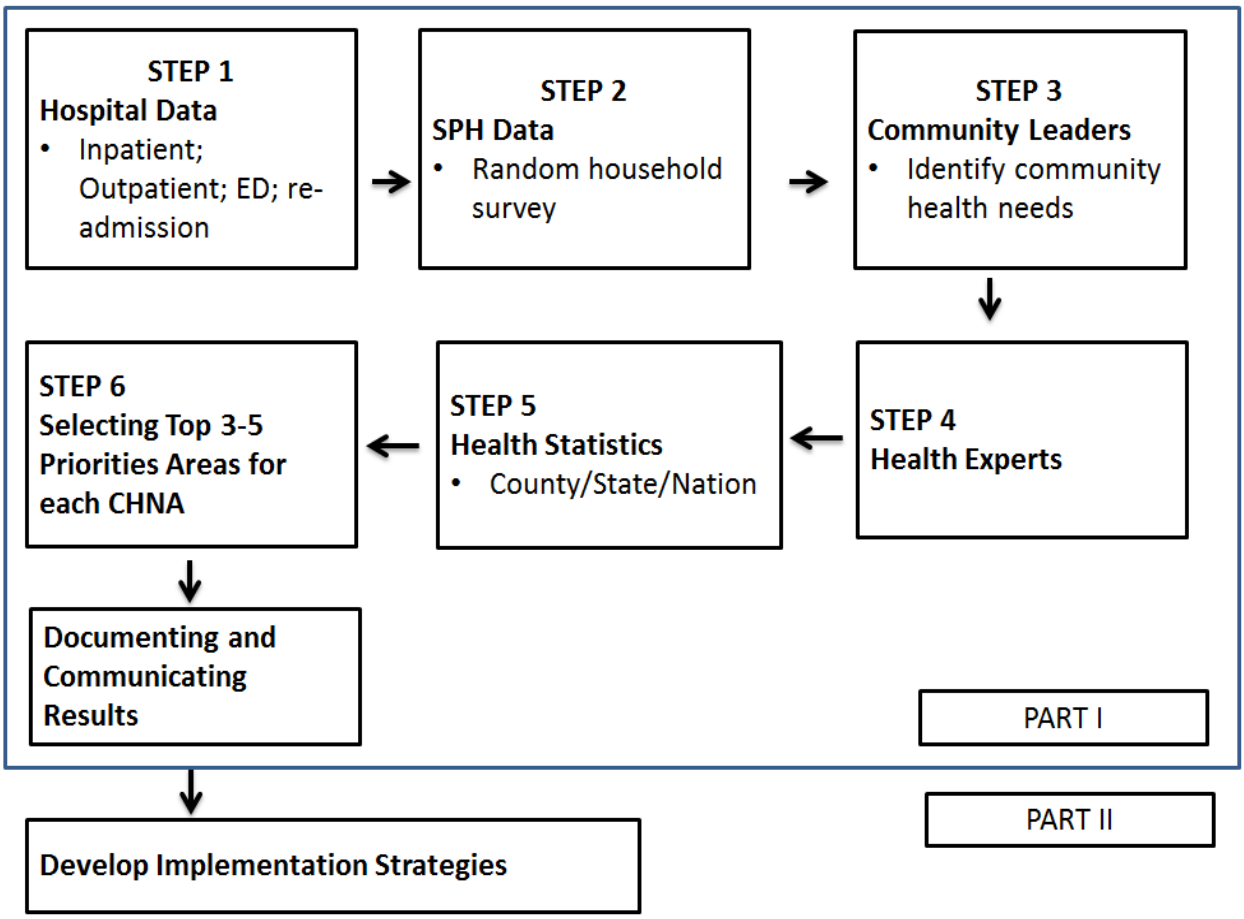
The CHNA must be made widely available to the public and accessible on the hospital's website. Any hospital that fails to comply with the CHNA requirement can lose their non-profit status and be subject to a $50,000 excise tax penalty.

According to the federal CHNA requirements, the PGHC CHNA has two parts.

Part 1: Community Health Needs Assessment

Multiple methods were used to study the significant health needs within PGHC hospital service area (HSA). Specifically, the PGHC CHNA has 6 sections (Figure 1).

Figure 1. ***PGHC CHNA Six-Step Analysis Strategy***



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

Part 2: Implementation Strategy Plan (ISP)

Based on CHNA developed in Part 1, PGHC will develop an ISP to address selected community health needs. The objective of the ISP is to engage in community benefits activities that effectively improve community health.

Step 1

Data. The primary data sources were PGHC Inpatient, Outpatient, and Emergency Department (ED) Discharge Data from January 2010 – November

2012. These hospital discharge data provided detailed information on patients, including age, gender, ICD9 codes, as well as the zip codes of their residence.

Method. The top zip codes listed in Table 2 represented 62% of all PGHC inpatient discharge data from 2010-2012, and hence were considered as PGHC Hospital Services Area (HSA). We summarized patient demographic characteristics and health insurance coverage, and calculated the ICD9 codes by frequency to identify the most common diseases reported in each of these three departments (i.e. inpatient, outpatient, and ED) at PGHC HSA (i.e. among the listed zip codes).

Results.

Patient demographic characteristics. Approximately 82%-86% of patients were African Americans, 7%-10% were Hispanics, and 4%-6% were Whites (see Table 3 for more detailed information). Discharges for female patients were from 56%-60% of the total discharges. The majority of patients were working age adults (63%-77%), followed by children (13%-19%), and elders (8%-18%).

Health care access. Medicaid provided the major insurance coverage (almost half of inpatients and about a third of outpatient and ED patients); private insurance covered about a quarter of patients; Medicare covered a smaller percentage of patients (ranging from 10% of outpatients to 23% of inpatients), and about a quarter of outpatients and ED patients were uninsured (Table 4).

Final health priorities identified using hospital discharge data.

The diseases listed in Table 5 were identified based on the findings from PGHC inpatient, outpatient and ED discharge data. The summary statistics for each of these health concerns were presented in the following Analysis section.

Analysis

1. Statistics from PGHC inpatient discharge data

   Top diseases (% of inpatient discharges) (Table 6):

   - Schizophrenic disorders (6%)
   - Current conditions complicating pregnancy childbirth, such as Diabetes or abnormal glucose tolerance complicating pregnancy (3%)
   - Septicemia (3%)
   - Mood disorders (3%)
   - Heart failure (3%)
   - Diabetes (2%)

2. Statistics from PGHC outpatient data

   Top diseases (% of outpatient discharges) (Table 7):

   - Symptoms involving respiratory system and other chest symptoms (5%)
   - Current conditions complicating pregnancy childbirth (5%)
   - Other symptoms involving abdomen and pelvis (3%)
   - General symptoms, such as fever, dizziness and giddiness, syncope and collapse (3%)

3. Statistics from PGHC ED discharge data

   Top diseases (% of ED discharges) (Table 8):

   - Symptoms involving respiratory system and other chest symptoms (10%)
   - Other symptoms involving abdomen and pelvis (6%)
   - General symptoms, such as fever, syncope and collapse, dizziness and giddiness (6%)

Study limitations. First, hospital discharge data might not fully reflect the health needs at different health care sectors, such as primary care, nursing home, etc. It is also likely that some residents in PGHC HSA might seek health care at other hospitals or clinic centers (Random Household Survey 2012). However, Step 2 – Step 5 of this report were conducted to complement these limitations. Please see the following sections for the details. Second, it is worth noting that our analyses presented the overall health needs at the HSA level. Top diseases of specific populations, such as elderly populations, racial and ethnic minorities, might differ.

Step 2

Data. The primary community data source employed in this study is the University of Maryland School of Public Health Public Health Impact Study (SPH PHIS) Random Household Survey 2012. The Random Household Survey is a telephone interview survey of Prince George's County residents 18 years and older (n = 1,001). The overall response rate is 29%. All the following findings

were adjusted for sampling weights to ensure that the results were county-wide representative (Random Household Survey Technique Report).

Results.

Self-reported health needs. The majority of the residents reported excellent or very good health status (52%). Residents reported the following urgent health conditions in Prince George's County: cancer (17.2%), diabetes (15.7%), obesity (10%), high blood pressure/hypertension (9.1%), HIV/AIDS (8.4%), and heart disease (8.1%) (Table 9).

Health care access. Approximately 25% of Prince George's County residents did not have a usual source of care, 17% were uninsured, and 17% had delayed necessary health care. Residents reported that the cost, access, and quality were the major barriers to receiving health care in Prince George's County (Table 10).

Health care urgency in Prince George's County. When asked about what services were perceived as being vital to have in Prince George's County, 77% reported urgent care, 68% reported alcohol and drug abuse treatment, and 63% reported mental health treatment (Table 11).

Perception of PGHC. Approximately 47% of the respondents reported favorable view to the overall opinion of PGHC, 35% reported an unfavorable view. Among those who reported an unfavorable view, respondents identified the most important factors that could change their opinions. Adding more quality staff was the most important factor, followed by adding quality physicians and improving facilities and equipment (Table 12).

Study limitations. SPH PHIS data were designed at the county level. Survey weights at PGHC HSA were not available. Nevertheless, we calculated the summary statistics of the PGHC hospital services area (n=391). Analysis revealed similar top health concerns and health care barriers.

Step 3 and Step 4

Background. Two community input meetings were conducted as part of the Prince George's Hospital Center (PGHC) Community Health Needs Assessment (CHNA), one with community leaders and one with health experts. The purpose of these meetings was to obtain the views from individuals who represent the broad interests of the community served by PGHC, as explicitly required by the IRS. Additionally, the qualitative data provided contextual and explanatory information to complement the quantitative findings. Furthermore, incorporating multiple types of data created convergence of findings, facilitated triangulation thereby strengthening the overall findings of the CHNA.

Methods. The community leaders input meeting was conducted on March 21, 2013 at the University of Maryland, College Park, School of Public Health (SPH). Participants were selected based on their knowledge of community health needs within the PGHC service area and representation of various community stakeholder groups, such as vulnerable and underserved populations. They were selected using the SPH Public Health Impact Study (PHIS) community leaders interview list, PHIS inventory of community health organizations, and with suggestions from Dimensions Healthcare System (DHS). Examples of participant affiliations include Prince George's County Health

Department, Federally Qualified Health Centers, faith-based organizations, and business leaders. A total of 9 community leaders participated.

The health experts input meeting was conducted on April 8, 2013 at PGHC. Participants were selected using input from DHS and PGHC hospital leaders who suggested key informants able to provide information about the community health needs within the PGHC service area. Examples of participant types include hospital board members, administrators, physicians, and nurses. A total of 11 health experts participated.

The protocol for each meeting was approved by the University of Maryland Institutional Review Board. Participants provided written informed consent at the beginning of each input meeting including their authorization to audio record the meeting discussion. Both meetings were professionally facilitated using a standard facilitator guide. The facilitator guide included the following discussion items which were consistent with the broader CHNA study questions:

- Based on your experience, what are the urgent health conditions facing the community?
- What are some of the root causes for these conditions?
- What are the top three to five health priorities on which the hospital should focus?
- How can the hospital work with other agencies in the community to address these public health priorities?
- What are existing community/hospital resources that can be leveraged as the hospital works to address these priorities?

- What are potential barriers to addressing these priorities?

Study team members attended both input meetings and used field note taking to capture the information that emerged throughout the meeting discussions. The audio recordings were used as necessary in order to clarify points of confusion and confirm study team observations. Field notes were consolidated, and then analyzed using an inductive/emergent coding approach in which similar information was organized by category/theme. A final list of themes was determined by consensus discussion in which study team members agreed on significant themes to be reported as findings. These findings are presented in the following results section.

Results. The following themes emerged from the community leaders and health experts input meetings. These themes represent the significant community health needs as identified by input meeting participants. A discussion of the significant dimensions of each theme is given. Observations provided exclusively by community leaders, exclusively by health experts, and overlapping observations are addressed. Themes are not listed in any particular order.

Access to health services. Participants from both meetings addressed the problem of access to health services. In particular, they discussed barriers associated with the high cost of care/insurance. Community leaders and health experts addressed the need for affordable prescription drugs. Health experts further discussed the problem of individuals using emergency department services for prescription refills. Both groups also discussed the large uninsured population, including the unemployed and working poor, who seek services at

PGHC, while a significant proportion of insured community members seek their health care outside of Prince George's County. Community leaders also addressed the need for more dental services and enhanced health services for the elderly.

Availability of specialists and health services. Community leaders and health experts discussed the need to increase the availability of specialty care providers and specific health services in the PGHC service area. Both groups discussed the need for more prenatal care specialists and services. Additionally, community leaders addressed a wide range of needed specialty care including nephrology, endocrinology, cardiology, orthopedics, podiatrist, nutritionists, gastroenterologists, HIV/AIDS infectious disease specialists. They also mentioned the need for more dental care, which is often overshadowed by other health care needs. Diversion programs were also suggested to redirect patients using the emergency department inappropriately (e.g. for primary care).

Coordinated and integrated care. Health experts discussed the need for coordinated and integrated care. Specifically, they addressed the need for continuity of behavioral health care from the emergency room to outpatient and then home/community based care. Meeting participants also discussed the need for continuity of maternal/child care. Health experts noted that PGHC has the opportunity to continue providing care to women and infants after childbirth, however, mothers and their children are not often followed-up. Additionally, participants discussed the need for improved coordination of treatment and services for the elderly post hospital discharge since this population is at high risk

of readmission. More coordination was suggested for supporting patients to navigate the health benefits system (e.g. prescription drugs).

Preventive and basic care. The need for adequate preventive and basic care was listed as a significant community health need by community leaders and health experts. Health experts discussed the need for a greater safety net to deliver basic health services and screenings, education materials, and other supports. They mentioned that annual health fairs do not adequately meet the community's need for prevention, compared to continuous care services. They also underscored the importance of access to screenings, noting that delayed diagnosis results in disease advancing more quickly, than it would if the disease had been detected earlier, and treated sooner.

High prevalence of behavioral health issues. Behavioral health was listed as one of the top health concerns in PGHC service area. Community leaders and health experts discussed the high prevalence of substance abuse including alcohol and illicit drug use as well as mental health problems including post-traumatic stress disorder (PTSD), depression, schizophrenia, and bipolar disorder. Alcohol use was listed as a significant problem because of the frequency of alcohol related hospital admissions. These admissions tend to occupy hospital beds, and delays admission for others. Also, the co-occurrence of substance abuse and mental health issues was noted as a particularly significant problem as it often negatively affects patients' ability to self-manage their conditions. These patients often have high levels of need but strained relationships with family, friends, employers and others in their support system.

Both community leaders and health experts talked about domestic and community violence as an underlying contributor to the high prevalence of behavioral health problems in the community. Community leaders reported that the origins of PTSD among certain immigrant populations in the community may also be associated with exposure to civil war in their native countries and fear of arrest/deportation.

High prevalence of chronic disease. Health experts discussed the high prevalence of chronic illness in the PGHC service area including obesity, diabetes, asthma, heart disease, coronary disease, renal failure, strokes, and congestive heart failure. They explained that these conditions result from untreated diabetes, cholesterol, and high blood pressure and that exacerbating these chronic illnesses are patient lack of education, access to care/insurance, and high rates of smoking.

Health education and awareness. Participants from both input meetings addressed the need for greater health education and awareness among community members of the PGHC service area. They discussed the need for better disease management education to patients before discharge. They urged increased awareness of community-based health services and support for organizations that assist with post-discharge care management and benefits navigation and enrollment.

Community perceptions of PGHC. Community leaders and health experts addressed the need to improve the community perception of PGHC. While PGHC is known to provide excellent trauma and neonatal intensive care

services, community leaders indicated that community members feel less positive about other services provided by PGHC. Both community leaders and health experts explained that a substantial proportion of community members seek health services outside of Prince George's county. They indicated that the problem may be due to the low visibility of PGHC in the community.

Commitment to collaboration. Community leaders and health experts expressed a strong desire to collaborate with PGHC to expand health care services and work together to meet community health needs.

Proposed strategies. Community leaders and health experts proposed a variety of strategies for PGHC to address the significant community health issues identified during the input meetings. These proposed strategies are organized in Table 13 according to the specific community health need(s) that the proposed strategy seeks to address.

Study limitations. No research methodology is without flaws. The information provided by sub-groups of community leaders and health experts may not fully represent the true community health needs of the PGHC hospital service area. Their views and opinions may not be generalizable to other community leaders and health experts in the PGHC hospital service area who did not participate in the input meetings. Also, the presence and behaviors of the study team during the input meetings may have introduced interviewer bias. For example, participants may have answered discussion questions based on their interpretation of interviewer cues or based their beliefs about what the study team expects to hear. Biases may have emerged from potential participant

motivation to draw attention to a particular community health issue or proposed strategy that aligns with their specific interests.

Step 5

National, State, and County health statistics were collected as reference for PGHC CHNA (Table 14). Healthy People 2020 sets several overarching health-related goals for America in the year 2020. These goals are to (1) attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; (2) achieve health equity, eliminate disparities, and improve the health of all groups; (3) create social and physical environments that promote good health for all; and (4) promote quality of life, healthy development, and healthy behaviors across all life stages. In addition, the National Prevention Strategy (2011) defines nationwide health priority areas. These priority areas are tobacco free living, preventing drug abuse and excessive alcohol use, healthy eating, active living, injury and violence free living, reproductive and sexual health, and mental and emotional well-being.

The state of Maryland issued a State Health Improvement Plan (2011) which identifies effective programs to achieve the top vision areas for the state. These programs focus on healthy babies, healthy social environments, safe physical environments, infectious diseases, chronic diseases, and health care access. The Prince George's County Health Improvement Plan from 2011 to 2014 identified the top priority areas for the county, which include access to health care, chronic diseases, reproductive health, infectious diseases, safe and healthy physical environments, and safe and healthy social environments. Prince

George's County Health Improvement Plan also sets out specific implementation strategies to achieve improvement in each priority area.

Discussion

This Community Health Needs Assessment (CHNA), based on multiple data sources and multiple types of data, provides a sound basis to guide hospital leaders in selecting priority areas for the CHNA Implementation Strategy Plan and developing a plan to address these areas. The U-MD SPH team based the CHNA findings upon the following quantitative and qualitative data sources:

1) Hospital data spanning January, 2010 – November, 2012 for inpatient, outpatient, and emergency department (ED) services, analyzed for Maryland zip codes comprising the hospital service area (HSA);
2) County-wide, household survey data (n=1001) collected for the U-MD SPH Public Health Impact Study that assessed residents' perceptions of health service needs;
3) A professionally facilitated meeting of nine Prince George's County community agency leaders designed to assess their views of health needs in the HSA; and
4) A professionally facilitated meeting of 11 Prince George's County health experts designed to assess their views of health needs in the HSA.
5) National, state, and county health service priority areas from Healthy People 2020, 2011 National Prevention Strategy, 2011 Maryland State Health Improvement Plan (SHIP), and 2011 Prince George's County Health Improvement Plan (CHIP);

This discussion will highlight key findings and identify areas of commonality among the various data sources. This section draws from the previously presented findings and a synthesis of all data sources presented in Table 1. This discussion informs recommendations intended to guide hospital leaders in conducting the next steps required for the CHNA.

PGHC patient demographic information. PGHC hospital inpatient, outpatient, and ED data describe a racially diverse patient population who are primarily working age adults with limited access to private insurance. The vast majority of patients are African American (over 80%), and there is a Hispanic presence (just under 10%). Medicaid provides the major insurance coverage (almost half of inpatients and about a third of outpatients and ED patients); private insurance covers about a quarter of patients (ranging from 20% of inpatients to 29% of ED patients); Medicare covers a smaller percentage of patients (ranging from 10% of outpatients to 23% of inpatients), and about a quarter of outpatients and ED patients were uninsured (Table 4).

The majority of patients (ranging from two-thirds of inpatients to three-fours of outpatient and ED patients) are working age adults, followed by children (ranging from 13% ED patients to 19% inpatients), and elders (ranging from 8% of outpatients to18% inpatients). Over half of all patients are women (ranging from 56% ED patients to 62% outpatients).

Top diseases to be addressed. All data sources spoke to some similar high priority diseases needing to be addressed. The SPH team analyses of PGHC data, across all hospital departments, indicated that the following six

disease areas are top priorities: mental disorders, conditions complicating pregnancy and childbirth (e.g. diabetes), septicemia, heart failure, diabetes, and respiratory disorders. Respondents from the county-wide survey identified two of these diseases, heart disease and diabetes, as urgent health conditions in the county. They also mentioned obesity and high blood pressure, which can be conditions complicating pregnancy and childbirth. The majority of respondents from the county-wide survey also identified nutrition education (59%) and physical activity programs (58%) as vital needs, which are often related to heart disease, diabetes, and pregnancy complications. Community leaders and health experts also discussed the importance of addressing diabetes, obesity, and heart disease. While the State and County Health Improvement Plans did not mention specific diseases, the top diseases identified by analyses of PGHC data fit in the categories discussed in these plans.

All respondents spoke about the need to expand mental health and substance abuse services. When asked if the availability of specific services was vital in the County, more than half of survey respondents mentioned mental health treatment (63%), alcohol and drug abuse treatment (68%), smoking cessation (46%) and stress management (48%). These four areas may be included in the broader category of “behavioral health,” which combines mental health and substance use disorder diagnoses. Community leaders and health experts addressed the high prevalence of behavioral health issues, specifically mentioning mental health issues, substance abuse, and the co-occurrence of these conditions. They pointed to the high prevalence of hospital admissions for

these problems, and the need for treatment of diseases including schizophrenia, bipolar disorder, depression, post-traumatic stress disorder for immigrants coming from war torn countries, and violence resulting from these behavioral health problems. These diseases reflect several national priority areas.

Access to health services. Three data sources spoke clearly about limitations in access to health services among patients in the PGHC service area. As indicated in Table 1, access includes five components: affordability, accessibility, availability, accommodation, and acceptability (Penchansky & Thomas, 1981). Community leaders and health experts spoke about the need to address all of these aspects of access to health care services, with a focus on the high cost of insurance, services, and prescription drugs. They specifically mentioned the need to increase the number of specialists, expand pre-natal and maternal/child services, enhance health services for elders, and increase access to dental care. The county-wide survey findings indicated that the vast majority of respondents reported having a usual source of care (75%) and insurance (84%). However, the majority of respondents identified cost of health care and health insurance (over 70%) as well as access to care (about 50%) and quality of care (45-50%) as major problems in Prince George's County. Clearly, stakeholders' concerns about access are important issues needing attention, and they reflect national, state, and county priority areas.

Coordinated and integrated care. The need for improved coordination of care and integration of various types of care (e.g. physical and behavioral health care) are major themes throughout the PPACA. Not surprisingly, the

community leaders and health experts spoke about this key issue. Specifically, they discussed the importance of coordinating behavioral health services from the emergency department to outpatient and community-based services. This coordination involves cross-training for emergency department, primary care, and behavioral health practitioners. Meeting participants also discussed the need to coordinate maternal/child and elder care after these patients leave the hospital and return to their homes and community services. Improved transitions from the hospital to home could also help prevent unnecessary readmissions – another priority for hospitals as they want to avoid financial penalties for these readmissions as defined in the PPACA.

Chronic diseases, prevention, and health education. The community leaders and health experts spoke about the high prevalence of chronic illnesses such as heart disease, diabetes, asthma, obesity, and stroke as well as the need for preventive services and health education. County survey respondents mirrored this focus on prevention and education when identifying programs to address smoking cessation, stress management, physical activity, nutrition counseling, and family planning as “vital” services needed in the County. National, state, and county priorities include these areas. Hospital leaders have an opportunity to acknowledge the importance of health promotion and disease prevention activities through the implementation strategy plan. For example, by creating strategies that align with existing programs, such as the extensive primary health care initiatives the hospital is in the process of developing and

implementing, the hospital can effectively leverage its resources and strengthen its ability to improve access to needed health care services.

Community perceptions about the hospital. The community leaders and health experts as well as county survey respondents addressed community perceptions about the PGHC, noting the high quality emergency department and trauma services. They also recommended that the hospital work toward improving community perceptions about the quality of other services as well as enhancing community involvement and visibility.

Recommendations

The following recommendations are intended to guide hospital leaders in conducting the next steps required by the Affordable Care Act – developing an Implementation Strategy Plan (ISP).

1. Evaluate hospital and community resources to select three top significant health needs to address in the ISP.
2. Create an infrastructure to develop the ISP.
    a. Form an Advisory Committee comprised of health experts and community health care organizations to assist in developing the ISP.
    b. The community health needs assessment (CHNA) findings clearly show that health experts and community leaders want to collaborate to address community health needs.
    c. Form a hospital department or team dedicated to addressing community benefit requirements.

3. Create and implement a plan to expand hospital visibility in the community.
4. Increase community engagement efforts to enhance the public perception that the PGHC offers access to high quality health care providers and services.
5. Increase the hospital's focus on community health initiatives, such as:
    a. developing community partnerships, and
    b. implementing an on-going evaluation of strategies to address community health needs.
6. Support the certificate of need application for the new regional academic medical center with CHNA findings.
7. Recommended CHNA next steps:
    a. PGHC identifies its strengths, resources, and existing programs to inform selection of needs for the ISP.
    b. Consider opportunities to coordinate efforts to select/address health needs with Laurel Regional Hospital, as many identified needs are similar.
    c. Select community health needs based on PGHC strengths, resources, previously stated recommendations (1-6), and IRS requirements. For example, capitalize on the hospital's current efforts and leverage the resources that are being focused on developing and implementing extensive primary health care initiatives.
    d. Develop PGHC ISP by November 15, 2013.

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APPENDIX I

Table 1. ***CHNA Findings – All Data Sources***

ACCESS TO HEALTH CARE SERVICES	LRH	PGHC
Affordability	X	X
Accessibility	X	X
Availability	X	X
Accommodation	X	X
Acceptability	X	X
Need to increase number of specialists	X	X
Need to expand prenatal, maternal/child services	X	X
Need to support and enhance senior health services	X	X
Need to expand health services for harder to reach, vulnerable populations (e.g. women, homeless, Hispanic community, immigrants)	X	
COORDINATION OF CARE	**LRH**	**PGHC**
Primary care	X	X
Prenatal, mother/child care	X	X
Senior care	X	X
Behavioral health	X	X
Integrated care (i.e. primary and behavioral health)	X	X
To access pharmaceuticals	X	X
To provide preventative care (e.g. health screenings)	X	X
Upon release from emergency department	X	X
BEHAVIORAL HEALTH	**LRH**	**PGHC**
Substance abuse/alcohol	X	X
Post-traumatic stress disorder (esp. among immigrants)		X
Violence as a root cause	X	X
HEALTH EDUCATION AND AWARENESS	**LRH**	**PGHC**
Chronic diseases	X	X
Prevention	X	X
Smoking cessation		X
DISEASE, CHRONIC DISEASE, CO-MORBIDITIES	**LRH**	**PGHC**
Schizophrenia, heart failure, diabetes, asthma, obesity	X	X
HIV/AIDS, septicemia, complications from pregnancy/childbirth (e.g. gestational diabetes)		X
Acute kidney failure, care involving rehab procedures	X	
COMMITMENT TO COLLABORATION	**LRH**	**PGHC**
Community leaders and health experts expressed a strong desire to collaborate with the hospital to expand health care services and work together to meet community health needs.	X	X
COMMUNITY PERCEPTIONS OF HOSPITAL	**LRH**	**PGHC**
Perception of high quality emergency department/trauma services		X
Need to enhance community engagement/involvement	X	X
Need to enhance community presence/visibility	X	X
Need to enhance ownership of hospital by community	X	
Need to improve perception quality health care services	X	X

Table 2. ***PGHC Hospital Service Area***

ZIP CODE	CITY
20743	Capitol Heights
20785	Hyattsville
20747	District Heights
20784	Hyattsville, Cheverly, Landover Hills New Carrollton
20706	Lanham, Glenarden, Seabrook
20774	Upper Marlboro, Glenarden, Kettering
20737	Riverdale
20710	Bladensburg
20746	Suitland
20748	Temple Hills
20745	Oxon Hill

Table 3. ***Patients' Demographic Characteristics***

	INPATIENT N=25,890	OUTPATIENT N=96,686	ED N=32,105
Age (%)			
0-17	18.7	13.8	12.7
18-64	63.4	78.4	77.0
65+	17.9	7.8	10.3
Gender (%)			
male	40.0	37.7	43.6
female	60.0	62.3	56.4
Race (%)			
White	5.6	3.8	4.2
African American	81.7	85.9	86.4
Hispanic	9.9	8.1	7.4
Asian	0.5	0.3	0.3
Other	2.4	1.9	1.7

Table 4. ***Patients' Health Insurance Coverage***

	INPATIENT (%)	OUTPATIENT (%)	ED (%)
Medicaid	47.6	36.9	30.2
Medicare	23.0	10.0	13.1
Private Health Insurance	19.6	26.7	28.5
Uninsured	8.8	21.9	25.1
Other	1.1	4.5	3.1

Table 5. ***Top Health Concerns for PGHC (all data sources)***

Top Health Concerns
Mental disorders (schizophrenic and other mood disorders)
Pregnancy and childbirth complications (particularly complications including diabetes and abnormal glucose tolerance)
Septicemia
Heart failure
Diabetes
Respiratory disorders

Table 6. ***Diseases with the Highest Frequency (PGHC Inpatient Discharges January, 2010 – November, 2012)***

Total inpatient discharges at the HSA (n=25,890)			
Disease	**Major ICD9 codes**	**N**	**%**
Schizophrenic disorders	*295.7, 295.3, 295.34, 295.72*	1418	5.5
Pregnancy complications, diabetes or abnormal glucose tolerance complicating pregnancy	*648.21, 648.91, 648.93, 648.81*	847	3.3
Septicemia	*38.9, 38.42, 38.49, 38.12, 38, 38.19, 38.8*	728	2.8
Mood disorders	*296.2, 296.23, 296.24, 296.3, 296.33, 296.34, 296.4, 296.5, 296.54, 296.6, 296.64, 296.8, 296.9*	686	2.6
Heart failure	*428, 428.23,428.3, 428.2*	667	2.6
Diabetes	*250.13, 250.12, 250.02, 250.22, 250.6, 250.62, 250.63, 250.8, 250.82*	622	2.4
Delivery	*V30.00, V30.01*	4307	16.6

Table 7. ***Diseases with the Highest Frequency (PGHC Outpatient Discharges January, 2010 – November, 2012)***

Total outpatient discharges at the HSA: n= 96,686			
Disease	**Major ICD9 codes**	**n**	**%**
Symptoms involving respiratory system and other chest symptoms	*786.5,786.59, 786.51, 786.09, 786.52, 786.05, 786.6*	5133	5.3
Pregnancy complications, diabetes or abnormal glucose tolerance complicating pregnancy	*648.93, 648.83, 648.23, 648.03, 648.13, 648.43*	5008	5.2
Abdominal pain	*789.09, 789.06, 789, 789.03, 789.04, 789.06, 789.01,789.05*	3166	3.3
General symptoms(fever, Malaise and fatigue, syncope, conditions associated with dizziness or vertigo)	*780.6, 780.79, 780.4, 780.2, 780.31*	2723	2.8

Table 8. ***Diseases with the Highest Frequency (PGHC Emergency Department Discharges January, 2010 – November, 2012)***

Total emergency department discharges at the HSA: n= 32,105			
Disease	**Major ICD9 codes**	**n**	**%**
Symptoms involving respiratory system and other chest symptoms	*786.5, 786.51, 786.59, 786.52, 786.2, 786.09, 786.05, 786.07*	3149	9.8
Other symptoms involving abdomen and pelvis	*789, 789.01, 789.02, 789.03, 789.04, 789.06, 789.09, 789.05*	1909	6.0
General symptoms(fever, malaise and fatigue, syncope, conditions associated with dizziness or vertigo)	*780.6, 780.79, 780.4, 780.2, 780.31*	1890	5.9

Table 9. ***County Level Analysis: Patients' Self-Reported Health Needs***

Perceived Health Status %	
Excellent	20.7
Very good	28.3
Good	35.9
Fair	12.8
Poor	2.3
Perceived urgent health condition in the county %	
Cancer	17.2
Diabetes	15.7
Don't know	14.7
Obesity	10.0
High blood pressure/hypertension	9.1
HIV/AIDS	8.4
Heart disease	8.1

Table 10. *County Level Analysis: Patients' Self-Reported Health Care Access*

Having usual source of care (%)	
Yes	75.4
No	24.6
Insured (%)	
Yes	83.8
No	16.2
Delayed any necessary care in the past 12 months (%)	
Yes	16.9
Delayed due to: no insurance coverage	42
Delayed due to: couldn't afford the cost	20
Delayed due to: couldn't get an appointment	24
Delayed due to: other	16
No	83.1
People are more likely to identify major problems in (%)	
Cost of health care	over 70
Cost of health insurance	over 70
Access to care	approximately 50
Quality of care	45-50

Table 11. *County Level Analysis: Patients' Self-Reported Health Care Urgency*

"Based on your experiences and the experiences of your family, please tell me if the availability of (insert service) is vital to have in Prince George's county?" (%)	
Urgent care	77.1
Alcohol & drug abuse treatment	67.9
Mental health treatment	62.5
Nutrition education or counseling	58.9
Physical activity program	57.7
Family planning services	54.6
Stress management program	47.6
Smoking cessation programs	45.6

Table 12. ***County Level Analysis: Perception of PGHC Health Care Quality***

"Would you say overall you have a favorable or unfavorable opinion of Prince George's Hospital Center?" (%)	
Favorable	47.2
Unfavorable	34.9
Don't know/not sure	17.5
"What would change your unfavorable opinion of Prince George's county hospital?" (%)	
Adding more quality staff other than physicians, such as nursing staff	31.0
All of these are equally important	20.7
Adding new quality physicians to the medical staff	19.1
Improving or modernizing the current facility or build a new facility	17.1
Other	12.1

Table 13. *Community Leaders' and Health Experts' Proposed Strategies to Address Community Health Needs*

Community Health Need	Proposed Strategy
Access to health services; Preventive and basic care; health education and awareness	• Start medical daycare centers and mobile clinics like Montgomery County, or partnering with organizations to provide these services. State waivers exist to financially support these programs. • Partner with mega churches and tiny churches. The faith-based community should be a partner to improve access because this is where the people are. The Board of Trustees, Pastoral Ministry, and other business leaders of the church are the key stakeholders to partner with because they have a pulse on the church and its operations. Churches often do Safe Haven and Warm Nights programs [overnight shelter programs], and interact with the homeless population in need. The churches have the opportunity to deliver health related services through these programs.
Preventive and basic care; Health education and awareness	• Bring services into the community to promote health and intervene early. This could be accomplished through partnerships with community-based organizations (e.g. health department, religious, etc.) by assessing, planning, and traveling into the community together to reach residents where they are. Creative strategies, such as group intervention/appointments in or outside of the hospital, should be used. Another example of a creative strategy suggested by the participants was to offer a cooking class for diabetics. This would bring residents together and increase education and awareness through peer learning and encouragement.
Availability of specialists and health services	• Attracting a better mix of insured and uninsured patients will involve increasing certain health services and providers. For example, PGHC could establish a high quality surgical team (e.g. GYN surgery - maternal and child health) in order to attract a better patient mix. • Place PGHC specialists in the community to increase access to care. • Partner with community based organizations and University of Maryland Medical System, Johns Hopkins Medicine, and Howard University Hospital to link patients to specialty care.
Coordinated and integrated care	• Establish clear processes for PGHC patients when discharged into the community. They need support services from community-based organizations to prevent readmission and be able to manage their disease(s). Doing this correctly requires thorough planning between PGHC and the community. • Establish partnerships between PGHC and the community agencies for emergency room diversion.

Table 14. ***Comparison of National, State, and Local Health Priorities***

Healthy People 2020 Overarching Goals	National Prevention Strategy 2011 Priority Areas	Maryland State Health Improvement Plan (SHIP) 2011 Vision Areas	Prince George's County Health Improvement Plan 2011 Priority Areas
Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.	Tobacco Free Living	Healthy Babies	Access to Health Care
Achieve health equity, eliminate disparities, and improve the health of all groups.	Preventing Drug Abuse and Excessive Alcohol Use	Healthy Social Environments	Chronic Diseases
Create social and physical environments that promote good health for all.	Healthy Eating	Safe Physical Environments	Reproductive Health
Promote quality of life, healthy development, and healthy behaviors across all life stages.	Active Living	Infectious Diseases	Infectious Diseases
	Injury and Violence Free Living	Chronic Diseases	Safe and Healthy Physical Environments
	Reproductive and Sexual Health	Health care Access	Safe and Healthy Social Environments
	Mental and Emotional Well-Being		

APPENDIX II

List of Organizations Participating in PGHC Community Leaders Input Meeting

1) Casa San Bernardo, Inc./St. Bernard Clairvaux Church

2) Rachel H. Pemberton Senior Health Center

3) Greater Baden Medical Services

4) Prince George's County Chamber of Commerce

5) Prince George's County Council

6) Prince George's County Health Department, Office of the Health Officer

7) Support Our Seniors