EXHIBIT 46

Community Health Needs Assessment
Implementation Strategy Plan
Fiscal Year 2014-2016

INTRODUCTION

Prince George's Hospital Center (PGHC) is an acute care teaching hospital and regional referral center, providing access to high quality healthcare to residents since 1944. The 224-bed facility located in Cheverly, MD, has the second busiest trauma center in the state of Maryland, servicing over 3,000 trauma patients per year. It is the only hospital in Prince George's County that offers a designated ST-Elevation Myocardial Infarction (STEMI) center with a comprehensive Cardiac Care Program, and has the only 24-hour hospital based comprehensive sexual assault center in Maryland. The hospital has also been ranked in the Honor Roll of America's Best Regional Hospitals by U.S. News and World Report.

PGHC is a member of Dimensions Healthcare System, the largest not-for-profit healthcare provider in Prince George's County, caring for more than 150,000 patients each year. The System is comprised of two hospital facilities, one emergency medical center and an ambulatory care/outpatient center. Providing services to individuals residing in Prince George's County and the surrounding areas, PGHC offers a comprehensive range of inpatient and outpatient medical and surgical services, as well as a wide scope of community programs that focus on diabetes management and education, breast health, domestic violence, HIV testing, smoking cessation, senior health, and childbirth.

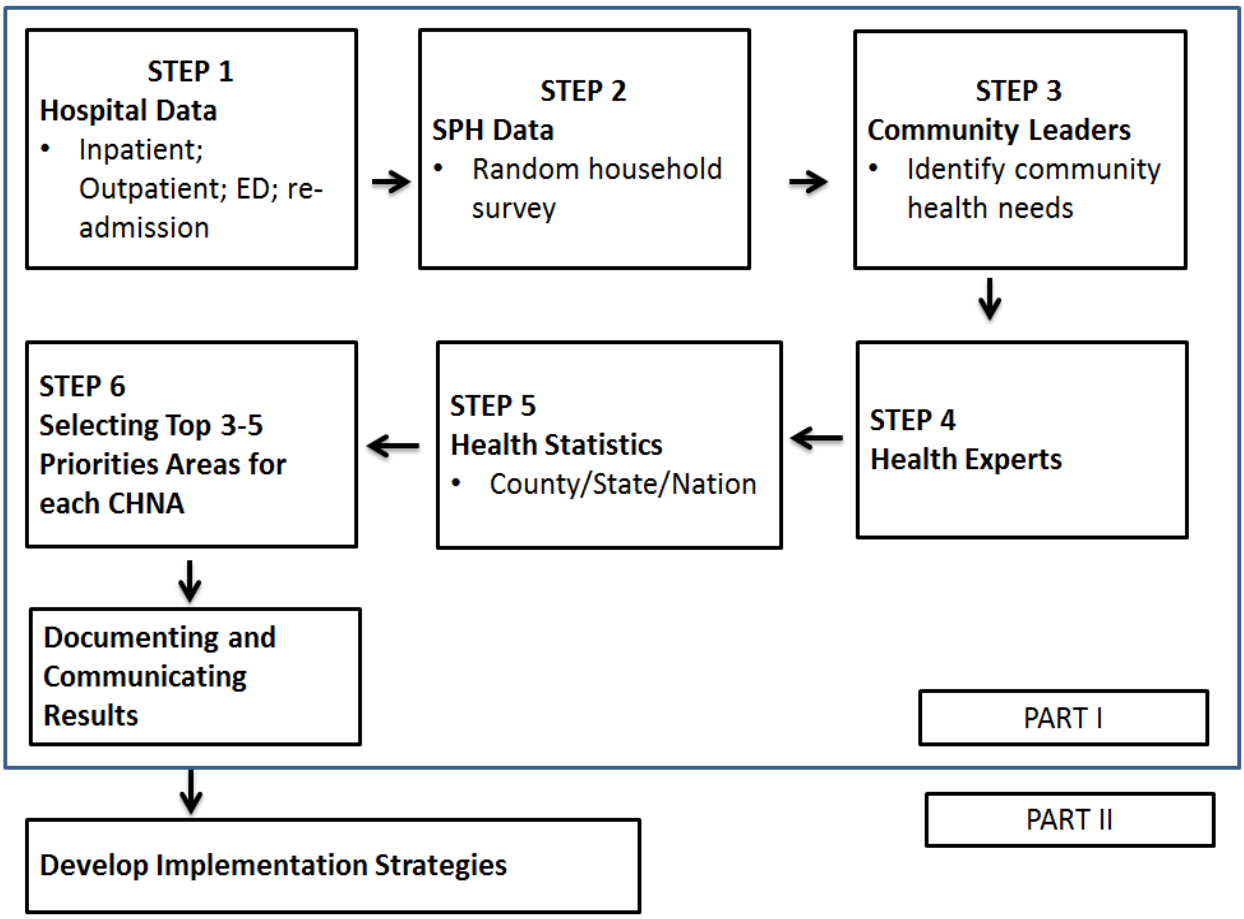
Prince George's Hospital Center, in conjunction with the University of Maryland School of Public Health (UMSPH), conducted a Community Health Needs Assessment (CHNA) in fiscal year 2013. This Implementation Strategy provides a summary of how the hospital plans to address the top community health priorities identified in the assessment for fiscal year 2014-2016.

HEALTH NEEDS IDENTIFICATION & SELECTION

Dimensions Healthcare System employed a system-wide approach inclusive of both Prince George's Hospital Center and Laurel Regional Hospital to identify and select community health needs. Community health needs assessments and implementation strategy plans (ISP) were completed for both hospitals individually with similarity due to some overlap in service area within Prince George's County. PGHC identified and selected community health needs in a two-phase process. In phase one, PGHC collaborated with the University of Maryland School of Public Health to identify community health needs. UMSPH conducted analyses utilizing multiple data sources to assess community needs and identify top health concerns in the PGHC service area. Community needs were assessed in a series of six steps culminating in the identification of significant health needs from which to select for implementation. These steps focused on the analyses of hospital discharge data, a household survey, community

leader and health expert focus groups, and compilation of existing health needs statistics. Each step yielded information about the most frequently presented diseases within PGHC's patient population, resident perception of health needs, community leader and health expert opinions, and county, state and national statistics of health needs.

PGHC CHNA Six-Step Analysis Strategy



In phase two of the process, identified needs were reviewed, selected and prioritized for implementation based on prevalence of community need, existing programming, strengths, resource allocation, operational alignment and partnerships. Need selection was conducted by the Implementation Strategy Plan Task Force (ISPTF), a multidisciplinary team of health administrators with expertise in each of the areas of most concern as documented in the CHNA. Three of the areas of concern were selected as community health needs focus areas for implementation of community health improvement programs and initiatives.

The community health needs focus areas are:

1) Diabetes
2) Heart Disease
3) Pregnancy and Childbirth Complications

Each of the three community health needs focus areas were then linked to three healthcare administration areas. They are:

1) Health Access & Primary Care
2) Disease Prevention & Management
3) Health Integration & Coordination

Community health needs focus areas and health administration areas were aligned, in part, with national, state and local health priorities. This alignment is designed to improve overall access, integration and coordination and to achieve better health outcomes across the continuum of care.

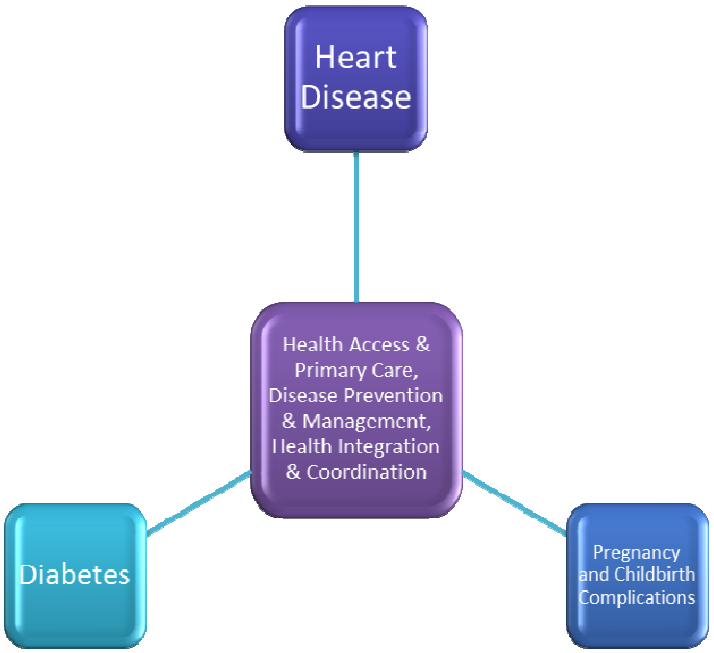
Comparison of National, State, and Local Health Priorities

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		

IMPLEMENTATION STRATEGY DEVELOPMENT

The development of the implementation strategy plan consisted of a comprehensive approach inclusive of the selected community health needs focus areas and the healthcare administration linkage. The community health needs focus areas are directly linked to each other and to the healthcare administration areas to ensure that health needs are met in the most effective manner. Many of the health challenges in the PGHC service area are due to the large population of uninsured of residents in Prince George's County as well as the lack of access to and availability of needed health services, including primary care services for which there is a shortage of providers. As a result, access to and availability of preventative care and disease management tools and resources, including education, are limited. Health integration and coordination affect and are affected by healthcare affordability, accessibility and availability, particularly for underserved, vulnerable and disparate populations.



Fragmented and uncoordinated health systems have perpetuated the dysfunction of healthcare administration in the PGHC service area, making effective and efficient health integration and coordination essential to meet community health needs. By acknowledging the relationship between inpatient care and community health improvement efforts, the ISPTF was able to develop a plan that will positively impact quality and safety across the continuum of care.

Building an Infrastructure for Community Health Improvement & Empowerment

Building the appropriate infrastructure is required to sustain community health improvement and empowerment efforts. This infrastructure will allow for effective administration of community health improvement and community benefit planning/implementation. The infrastructure build focuses on evidence-based community health/wellness program development and management through partnerships with community organizations. While the expansion and restructuring of current programming is a priority, the development of new programming to improve health status and outcomes through assessment, response, measurement and evaluation are also of great significance. As PGHC continues to build the infrastructure to respond to selected community health needs, community/staff engagement, and education and training are all integral components of community health improvement. Other integral components include physician recruitment and establishing health access points such as primary care offices within the community.

Partnerships for Health Promotion & Improvement

Prince George's Hospital Center recognizes the value of community collaboration through partnerships to promote and improve community health. Therefore, PGHC will continue to develop and strengthen collaborative relationships with national and local health/ wellness and community organizations, including federally qualified health centers and the Prince George's County Health Department, faith based, government, and academic institutions.

Unaddressed Needs

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

hospital will explore opportunities to collaborate with other community and public health organizations such as the health department and federally qualified health centers to address these needs.

COMMUNITY HEALTH NEEDS FOCUS AREAS

Goals and strategies for each of the selected community health needs focus areas are documented in this section. Each goal and strategy can be linked to one or more of the healthcare administration areas to ensure effective response to needs. Metrics and methods of evaluation will be incorporated into each focus area as work plans are developed.

Focus Area: Diabetes

Goal I: **Improve the availability of diabetes self-management education and services to the community.**

Strategies:

- Enhance screenings and information offered at community health events.
- Increase frequency of education and information offerings to area churches, senior centers, and activity centers.
- Continue to offer quarterly on-site free information sessions to community to provide access to resources that are usable by residents with diabetes/pre-diabetes.

Goal II: **Engage and partner with community physicians to increase awareness of diabetes services and education availability.**

Strategies:

- Create an engagement process inclusive of information package to inform and educate community physicians about diabetes services.
- Distribute program description and promotional materials to physician offices and patients with face-to-face visits to physician/practice administrator.

Goal III: **Advance quality and continuity of diabetic care through formation of outpatient care teams and group visits.**

Strategies:

- Increase the accurate/adequate coordination of care post ED visit.
- Streamline follow up appointments into outpatient clinics to improve continuity of care.
- Form outpatient care teams to include MD, RN, nutrition and diabetes educator, case manager, podiatrist and wound care RN when needed.
- Educate patients about group visits and coordinate care with outpatient care team to conduct visits.

Goal IV. Promote diabetes literacy – particularly focusing on prevention of diabetes.

Strategies:

- Partner with community partners to create diabetes awareness and education for all ages, focusing on prevention, in local libraries, other public buildings. Advertise via posters newspaper, radio, etc.
- Partner with school system to incorporate nutrition and exercise education into school curriculum via newsletters, health fairs at schools, PTA meetings, and Board of Education.

Focus Area: Heart Disease

Goal I: Educate women on how uncontrolled high blood pressure can lead to cardiovascular disease

Strategies:

- Participate in health fairs at community centers and faith based organizations providing blood pressure screening, educate women on understanding their "Numbers". Discuss signs & symptoms of stroke.
- Provide Blood Pressure information that explains how uncontrolled blood pressure relates to women's heart disease in key areas like clinical waiting rooms at Prince George's Hospital Center. (Information from Women Heart, Go Red, American Heart Association)
- Clinical staff from Prince George's Hospital Center (PGHC) and Doctor's Community Hospital (DCH) currently partner with Women Heart, The National Coalition for Women with Heart Disease. The meetings will continue to be held monthly alternating the location between PGHC and DCH. Participants are women heart attack survivors and their support system, speakers and clinical staff.

Goal II: **Education on recognition of symptoms and risk factors of heart disease in women.**

Strategies:

- Organize a women's clinic at Prince George's Hospital Center that will provide screening services for heart disease. Clinic will be held quarterly.
    1. Educate women with results of screening
    2. Provide onsite educational support for abnormal clinical values
    3. Provide proper referrals (diabetes, nutritionist, cardiology listing, local exercise programs)
    4. Provide educational material on Women and Heart Disease
    5. Provide education on smoking cessation and its effect on heart disease and stroke.
- Refer to different educational websites: American Heart Association, Go Red, Women Heart, Sister to Sister, Center for Disease Control, Healthy Hearts.

Goal III: **Increase exercise & diet awareness, education and opportunities for women.**

Strategies:

- Encourage Heart Healthy Diets and Exercise at participating Health Fairs; provide information about heart healthy foods and recipes.
- Provide websites encouraging Health Heart diets to hospital staff and community fairs (Womenshealth.gov, American Heart Association)
- Partner with Diabetes Center at Prince George's Hospital Center for information and nutritional consultation to distribute to women with diabetes.
- Contact community-based exercise programs and provide information at clinic and health fairs.
- Continue to follow up with patients in Prince George's Hospital Center Cardiac Rehab.
- Provide opportunities for staff exercise or gym at Prince George's Hospital Center.
- Provide nutritional information for foods served in hospital cafeteria.

Focus Area: Pregnancy and Childbirth Complications

Goal I: Enhance access to obstetrical care providers to include Maternal-Fetal Medicine specialists.

Strategies:

- Develop office practices in new locations:
  1. Suitland family Health and Wellness (Suitland, Md.)
  2. Community Clinic, Inc. (Greenbelt, Md.)
  3. Perinatal Diagnostic Center (Laurel, Md.)

- Partner with community/governmental agencies to enhance care and access services:
  1. Infant-At-Risk
  2. Bright Beginnings
  3. WIC
  4. Pregnancy Aid Center
  5. Prince George's County Health Department
  6. Fetal and Infant Mortality Review Committee
  7. Greater Baden Medical Services

Goal II: Provide continuity of care, through a seamless process that supports the patient/family need for education, care coordination, and psychosocial support for the high risk pregnancy.

Strategies:

- Implement the role of Nurse Navigator for high risk patients to include:
  1. Develop a job description
  2. Identify a funding source
  3. Develop/implement a database to track high risk patient's care

- Development of a Lactation Resource Center that provides the following:
  1. On-site rounding of all breastfeeding patients
  2. Staff education
  3. Outpatient breastfeeding classes
  4. Outpatient consultations for patients
  5. Warm-line for questions

IMPLEMENTATION STRATEGY EXECUTION

The next phase of the ISP will focus on proper execution of the plan. This will be achieved by allocating the necessary resources, aligning strategies with operations and engaging partners. The ISPTF will be expanded into a body of internal and external advisors who will continue to build the infrastructure to fully execute the ISP, develop sustain, monitor and evaluate community health improvement initiatives and programs.