IN THE MATTER OF	*	
	*	
THE CONVERSION OF	*	BEFORE THE
	*	
UNIVERSITY OF MARYLAND	*	MARYLAND HEALTH CARE
	*	
LAUREL REGIONAL HOSPITAL TO A	*	COMMISSION
	*	
FREESTANDING MEDICAL FACILITY	*	No. _____
	*	

* * * * * * * * * * * * * *

NOTICE OF INTENT TO SEEK EXEMPTION
FROM CERTIFICATE OF NEED REVIEW FOR THE
CONVERSION OF UNIVERSITY OF MARYLAND LAUREL REGIONAL HOSPITAL
TO A FREESTANDING MEDICAL FACILITY

Dimensions Health Corporation *d/b/a* University of Maryland Capital Region Health ("UM CRH"), University of Maryland Laurel Regional Hospital ("UM LRH"), and University of Maryland Prince George's Hospital Center, by the undersigned counsel, provides notice that it is seeking approval from the Maryland Health Care Commission to convert UM LRH to a freestanding medical facility.

For the reasons set forth in the attached Request for Exemption, UM CRH respectfully requests that the Commission grant an exemption from Certificate of Need ("CON") review for the conversion of UM LRH to a freestanding medical facility and for associated capital expenditures.

Respectfully submitted,

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April 13, 2018

IN THE MARYLAND HEALTH CARE COMMISSION

REQUEST FOR EXEMPTION
FROM CERTIFICATE OF NEED REVIEW

to
Convert University of Maryland Laurel Regional Hospital
to a Freestanding Medical Facility

Applicant
Dimensions Health Corporation d/b/a
University of Maryland Capital Region Health, University of Maryland Laurel Regional Hospital, and University of Maryland Prince George's Hospital Center
April 13, 2018

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BACKGROUND

University of Maryland Laurel Regional Hospital ("UM LRH") is an acute care hospital with forty-five (45) licensed MSGA beds and sixteen (16) licensed psychiatric beds located at 7300 Van Dusen Road, Laurel, Maryland 20707. University of Maryland Prince George's Hospital Center ("UM PGHC") is a 230-bed licensed acute care hospital, with 166 MSGA beds, 34 obstetrics beds, two pediatric beds, and 28 psychiatric beds located at 3001 Hospital Drive, Cheverly, Maryland 20785. Both UM LRH and UM PGHC are owned and operated by Dimensions Health Corporation d/b/a University of Maryland Capital Region Health ("UM CRH"), a not-for-profit health system owned by the University of Maryland Health System ("UMMS").

UM CRH is dedicated to maintaining and improving the health of the people in the communities it serves through an integrated health delivery system that provides the highest quality of care to all. UM CRH has been affiliated with UMMS since September 1, 2017. In addition to UM LRH and UM PGHC, UM CRH consists of: (1) a 28-bed inpatient acute rehabilitation hospital currently located at UM LRH; (2) a 46-bed chronic care special hospital currently located at UM LRH; (3) Mt. Washington Pediatric Hospital at UM PGHC, a 15-bed special pediatric hospital located at UM PGHC; (4) the UM Bowie Health Center, a freestanding medical facility located at 15001 Health Center Drive, Bowie, Maryland 20716; (5) the UM Capital Region Surgery Center, an ambulatory surgical facility located on the campus of the UM Bowie Health Center; and (6) four health and wellness centers offering a variety of primary care services to families and seniors, located in Laurel, Cheverly, Capital Heights, and Suitland.

UM LRH was established in 1978 as the "Greater Laurel-Beltsville Hospital." Its inpatient utilization has declined for a number of years, it spiked in fiscal year 2013, and then declined from fiscal year 2014 through fiscal year 2017, resulting in consistent annual financial losses. See **Table 1** below for UM LRH's inpatient utilization trends for fiscal years 2007 through 2017.

Table 1
Laurel Regional Hospital v. State
Admissions Trend
FY2007-FY2017

Laurel Regional Hospital	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	% Change
Med/Surg	5,823	5,916	7,636	7,091	5,831	5,316	6,268	6,095	5,497	4,808	4,389	-24.6%
Obstetrics	739	700	677	822	972	1,033	923	854	709	197	-	-100.0%
Psychiatry	603	666	762	960	939	782	836	800	696	940	831	37.8%
Rehabilitation	896	920	1,224	1,493	1,560	1,542	1,224	993	836	551	1,098	22.5%
Chronic Care	-	-	-	-	-	160	146	117	147	149	92	0.0%
LRH Total	8,061	8,202	10,299	10,366	9,302	8,833	9,397	8,859	7,885	6,645	6,410	-20.5%
LRH % Change		*1.7%*	*25.6%*	*0.7%*	*-10.3%*	*-5.0%*	*6.4%*	*-5.7%*	*-11.0%*	*-15.7%*	*-3.5%*	
State												
Med/Surg	745,767	766,136	780,850	770,705	733,288	705,821	667,436	604,431	601,790	604,332	604,075	-19.0%
Obstetrics	91,091	92,944	88,808	87,518	88,136	85,398	81,364	77,220	78,165	76,578	75,089	-17.6%
Psychiatry	45,670	47,426	47,696	48,929	49,519	48,377	48,472	49,148	47,769	49,809	51,778	13.4%
Rehabilitation	11,398	11,811	12,084	12,053	12,306	11,965	11,387	11,106	11,018	10,105	10,073	-11.6%
Chronic Care	2,555	2,312	2,387	2,522	2,821	3,053	3,165	3,370	3,054	3,348	3,430	34.2%
Statewide Total	896,481	920,629	931,825	921,727	886,070	854,614	811,824	745,275	741,796	744,172	744,445	-17.0%
State % Change		*2.7%*	*1.2%*	*-1.1%*	*-3.9%*	*-3.6%*	*-5.0%*	*-8.2%*	*-0.5%*	*0.3%*	*0.0%*	
LRH v. State		*-0.9%*	*24.4%*	*1.7%*	*-6.4%*	*-1.5%*	*11.4%*	*2.5%*	*-10.5%*	*-16.0%*	*-3.6%*	

Note (1): Includes transfers
Source: HSCRC Experience Data

The hospital's physical plant is almost 40 years old, and is costly and inefficient to maintain given UM LRH's current utilization levels. Consistent with local and national healthcare trends and to best promote access to convenient and quality care for the population it serves, UM CRH proposes to convert UM LRH to a freestanding medical facility ("FMF") to be developed at the UM LRH campus. As described in this application, the proposed project resulting from the conversion of UM LRH to an FMF will be referred to as the "UM Laurel Medical Center." Initially, the FMF will be housed in the existing hospital building while a new

building is constructed on the campus. When the new building is complete, the FMF will be located there and UM CRH expects to demolish the existing hospital building.

UM CRH has also obtained Commission approval in the form of determinations of CON coverage to relocate the two special hospitals currently located at UM LRH to UM PGHC. Pursuant to the approvals, the acute inpatient rehabilitation hospital and the chronic care hospital will move to space within UM PGHC.[1]

For some time, several acute general hospitals in Maryland have been exploring options to reconfigure and modernize facilities in the face of aging physical plants and declining utilization for acute inpatient admissions, while recognizing the continued need to provide high quality and effective care to the communities they serve. Through recently enacted legislation, Chapter 420, Acts of 2016 (Senate Bill 707), the General Assembly, with the urging of the Maryland Health Care Commission (the "Commission"), elected to use the FMF as the preferred facility type for the conversion of acute general hospitals by amending Maryland Code, Health-General to: (1) authorize a CON exemption process for conversion of an existing hospital to an FMF along with associated capital expenditures; and (2) authorize the Health Services Cost Review Commission ("HSCRC") to regulate rates for outpatient services in an FMF, including observation services and ancillary services needed to support emergency and observation services. As contemplated by this enactment, acute general hospitals converting to FMFs are authorized to provide a much broader array of services in order to continue to treat patients with more complex and more acute health care needs than the three currently established

[1] UM CRH intends to seek temporary delicensure of a certain number of the acute inpatient rehabilitation beds and the chronic care beds. Thus, not all of the physical beds will be relocated to UM PGHC.

Maryland FMFs, none of which converted from an acute general hospital serving a community. For example, by permitting hospitals that convert to FMFs to provide observation services it will support further decreases in utilization of inpatient services but also provide a level of service needed by the community. In addition, hospitals converting to FMFs often have established service areas, and by remaining in the same or an adjacent location to the hospital it enables the facility to continue delivering services needed by the community without disrupting established utilization patterns and expectations from service area residents.

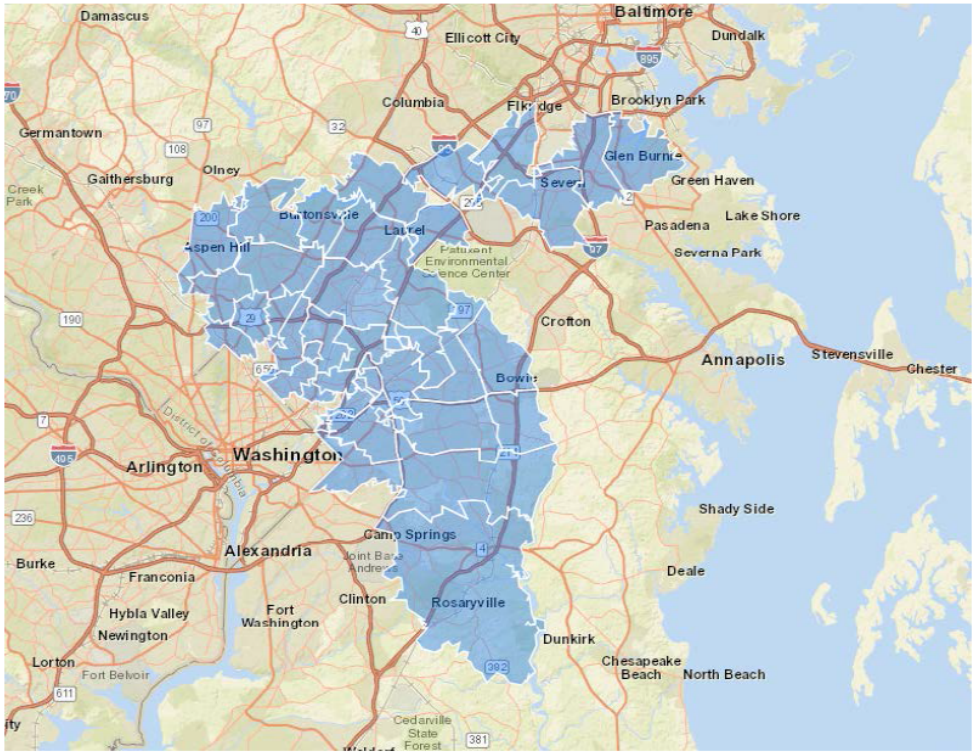
Pursuant to amended Health-General § 19-120 and the State Health Plan Chapter for Freestanding Medical Facilities, COMAR 10.24.19 (the "State Health Plan"), an acute general hospital may convert to an FMF if it follows certain procedures and demonstrates that: (1) the conversion is consistent with the State Health Plan; (2) the conversion will result in the delivery of more efficient and effective health care services; and (3) the conversion is in the public interest. As explained below, the proposed conversion of UM LRH to UM Laurel Medical Center satisfies each of these criteria. Accordingly, UM CRH requests that the Commission grant an exemption from CON review to permit conversion of UM LRH to an FMF and for associated capital expenditures.

I. COMPREHENSIVE PROJECT DESCRIPTION

UM LRH's conversion to an FMF is part of UM CRH's plan to create an optimal patient care delivery system for the future health care needs of residents living in UM LRH's Inpatient Service Area, which in 2018 includes a population of 1,144,363 residents. See **Table 2** below for a map of UM LRH's inpatient primary and secondary service area and **Exhibit 3** for UM LRH's inpatient service area population estimates by age cohort for fiscal years 2010 to 2024.

Table 2
UM Laurel Regional Hospital
Inpatient Service Area

Zip Codes	City/State
20705	Beltsville, MD
20706	Lanham, MD
20707	Laurel, MD
20708	Laurel, MD
20715	Bowie, MD
20716	Bowie, MD
20720	Bowie, MD
20721	Bowie, MD
20723	Laurel, MD
20724	Laurel, MD
20737	Riverdale, MD
20740	College Park, MD
20742	College Park, MD
20743	Capitol Heights, MD
20769	Glenn Dale, MD
20770	Greenbelt, MD
20772	Upper Marlboro, MD
20774	Upper Marlboro, MD
20781	Hyattsville, MD
20782	Hyattsville, MD
20783	Hyattsville, MD
20784	Hyattsville, MD
20785	Hyattsville, MD
20794	Jessup, MD
20866	Burtonsville, MD
20901	Silver Spring, MD
20902	Silver Spring, MD
20903	Silver Spring, MD
20904	Silver Spring, MD
20905	Silver Spring, MD
20906	Silver Spring, MD
20910	Silver Spring, MD
21060	Glen Burnie, MD
21061	Glen Burnie, MD
21076	Hanover, MD
21144	Severn, MD
20771	Goddard Flight Center



UM CRH proposes to establish the UM Laurel Medical Center in two phases. Initially, the FMF will be located within the existing UM LRH building (Phase 1). Then, the FMF will be located in a newly constructed building on the existing hospital campus (Phase 2). The existing hospital campus consists of a 48 acre parcel on which the existing hospital, medical office building, and wound care center are located.

A. Phase 1 – The Existing UM LRH Building

UM CRH will commence the FMF operations in the existing building using existing space configurations to provide the FMF services.

During Phase 1, while operating in the current building, UM CRH will decrease the square foot usage of the current building with a reasonable budget. Only minor physical changes will be made on the first and second floors of the building. The following changes will be made on the other floors:

Third floor: The third floor will continue to house the surgical services suite, laboratory services, the observation unit (which will be in a previously closed unit) and offices. The critical care unit will close.

Fourth floor: The fourth floor will not be occupied. It is currently occupied by a special chronic care hospital, medical surgical unit, inpatient behavioral health and the behavioral health's partial hospitalization program. The chronic care hospital will be moved to UM PGHC pursuant to the determination of CON coverage granted by the Commission. The inpatient medical surgical and the behavioral health units will close as a result of the planned conversion. The partial hospitalization program will move to the second floor to the current outpatient physical medicine department. The outpatient physical medicine department will close.

Fifth floor: The fifth floor will not be occupied. The fifth floor is currently occupied by the special acute inpatient rehabilitation hospital, which will move to UM PGHC pursuant to the determination of CON coverage granted by the Commission. Fifth floor offices currently used by education and the hospitalist group will move to vacant spaces on the third floor.

As shown in Table E, UM CRH expects to spend $125,855 in capital costs for converting the existing building for use as an FMF. In addition, UM CRH expects to spend approximately

$60,000 in operating costs to decommission space on the fourth and fifth floors of the building. It is difficult to quantify the cost savings associated with decreasing the building usage, but there will be operational savings through energy management savings as a result of mothballing 86,002 square feet of 304,174 square feet of space.

Phase 1 of the UM Laurel Medical Center will include the following features:

1. An emergency department with 23 exam rooms at approximately 120 square feet each,[2] three patient toilets, and one staff toilet, as well as related staff and support spaces, including an ambulance entrance and decontamination facilities;

2. Four (4) exam rooms designated for behavioral health, at 130 square feet each and related staff and support spaces;

3. An observation suite with ten (10) patient rooms at 260 square feet each having its own private toilet at 60 square feet, and related staff and support spaces;[3]

4. A diagnostic imaging suite with x-ray, ultrasound, CT, nuclear medicine, two (2) cardio-vascular ultrasound modalities, and related staff and support spaces; and an MRI machine in a modular building adjacent to the FMF, which will be accessible by a covered walkway;

5. Space for outpatient behavioral health services, including partial day hospitalization;

6. Two (2) outpatient operating rooms and two (2) procedure rooms with related pre-operative preparation spaces, post-anesthesia care unit, and staff and support spaces;

7. A laboratory and in-house pharmacy;

8. Ancillary services including respiratory and physical medicine; and

9. Administration and staff and support spaces.

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[2] Emergency and behavioral health exam room sizes vary within the existing building vary.

[3] Inpatient units in the existing building will be converted to create the observation suite, which is why the observation spaces in Phase I will be slightly larger than the standard 140 square feet.

In addition, the Wound Care and Hyperbaric Medicine Center, which is a part of UM LRH but located in a separate building on the campus of the hospital will continue to operate in this separate building on the campus of the FMF during Phases 1 and 2.

B. Phase 2 – The New Building

In Phase 2, the FMF will be located in a new building located on the southwestern portion of the existing UM LRH campus. The services in the new FMF building will be organized on two floors. The combined total gross square footage of the space is approximately 75,855. As mentioned above and in accordance with recent statutory changes allowing hospital conversions to FMFs, UM CRH's planned FMF will be much different than the three existing Maryland FMFs. It will be a fully functional, full service emergency department, open 24/7 with the capability of caring for patients categorized in EMS priority levels 1 through 4, replacing an existing emergency department that has been serving UM LRH's service area for years. UM CRH has worked closely with Prince George's County EMS, which has advised UM CRH that the ambulance transport patterns will not change as a result of this conversion.

UM Laurel Medical Center will have the ability to rapidly transfer those who cannot be definitively cared for at the facility via a dedicated commercial ambulance service and ground helipad (located at UM Laurel Medical Center) with proximity to several hospitals and tertiary centers.

The facility will include the following features:

1. An emergency department with two (2) triage rooms at 110 square feet each, 20 exam rooms at 140 square feet each (including one trauma/resuscitation room at 280 square feet), four patient toilets, and two staff toilets, as well as related staff and support spaces, including an ambulance entrance and decontamination facilities;

2. Four (4) exam rooms designated for behavioral health, at 130 square feet each and related staff and support spaces;

3. An observation suite with ten (10) patient rooms at 170 square feet (including two bariatric rooms at 215 square feet) each having its own private toilet at 60 square feet, and related staff and support spaces;

4. A diagnostic imaging suite with x-ray, ultrasound, CT, two (2) cardio-vascular ultrasound modalities, and related staff and support spaces; and an MRI machine in a modular building adjacent to the FMF, which will be accessible by a covered walkway;[4]

5. Space for outpatient behavioral health services, including partial day hospitalization;

6. Two (2) outpatient operating rooms and two (2) procedure rooms with related pre-operative preparation spaces, post-anesthesia care unit, and staff and support spaces;

7. A laboratory and in-house pharmacy; and

8. Administration and staff and support spaces.

UM Laurel Medical Center's emergency department will be staffed by Board Certified Emergency Medicine physicians and nursing staff specializing in emergency medicine with up to forty (40) hours of emergency physician and twelve (12) hours of emergency Advanced Practice Clinicians per day. Additionally, the four-bed behavioral health crisis center will be staffed by personnel specializing in the diagnosis and treatment of patients suffering from psychiatric conditions.

UM Laurel Medical Center will maintain UM LRH's EMS Base Station designation to allow communication with EMS providers in transport and the ability to direct patients to the appropriate level of service; such communications are required for all EMS priority 1 and 2 patients before arrival at UM Laurel Medical Center.

[4] The MRI will be provided by a third party under contract with UM CRH.

UM CRH anticipates maintaining nearly the same level of emergency and observation services as currently provided at UM LRH. Patients requiring other acute levels of service will be transferred from UM Laurel Medical Center to UM PGHC or other acute facilities as needed. Patients requiring observation stays would be transferred only in the event that UM Laurel Medical Center was at full capacity or the patients' condition deteriorated and warranted an acute care admission or transfer to a tertiary facility. Once patients are stabilized at the FMF by the emergency physician and clinical staff, the "One Call" system that is currently used to transfer patients within the UM CRH system will be activated. This system allows for physician to physician communication to coordinate transportation and acceptance of patients at other facilities. Currently, there is a 30-60 minute turnaround time for patient transports once the patient is accepted by UM PGHC. Optimal transport times to UM PGHC and other facilities will be supported by having dedicated commercial ambulance service that can commit to specified performance metrics around availability and response times, and helicopter ambulance services via the on-site helipad.

The building for Phase 2 of UM Laurel Medical Center was designed in accordance with the Facilities Guidelines Institute, Guidelines for Design and Construction of Hospitals and Outpatient Facilities 2014 Edition ("FGI Guidelines"), the 2015 National Fire and Protection Association 101 Life Safety Code, and the 2015 International Building Code. More specifically, the FMF was designed considering the FGI Guidelines Part 2 – Hospitals, Section 2.2-3 Diagnostic and Treatment Facilities, and Section 2.3 – Specific Requirements for Freestanding Emergency Departments.

The FGI Guidelines do not prescribe minimum or maximum ranges of overall program area/square footage, but rather prescribe minimum requirements, including some minimum square footage/clear floor area requirements, based on the functional program for the project. For example, Section 2.2-3.1.3.6 provides requirements for treatment rooms and states, "Single-bed treatment room(s) shall have a minimum clear floor area of 100 square feet." The proposed project currently includes 137 to 158 square feet for the single-bed treatment room. This allows for the patient stretcher and other required furniture such as side chairs and storage for supplies to be accommodated in the room, leaving more than the 100 square feet of clear floor area as required by the FGI Guidelines.

The behavioral health crisis treatment center at UM Laurel Medical Center was designed according to the FGI Guidelines Part 2 – Hospitals, Section 2.2-3 Diagnostic and Treatment Facilities, Section 2.2-3.1.3 Emergency Department; and specifically 2.2-3.1.4.3 Secure Holding Room which states, the secure holding room shall have a minimum clear floor area of 60 square feet with a minimum wall length of 7 feet and a maximum wall length of 11 feet. Accordingly, the proposed project includes treatment rooms in the range of 116.4 to 139.7 square feet. Taking into account the patient stretcher within this space, the remaining clear floor area complies with the requirements of FGI Guidelines.

C. Project Budget and Schedule.

The total project budget is $53.1 Million. The proposed project and as well as the other capital projects for which UM Laurel Medical Center and its constituent hospitals have sought approval from the Commission will be funded through a combination of $38.1 million in tax

exempt bonds, $500 thousand in interest earnings on the bonds, and $14.5 million in grant funding from the state of Maryland. The bonds were issued in FY 2018 through UMMS.

UM CRH intends to convert UM LRH to an FMF in the existing hospital building (Phase 1) within approximately two months following Commission approval of this exemption request. Construction of Phase 2 of the proposed project is projected to take place according to the following project schedule: (a) commitment of at least 51% of the approved capital expenditure within six (6) months following Commission approval of the CON exemption; and (b) completion of construction within 22 months after commitment of at least 51% of the approved capital expenditure.

UM CRH has provided project drawings, including two copies of full scale drawings, at **Exhibit 2**. UM CRH has also completed hospital CON **Tables A- K**, which are provided at **Exhibit 1**. **Tables A-E** present physical bed capacity, department square feet, construction characteristics, construction costs, and project budget. **Tables F-K** present utilization and financial projections that include a comprehensive statement of assumptions related to revenue and expenses and financial performance for UM Laurel Medical Center, as well as UM CRH, the parent of UM PGHC and the UM Laurel Medical Center.

II. THE CONVERSION OF UM LRH TO UM LAUREL MEDICAL CENTER IS CONSISTENT WITH THE STATE HEALTH PLAN, COMAR 10.24.19.

The conversion of UM LRH to UM Laurel Medical Center is consistent with the State Health Plan Chapter for Freestanding Medical Facilities, COMAR 10.24.19 (the "State Health Plan").

A. Location - COMAR 10.24.19.04(C)(4).

(4) The Commission shall require that a freestanding medical facility created through the conversion of a general hospital remain on the site of, or on a site adjacent to, the converting general hospital unless:

(a) The converting general hospital is the only general hospital in the jurisdiction or is one of only two general hospitals in the jurisdiction and both belong to the same merged asset system; and

(b) The site is within a five-mile radius and in the primary service area of the converting general hospital.

The State Health Plan requires that an FMF established as a result of a general hospital conversion remain on the site of, or adjacent to, the converting general hospital. COMAR 10.24.19.04(C)(4). UM CRH proposes to locate the UM Laurel Medical Center on the campus of UM LRH. Initially, the FMF will operate within the existing hospital building. Then, when a new building is constructed on the site, the FMF will operate in the new building. Thus, the proposed project complies with this standard.

B. UM PGHC's Compliance With COMAR 10.24.10.04(A) – COMAR 10.24.19.04(C)(5)

(5) The parent hospital shall demonstrate compliance with applicable general standards in COMAR 10.24.10.04A.

The State Health Plan requires that applicants seeking to convert an acute general hospital to an FMF shall demonstrate compliance with applicable general standards in COMAR 10.24.1.0.04A. *See* COMAR 10.24.19.04(C)(5). UM CRH complies with each of these standards.

1. Information Regarding Charges.

Information regarding hospital charges shall be available to the public. After July 1, 2010, each hospital shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:

(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;

(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and

(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

UM CRH's policy regarding charges, which applies at both UM LRH and UM PGHC, is attached as **Exhibit 4**. This policy will be extended to UM Laurel Medical Center when it opens. The most recent list of representative charges is attached as **Exhibit 5** and is also is available on UM CRH's website at the following link: https://umcapitalregion.org/for-patients/estimated-charges/.

2. Charity Care Policy.

Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay. COMAR 10.24.10 10

(a) The policy shall provide:

(i) Determination of Probable Eligibility. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.

(ii) Minimum Required Notice of Charity Care Policy.

1. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;

2. Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital; and

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

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

UM CRH's financial assistance policy, implemented at both UM PGHC and UM LRH, complies with this standard and is attached as **Exhibit 6**. This policy will be implemented at UM Laurel Medical Center when it opens. The policy states that UM PGHC and UM LRH will make a determination of probable eligibility within two (2) business days following a patient's request for charity care services, application for medical assistance, or both. *See* **Exhibit 6**, at 5.

Notices regarding the availability of financial assistance are posted in English and Spanish in the admissions and registration offices, the business offices, and emergency departments of the two hospitals, and notice of financial assistance is provided at admission or preadmission to each person who seeks services in the hospitals. Patient information sheets and brochures are also made available to patients. See **Exhibit 7**. An annual notice regarding UM CRH's financial assistance policy is also published in the *Washington Post*, the *Laurel Leader*, and the *Bowie Blade*. Copies of recent newspaper notices are attached as **Exhibit 8**.

As shown in **Table 3** below, neither UM PGHC nor UM LRH are in the bottom quartile in terms of percentage of charity care to total operating expense for acute general hospitals in the State of Maryland. In fact, both hospitals are ranked in the top quartile.

Table 3
HSCRC Community Benefit Report, Data Excerpts
FY2016

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	% Charity Care/Expenses	Quartile
Holy Cross Hospital	$411,176,881	$33,462,706	8.14%	1st
Adventist Washington Adventist*	$217,955,646	$14,800,908	6.79%	

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	% Charity Care/Expenses	Quartile
Doctors Community	$186,693,541	$12,200,284	6.53%	
Garrett County Hospital	$42,622,790	$2,316,474	5.43%	
UM Midtown	$191,264,500	$9,787,000	5.12%	
St. Agnes	$434,193,000	$21,867,282	5.04%	
Mercy Medical Center	$461,664,800	$19,521,700	4.23%	
UM Prince George's Hospital Center	$263,131,867	$9,769,558	3.71%	
Frederick Memorial	$330,320,000	$11,277,000	3.41%	
UM Charles Regional Medical Center	$113,371,227	$3,798,238	3.35%	
Western Maryland Health System	$314,069,685	$9,670,307	3.08%	
UM Laurel Regional Hospital	$95,998,834	$2,869,600	2.99%	
Atlantic General	$112,904,430	$3,277,824	2.90%	2nd
Holy Cross Germantown	$86,826,724	$2,382,942	2.74%	
UM Harford Memorial	$82,723,000	$1,915,000	2.31%	
Ft. Washington	$42,405,282	$914,689	2.16%	
Johns Hopkins Bayview Medical Center	$596,562,000	$12,679,000	2.13%	
Shady Grove*	$316,512,363	$6,620,218	2.09%	
UMMC	$1,445,705,000	$28,945,000	2.00%	
Peninsula Regional	$405,639,685	$7,836,700	1.93%	
UM Baltimore Washington	$330,823,000	$5,655,016	1.71%	
Meritus Medical Center	$299,130,713	$4,903,600	1.64%	
MedStar Harbor Hospital	$190,376,563	$2,995,264	1.57%	
Lifebridge Northwest Hospital	$233,286,000	$3,524,100	1.51%	3rd
UM Upper Chesapeake	$261,076,000	$3,818,000	1.46%	
Howard County Hospital	$250,602,000	$3,560,370	1.42%	
UM Shore Medical Dorchester	$39,677,059	$499,553	1.26%	
McCready	$14,968,260	$185,796	1.24%	
Suburban Hospital	$271,382,000	$3,294,000	1.21%	
MedStar Montgomery General	$151,876,735	$1,821,317	1.20%	
MedStar Southern Maryland	$242,526,804	$2,691,523	1.11%	
MedStar Good Samaritan	$302,367,777	$3,308,833	1.09%	
UM St. Joseph	$330,061,000	$3,488,000	1.06%	
Johns Hopkins Hospital	$2,173,349,000	$22,047,000	1.01%	
MedStar Franklin Square	$508,064,432	$5,147,191	1.01%	
MedStar St. Mary's Hospital	$149,998,897	$1,508,919	1.01%	4th
MedStar Union Memorial	$424,392,626	$4,012,263	0.95%	
UM Shore Medical Easton	$174,850,678	$1,575,225	0.90%	
UM Shore Medical Chestertown	$48,488,291	$407,715	0.84%	

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	% Charity Care/Expenses	Quartile
LifeBridge Sinai	$714,926,000	$5,452,000	0.76%	
Anne Arundel Medical Center	$531,698,000	$3,486,700	0.66%	
Carroll Hospital Center	$216,062,000	$1,303,875	0.60%	
Union Hospital of Cecil County	$152,850,972	$899,826	0.59%	
Bon Secours	$115,814,419	$607,325	0.52%	
GBMC	$402,046,322	$2,007,183	0.50%	
Calvert Hospital	$1,128,684,174	$3,808,206	0.34%	
All Hospitals	$15,811,120,977	$307,921,230	1.95%	
* The Adventist Hospital System requested and received permission to report Community Benefit activities on a CY Basis.				

Source: HSCRC Maryland Hospitals' Community Benefits Financial Report FY 2016, http://www.hscrc.state.md.us/Documents/HSCRC_Initiatives/CommunityBenefits/CBR-FY16/FiscalYear16-HCBFinancialReport-final.xlsx, *Accessed 1/4/2017*

3. Quality of Care

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene; COMAR 10.24.10 11

(ii) Accredited by the Joint Commission; and

(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

(b) A hospital with a measure value for a Quality Measure included in the most recent update of the Maryland Hospital Performance Evaluation Guide that falls within the bottom quartile of all hospitals' reported performance measured for that Quality Measure and also falls below a 90% level of compliance with the Quality Measure, shall document each action it is taking to improve performance for that Quality Measure.

UM Laurel Medical Center, as a provider-based department of UM PGHC under 42 C.F.R. § 413.65 and Health-General § 19-3A-01(3), will comply with requirements issued by the Maryland Department of Health for licensure as an FMF, be accredited by the Joint

Commission, and will comply with all conditions of participation in the Medicare and Medicaid programs.

The Commission has recognized that "subpart (b) of [COMAR 10.24.10.04(A)(3)] is essentially obsolete in that it requires an improvement plan for any measure that falls within the bottom quartile of all hospitals' reported performance on that measure as reported in the most recent Maryland [Hospital Evaluation Performance Guide], which has been reengineered with a different focus, and no longer compiles percentile standings." *In re Dimensions Health Corporation*, Docket No. 13-16-2351, Decision at 19 (Sept. 30, 2016).

UM Laurel Medical Center will be a provider-based department of UM PGHC. UM PGHC scored "better than average" or "average" on 41 of the seventy (70) quality measures. For an additional 13 quality measures, UM PGHC did not have sufficient data to report. UM PGHC scored "below average" on 21 quality measures, and for one measure it scored as "worse." **Exhibit 9** identifies those quality measures for which UM PGHC was scored "below average" or "worse" along with a corrective action plan

C. Licensure – COMAR 10.24.19.04(C)(6)

(6) The applicants shall document that the proposed FMF will meet licensure standards established by DHMH.

The State Health Plan Chapter requires that applicants demonstrate that the proposed FMF will meet licensure standards established by the Department of Health. UM Laurel Medical Center will meet or exceed licensure standards established by the Department of Health.

D. Financial Assistance and Charity Care – COMAR 10.24.19.04(C)(7)

(7) The applicants shall establish and maintain financial assistance and charity care policies at the proposed freestanding medical facility that match the parent hospital's policies and that are in compliance with COMAR 10.24.10.

The State Health Plan requires that applicants seeking to establish an FMF through conversion of an acute general hospital establish and maintain financial assistance and charity care policies at the proposed FMF that match the parent hospital's policies and that comply with COMAR 10.24.10. Submitted as **Exhibit 6** is UM CRH's financial assistance policy currently in effect at both UM PGHC and UM LRH, which policy complies with COMAR 10.24.10. This same policy will be implemented at UM Laurel Medical Center.

E. Emergency Department Visits in UM LRH's Service Area for the Last Five Years – COMAR 10.24.19.04(C)(8)(a)

(8) Applicants seeking to convert a general hospital to a freestanding medical facility, in addition to meeting the applicable requirements in 10.24.01.04, shall:

(a) Provide the number of emergency department visits and FMF visits by residents in the converting hospital's service area for at least the most recent five years;

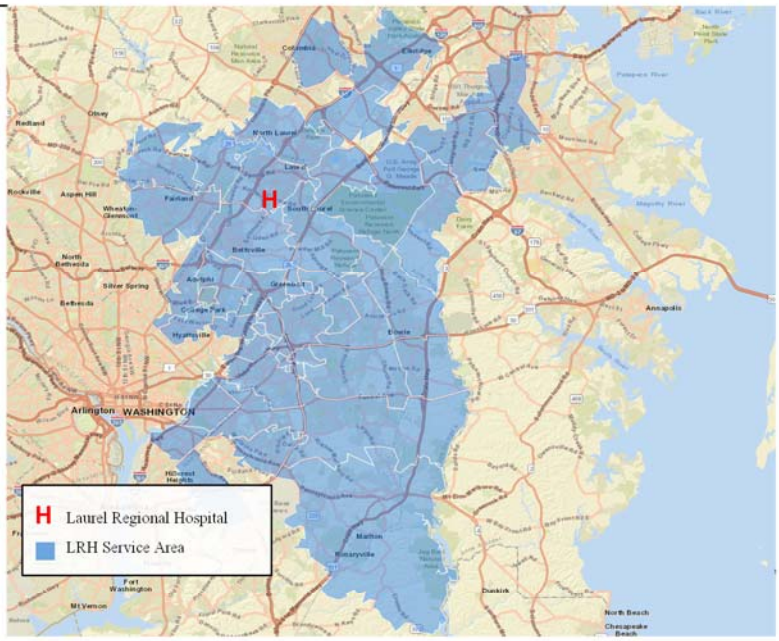
The State Health Plan requires that applicants seeking to convert an acute general hospital to an FMF provide the number of emergency department visits and FMF visits by residents in the converting hospital's service area for at least the most recent five years.

1. Definition of UM Laurel Medical Center Service Area

In fiscal year 2017, 85% of UM LRH's emergency department visits came from residents of thirty-five (35) zip codes in Prince George's County, Anne Arundel County , Montgomery County, Howard County and the District of Columbia (*i.e.*, UM Laurel Medical Center's Service Area) as listed and depicted in **Table 4** below.

Table 4
UM LRH ED Service Area
FY2017

Zip Codes	City
20707	Laurel
20708	Laurel
20705	Beltsville
20724	Laurel
20723	Laurel
20904	Silver Spring
20866	Burtonsville
20740	College Park
20706	Lanham
20770	Greenbelt
20785	Hyattsville
20783	Hyattsville
20774	Upper Marlboro
20784	Hyattsville
20715	Bowie
20743	Capitol Heights
20794	Jessup
21113	Odenton
20720	Bowie
20019	Washington
20755	Fort George G Meade
20747	District Heights
21144	Severn
21045	Columbia
20905	Silver Spring
20782	Hyattsville
21075	Elkridge
20737	Riverdale
20716	Bowie
20772	Upper Marlboro
20763	Savage
20721	Bowie
21061	Glen Burnie
20748	Temple Hills
20020	Washington



2. Historical Emergency Department Utilization in Service Area

In fiscal year 2017, there were 305,073 visits to Maryland hospital emergency departments by residents of the UM Laurel Medical Center's ED Service Area (see **Table 5**). This utilization represents a 9% reduction from the utilization of hospital emergency departments by residents of this service area since fiscal year 2013. UM LRH's emergency department

utilization by residents of its service area declined by 26.0% from 30,503 visits in fiscal year 2013 to 22,565 visits in fiscal year 2017. With declining volumes, the conversion of UM LRH to an FMF is appropriate to size the facility correctly to enable it to continue to provide access to emergency services for the service area population.

Table 5
UM LRH Service Area Emergency Department Visits
FY2013 – FY2017

	Historical ED Visits					FY2017	FY 13-17
Hospital Name	FY2013	FY2014	FY2015	FY2016	FY2017	Market Share	Change
Doctors Community Hospital	41,654	42,447	46,775	46,886	46,537	15.3%	11.7%
Baltimore Washington Medical Center	42,120	40,736	40,885	38,977	37,592	12.3%	-10.8%
Prince George's Hospital Center	38,791	37,110	37,255	38,268	35,997	11.8%	-7.2%
Howard County General Hospital	28,997	26,712	25,030	26,188	30,636	10.0%	5.7%
Holy Cross Hospital	30,035	28,647	29,139	29,449	28,074	9.2%	-6.5%
Laurel Regional Hospital	30,503	28,207	28,328	24,205	22,565	7.4%	-26.0%
Washington Adventist Hospital	23,748	21,990	22,162	21,785	21,343	7.0%	-10.1%
Southern Maryland Hospital Center	26,745	24,195	23,147	21,728	19,880	6.5%	-25.7%
Anne Arundel Medical Center	16,144	16,595	17,543	18,422	18,847	6.2%	16.7%
Fort Washington Medical Center	9,751	9,226	9,229	9,102	8,834	2.9%	-9.4%
Montgomery General Hospital	5,674	5,518	5,786	5,736	6,042	2.0%	6.5%
Johns Hopkins Hospital	2,917	3,214	3,162	3,568	4,413	1.4%	51.3%
St Agnes Hospital	2,756	2,850	3,103	3,274	3,330	1.1%	20.8%
Harbor Hospital	3,686	3,271	3,369	3,640	3,295	1.1%	-10.6%
University of Maryland Hospital	2,770	2,780	2,658	2,328	2,957	1.0%	6.8%
Suburban Hospital	2,148	2,204	2,266	2,535	2,746	0.9%	27.8%
Shady Grove Adventist Hospital	1,854	1,889	1,947	1,931	2,035	0.7%	9.8%
UM Charles Regional Medical Center	1,022	1,004	1,144	1,167	1,106	0.4%	8.2%
Other Hospitals with less than 1000 visits	23,872	11,811	8,342	8,693	8,844	2.9%	-63.0%
Total Service Area ED Visits	335,187	310,406	311,270	307,882	305,073	100.0%	-9.0%

Source: St. Paul's Non-Confidential Discharge Database

UM LRH's 22,565 emergency department service area visits in fiscal year 2017 represented 7.4% of the total service area emergency department visits. Other hospitals with greater market share of emergency department visits in the service area include Doctors Community Hospital (15.3%), UM Baltimore Washington Medical Center (12.3%), UM PGHC (11.8%), Howard County General Hospital (10.0%) and Holy Cross Hospital (9.2%). The emergency departments of these other hospitals are fully utilized. These other hospitals could be overwhelmed by an overflow of patient visits if the UM Laurel Medical Center is not developed

to the appropriate size and with the capabilities designed to meet the needs of the service area population.

F. Availability and Accessibility of Emergent, Urgent, and Primary Care – COMAR 10.24.19(C)(8)(b)

> (8) Applicants seeking to convert a general hospital to a freestanding medical facility, in addition to meeting the applicable requirements in 10.24.01.04, shall:
>
> * * * *
>
> (b) Assess the availability and accessibility of emergent, urgent, and primary care services otherwise available to the population to be served, including information on the number and location of other hospital emergency departments, FMFs, and urgent care centers in the service area of the converting hospital or within five miles of any zip code area in the service area of the converting hospital.

The State Health Plan requires that that applicants seeking to convert an acute general hospital to an FMF assess the availability and accessibility of emergent, urgent, and primary care services otherwise available to the population to be served, including information on the number and location of other hospital emergency departments, FMFs, and urgent care centers in the service area of the converting hospital or within five miles of any zip code in the service area of the converting hospital.

UM Laurel Medical Center has been designed to provide similar emergency and observation services as have been historically provided at UM LRH. UM CRH has been engaged in community education and outreach efforts for some time in order to inform the community of the significant capabilities and services that will be available at the UM Laurel Medical Center. *See* Section IV.E for details on UM CRH's community outreach efforts. As noted above, the applicant anticipates that UM Laurel Medical Center will maintain the nearly same level of emergency care services as currently provided at UM LRH. Accordingly,

UM CRH projected UM Laurel Medical Center's service area and number of emergency department visits based on historical utilization at UM LRH.

Within UM Laurel Medical Center's Service Area, there are three other acute general hospitals and one FMF: Doctor's Community Hospital (10.9 miles from UM LRH campus); UM PGHC (14.1 miles from UM LRH campus), UM Bowie Health Center (15.2 miles from UM LRH campus), and UM Baltimore Washington Medical Center (20.2 miles from the UM LRH campus). Based on current calculations from Google Maps, the following acute general hospitals, although not in the UM Laurel Medical Center's Service Area, are a relatively short distance to the proposed project site using public roadways: Anne Arundel Medical Center – 14.2 miles; Holy Cross Hospital – 11.5 miles; Howard County General Hospital – 14.3 miles; Washington Adventist Hospital, Takoma Park (current campus) – 11.5 miles; and Washington Adventist Hospital, White Oak (future campus) – 7.0 miles.

Within UM Laurel Medical Center's primary service area, UM CRH has identified the following urgent care centers and their proximity to UM Laurel Medical Center by roadway travel as set forth in **Table 6.**

Table 6
Urgent Care Centers in UM Laurel Medical Center's Service Area

Name	Address	Phone	Hours of operation	distance
Adventist HealthCare Urgent Care Laurel	14421 Baltimore Avenue Laurel, MD 20707	240-786-6684	8A - 8P seven days a week	1.5
Express Care Urgent Center-Lifebridge	14700 Baltimore Ave. Suite 108	301-317-4000	9am-9pm (7 days/week)	1.9
Kindermender Laurel (Pediatrics Walk-In)	805 Washington Blvd Laurel, MD 20707	443-599-4040	7am - 10pm (Mon-Fri) 8am - 10pm (Sat-Sun)	2.4
Elite Multi Specialty Clinic	9811 Mallard Dr #217 Laurel, MD 20708	(301) 604-4033	9am - 5pm (Mon, Wed, Fri) 8:30am - 3pm (Every other Sat)	4.1
Silver Spring Medical Center | Kaiser Permanente	12201 Plum Orchard Drive Silver Spring, MD 20904		Kaiser patients only	4.5
Briggs Chaney Walk-in Clinic	13823 Outlet Drive Silver Spring, MD 20904		9am - 7pm M-F 9am - 5pm Sa-Su	4.6
Patient First (Laurel - Urgent & Primary Care)	3357 B Corridor Marketplace Laurel, MD 20724	301-497-1820	8am - 10pm (Sun-Sat & holidays)	5
Secure Medical Care Urgent care center, Drug & Alcohol Screening, Pharmacy, Radiology	10452 Baltimore Ave Beltsville, MD 20705	301-441-3355	8am - 8pm (Mon-Fri) 10am - 6pm (Sat-Sun & holidays)	5.1
Quality First Urgent Care	15646 Old Columbia Pike Burtonsville, MD 20866			5.1
Patient First (Beltsville - Urgent Care &	10424 Baltimore Avenue		8am - 10pm (Sun-Sat & holidays)	5.2
Kaiser Permanente Medical Group	11961 Bournefield Way Silver Spring, MD 20904		Kaiser patients only	7
Maryland Urgent Care (Urgent & Primary	9831 Greenbelt Rd Ste 208	(301) 277-3555	8am - 5pm (Mon-Fri)	7.1
Express Healthcare	4701 Melbourne Pl College Park, MD 20740	301-345-4400	8A - 10P M-F 9A - 7P Sat/Sun	8
Med Ped Healthcare	4701 Melbourne Pl College Park, MD 20740	(301) 345-4700	8am - 8pm (Mon-Fri) 10am-6pm (Sat-Sun)	8
Express Healthcare	6201 Greenbelt Road Berwyn Heights, Maryland 20740	301-441-1112	8am - 8pm (Mon-Fri) 8am - 4pm (Sat, Sun)	8.2
Fast Track Urgent Care	13428 New Hampshire Ave Silver Spring, MD 20704		pam-9pm M-F 9am-6pm Sat-Sun	8.2
Centennial Medical Group Urgent Care / First Call Urgent Care	10981 John Hopkins Road Laurel, MD 20723	410-730-3399 x1 x1	8A - 8P Monday-Friday 8A - 5 P Sat/Sun	8.8
PM Pediatrics	7401 Greenbelt Road Greenbelt, MD 20770	301-982-5437	12P - 12A (Sun-Sat)	9.1
Ace Urgent CARE & Clinic	7347 Hanover Parkway, Suite B Greenbelt, MD 20770	301-220-2277	10am - 8pm (Mon-Fri) 10am - 3pm (Sat) 2pm - 6pm (Sun) last appt 30 mins before closing	9.7
Righttime Medical Care	20 University Blvd E Silver Spring, MD 20901			10.1
Express Healthcare	7582 Annapolis Road C2 Hyattsville, Maryland 20784	301-577-6665	8am - 4 pm	12
Concentra Urgent Care	4451 Parliament Pl Ste G Lanham Seabrook, MD 20706-1873	301-459-9113	7am - 6pm (Mon-Fri) No weekends	15

As shown in **Table 6**, there are an ample number of urgent care centers in UM Laurel Medical Center's projected Service Area. Despite the presence of these urgent care centers,

emergency department visits at area hospitals have not declined sufficiently to warrant the closure of emergency services on the UM LRH campus. Furthermore, the limited hours of operation of these urgent care centers does not provide an alternative for patients experiencing emergency medical conditions during after-hours. The development of UM Laurel Medical Center with the proposed level of beds and ancillary equipment is critical to ensure continued access to emergency and observation services for the service area population.

G. The Proposed Conversion of UM LRH to an FMF is Consistent UM CRH's Community Health Needs Assessment – COMAR 10.24.19.04(C)(8)(c).

> (8) Applicants seeking to convert a general hospital to a freestanding medical facility, in addition to meeting the applicable requirements in 10.24.01.04, shall:
>
> * * * *
>
> (b) Demonstrate that the proposed conversion is consistent with the converting hospital's most recent community health needs assessment;

The State Health Plan requires that applicants seeking to convert an acute general hospital to an FMF demonstrate that the proposed conversion is consistent with the converting hospital's most recent community health needs assessment. UM LRH's most recent community health assessment report, which was prepared as a joint report in collaboration with other area hospitals and the Prince George's County Health Department, is included in this submission as **Exhibit 10**.

In defining the "community" for purposes of assessing health needs, UM LRH takes into account the relevant facts and circumstances that drive community health status. This includes the geographic area served by the hospital facility, segment populations with specific needs, and disease states of significant incidence. UM LRH's definition of community includes medically

underserved, low-income, or minority populations who live in the geographic areas from which the hospital draws its patients. In addition, in determining its patient populations for purposes of defining its community, the hospital takes into account all patients without regard to whether (or how much) they or their insurers pay for the care received or whether they are eligible for assistance under the hospital facility's financial assistance policy. The hospital serves different geographic areas or populations, and the community served by the hospital is the aggregate of such areas or populations.

UM LRH is improving and adapting current health programs into sustainable community-based programs to positively impact the overall health and wellness of the community and achieve population health management objectives. This service expansion and adaptation is being achieved through collaborative partnerships with community organizations as well as with State and local health agencies. UM LRH management actively solicits information from community stakeholders and other community-based organizations to assess the health needs in our community. UM LRH representatives serve as members of a variety of healthcare focused community organizations and provide staff expertise and other resources, including hosting meetings at the hospital and the provision of health screening services at local community events.

Conversion of UM LRH to an FMF will support and advance UM CRH's objectives to improve community health. UM CRH is developing more health initiatives directed toward promoting prevention, and raising awareness of risks associated with health conditions such as asthma, diabetes, and mental health. UM CRH has also worked with local and state health officials to develop and implement programs that address the County's health plan goals.

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

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

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

Each participating hospital, including UM LRH, then produced a hospital-specific Community Health Implementation Plan ("CHIP"), which outlined the priorities for each

hospital and the initiatives it will implement to address the needs identified in the CHNA. The following priorities were identified based on the needs of the community UM LRH serves:

- **Priority Area 1:** ***Social Determinants of Health Risk Factors***
  The objectives under this priority are: (1) raise awareness about health risk factors, health promotion, and wellness; (2) promote engagement in primary care and behavioral health services; and (3) raise awareness about mental, emotional, and behavioral risk factors. The CHIP activities for this priority include health education and prevention programing, nutrition education, linkage to care (primary and specialty), health screenings and peer support programs.

- **Priority Area 2:** ***Physical Health and Chronic Disease Management***
  The objectives for priority area 2 are: (1) increase evidence-based screening, education, referral and/or treatment services for adults with chronic disease; (2) identify condition-specific priorities and barriers to care coordination; (3) develop and implement enhanced care coordination plans for chronic disease patients discharged from the hospital; (4) promote enhanced primary care follow-up and home care services; (5) partner with elder services programs to enhance linkages to care; and (6) reduce 30 day emergency department and inpatient admissions. To achieve the objectives, activities and programs focus on chronic disease self-management, care transitions and care coordination through partnership and collaboration with community providers.

- **Priority Area 3:** ***Behavioral Health***
  The CHIP includes the following objectives related to behavioral health: (1) improve behavioral health screening and identification protocols; (2) develop an internal strategy to address behavioral health needs of the community; (3) create a resource inventory of mental health and substance abuse providers to streamline the referral process; (4) reduction of hospital length of stay; and (5) educate the public about behavioral health risk factors and other behavioral health and wellness issues. The activities to achieve the objectives are designed to refine behavioral health infrastructure to better serve the

community, improve education and awareness to reduce stigma, integrate primary care and behavioral health screening and treatment services, and more effectively coordinate to improve referrals and access to behavioral health services in clinical and community settings.

The conversion of UM LRH to UM Laurel Medical Center is consistent with the CHNA. The proposed UM Laurel Medical Center will include comprehensive outpatient medical and surgical services to address the identified health needs of the community. The transition of UM LRH to an outpatient facility will allow UM CRH to provide needed community outpatient clinical services within an efficient and modern facility, integrated with other community providers and agencies. The array of services to meet community healthcare needs will include the following:

- Emergency Medicine Services available 24 hours a day, seven days a week.
    - Imaging and diagnostic services to support the emergency department
- Behavioral Health Services
    - Behavioral Health assessment center within a designated area of the emergency department.
    - Expanded Partial Hospitalization Program and Intensive Outpatient Program offering an array of treatment modalities
- Observation / Clinical Decision Unit to treat and monitor patients to determine the need for inpatient care

Within the FMF campus, other services will be provided including:

- Wound Care and Hyperbaric Medicine Center
- Primary Care
- Specialty Care
    - OB/GYN

- Cardiopulmonary Care
- Diabetes treatment and self-management education
- Chronic pain management
- Lung health program (asthma)
- Treatment for chronic obstructive pulmonary disease (COPD)
- Sleep medicine
- Lung cancer screening

The UM Laurel Medical Center will remain part of the UM CRH integrated health system as an outpatient department of UM PGHC. Patients and residents who receive outpatient medical and surgical services at the FMF will also continue to have access to community health programs and services to address their health needs. Programs and activities to identify FMF patients who are impacted by social determinants of health risk factors, diagnosed with chronic diseases and who require behavioral health education and support will continue. Additionally, as is the case currently, patients treated in the UM Laurel Medical Center emergency department or discharged from the UM Laurel Medical Center will be provided care transitions and care coordination support to ensure positive health outcomes and avoid unnecessary hospital stays or hospital readmissions.

In addition, greater alignment with community partners will allow UM CRH to deploy additional services to residents in the Laurel service area. Current partnerships with Totally Linking Care Maryland, Prince George's County Health Department, Prince George's County Area Agency on Aging, Prince George's County Fire and Emergency Medical Services and the University of Maryland School of Pharmacy, facilitate the delivery of services to the community and are designed to improve the physical health of resident and management of chronic disease.

Planned partnerships with The Maryland-National Capital Park and Planning Commission, Prince George's County Department of Parks and Recreation, Prince George's County Department of Housing, community based organizations, and local employers will expand health education and preventive health programs to address social determinants of health risk factors and reduce the incidence of chronic diseases such as obesity, diabetes, heart disease and hypertension/stroke.

An FMF in Laurel, partnered with an array of other outpatient health services, will provide comprehensive outpatient medical and surgical services, as well as health education and preventive health programs to address the identified needs of the Laurel community. Services provided on the campus of the FMF and at a variety of community locations will ensure appropriate access to care and community-based resources to improve the overall health of residents within Laurel and surrounding communities.

H. Number and Size of Emergency Treatment Spaces – COMAR 10.24.19.04(C)(8)(d)

(8) Applicants seeking to convert a general hospital to a freestanding medical facility, in addition to meeting the applicable requirements in 10.24.01.04, shall:

* * * *

(d) Demonstrate that the number of treatment spaces and the size of the FMF proposed by the applicant are consistent with the applicable guidance included in the most current edition of Emergency Department Design: A Practical Guide to Planning for the Future, published by the American College of Emergency Physicians, based on reasonably projected levels of visit volume.

(i) Demonstrate that the proposed number of treatment spaces is consistent with the low range guidance, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for a greater number of treatment spaces.

(ii) Demonstrate that the building gross square footage is consistent with the low range guidance, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for additional building gross square footage.

The State Health Plan requires that applicants seeking to convert an acute general hospital to an FMF demonstrate the proposed number and size of emergency treatment spaces and the size of the FMF proposed by the applicant are consistent with applicable guidance included in the most current edition of the *Emergency Department Design: A Practical Guide to Planning for the Future*, published by the American College of Emergency Physicians (the "ACEP Guide"), based on reasonably projected visit volume. Further, the State Health Plan requires that an applicant demonstrate that the proposed number of treatment spaces is consistent with the low range guidance in the ACEP Guide, *unless*, based on the particular characteristics of the population to be served, the applicant demonstrates the need for a greater number of treatment spaces. Finally, the State Health Plan requires that an applicant demonstrate that the building gross square footage is consistent with the low range guidance, *unless*, based on the particular characteristics of the population to be served, the applicant demonstrates the need for additional building gross square footage.

1. The Number and Size of UM Laurel Medical Center's Emergency Department Treatment Spaces is Consistent with an Average of the ACEP High and Low Range Guidelines.

As presented in **Table 7**, the emergency department visits to UM LRH from its service area Zip Codes declined by 26.0% between fiscal years 2013 and 2017. This decline in service area visits was exceeded by a 30.1% decline in visits from outside of the service area. Combined, UM LRH's total emergency department visits declined from 36,179 visits in fiscal year 2013 to 26,533 visits in fiscal year 2017 (see **Table 7**).

Table 7
UM LRH Historical Emergency Department Visits
FY2013 – FY2017

	Historical ED Visits					% Change
	FY2013	FY2014	FY2015	FY2016	FY2017	FY13 - FY17
Service Area Visits						
IP Visits	3,835	3,564	3,239	2,578	2,544	-33.7%
OP Visits	26,668	24,643	25,089	21,627	20,021	-24.9%
Service Area Visits	**30,503**	**28,207**	**28,328**	**24,205**	**22,565**	**-26.0%**
% Change		*-7.5%*	*0.4%*	*-14.6%*	*-6.8%*	
Out of Service Area						
IP Visits	656	630	540	444	353	-46.2%
OP Visits	5,020	4,536	4,392	3,971	3,615	-28.0%
Out of Service Area Visits	**5,676**	**5,166**	**4,932**	**4,415**	**3,968**	**-30.1%**
% Change		*-9.0%*	*-4.5%*	*-10.5%*	*-10.1%*	
Total LRH Visits						
IP Visits	4,491	4,194	3,779	3,022	2,897	-35.5%
OP Visits	31,688	29,179	29,481	25,598	23,636	-25.4%
Total LRH ED Visits	**36,179**	**33,373**	**33,260**	**28,620**	**26,533**	**-26.7%**
% Change		*-7.8%*	*-0.3%*	*-14.0%*	*-7.3%*	

Source: St. Paul's Non-Confidential Discharge Database

In fiscal year 2018 to date, UM LRH's total emergency department visits have declined an additional 2.5%, but with the recent affiliation with UMMS, the decline in UM LRH's emergency department visits is expected to continue to level off (2016: 14.0%; 2017: 7.3%; 2018: 2.5%). UM LRH has engaged in efforts to rebrand, market, and perform outreach to the community regarding its affiliation with UMMS, which it expects will give the community a better impression of the quality of its care. While nearby urgent care centers may have contributed to the decline in UM LRH's historical emergency room visits, UM LRH is not aware of new urgent care centers that are entering the market. In fiscal year 2019, UM LRH expects to provide care for emergency department patients with behavioral health diagnoses in a unit dedicated to their unique needs. In fiscal year 2017, behavioral health emergency department patients accounted for approximately 7% of UM LRH's total emergency department visits.

Based on the website for Washington Adventist Hospital ("WAH"), it is expected that the new hospital in White Oak, Maryland will open in May 2019. It is expected that patients in UM LRH's service area who reside in Zip Codes that are closer to the new WAH facility than to UM LRH, will go to the new WAH facility. The number of patients who are expected to go to WAH was determined using a drive-time analysis from each Zip Code in UM LRH's service area that measures the drive time of patients, both during non-rush hour and rush hour, to the proposed UM Laurel Medical Center and the new WAH facility upon its opening. It is expected that UM Laurel Medical Center will lose approximately 9% of its emergency department visits to WAH beginning in fiscal year 2020.

With a carve-out for behavioral health patients in a dedicated unit within the emergency department and the expected impact of WAH, the applicant projects that the UM Laurel Medical Center will see 21,704 emergency department visits by fiscal year 2024 (**Table 8**).

Table 8
UM LRH's Historical and Projected Emergency Department Visits
FY2015 – FY2024

	Actual	Annualized	Projected In Existing Hospital			Projected at New Facility		
	2017	2018	2019	2020	2021	2022	2023	2024
ED Visits								
Inpatient	2,897	2,824	2,824	2,824	2,824	2,824	2,824	2,824
Outpatient	23,636	23,039	23,039	23,039	23,039	23,039	23,039	23,039
Total	26,533	25,863	25,863	25,863	25,863	25,863	25,863	25,863
% Change	*-7.3%*	*-2.5%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
Less: ED Visits from Zip Codes with Less Drive Time to WAH								
Non-Rush Hour				(1,748)	(1,748)	(1,748)	(1,748)	(1,748)
Rush Hour				(507)	(507)	(507)	(507)	(507)
WAH Impact (b)	-	-	-	(2,254)	(2,254)	(2,254)	(2,254)	(2,254)
Adjusted LRH Visits (a+b)	26,533	25,863	25,863	23,608	23,608	23,608	23,608	23,608
% Change	*-7.3%*	*-2.5%*	*0.0%*	*-8.7%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
Less: LRH Behavioral Health Primary Diagnoses (c)	-	-	(1,904)	(1,904)	(1,904)	(1,904)	(1,904)	(1,904)
Adjusted LRH Non-BH ED Visits (a+b+c)	26,533	25,863	23,959	21,704	21,704	21,704	21,704	21,704
% Change	*-7.3%*	*-2.5%*	*-7.4%*	*-9.4%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

Source: St. Paul's Non-Confidential Discharge Database

In addressing the number of emergency treatment space and its consistency with ACEP guidance, it should be noted that the ACEP Guide indicates that the low, mid, and high ranges are "general guideline[s]" used to set "preliminary benchmarks for sizing emergency departments," which can be adjusted for "each unique emergency department project" and that the size parameters are merely "estimates." *Id*. at 109, 116-117. The low, mid, and high ranges are also not exacting tiers but represent a continuum based on projections. Further the ACEP Guide's consideration of a freestanding emergency department does not contemplate such a facility as a replacement for an existing hospital's emergency and observation capacity. On the contrary, the ACEP Guide's discussion of freestanding emergency departments suggests that these facilities may be developed to "decant" or move certain emergency services from an existing crowded main hospital emergency department.

The ACEP Guide categorizes emergency department designs into low, mid, and high range using sixteen (16) factors. As presented in **Table 9**, seven (7) or 43.8% of the sixteen (16) factors fall in the "mid-range". These mid-range factors include: (a) 14% of patients will be expected to be admitted to a hospital; (b) turnaround time for diagnostic testing is approximately 60 minutes; (c) 25% of patients are non-urgent; (d) greater than 10% of patients are expected to be older than 65; (e) general imaging services will be provided within the FMF; (f) there will be limited family amenities; and (g) the FMF will provide moderate administrative and teaching space (see **Table 9**).

Table 9
UM LRH Comparison to ACEP Guide

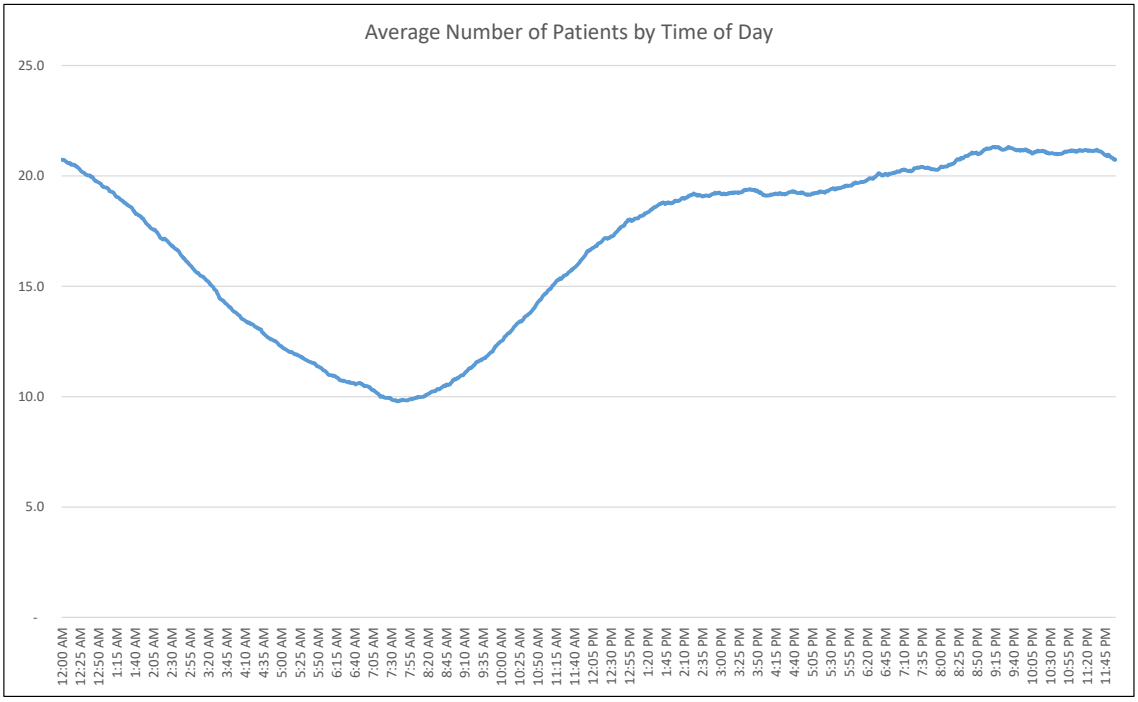
Factor	Treatment Space Range			Projected
	Low	Medium	High	FMF
% Admitted Patients	< 8%	12-20%	> 25%	Medium
ALOS	<2.25 Hours	2.5-3.75 Hours	>4 Hours	High
Private Rooms	Few	Majority	All	High
Inner Waiting and Result Waiting Areas	Available	Limited	Pts. Stay in Bay	Low
Location of Observation Beds	Outside ED	Limited	Inside ED	Low
Boarding of Admitted Pts.	Stay < 60 Min	Stay 90-120 Min	Stay Over 150 Min.	High
Turnaround Time Dx Tests	< 45 Minutes	60 Minutes	> 90 Minutes	Medium
% Behavioral Health Patients	< 3%	4-6%	>7	High
% Nonurgent Pts.	>45%	25-45%	<25%	Medium
Age of Patient	<10% Age 65+	10-20% Age 65+	>20% Age 65+	Medium
Imaging w/n ED	No	General and CT	Extensive	Medium
Family Amenities	None	Limited Consult	Multiple Consult, Grieving	Medium
Specialty Components: Geriatrics	None	Designated Area	Module with Support	Low
Specialty Components: Pediatrics	None	Designated Area	Module with Support	Low
Specialty Components: Detention	None	Designated Area	Module with Support	Low
Admin/Teaching Space	Minimal	Moderate	Extensive	Medium

Source: Factors = Emergency Department Design: A Practical Guide to Planning for the Future, published by the American College of Emergency Physicians
Proposed FMF = LRH managemet reports and input by LRH Department of Emergency Medicine Medical Director

Another four factors fall in the "high range" including: (a) an average length of stay of 4.0 hours; (b) all private rooms; (c) boarding of admitted patients over 150 minutes; and (d) percent of Behavioral Health patients equal to 7% of emergency department visits. As such, the ACEP "low range" guidelines are not applicable in determining the number of emergency department treatment spaces. Based on these factors, UM LRH is in the mid-range based on the ACEP Guide criteria.

Using the ACEP Guide is problematic in that it addresses only the *average* number of patients in the emergency department in a year to determine the number of emergency department treatment spaces. The ACEP Guide does not address the peak number of patients in the emergency department, each of which will require a treatment space. In January through June 2017, there was a peak number of 21.3 non-behavioral health patients in the emergency department during the 9:00 pm hour (see **Table 10**).

Table 10
LRH Number of Non-Behavioral Health Emergency Department Patients by Minute
January – June 2017



Source: LRH internal database of ED visits

This peak number of patients represents a 27% increase over the average number of 16.8 patients per day. Sizing to the peak volume requires this 27% add-on to the projected ED visits before applying the ACEP guidelines of treatment spaces per number of ED visits. Under the current edition of the ACEP Guide (2d. ed. 2016), Figure 5.1 estimates treatment space need for emergency department visits in five thousand visit increments, starting at 10,000 visits per year. ACEP Guide, at 116. Excluding behavioral health emergency visits, which are addressed separately, the peak emergency department visit projections fall between the ACEP groupings of 25,000 and 30,000 annual visits. The ACEP Guide for "low range" projects a need for 18 to 21 treatment spaces. The "high range' projects a need for 20 to 25 treatment spaces between fiscal

year 2019 and 2024. UM LRH is in the "mid-range" of the ACEP Guide criteria. Taking the average of the "low range' and 'high range' treatment spaces in fiscal year 2019 results in an expected need for 23 emergency department treatment spaces which will be maintained until the opening of the new FMF facility. The opening of the new WAH facility is expected to reduce the FMF ED treatment space need to 21 spaces through fiscal year 2024 (see **Table 11**). However, UM CRH plans to only construct and operate 20 emergency department treatment spaces in the new FMF facility, which it anticipates opening in fiscal year 2022.

Table 11
UM LRH Projected Need for Emergency Department Treatment Spaces

	Actual	Annualized	Projected In Existing Hospital			Projected at New Facility		
	2017	2018	2019	2020	2021	2022	2023	2024
ED Visits								
Adjusted LRH Non-BH ED Visits (a+b+c)	26,533	25,863	23,959	21,704	21,704	21,704	21,704	21,704
Average ED Patients per Minute (January - June 2017)	16.8							
Peak ED Patients per Minute (January - June 2017)	21.3							
Adjustment for Peak Period	127%	127%	127%	127%	127%	127%	127%	127%
Annualized Peak Period Visits	33,617	32,768	30,356	27,499	27,499	27,499	27,499	27,499
% Change		*-2.5%*	*-7.4%*	*-9.4%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
Main ED Need for Treatment Spaces (excludes treatment spaces for Behavioral Health)								
ACEP Interpolated Need for ED Treatment Spaces (1)								
Low	22.4	22.1	21.1	19.5	19.5	19.5	19.5	19.5
High	27.2	26.7	25.2	22.5	22.5	22.5	22.5	22.5
Average	24.8	24.4	23.2	21.0	21.0	21.0	21.0	21.0
Requested FMF Main ED Treatment Spaces			**23**	**23**	**23**	**20**	**20**	**20**

Note (1): Reflects LRH internal database of ED visist for the period January-June 2017
Note (2): Reflects interpolation of ACEP guidelines for ED spaces with 25,000 and 30,000 ED visits

Based on the ACEP guidelines presented in **Table 12**, the expected size of these treatment spaces will be approximately 838 square feet per treatment space. With the projection of 20 treatment spaces in the new FMF facility, the Building Gross Square Feet associated with these treatment spaces is expected to equal 20,938 square feet.

Table 12
UM LRH Projected Square Feet for Emergency Department Treatment Spaces

	Actual	Projected In Existing Hospital				Projected at New Facility		
	2017	2018	2019	2020	2021	2022	2023	2024
Main ED Square Feet (excludes treatment spaces for Behavioral Health)								
ACEP Square Feet per ED Treatment Space (1)								
Low	800	800	800	800	800	800	800	800
High	875	875	875	875	875	875	875	875
Average	838	838	838	838	838	838	838	838
Requested FMF Main ED Treatment Spaces			24	24	24	20	20	20
Departmental Gross Square Feet			20,100	20,100	20,100	16,750	16,750	16,750
Building Gross Square Feet @ 1.25 Multiplier			**25,125**	**25,125**	**25,125**	**20,938**	**20,938**	**20,938**

Note (1): Reflects ACEP guidelines for ED spaces with 25,000 and 35,000 ED visits

2. UM CRH Demonstrates a Need for Four Behavioral Health Emergency Department Treatment Spaces in the UM Laurel Medical Center.

The proposed UM Laurel Medical Center also includes four (4) behavioral health treatment spaces adjacent to the general emergency department. In fiscal years 2016 and 2017, an average of 6.7% of UM LRH's emergency department visits were diagnosed with a behavioral health condition. In fiscal year 2024, the UM Laurel Medical Center is projected to have 1,904 behavioral health emergency department visits. The challenge with using the ACEP Guide to size the number of behavioral health treatments spaces for less than 10,000 visits is that the guidelines suggest a range of 909 to 1,250 visits per treatment space. This utilization reflects 2.5 to 3.4 patients per treatment space per day with average lengths of stay between 7.0 to 9.6 hours. In January through June 2017, UM LRH's behavioral health emergency department patients experienced a peak average length of stay of 15.4 hours.

With an average length of stay of 15.4 hours per visit, the behavioral health is unit is projected to have an average daily census of 3.5 patients. With an assumed occupancy of 95.0%, there is need for four (4) behavioral health emergency department treatment spaces (see **Table 13**).

Table 13
UM Laurel Medical Center's Projected Behavioral Health Emergency Department Visits
2019 - 2024

	Projected In Existing Hospital			Projected at New Facility		
	2019	2020	2021	2022	2023	2024
Behavioral Health ED Visits	1,904	1,904	1,904	1,904	1,904	1,904
% Change		*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
Average Hours Per Visit (1)	15.4	15.4	15.4	15.4	15.4	15.4
Behavioral Health ED Days	1,219	1,219	1,219	1,219	1,219	1,219
Average Daily Census	3.3	3.3	3.3	3.3	3.3	3.3
Occupancy Target	95%	95%	95%	95%	95%	95%
Behavior Health Need for ED Treatment Spaces	3.5	3.5	3.5	3.5	3.5	3.5
Requested FMF Behavioral Health ED Treatment Spaces	**4**	**4**	**4**	**4**	**4**	**4**
% Change		*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

Note (1): Reflects LRH's peak experience in January - June 2017
Source: St. Paul's Non-Confidential Discharge Database

Based on the ACEP guidelines presented in **Table 14**, the expected size of these treatment spaces will approximate 850 square feet per treatment space. With the projection of four behavioral health treatment spaces in the new FMF facility, the Building Gross Square Feet associated with these treatment spaces is expected to equal 4,250 square feet.

Table 14
LRH Projected Square Feet for Behavioral Health Emergency Department Treatment Spaces

	Projected In Existing Hospital			Projected at New Facility		
	2019	2020	2021	2022	2023	2024
Behavioral Health Emergency Department Square Feet						
ACEP Interpolated Square Feet per ED Treatment Space (1)						
Low	825	825	825	825	825	825
High	875	875	875	875	875	875
Average	850	850	850	850	850	850
Requested FMF Behavioral Health ED Treatment Spaces	4	4	4	4	4	4
Departmental Gross Square Feet	3,400	3,400	3,400	3,400	3,400	3,400
Building Gross Square Feet @ 1.25 Multiplier	**4,250**	**4,250**	**4,250**	**4,250**	**4,250**	**4,250**

Note (1): Reflects interpolation of ACEP guidelines for ED spaces with less than 10,000 ED visits

I. The Number and Size of UM Laurel Medical Center's Observation Treatment Spaces is Consistent with the Population to be Served – COMAR 10.24.19.04(C)(8)(e).

(8) Applicants seeking to convert a general hospital to a freestanding medical facility, in addition to meeting the applicable requirements in 10.24.01.04, shall:

* * * *

(e) Demonstrate that the proposed number and size of observation spaces for the FMF are consistent with applicable guidance included in the most current edition of *Emergency Department Design: A Practical Guide to Planning for the Future,* published by the American College of Emergency Physicians, based on reasonably projected levels of visit volume and average patient time in observation spaces.

(i) Demonstrate that the FMF will achieve at least 1,100 visits per year per observation space, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for a greater number of observation spaces;

(ii) Demonstrate that the size of each observation space does not exceed 140 square feet, exclusive of any toilet or bathing area incorporated into an individual observation space, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for larger observation spaces.

The State Health Plan requires that applicants seeking to convert an acute general hospital to an FMF demonstrate the proposed number and size of observation spaces is consistent with applicable guidance included in the most current edition of the ACEP Guide, based on reasonably projected levels of visit volumes. The ACEP Guide does not provide a projection of need for the number of treatment spaces. Instead, the ACEP Guide contains the following guidance from its author:

> [G]enerally program[s] [clinical decision unit or observation] spaces in the range of 900 to 1,100 patients per space annually. Use the lower number if your patients use the [clinical decision unit] for 12+ hours, and use the higher number if your patients use the space for 8 to 12 hours.

ACEP Guide at 273. The State Health Plan also states that applicants must demonstrate that the FMF will achieve 1,100 visits per year per observation space, *unless*, based on the particular characteristics of the population to be served, the applicants demonstrate the need for a greater number of observation spaces. COMAR 10.24.19.04(C)(8)(e)(i).

As set forth below in **Table 15**, in fiscal years 2016 and 2017 approximately 96% of UM LRH's observation patients came through the emergency department. From fiscal years 2016 to 2017, observation cases at UM LRH increased 5.4% with a 0.6% increase in the average length of stay.

Table 15
Historical UM LRH Observation Cases and Hours

	Actual		
	FY2016	FY2017	% Change
Observation Cases	1,369	1,443	5.4%
Observation Cases through ED	1,319	1,397	5.9%
% of Observation Cases through ED	96.3%	96.8%	0.5%
Observation Hours	32,857	34,833	6.0%
Observation Hours per Case	24.0	24.1	0.6%

Source: St. Paul Non-Confidential IP and OP Databases

Based on the significant number of observation patients that come through the emergency department, UM LRH began the projection of future observation treatment spaces based on expected changes in the emergency department visits, including a reduction in fiscal year 2020 with the opening of the new WAH facility nearby in White Oak. Expected increases to this baseline projection of emergency department visits include:

- Due to the elimination of inpatient beds, the emergency department providers will place approximately 2% more of the emergency department patients in the observation unit to preserve emergency department throughput.
- Reduction in inpatient potentially avoidable utilization will increase the number of projected observation patients.
- Additional higher acuity outpatient surgical cases that will require an overnight stay in the observation unit.

With these adjustments, UM CRH projects 1,822 observation cases at the UM Laurel Medical Center in fiscal year 2024 (see **Table 16**).

Table 16
Projected Observation Cases

	Actual	Actual	Projected In Existing Hospital				Projected at New Facility		
	2016	2017	2018	2019	2020 (1)	2021	2022	2023	2024
Observation Cases									
Baseline (Population Growth plus Impact of WAH)									
Inpatient	330	296	289	289	263	263	263	263	263
Outpatient	1,039	1,147	1,118	1,118	1,021	1,021	1,021	1,021	1,021
Subtotal	1,369	1,443	1,407	1,407	1,284	1,284	1,284	1,284	1,284
Impact of No IP Beds at LRH = 2% of OP	-	-	-	427	387	387	387	387	387
Shift of LRH Inpatients to Outpatient	-	-	-	101	101	101	101	101	101
Additional Higher Acuity Cases	-	-	-	50	50	50	50	50	50
Total	1,369	1,443	1,407	1,984	1,822	1,822	1,822	1,822	1,822
% Change	*-36.0%*	*-7.5%*	*-2.5%*	*41.1%*	*-8.2%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

In addition to adjustments to the projected number of observation cases, UM CRH also expects that the average length of stay of the observation cases will increase 25% beginning in 2019 due to prior borderline acuity inpatients that were placed in observation that were denied for level of care. Also, inefficiencies or social determinants of the current state caused some observation patients to be prematurely changed to inpatient status due to delay in discharges. By fiscal year 2024, the average length of stay is projected to equal 31.1 hours (see **Table 17**).

Table 17
Projected Observation Length of Stay at UM Laurel Medical Center

	Actual	Actual	Projected In Existing Hospital				Projected at New Facility		
	2016	2017	2018	2019	2020 (1)	2021	2022	2023	2024
Average Hours Per Case (Includes 25% Increase in LOS Beginning in 2019)									
Inpatient	15.8	14.8	14.8	18.4	18.4	18.4	18.4	18.4	18.4
Outpatient	26.6	26.6	26.6	33.2	33.2	33.2	33.2	33.2	33.2
Average	24.0	24.1	24.1	31.1	31.1	31.1	31.1	31.1	31.1
% Change	*-20.6%*	*0.0%*	*0.0%*	*28.7%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

Note (1): Reflects loss of ED visits to the new WAH

Source: St. Paul's Non-Confidendtial databases for FY2016 and FY2017

This projected length of stay is inconsistent with the State Health Plan suggestion to assume 1,100 visits per year per observation space. With a resulting average daily census of 3 patients per observation space, this direction would limit the length of stay of observation patients to 8 hours, an unreasonably low estimate. Applying the State Health Plan's recommendation of 1,100 observation visits per observation space would result in only two (2) observation spaces at UM Laurel Medical Center, which would be grossly inadequate to serve the needs of the service area population and overwhelm other area hospitals with transfers from UM Laurel Medical Center for patients who could otherwise be safely and effectively treated in the observation unit at UM Laurel Medical Center, and result in significant increased costs to the health delivery system in the form of inter-facility ambulance transfers. Such transfers could also jeopardize patient care outcomes and patient satisfaction. Moreover, the increased number of transports resulting from a lack of observation treatment spaces at UM Laurel Medical Center would be certain to burden EMS providers.

Rather than using the State Health Plan to project observation bed need for a hospital converting to an FMF, it is more appropriate to project observation bed need at UM Laurel

Medical Center similar to MSGA bed need that considers length of stay and occupancy. Because there will be no MSGA beds to accommodate any overflow of observation cases and because any overflow of observation cases would necessitate potentially unnecessary inter-facility transports, LRH assumes a 70% occupancy of observation beds at the UM Laurel Medical Center. This occupancy assumption is based on the State Health Plan for Acute Care Hospital Services (COMAR 10.24.10), which provides the minimum occupancy standard for MSGA services with average daily census of 0-49 patients.

Given the assumptions described above, UM CRH projects the need for ten observation spaces in fiscal years 2019 through 2024. This number of observation spaces is consistent with the needs and characteristics of the population to be served.

Table 18
Projected Observation Spaces

	Actual	Actual	Projected In Existing Hospital				Projected at New Facility		
	2016	2017	2018	2019	2020 (1)	2021	2022	2023	2024
Observation Days	1,369	1,451	1,415	2,568	2,358	2,358	2,358	2,358	2,358
% Change		*6.0%*	*-2.5%*	*81.5%*	*-8.2%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
Average Daily Census	3.8	4.0	3.9	7.0	6.5	6.5	6.5	6.5	6.5
% Change		*6.0%*	*-2.5%*	*81.5%*	*-8.2%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
Occupancy Target	70%	70%	70%	70%	70%	70%	70%	70%	70%
Observation Space Need	5.4	5.7	5.5	10.1	9.2	9.2	9.2	9.2	9.2
% Change		*6.0%*	*-2.5%*	*81.5%*	*-8.2%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
Requested FMF Observation Spaces				**10**	**10**	**10**	**10**	**10**	**10**

Note (1): Reflects loss of ED visits to the new WAH
Source: St. Paul's Non-Confidendtial databases for FY2016 and FY2017

J. Utilization, Revenue, and Expense Projections – COMAR 10.24.19.04(C)(8)(f)

(8) Applicants seeking to convert a general hospital to a freestanding medical facility, in addition to meeting the applicable requirements in 10.24.01.04, shall:

* * * *

(f) Provide utilization, revenue, and expense projections for the FMF, along with a comprehensive statement of the assumptions used to develop the projections, and demonstrate that:

(i) The utilization projections are consistent with observed historic trends in ED use by the population in the FMF's projected service area;

(ii) The utilization projections for rate-regulated outpatient services under Health-General Article §19-201(d)(ii) and (iv) and COMAR 10.37.10.07-2 are consistent with the observed historic trends by the population in the FMF's projected service area.

(iii) The revenue estimates for emergency services and other outpatient services specified by the HSCRC under Health-General Article §19-201(d)(iv) and COMAR 10.37.10.07-2 are consistent with utilization projections and the most recent HSCRC payment policies for FMFs;

(iv) The staffing assumptions and expense projections for emergency services and any other rate-regulated outpatient services under Health-General Article §19-201(d)(ii) and (iv) and COMAR 10.37.10.07-2 are based on current expenditure levels, utilization projections, and staffing levels experienced by the applicant hospital's ED and with the recent experience of similar FMFs; and

(v) Within three years of opening, the combined FMF and parent hospital will generate net positive operating income.

The State Health Plan requires that applicants seeking to convert an acute general hospital to an FMF provide utilization, revenue, and expense projections for the FMF, along with a comprehensive statement of the assumptions used to develop the projects. UM CRH has completed **Tables A- K**, which are submitted as **Exhibit 1**. Included in **Exhibit 1** for **Tables F**, **G**, **H**, **I**, **J** and **K** are utilization and financial projections that include a comprehensive statement of assumptions related to revenue and expenses and financial performance for UM Laurel Medical Center, as well as UM CRH, the parent of UM PGHC and UM Laurel Medical Center. **Table F** includes utilization projection that reflect both the inpatient and outpatient utilization of UM CRH and outpatient emergency department visits, observation cases, operating room cases, and related outpatient ancillary services at UM Laurel Medical Center. **Table I** includes

utilization projections that reflect UM Laurel Regional Hospital and UM Laurel Medical Center, including outpatient emergency department visits, observation cases, operating room cases, and related outpatient ancillary services at UM Laurel Medical Center.

1. UM Laurel Medical Center Emergency Department Utilization

The projection of emergency department visits at UM Laurel Medical Center assumes the continuation of existing emergency services through fiscal year 2024 adjusted for the creation of a distinct unit within the emergency department for psychiatric patients in fiscal year 2019 and the expected impact of a new Washington Adventist Hospital in fiscal year 2020. The projected emergency visits are presented in **Table 19**.

Table 19
UM Laurel Medical Center Historical and Projected Emergency Department Visits
FY2015 – FY2024

	Actual	Projected In Existing Hospital				Projected at New Facility		
	2017	2018	2019	2020	2021	2022	2023	2024
ED Visits								
Inpatient	2,897	2,824	2,824	2,824	2,824	2,824	2,824	2,824
Outpatient	23,636	23,039	23,039	23,039	23,039	23,039	23,039	23,039
Total	26,533	25,863	25,863	25,863	25,863	25,863	25,863	25,863
% Change	*-7.3%*	*-2.5%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
Less: ED Visits from Zip Codes with Less Drive Time to WAH								
Non-Rush Hour				(1,748)	(1,748)	(1,748)	(1,748)	(1,748)
Rush Hour				(507)	(507)	(507)	(507)	(507)
WAH Impact (b)	-	-	-	(2,254)	(2,254)	(2,254)	(2,254)	(2,254)
Adjusted LRH Visits (a+b)	26,533	25,863	25,863	23,608	23,608	23,608	23,608	23,608
% Change	*-7.3%*	*-2.5%*	*0.0%*	*-8.7%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
Less: LRH Behavioral Health Primary Diagnoses (c	-	-	(1,904)	(1,904)	(1,904)	(1,904)	(1,904)	(1,904)
Adjusted LRH Non-BH ED Visits (a+b+c)	26,533	25,863	23,959	21,704	21,704	21,704	21,704	21,704
% Change	*-7.3%*	*-2.5%*	*-7.4%*	*-9.4%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

Source: St. Paul's Non-Confidential Discharge Database

2. UM Laurel Medical Center Observation Utilization

As 96% of observation cases come through the emergency department at UM LRH, the applicant projects changes in observation cases consistent with that of the emergency department in fiscal years 2018 through 2024. Because of the elimination of inpatient services on the campus, several additional adjustments were made to the projection of observation cases including:

- Approximately 2% more of the emergency department patients will receive care in the observation unit to preserve emergency department throughput.
- Reduction in inpatient potentially avoidable utilization will increase the number of projected observation patients.
- Additional outpatient surgical cases that will require an overnight stay in the observation unit.

The projected Observation cases are presented in **Table 20**.

Table 20
UM Laurel Medical Center Historical and Projected Observation Cases
FY2015 – FY2024

	Actual	Actual	Projected In Existing Hospital				Projected at New Facility		
	2016	2017	2018	2019	2020 (1)	2021	2022	2023	2024
Observation Cases									
Baseline (Population Growth plus Impact of WAH)									
Inpatient	330	296	289	289	263	263	263	263	263
Outpatient	1,039	1,147	1,118	1,118	1,021	1,021	1,021	1,021	1,021
Subtotal	1,369	1,443	1,407	1,407	1,284	1,284	1,284	1,284	1,284
Impact of No IP Beds at LRH = 2% of OP	-	-	-	427	387	387	387	387	387
Shift of LRH Inpatients to Outpatient	-	-	-	101	101	101	101	101	101
Additional Higher Acuity Cases	-	-	-	50	50	50	50	50	50
Total	1,369	1,443	1,407	1,984	1,822	1,822	1,822	1,822	1,822
% Change	*-36.0%*	*-7.5%*	*-2.5%*	*41.1%*	*-8.2%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

Note (1): Reflects loss of ED visits to the new WAH

Source: St. Paul's Non-Confidendtial databases for FY2016 and FY2017

3. UM Laurel Medical Center Outpatient Surgery

While outpatient surgery at UM LRH has declined in recent years, the recent affiliation with UMMS is expected to reverse this trend. The affiliation has provided UM LRH physicians and medical staff a more collaborative relationship with UMMS and its faculty leadership, which has been valuable and improved UM LRH's ability to retain its outpatient surgical cases. Beginning in fiscal year 2018, UM LRH's outpatient surgery cares are projected to grow with the population and add additional market share. In fact, UM LRH's outpatient cases grew 7.6% from the six month period of June to December 2016 to the six month period of June to December 2017. The projected outpatient surgery cases at the UM Laurel Medical Center are presented in **Table 21.**

Table 21
UM Laurel Medical Center Historical and Projected Outpatient Surgery Cases
FY2017 – FY2024

	Actual	Projected In Existing Hospital				Projected at New Facility		
	2017	2018	2019	2020	2021	2022	2023	2024
LRH Cases								
Service Area	1,606	1,621	1,662	1,703	1,720	1,736	1,752	1,769
Out of Service Area	277	280	287	294	297	299	302	305
Total	1,883	1,901	1,948	1,997	2,016	2,035	2,055	2,074
% Change	*-5.2%*	*0.9%*	*2.5%*	*2.5%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*

4. Laboratory and Imaging

Laboratory and imaging services are projected to grow and decline in relation to the projection of emergency and observation patients that are presented above.

5. Projected UM Laurel Medical Center Revenue

The presentation of projected revenue in **Tables H** and **K** reflect the utilization projections presented above and the 2018 regulated Global Budget Revenue (GBR) assumptions

related to update factors, demographic adjustments, revenue variability, and uncompensated care. These assumptions are included with the tables.

6. Projected UM Laurel Medical Center Staffing and Expenses

The presentation of projected staffing at the FMF, as presented in **Table L**, reflects the outpatient services to be provided in the existing facility when UM LRH converts to an FMF in fiscal year 2019 and then one-time adjustments to the projection of staffing and expense when the existing facility closes and the new FMF opens in fiscal year 2022.

7. Projected UM CRH and UM Laurel Medical Center Financial Performance

As presented in **Table K**, UM Laurel Medical Center is projected to incur operating losses in fiscal years 2019 through 2021 as the outpatient services continue to be provided in the existing facility, but achieve operating profits in fiscal years 2022 through 2024 as the new facility is appropriately sized to the outpatient volumes. UM Laurel Medical Center's operating losses in fiscal years 2020 and 2021 will be absorbed by the operating profits of UM CRH which are presented in **Table H**. As shown in **Table H**, UM CRH will generate net positive operating income in fiscal year 2021, the third year of operation of UM Laurel Medical Center.

K. The Number and Size of UM Laurel Medical Center's Operating Rooms is Consistent with the State Health Plan – COMAR 10.24.19.04(C)(8)(g).

(8) Applicants seeking to convert a general hospital to a freestanding medical facility, in addition to meeting the applicable requirements in 10.24.01.04, shall:

* * * *

(g) Demonstrate that each operating room at the FMF will be utilized at an optimal level within three years consistent with the standards in COMAR 10.24.11 for operating room capacity and needs assessment for dedicated outpatient operating rooms and that the design is consistent

with requirements in COMAR 10.24.11 for health care facilities with surgical capacity.

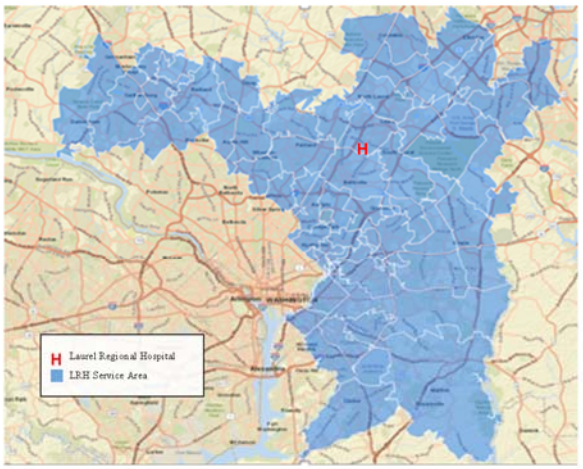
Applicants seeking to convert a general hospital to a freestanding medical facility shall demonstrate that each operating room at the FMF will be utilized at an optimal level within three years consistent with the standards in the State Health Plan for General Surgical Services (COMAR 10.24.11) for operating room capacity and needs assessment for dedicated outpatient operating rooms.

1. Definition of UM Laurel Medical Center Outpatient Surgery Service Area

In fiscal year 2017, 85% of UM LRH's outpatient surgery cases came from residents of sixty-three (63) Zip Codes in Prince George's County, Anne Arundel County, Montgomery County, Howard County and the District of Columbia ("UM Laurel Medical Center's Outpatient Surgery Service Area") as listed and depicted in **Table 22** below.

Table 22
Laurel FMF Outpatient Surgery Service Area
FY2017

Zip Codes	City	Zip Codes	City
20707	Laurel	21114	Crofton
20708	Laurel	20832	Olney
20705	Beltsville	20710	Bladensburg
20723	Laurel	20769	Glenn Dale
20724	Laurel	21061	Glen Burnie
20785	Hyattsville	20879	Gaithersburg
20904	Silver Spring	20903	Silver Spring
20706	Lanham	20853	Rockville
20784	Hyattsville	20020	Washington
20774	Upper Marlboro	20901	Silver Spring
20740	College Park	20720	Bowie
20770	Greenbelt	21045	Columbia
20772	Upper Marlboro	21144	Severn
20783	Hyattsville	20712	Mount Rainier
20866	Burtonsville	20722	Brentwood
20715	Bowie	21044	Columbia
20874	Germantown	21046	Columbia
20906	Silver Spring	20019	Washington
20743	Capitol Heights	20850	Rockville
20747	District Heights	20781	Hyattsville
20782	Hyattsville	21075	Elkridge
20721	Bowie	20878	Gaithersburg
20716	Bowie	20763	Savage
21113	Odenton	20905	Silver Spring
20748	Temple Hills	21076	Hanover
20746	Suitland	20755	Fort George G Meade
20886	Montgomery Village	20701	Annapolis Junction
20794	Jessup	20855	Derwood
20877	Gaithersburg	20762	Andrews Air Force Base
20735	Clinton	20742	College Park
20902	Silver Spring	20771	Greenbelt
20737	Riverdale		



Total outpatient surgery cases at Maryland hospitals for residents in the service area declined by 1.6% from 55,996 cases in fiscal year 2014 to 55,085 cases in fiscal year 2017 (see **Table 23**).

Table 23
UM LRH Service Area Outpatient Surgery Cases
FY2014 – FY2017

Hospital	Cases				FY2017 Market Share	FY14-FY17 Change
	FY2014	FY2015	FY2016	FY2017		
Shady Grove Adventist Hospital	6,376	6,390	6,532	6,188	11.2%	-2.9%
Doctors Community Hospital	5,422	5,136	5,440	5,118	9.3%	-5.6%
Holy Cross Hospital	5,162	4,929	5,235	4,878	8.9%	-5.5%
Howard County General Hospital	4,170	4,500	4,573	4,564	8.3%	9.4%
Anne Arundel Medical Center	3,618	4,355	4,511	4,528	8.2%	25.2%
Johns Hopkins Hospital	2,969	2,905	3,232	4,222	7.7%	42.2%
Washington Adventist Hospital	3,143	3,625	3,236	3,077	5.6%	-2.1%
Montgomery General Hospital	3,570	3,346	2,763	2,790	5.1%	-21.8%
Suburban Hospital	2,734	2,410	2,172	2,390	4.3%	-12.6%
Baltimore Washington Medical Center	2,376	2,156	2,281	2,220	4.0%	-6.6%
Southern Maryland Hospital Center	2,121	2,477	2,165	1,808	3.3%	-14.8%
Laurel Regional Hospital	2,811	2,483	1,708	1,606	2.9%	-42.9%
Prince George's Hospital Center	1,991	2,113	1,750	1,355	2.5%	-31.9%
University of Maryland Hospital	1,411	1,547	1,281	1,298	2.4%	-8.0%
Mercy Medical Center	1,149	1,282	1,199	1,283	2.3%	11.7%
Holy Cross Germantown Hospital	-	332	910	1,154	2.1%	247.6%
Other Hospitals with less than 1000 visits	6,973	7,222	7,220	6,606	12.0%	-5.3%
Total Service Area OP Surgery Cases	55,996	57,208	56,208	55,085	100.0%	-1.6%

Source: St. Paul's non-confidential outpatient utilization database

Of the 55,085 outpatient surgery cases in fiscal year 2017, 2.9% of them or 1,606 service area cases were performed at UM LRH. The 1,606 service area cases at UM LRH in fiscal year 2017 represents a 42.9% reduction from the UM LRH's outpatient surgery cases in fiscal year 2014. With declining volumes, the conversion of UM LRH to an FMF is critical to right size the facility to enable it to continue to provide access to surgical services for the service area population.

2. Historical and Projected Outpatient Surgery Cases at UM Laurel Medical Center

Comparable to the 42.9% reduction in service area outpatient surgery cases, the out-of-service area cases declined 39.8% from fiscal year 2014 to 2017. Total outpatient surgery

cases declined 42.4% from 3,271 cases in fiscal year 2014 to 1,883 cases in fiscal year 2017 (see **Table 24**).

Table 24
UM LRH Historical Outpatient Surgery Cases
FY2014 – FY2017

	Historical				% Change
	FY2014	FY2015	FY2016	FY2017	2014 - 2017
Service Area Cases	2,811	2,483	1,708	1,606	-42.9%
% Change		*-11.7%*	*-31.2%*	*-6.0%*	
Out of Service Area Cases	460	392	278	277	-39.8%
% Change		*-14.8%*	*-29.1%*	*-0.4%*	
Total LRH Cases	**3,271**	**2,875**	**1,986**	**1,883**	-42.4%
% Change		*-12.1%*	*-30.9%*	*-5.2%*	

Source: St. Paul's non-confidential outpatient utilization database

While total outpatient surgical cases at UM LRH have declined since fiscal year 2014, the hospital has experienced a 6.3% increase in its Medicaid patient outpatient surgery cases from fiscal year 2016 to 2017 (see **Table 25**). Medicaid is the largest payor of UM LRH's outpatient surgery cases. To continue to serve these Medicaid patients, it is imperative that the revenue associated with the UM Laurel Medical Center operating rooms continue to be regulated by the HSCRC. Medicaid patients do not typically utilize freestanding ambulatory surgery centers that are unregulated by the HSCRC. If the outpatient surgical services at the UM Laurel Medical Center are not regulated, the Medicaid patients are likely to seek care at another regulated hospital.

Table 25
UM LRH Historical Payor Mix of Outpatient Surgery Cases
FY2016 – FY2017

	FY2016		FY2017		FY16 - FY17 Change in
Payor	Cases	% of Total	Cases	% of Total	% of Total
Medicaid	520	26.2%	612	32.5%	6.3%
Blue Cross	497	25.0%	433	23.0%	-2.0%
HMO	422	21.2%	362	19.2%	-2.0%
Medicare	332	16.7%	269	14.3%	-2.4%
Other	63	3.2%	79	4.2%	1.0%
Commercial	100	5.0%	67	3.6%	-1.5%
Self Pay	52	2.6%	61	3.2%	0.6%
Total	**1,986**	**100%**	**1,883**	**100.0%**	**0.0%**

Source: St. Paul's non-confidential outpatient utilization databases

With the recent affiliation with UMMS, the decline in UM LRH's outpatient surgery cases are expected to level off and beginning in fiscal year 2018, UM LRH's outpatient surgery cares are projected to grow with population and capture additional market share. The affiliation has provided UM LRH physicians and medical staff a more collaborative relationship with UMMS and its faculty leadership, which has been valuable and improved UM LRH's ability to retain its outpatient surgical cases. In FY 2017 and FY 2018 to date, HSCRC volume reports show that July 2017 to January 2018 same day surgery volumes are already approximately 8% higher than the same period the previous year. Combined, UM LRH's service area market share is projected to increase from 2.9% in fiscal year 2017 to 3.0% by fiscal year 2019. UM LRH's expectations around capturing this market share are based on discussion with orthopedics and pediatric dentists that are seeking to expand their surgical practices at UM LRH. See **Exhibit 11** for letters of support from Precision Orthopedics and Sports Medicine and Children's Dental Office. As a result of growth in population and market share, UM LRH projects that the UM Laurel Medical Center will see 2,074 surgical cases by fiscal year 2024 (**Table 26**).

Table 26
UM LRH / UM Laurel Medical Center Historical and Projected Outpatient Surgery Cases
FY2017 – FY2024

	Actual	Projected In Existing Hospital				Projected at New Facility		
	2017	2018	2019	2020	2021	2022	2023	2024
Population	1,925,341	1,943,616	1,962,064	1,980,688	1,999,488	2,018,467	2,037,626	2,056,967
% Change	*1.1%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*
LRH Market Share	2.9%	2.9%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
% Change	*-4.1%*	*0.0%*	*1.5%*	*1.5%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
LRH / FMF Cases								
Service Area	1,606	1,621	1,662	1,703	1,720	1,736	1,752	1,769
Out of Service Area	277	280	287	294	297	299	302	305
Total	1,883	1,901	1,948	1,997	2,016	2,035	2,055	2,074
% Change	*-5.2%*	*0.9%*	*2.5%*	*2.5%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*

Source: Population = Claritas; FY2017 OP Surgery Cases = St. Paul's non-confidential outpatient utilization database

In fiscal year 2017, the 1,883 surgical cases required 130,737 minutes or an average of 69.4 minutes per case. This average time per case is projected to continue through fiscal year 2024. Added to the surgical time is an assumed 25 minutes per case for turnaround time. This assumption is provided in the State Health Plan for General Surgical Services (COMAR 10.24.11.06.A.(2)(a)).

Applying the surgical and turnaround times to the projected surgical cases drives a need for two (2) operating rooms throughout the projection period (see **Table 27**). Determination of this need reflects the operating room capacity assumptions outlined in the State Health Plan for General Surgical Services, specifically dedicated outpatient general purpose operating rooms (COMAR 10.24.11.06.A.(1)(b)).

Table 27
UM LRH / UM Laurel Medical Center Historical and Projected Operating Room Need
FY2017 – FY2024

	Actual	Projected In Existing Hospital				Projected at New Facility		
	2017	2018	2019	2020	2021	2022	2023	2024
LRH / FMF Cases	1,883	1,901	1,948	1,997	2,016	2,035	2,055	2,074
Average Minutes per Case								
Surgical Minutes	69.4	69.4	69.4	69.4	69.4	69.4	69.4	69.4
Turnover Minutes	25.0	25.0	25.0	25.0	25.0	25.0	25.0	25.0
Total	94.4	94.4	94.4	94.4	94.4	94.4	94.4	94.4
Total Minutes	177,812	179,500	183,990	188,593	190,383	192,190	194,014	195,856
OP Operating Room Optimal Capacity (1)	97,920	97,920	97,920	97,920	97,920	97,920	97,920	97,920
OR Need	1.8	1.8	1.9	1.9	1.9	2.0	2.0	2.0
% Change	*-2.8%*	*0.9%*	*2.5%*	*2.5%*	*0.9%*	*0.9%*	*0.9%*	*0.9%*
Requested FMF Operating Rooms			**2**	**2**	**2**	**2**	**2**	**2**

Note (1): Reflects operation of 8 hours per day, 5 days per week, 51 weeks per year and 80% optimal utilization
Source: FY2017 OP Surgery Minutes = St. Paul's non-confidential outpatient utilization database

Please see **Exhibit 12**, which is a letter from the architectural firm Wilmot Sanz attesting that the design of the UM Laurel Medical Center, including the outpatient operating rooms, is consistent with the FGI Guidelines.

L. The Proposed Construction Costs are Reasonable and Consistent with Industry Experience – COMAR 10.24.19.04(C)(8)(h).

(8) Applicants seeking to convert a general hospital to a freestanding medical facility, in addition to meeting the applicable requirements in 10.24.01.04, shall:

* * * *

(h) Demonstrate that the proposed construction cost of the FMF is reasonable and consistent with current industry cost experience in Maryland, as provided in Regulation .04B(5) of this chapter.

The State Health Plan requires that construction costs of the project be reasonable and consistent with industry cost experience in Maryland. The following compares the project costs

to the Marshall Valuation Service ("MVS") benchmark. The FMF will be built to hospital standards.

Standard .04B(7) – Construction Cost of Hospital Space

(a) The cost per square foot of hospital construction projects shall be no greater than the cost of good quality Class A hospital construction given in the Marshall and Swift Valuation Quarterly, updated to the nearest quarter using the Marshall and Swift update multipliers, and adjusted as shown in the Marshall and Swift guide as necessary for terrain of the site, number of levels, geographic locality, and other listed factors.

(b) Each Certificate of Need applicant proposing costs per square foot above the limitations set forth in the Marshall and Swift Guide must demonstrate that the higher costs are reasonable.

The following compares the project costs to the Marshall Valuation Service ("MVS") benchmark. The FMF will be built to hospital standards.

I. Marshall Valuation Service
Valuation Benchmark

Type		General Hospitals
Construction Quality/Class		Good/A
Stories		2
Perimeter		864
Average Floor to Floor Height		15.0
Square Feet		75,855
f.1	Average floor Area	37,928
A. Base Costs		
	Basic Structure	$374.00
	Elimination of HVAC cost for adjustment	0
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
Total Base Cost		$374.00
Adjustment for Departmental Differential Cost Factors		1.19

Adjusted Total Base Cost		$374.00
B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$374.00
C. Multipliers		
Perimeter Multiplier		0.90432678
	Product	$338.22
Height Multiplier		1.07
	Product	$361.56
Multi-story Multiplier		1.000
	Product	$361.56
D. Sprinklers		
	Sprinkler Amount	$3.14
Subtotal		$364.70
E. Update/Location Multipliers		
Update Multiplier		1.03
	Product	$375.64
Location Multiplier		1.06
	Product	$398.18
Calculated Square Foot Cost Standard		**$398.18**

The MVS estimate for this project is impacted by the Adjustment for Departmental Differential Cost Factor. In Section 87 on page 8 of the Valuation Service, MVS provides the cost differential by department compared to the average cost for an entire hospital. The calculation of the average factor is shown below.

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
ACUTE PATIENT CARE				
Emergency Department	17,960	Emergency Suite	1.18	21,193
Observation Unit	6,810	Inpatient Units	1.06	7,219
Imaging	3,535	Radiology	1.22	4,313
Pharmacy	260	Operating Suite, Total	1.68	437
Lab	1,500	Laboratories	1.15	1,725
Outpatient Surgery/SPD	19,200	Operating Suite, Total	1.68	32,256
Respiratory Therapy	230	Outpatient Department	0.99	228
Dietary (includes coffee kiosk)	700	Dietary	1.52	1,064
Psychiatric Day Treatment	3,170	Outpatient Department	0.99	3,138
Administration	1,550	Offices	0.96	1,488
Building Services	7,100	Offices	0.96	6,816
Vertical Circulation	780	Internal Circulation	0.6	468
Lobby	1,570	Public Space	0.8	1,256
General Circulation	7,670	Internal Circulation	0.6	4,602
Security	330	Offices	0.96	317
Unregulated Medical Office Suite	3,490	Outpatient Department	0.99	3,455
Total	**75,855**		**1.19**	**89,974**

Cost of New Construction

A. Base Calculations	**Actual**	**Per Sq. Foot**
Building	$24,700,000	$325.62
Fixed Equipment	$480,000	$6.33
Site Preparation	$2,900,000	$38.23
Architectural Fees	$2,060,000	$27.16
Permits	$100,000	$1.32
Capitalized Interest & Loan Placement Fees	Calculated Below	$0
Subtotal	$30,240,000	$398.66

However, as related below, this project includes expenditures for items not included in the MVS average.

B. Extraordinary Cost Adjustments

	Project Costs			Associated Cap Interest and Financing Fees
Storm Drains	$100,000	Site		$100,000
Paving	$700,000	Site		$700,000
Exterior Signs	$150,000	Site		$150,000
Landscaping	$200,000	Site		$200,000
Walls	$400,000	Site		$400,000
Rock Blasting Allowance	$250,000	Site		$250,000
Site Fill	$750,000	Site		$750,000
Yard Lighting	$100,000	Site		$100,000
MBE Premium	$10,000	Site		$10,000
Canopies	$300,000	Building	$63,158	$363,158
MBE Premium	$976,000	Building	$205,474	$1,181,474
MBE Premium	$19,200	Fixed	$4,042	$23,242
Total Cost Adjustments	**$3,955,200**		**$272,674**	**$26,284,800**

Associated Capitalized Interest and Loan Placement Fees should be excluded from the comparison for those items which are also excluded from the comparison. Since only Capitalized Interest and Loan Placement fees relating to the Building costs are included in the MVS analysis, we have only eliminated them for the Extraordinary Costs that are in the Building cost item. This was calculated as follows, using the Canopy as an example:

(Cost of the Canopy/Building Cost) X
(Building related Capitalized Interest and Loan Placement Fees).

Explanation of Extraordinary Costs

Below are the explanations of the Extraordinary Costs that are not specifically mentioned as not being in contained in the MVS average costs in the MVS Guide (at Section 1, Page 3) but that are specific to this project and would not be in the average cost of a hospital project.

1. Premium for Minority Business Enterprise Requirement – UMMS projects include a premium for Minority Business Enterprises that would not be in the average cost of hospital construction. This premium was conservatively projected on this project to be 4%.

Eliminating all of the extraordinary costs reduces the project costs that should be compared to the MVS benchmark.

C. Adjusted Project Cost

	Adjusted Project Costs	Per Square Foot
Building	$23,424,000	$308.80
Fixed Equipment	$460,800	$6.07
Site Preparation	$240,000	$3.16
Architectural Fees	$1,769,839	$23.33
Permits	$100,000	$1.32
Subtotal	$25,994,639	$342.69
Capitalized Interest & Loan Placement Fees	$3,974,681	$52.40
Total	**$29,969,320**	**$395.09**

Building associated Capitalized Interest and Loan Placement Fees were calculated as follows:

Hospital	New	Renovation	Total	
Building Cost	$24,700,000	$0		
Subtotal Cost (w/o Cap Interest)	$30,240,000	$0	$30,240,000	
	100.0%	0.0%	Cap Interest	Loan Placement Fees
Subtotal/Total				
Total Project Cap Interest &Financing [(Subtotal Cost/Total Cost) X Total Cap Interest]	$5,200,000	$0	$4,902,000	$298,000
Building/Subtotal	81.7%			
Building Cap Interest & Loan Place.	$4,247,354			
Associated with Extraordinary Costs	$272,674			
Applicable Cap Interest & Loan Place.	$3,974,681			

As noted below, the project's cost per square foot is below the MVS benchmark.

MVS Benchmark	$398.18
The Project	$395.09
Difference	-$3.09
	-0.78%

III. THE CONVERSION OF UM LRH TO A FREESTANDING MEDICAL FACILITY WILL RESULT IN THE DELIVERY OF MORE EFFICIENT AND EFFECTIVE HEALTH CARE SERVICES.

The State Health Plan requires that applicants seeking to convert an acute general hospital to an FMF demonstrate that the conversion to an FMF will result in the delivery of more efficient and effective health care services, including an explanation of why the services proposed for the FMF cannot be provided at other area hospital EDs, FMFs, or other health care facilities, and demonstrate why other less expensive models of care delivery cannot meet the needs of the population to be served. COMAR 10.24.17.04(C)(8)(i).

As an initial matter, in addressing the efficiency and cost effectiveness of health care service delivery, UM CRH incorporates by reference the assessment of the availability and accessibility of emergent and urgent care in UM Laurel Medical Center's projected service area is set forth in Section II.F above.

An FMF is needed in Laurel. It cannot be disputed that the emergency departments at acute general hospitals in nearest proximity to UM Laurel Medical Center could not absorb the more than 26,500 emergency visits currently treated at UM LRH's emergency department and the almost 24,000 visits projected for UM Laurel Medical Center.

While WAH is relocating from Takoma Park to White Oak, its projections of emergency department need preceded the announcement of UM LRH's conversion to an FMF and did not

account for increased visits caused by possible closure of any nearby hospital emergency departments. On page 53 of its Modified CON application it stated: "[f]inally, should future volumes increase beyond the projections, the hospital design includes emergency department expansion capability directly to the north." *In re Washington Adventist Hospital*, Docket 13-15-2349 (Modified CON Application dated September 29, 2014). Hence, the ability to accommodate an additional 24,000 ED visits would require expensive construction of an addition to the new hospital.

In addition, the newly approved University of Maryland Capital Region Medical Center, to be located in Largo, will not be in a position to absorb even a significant fraction of this volume of emergency department visits without its own substantial emergency department expansion project and associated capital expenditures.

While there are 22 urgent care centers in UM Laurel Medical Center's service area (see **Table 6** above), in fiscal year 2017, 64.34% of UM LRH's emergency department visits fell within a range of the ESI Priority Levels which could not be successfully transitioned to an urgent care center (see **Table 28**). This assumes that only patients at ESI Levels 4 and 5 (plus those that were unclassified) who were discharged from UM LRH's emergency room could be transitioned to an urgent care center. UM CRH believes that the remaining 35% self-select to come to the hospital's emergency department, rather than go to the existing urgent care centers.

Table 28
UM LRH ED Visits by ESI Priority Level
FY 2017

ESI Level	Priority 1	Priority 2	Priority 3	Priority 4	Priority 5	Unclassified
Percent of Visits	0.28%	6.50%	57.56%	32.99%	0.58%	2.09%

Source: UM CRH

There are a number of factors that drive patient selection for site-of-service. One key factor is a patient's inability to discern the lowest level of care for their presenting need(s). Another factor is the limited hours of operation of urgent care centers (see **Table 29**). As the data for May through November 2017 show, nearly half (42.6%) of the emergency department visits at UM LRH occurred between 8:00 PM and 8:00 AM.

Table 29
Emergency Department Visits by Hour of Visit At UM LRH
May – November 2017

Hour	% of Visits	
Midnight - 12:59a	3.4%	
1a-1:59a	2.7%	
2a-2:59a	2.2%	
3a-3:59a	1.8%	
4a-4:59a	1.8%	
5a-5:59a	1.7%	
6a-6:59a	2.0%	
7a-7:59a	2.5%	
% 12-8 am		21.6%
8a-8:59a	3.4%	
9a-9:59a	4.3%	
10a-10:59a	4.9%	
11a-11:59a	5.3%	
12p-12:59p	5.2%	
1p-1:59p	5.4%	
2p-2:59p	5.3%	
3p-3:59p	5.0%	
4p-4:59p	5.0%	
5p-5:59p	5.7%	
6p-6:59p	5.5%	
7p-7:59p	5.8%	
8p-8:59p	6.0%	
9p-9:59p	5.5%	
10p-10:59p	4.9%	
11p-11:59p	4.6%	
% 8 pm-12 am		21.0%
% 8 pm-8 am		**42.6%**

Source: UM LRH

UM CRH has engaged in a number of population health initiatives as described in Section II.G above. Despite these ongoing efforts, the number of emergency department visits from UM Laurel Medical Center's projected service area has not seen an appreciable decline in utilization. As the need projections demonstrate (see Section II.H), the utilization projections are consistent with observed historic trends in emergency department use by the population in the FMF's projected service area. The projections are based on population projections, use rates, and market share. In developing the need projections, UM CRH also has worked with the Prince George's County EMS to determine the projected volume, including: (1) the impact of closing the inpatient psychiatric unit at UM LRH and (2) the impact of the relocated WAH in White Oak, approximately seven miles from UM LRH.

Table F (included in **Exhibit 1**) presents utilization projections for both the inpatient and outpatient utilization of UM CRH and outpatient emergency department visits, observation cases, operating room cases, and related outpatient ancillary services at UM Laurel Medical Center, as well as **Table I** that presents utilization projections for Laurel Regional Hospital and Laurel Medical Center, including the outpatient emergency department visits, observation cases, operating room cases, and related outpatient ancillary services at UM Laurel Medical Center.

Tables G, **H**, **J** and **K** (included in **Exhibit 1**) present revenue estimates for emergency services that are consistent with the utilization projections and the most recent HSCRC payment policies for FMFs. Included with both the utilization and financial projections are comprehensive statements of assumptions for UM Laurel Medical Center, as well as UM CRH.

The staffing assumptions and related labor expense projections for emergency and other FMF services are based on current expenditure levels, utilization projections, and staffing levels

experienced by the converting hospital's emergency department, as well as recent experience of similar proposed FMFs, including the Upper Chesapeake FMF.

Finally, the current UM LRH facility is not an efficient or cost effective solution for continuing to provide needed services to residents of its services area. The current UM LRH facility is 299,188 SF and is not appropriately sized based on its utilization levels. Once the FMF relocates in fiscal year 2022 to the new FMF building, which will be appropriately sized at approximately 76,000 SF, it will result in significant operational cost efficiencies. **Table 30** below provides an analysis of UM LRH's fiscal year 2016 cost per square foot in the existing building for various operational expenses, and then applies this cost per square foot assessment (along with an adjustment for inflation) to the 76,000 SF assumed for the new FMF building. UM LRH projects that it will reduce its building operational costs by approximately 75% simply due to the reduced costs of relocating in Phase II to the smaller, right-sized facility.

Table 30
Comparison of Operational Costs per
Square Foot in Existing Building and New FMF

Building Operating Costs	LRH 2016 Cost			LRH Cost per Sq. Ft. for sq. ft. = 299,188			FMF Costs for Square Feet = 76,000		
	Salaries	Other	Total	Salaries	Other	Total	Salaries	Other	Total
Electricity	$ -	$ 737,045	$ 737,045	$ -	$ 2.46	$ 2.46	$ -	$ 187,224.71	$ 187,224.71
Gas	0	199,652	199,652	0.00	0.67	0.67	-	50,716	50,716
Water	0	284,868	284,868	0.00	0.95	0.95	-	72,363	72,363
Other	0	206,468	206,468	0.00	0.69	0.69	-	52,447	52,447
Total Plant Operations		**1,428,033**	**1,428,033**	**0.00**	**4.77**	**4.77**	**0**	**362,750**	**362,750**
Purchased Services	938,184		938,184	3.14	0.00	3.14	238,318	-	238,318
Waste Removal	0	246,486	246,486	0.00	0.82	0.82	-	62,613	62,613
Contract Cleaning	0	178,571	178,571	0.00	0.60	0.60	-	45,361	45,361
Cleaning Supplies	0	160,458	160,458	0.00	0.54	0.54	-	40,760	40,760
Other	148,031	100,055	248,086	0.49	0.33	0.83	37,603	25,416	63,019
Total Environmental Services	**1,086,215**	**685,570**	**1,771,785**	**3.63**	**2.29**	**5.92**	**275,921**	**174,149**	**450,070**
Maintenance	455,512	917,433	1,372,946	1.52	3.07	4.59	115,710	233,047	348,757
Repairs	0	1,310,512	1,310,512	0.00	4.38	4.38	-	332,897	332,897
Protective Services	487,305	144,342	631,647	1.63	0.48	2.11	123,786	36,666	160,451
Property Insurance	0	220,198	220,198	0.00	0.74	0.74	-	55,935	55,935
Other Building Operating Costs	**942,817**	**2,592,485**	**3,535,302**	**3.15**	**8.67**	**11.82**	**239,495**	**658,545**	**898,041**
Total Building Operating Costs	**$ 2,029,033**	**$ 4,706,087**	**$ 6,735,120**	**$ 6.78**	**$ 15.73**	**$ 22.51**	**$ 515,417**	**$ 1,195,444**	**$ 1,710,861**

FMF Square Feet % Reduction from LRH Square Feet -75%
FMF Building Operating Costs % Reduction from LRH Building Operating Costs -75%

Within three years of opening, the combined FMF and parent health system will generate net positive operating income. In fact, UM CRH is expect to generate positive operating income in fiscal years 2019 to 2021, the first three fiscal years of the FMF. Once the FMF moves to its new facility in fiscal year 2022, it is expected to generate its own positive income each year.

IV. THE CONVERSION OF UM LRH TO A FREESTANDING MEDICAL FACILITY IS IN THE PUBLIC INTEREST.

The State Health Plan requires that applicants seeking to convert an acute general hospital to an FMF demonstrate the conversion is in the public interest, based on an assessment of the converting hospital's long-term viability as a general hospital through addressing such matters as: (i) trends in the hospital's inpatient utilization for the previous five years in the context of statewide trends; (ii) the financial performance of the hospital over the past five years and in the context of the statewide financial performance of Maryland hospitals; (iii) the age of the physical plant relative to other Maryland hospitals and the investment required to maintain and modernize the physical plant; (iv) the availability of alternative sources for acute care inpatient and outpatient services that will no longer be provided on the campus after conversion to a freestanding medical facility; (v) the adequacy and appropriateness of the hospital's transition plan; and (vi) an assessment of the parent hospital's projected financial performance or the projected financial performance of the parent hospital and other health care facilities that share a global budget with the parent hospital.

The conversion of UM LRH to UM Laurel Medical Center is in the public interest with respect to each of these criteria based on the analyses presented below.

A. The Conversion of UM LRH to UM Laurel Medical Center is in the Public Interest Based on UM LRH's Inpatient Utilization for the Previous Five Years in the Context of Statewide Trends.

Table 31 presents a 37.1% decline in UM LRH's inpatient admissions between fiscal years 2013 and 2017. This decline is greater than the 10.3% total decline in acute care hospital admissions across the State of Maryland.

Table 31
Comparison of UM LRH Historical Admissions to Statewide Trends
FY2013 – FY2027

	Admissions					
	2013	2014	2015	2016	2017	FY13 - FY17
Laurel Regional Hospital	5,989	5,494	4,862	4,130	3,766	-37.1%
Statewide	629,424	602,547	583,885	569,994	564,644	-10.3%

UM LRH's decline in inpatient admissions has created a financial hardship for the hospital as the cost of maintaining the hospital infrastructure with declining admissions is adding to its financial losses. Continuing to operate the current UM LRH facility with reduced volumes is not in the public's best interest. Converting to an outpatient focused FMF that is right sized to current utilization and that will provide an array of services to meet the service area's needs is in the public interest.

B. The Conversion of UM LRH to UM Laurel Medical Center is in the Public Interest Based on UM LRH's Financial Performance Over the Past Five Years and in the Context of the Statewide Financial Performance of Maryland Hospitals.

As presented in **Table 32**, UM LRH generated operating margins ranging from 2.3% to -10.3% between fiscal years 2013 and 2017. These operating margins are significantly below those of the statewide average operating margins which ranged from 1.2% to 3.5% between

fiscal years 2013 and 2016. The Statewide Hospital Disclosure Report that presents statewide operating margins for fiscal year 2017 is not yet available.

Table 32
Comparison of UM LRH Operating Margins to Statewide Financial Performance
FY2012 – FY2016

	Operating Margin					Change
	2013	2014	2015	2016	2017	FY13 - FY17
Laurel Regional Hospital	2.3%	-3.8%	-11.3%	-9.1%	-10.3%	-12.7%
Statewide	1.3%	2.9%	3.5%	3.3%		2.0%

Sources:
- LRH Internal Financial Statements
- Statewide Hospital Disclosure Report

Consistent with the decline in inpatient admissions presented in **Table 31**, the continued decline in operating margin at UM LRH is not in the public's best interest. Converting to a FMF that can be profitable is in the public interest.

C. The Conversion of UM LRH to UM Laurel Medical Center is in the Public Interest Based on the Age of UM LRH's Physical Plant Relative to Other Maryland Hospitals and the Investment Required to Maintain and Modernize the Physical

As presented in **Table 33**, the average age of UM LRH's physical plant was 19.1 years in 2016. This compares to the statewide average of 10.8 years. In a publication by Moody's Investors Service, dated September 8, 2016, the median average age of plant for hospitals that it rates was 11.0 years. The statewide average is consistent with Moody's median while UM LRH is well above it. Due to the removal of the H1 schedule from the Annual Filing, average plant age information is not provided for the state for fiscal year 2017.

Table 33
Comparison of UM LRH Average Age of Plant to Statewide Trends
FY2012 – FY2016

	Average Age of Plant (years)				
	2012	2013	2014	2015	2016
Laurel Regional Hospital	17.5	16.1	14.7	16.0	19.1
Statewide Average (years)	12.0	11.2	12.7	12.0	10.8

Source: Annual Filings

For UM LRH to achieve the statewide average would require approximately $73 million in capital expenditures to modernize its physical plant. This estimate of capital expenditures reflects the level of investment in assets with a 25 year useful life that would be required to increase annual depreciation expense to achieve a 10.8 year average age of plant. Spending this amount of money to modernize an aged facility is not in the public's best interest. Investing $48 million in a new right sized facility is in the public interest.

D. The Conversion of UM LRH to UM Laurel Medical Center is in the Public Interest Taking into Consideration the Alternative Sources for Acute Care Inpatient and Outpatient Services That Will no Longer be Provided on the Campus After Conversion to a Freestanding Medical Facility.

As presented in **Table 34**, UM LRH accounted for 2.4% of acute hospital discharges in UM LRH's service area in fiscal year 2017 market share. Twelve (12) other Maryland hospitals had a greater market share of discharges in UM LRH's service area led by Holy Cross Hospital with a 17.4% market share.

Table 34
UM LRH Inpatient Discharge Market Share
FY2017

Hospital Name	Discharges	Market Share
Holy Cross Hospital	23,339	17.4%
Anne Arundel Medical Center	14,732	11.0%
Howard County General Hospital	12,840	9.6%
Baltimore Washington Medical Center	11,930	8.9%
Prince George's Hospital Center	10,001	7.5%
Doctors Community Hospital	8,573	6.4%
Washington Adventist Hospital	7,401	5.5%
Southern Maryland Hospital Center	6,356	4.7%
Johns Hopkins Hospital	5,421	4.0%
Shady Grove Adventist Hospital	4,162	3.1%
University of Maryland Hospital	4,104	3.1%
Montgomery General Hospital	3,755	2.8%
Laurel Regional Hospital	3,238	2.4%
Suburban Hospital	3,062	2.3%
St Agnes Hospital	2,596	1.9%
Harbor Hospital	2,050	1.5%
Holy Cross Germantown Hospital	1,744	1.3%
Fort Washington Medical Center	1,612	1.2%
Mercy Medical Center	1,114	0.8%
Johns Hopkins Bayview Medical Center	1,058	0.8%
Other Hospitals with less than 1000 visits	4,825	3.6%
Total Service Area ED Visits	133,913	100.0%

Source: St. Pauls Non-Confidential Data Tapes

With a dozen hospitals that already provide inpatient services to the residents of UM LRH's service area, it is in the public interest to allow UM LRH to convert to an FMF and focus on outpatient services.

E. The Conversion of UM LRH to UM Laurel Medical Center is in the Public Interest Taking into Consideration the Adequacy and Appropriateness of UM CRH's Transition Plan.

The University of Maryland Laurel Regional Hospital (UM LRH) has the mission and vision to be the health care provider to meet the needs of the community we serve. As health care delivery and focus has changed across the nation and the state, the focus of care has shifted

to invest in more preventative care and wellness for patients but still provide a safety net for patients' immediate urgent care needs and stabilization.

The Prince George's County Community Needs Assessment and current emergency room utilization has guided the planning process to ensure the new UM Laurel Medical Campus will continue to meet the health care needs of the community it serves. In addition, UM LRH has engaged in extensive planning involving many community stakeholders in developing its plans to convert UM LRH to the UM Laurel Medical Center. Phase I of the planning process for the UM Laurel Medical Center began more than two years ago in July 2016 when UMMS, Laurel Mayor Craig Moe and other elected leaders launched a community engagement work group called the Laurel Strategic Planning Work Group (the "SPWG").

The SPWG was tasked with the coordination of "an open, collaborative process to obtain community input that would inform a set of recommendations regarding the transformation and modernization of Laurel Regional Hospital." It was comprised of an 11-member Executive Committee co-chaired by Mayor Moe and Dr. Stephen T. Bartlett, EVP and Surgeon in Chief for UMMS. The Co-Chairs identified seven major issues that would be key to a successful campus transition and created subcommittees that were open to the public and focused on the following areas:

- Behavioral Health
- Campus Development
- Clinical Operations
- Emergency Medicine / EMS
- On-Campus Services
- Volunteer Services
- Workforce Development

The membership of both the Executive Committee and subcommittees included local elected representatives, business leaders, first responders, health care providers, hospital administrators, LRH employees and volunteers, union representatives, K-12 and higher education leaders and members of the community at large. In total, this group included over 100 stakeholders who provided invaluable input regarding the transition of the Laurel medical campus.

The work of the SPWG spanned the better part of a year. It submitted its recommendations to UMMS President and CEO Robert Chrencik and the UMMS Board of Directors in July 2017. Shortly thereafter, in September 2017, UMMS and Dimensions Health System (DHS) formally affiliated and rebranded DHS as University of Maryland Capital Region Health. The deliberations and recommendations of the SPWG laid the foundation for subsequent Phase II planning for the transition of UM LRH to the UM Laurel Medical Center began at the time of the UMMS affiliation and is ongoing.

The Phase II planning work has included more detailed planning around the sizing and design of the proposed freestanding medical facility and the other services that will be offered at the UM Laurel Medical Center and on the campus in order to continue serving the needs of the surrounding community. Meetings with various stakeholders including emergency room clinicians, EMS personnel, law enforcement and other LRH and UMMS clinicians have informed the design of this facility. In addition, market research, ongoing community needs assessments and feasibility analyses helped refine the optimal list of services to be provided in the freestanding medical facility and the surrounding medical campus. Phase II planning efforts

have also focused on system integration at UM CRH and UMMS to better coordinate services between and among our affiliate hospitals, including interfacility transport services.

The Phase II planning efforts have also focused on continued community engagement and the implementation of robust internal and external communications plans regarding the transition and services that will be available at the UM Laurel FMF Center. UM LRH is unique in that its ED service area spans four Maryland counties, Prince George's, Howard, Anne Arundel and Montgomery Counties, as well as the District of Columbia. Approximately 70% of the patients transported by ambulance to UM LRH come via the Prince George's County EMS system, whose leadership was a part of the SPWG committee and the facility design team for the FMF building. UM LRH has met with EMS and hospital leadership in neighboring counties to advise them of planning efforts to date, hear their concerns, and discuss opportunities to further coordinate with them. UM LRH intends to continue ongoing dialogue with them to coordinate throughout the transition process. UM LRH has also engaged in other community outreach and education efforts to inform community members of the transition and hear their concerns. UM LRH's outreach efforts have included meeting with Senior Community Groups, Civic Associations, Senior Housing, Local post-acute facilities, Pastoral Care Groups, and the Laurel City Council. UM LRH is confident that these communications and outreach efforts will help to ensure a smooth transition from UM LRH to the UM Laurel Medical Center.

Plan for Transitioning of Acute Care Services
Previously Provided at UM LRH

The projected timeline for the transitioning of acute care services at UM LRH will depend on the regulatory approval of the UM Laurel Medical Center. UM LRH is engaged in ongoing planning in order to prepare for the upcoming transition. Emergency services currently

provided by UM LRH will continue to be provided at the UM Laurel Medical Center. The FMF's emergency treatment spaces will be staffed by University of Maryland Emergency Physicians who are board certified emergency physicians. The FMF will continue to accept all priority levels and communicate via base station to EMS providers and coordinate care that is in the best interest of the patients. The FMF will also continue to provide diagnostic testing, respiratory and ancillary services, case management, and observation care.

Patients who present at the UM Laurel Medical Center and are in need of inpatient medical, surgical or critical care will, subject to the patient's expressed preferences, be transferred to UM PGHC. UM PGHC will increase its staffing and re-operationalize physical bed capacity in order to accommodate the increase in inpatient cases that are anticipated to be transferred from the UM Laurel Medical Center. UM PGHC will budget for staffing of existing overflow beds and of additional rooms that are not currently occupied. Once patients are stabilized at the FMF by the emergency physician and clinical staff, the "One Call " system that is currently used to transfer patients within the UM CRH system will be activated. This system allows for physician to physician communication to coordinate acceptance of patients at other facilities and transportation. Currently, there is a 30-60 minute turnaround time for patient transports once the patient is accepted by UM PGHC. The increase in capacity and staffing at UM PGHC are currently being planned for and will be in operation at the time of the transition.

Patients arriving at the UM Laurel Medical Center in need of behavioral health services will continue to have a psychiatry liaison and psychiatry assessment and outpatient support services available to them. Patients who need inpatient behavioral health services will, if appropriate to the patient's needs and consistent with the patient's preferences, be transferred to

UM PGHC inpatient behavioral health unit. UM CRH expects that this unit should have sufficient capacity to handle behavioral health patients transferred from the UM Laurel Medical Center, as it has 28 beds and is usually at 80% capacity.

UMMS is also working to expand the capacity and efficiency of its ExpressCare service to accept transfers of UM Laurel Medical Center patients requiring acute inpatient or critical care services. UMMS ExpressCare service includes a Transfer/Communications Central Access Center that provides 24/7 access to physician consultations and transportation coordination services. UMMS intends to create an additional Central Access Center for the University of Maryland Medical Center (UMMC) and will combine Maryland ExpressCare, UMMC Patient Placement Center, Tele-ICU and UMMC Services. This integration is being done in an effort to facilitate timelier and improved access to care for patients within UMMS and throughput the state so that the right care for the right patient, can be delivered at the right time, in the right place. All of the components above will be co-located to facilitate better internal communication, collaboration and coordination of the patient transfer process. The Central Access Center will be the coordinating center for the patient transfer process. The Center will have access to existing electronic health record (EHR) systems of facilities and accompanying bed board information, which will provide contemporaneous hospital occupancy or bed utilization levels. UMMS also anticipates that all its hospitals will be on a single integrated EHR in the near future and the Center will have access to this information to timely coordinate transfers. Patient preference and bed capacity levels will also factor into transfer destinations outside of UMMS facilities.

In addition, to increase the efficiency of interfacility transportation, UM CRH is in the process of engaging a dedicated commercial ambulance service that can commit to certain performance metrics that will improve the availability of local ambulances and response times. UM CRH anticipates that the dedicated commercial ambulance service will utilize Specialty Care Transport services, which includes highly trained critical care paramedic, an ALS paramedic and an EMT driver on an ALS ambulance when needed to accommodate critical care patients requiring transports; this will create efficiencies for UM Laurel Medical Center by alleviating the need for its emergency nursing staff to travel with critical care patients. UM CRH will also have a dedicated commercial service to provide air transports using the helipad to efficiently transport the appropriate patients to the next level of care after stabilization.

Plan for Job Retraining and Placement of UM LRH's Employees

The SPWG that was formed in June 2016 included a workforce subcommittee that helped develop an initial plan to address the comprehensive needs of the workforce related to the transition. The subcommittee engaged in a collaborative process, including perspectives from across multiple disciplines. Internal and external stakeholders were tasked with reviewing options and making recommendations regarding alternative placement and training options for employees in the event of job loss, as well as providing strategies to ensure employees were kept well-informed and engaged throughout the transition process. The workforce subcommittee developed a draft set of recommendations for the transition, which were submitted to UM LRH in early 2017. UM LRH then organized a work group, the Staff Transition Plan Team, comprised of Human Resources Department and other key stakeholders to begin implementing

the recommendations of the SPWG workforce subcommittee, including a plethora of activities to train, engage, and present opportunities of benefit to the UM LRH workforce.

UM LRH conducted an initial projection of the number of full time equivalent employees needed for the freestanding medical facility. The initial projections identified those employees whose roles may be impacted by the transition and focused outreach efforts to these employees. UM LRH has worked to provide clear and regular communications to employees about the transition, including various means of internal communications, hosting town hall meetings to answer questions about the conversion and timeline, and other methods to engage employees regarding their interests and plans. UM LRH Human Resources representatives continue to meet and work one-on-one with employees to provide information about resources and opportunities available to them.

UM LRH has prioritized finding placements for current staff at the new UM Laurel Medical Center or within the UM CRH System. The Human Resources Department has worked to identify open positions and any training that may be needed to successfully transition UM LRH staff to other positions within UM CRH. UM LRH will also provide training, career shadow days, and other resources to help staff transition to new roles. In addition, UM LRH plans to provide a link to other position vacancies within the UMMS system to connect those staff members would prefer to transfer to another UMMS facility with additional job opportunities. By identifying open positions and offering additional training, UM LRH is hopeful that it will be able to place all staff within UM CRH or UMMS should employees elect to stay within the system. UM LRH will be providing resources to its staff regarding other job opportunities in the community for staff members who want to pursue other opportunities.

Human Resources leadership has worked to build meaningful relationships with community partners, such as Prince George's Community College, Prince George's Economic Development Corporation, and others in the surrounding area to provide information to employees on how UM LRH can assist with the development of skills they need to expand their job placement opportunities. UM LRH has collaborated with these groups and plans to host a job fair to provide opportunities for employees to meet with recruiters and learn of job opportunities in the area. UM CRH is beginning to provide onsite computer skills training classes as well as a certified nursing assistant certification course, which are offered free of charge to employees and taught by educators from Prince George's Community College at the College's Laurel College Center.

In addition, plans are in place to organize a job shadowing exercise, an activity that will provide employees with an enriched experience to show them a typical work day at another UM CRH location, UM PGHC. Employees at UM LRH will be provided a shuttle to transport them to UM PGHC to experience a first-hand account of working at an alternative location. The goal of this activity is to proactively show UM LRH employees what they can expect from working at a different location.

Over the next several months, plans are in place to continue to implement recommendations and prepare employees for the changes that will accompany transitioning to a freestanding medical facility.

Plan for Existing UM LRH Plant and Site

Once the FMF relocates to the new building, UM CRH intends to demolish the existing building in order to facilitate redevelopment of that portion of the medical campus. UM LRH is

considering partnering with other organizations to bring a variety of other health related services to this portion of the campus.

F. The Conversion of UM LRH to UM Laurel Medical Center is in the Public Interest Based on an Assessment of UM PGHC's Projected Financial Performance.

As presented in **Table 32**, UM LRH has experienced operating losses since fiscal year 2014. As volumes have declined, the existing hospital facility has burdened the remaining clinical services with a costly infrastructure. While the FMF will continue to experience operating losses while in the existing hospital in fiscal years 2019-2021, it will generate positive operating incomes once it moves to a smaller and right-sized facility in fiscal year 2022 (**Exhibit 1**, **Table K**). The assumptions that support the financial projection of the FMF are included with **Table K**.

UM CRH will generate positive operating incomes in the first three fiscal years of the FMF, 2019-2021 (**Exhibit 1**, **Table H**). Achieving this financial performance by fiscal year 2021 and beyond will require performance improvements, most of which are outlined in the Prince George's Hospital Center CON application for a replacement hospital that was approved in October 2016. These performance improvements, along with other financial projection assumptions for UM CRH are included with **Table H**.

CONCLUSION

For all of the reasons set forth above, UM CRH respectfully requests that the Commission authorize the conversion of UM LRH to a freestanding medical facility and associated capital expenditures.

Table of Exhibits

Table of Tables

I hereby declare and affirm under the penalties of perjury that the facts stated in this Request for Exemption From Certificate of Need Review and its exhibits are true and correct to the best of my knowledge, information, and belief.

4/6/18
Date

Jeffrey L. Johnson, MBA, FACHE
Senior Vice President, Strategic
Planning & Business Development
Dimensions Healthcare System

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013849-0001

I hereby declare and affirm under the penalties of perjury that the facts stated in this Request for Exemption From Certificate of Need Review and its exhibits are true and correct to the best of my knowledge, information, and belief.

4/6/2018
Date

William A. Brosius
Bill Brosius
Senior Vice President & Chief Financial Officer
University Of Maryland Capital Region Health

#621039
013849-0001

I hereby declare and affirm under the penalties of perjury that the facts stated in this Request for Exemption From Certificate of Need Review and its exhibits are true and correct to the best of my knowledge, information, and belief.

3/7/2018
Date

Trudy R. Hall, M.D.
Interim President & Vice President for Medical Affairs
UM Laurel Regional Hospital

#621039
013849-0001

I hereby declare and affirm under the penalties of perjury that the facts stated in this Request for Exemption From Certificate of Need Review and its exhibits are true and correct to the best of my knowledge, information, and belief.

4/10/18
Date

Darryl Mealy
Vice President of Construction and
Facilities Planning
University of Maryland Medical System

#621037
013849-0001

I hereby declare and affirm under the penalties of perjury that the facts stated in this Request for Exemption From Certificate of Need Review and its exhibits are true and correct to the best of my knowledge, information, and belief.

3/7/18
Date

Lisa Hardesty
Project Manager, Performance Improvement & Project Management
University of Maryland Capital Region Health

#621039
013849-0001

I hereby declare and affirm under the penalties of perjury that the facts stated in this Request for Exemption From Certificate of Need Review and its exhibits are true and correct to the best of my knowledge, information, and belief.

4/5/18
Date

Andrew L. Solberg
A.L.S. Healthcare Consultant Services

#621036
013849-0001

I hereby declare and affirm under the penalties of perjury that the facts stated in this Request for Exemption From Certificate of Need Review and its exhibits are true and correct to the best of my knowledge, information, and belief.

March 7, 2018

Date

Craig Moskowitz
Wilmot Sanz, Inc.

EXHIBIT 1

Table Number	Table Title	Instructions
Table A	**Physical Bed Capacity Before and After Project**	All applicants whose project impacts any nursing unit, regardless of project type or scope, must complete Table A.
Table B	**Departmental Gross Square Feet**	All applicants, regardless of project type or scope, must complete Table B for all departments and functional areas affected by the proposed project.
Table C	**Construction Characteristics**	All applicants proposing new construction or renovation must complete Table C.
Table D	**Site and Offsite Costs Included and Excluded in Marshall Valuation Costs**	All applicants proposing new construction or renovation must complete Table D.
Table E	**Project Budget**	All applicants, regardless of project type or scope, must complete Table E.
Table F	**Statistical Projections - Entire Facility**	Existing facility applicants must complete Table F. All applicants who complete this table must also complete Tables G and H.
Table G	**Revenues & Expenses, Uninflated - Entire Facility**	Existing facility applicants must complete Table G. The projected revenues and expenses in Table G should be consistent with the volume projections in Table F.
Table H	**Revenues & Expenses, Inflated - Entire Facility**	Existing facility applicants must complete Table H. The projected revenues and expenses in H should be consistent with the projections in Tables F and G.
Table I	**Statistical Projections - New Facility or Service**	Applicants who propose to establish a new facility, existing facility applicants who propose a new service, and applicants who are directed by MHCC staff must complete Table I. All applicants who complete this table must also complete Tables J and K.
Table J	**Revenues & Expenses, Uninflated - New Facility or Service**	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant who completes a Table I must complete Table J. The projected revenues and expenses in Table J should be consistent with the volume projections in Table I.
Table K	**Revenues & Expenses, Inflated - New Facility or Service**	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant that completes a Table I must complete Table K. The projected revenues and expenses in Table K should be consistent with the projections in Tables I and J.
Table L	**Work Force Information**	All applicants, regardless of project type or scope, must complete Table L.

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

INSTRUCTION: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project in accordance with the definition of physical capacity no below. Applicants should add columns and recalculate formulas to address rooms with 3 and 4 bed capacity. See additional instruction in the column to the right of the table.

NOTE: Physical capacity is the total number of beds that could be physically set up in space without significant renovations. This should be the maximum operating capacity under normal, non-emergency circumstances and is a physical count of bed capacity, rather than a measure of staffing capacity. A room with two headwalls and two sets of gasses should be counted as having capacity for two beds, even if it typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough from a square footage perspective to be used as a semi-p room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain no headwalls or a single headwall, but are normally used to accommoda or more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms should be counted as they are currently used.

Before the Project							After Project Completion						
Hospital Service	Location (Floor/Wing)*	Licensed Beds: July 1, 2017	Based on Physical Capacity				Hospital Service	Location (Floor/Wing)*	Based on Physical Capacity			
			Room Count			Bed Count			Room Count			Bed Count
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity
ACUTE CARE							**ACUTE CARE**					
General Medical/Surgical*	4C	35	2	18	20	38	**General Medical/Surgical***	4C	0	0	0	0
General Medical/Surgical*	3B - IMC	0	6	2	8	10	**General Medical/Surgical***	3B - IMC	0	0	0	0
SUBTOTAL Gen. Med/Surg*		**35**	**8**	**20**	**28**	**28**	**SUBTOTAL Gen. Med/Surg***		**0**	**0**	**0**	**0**
ICU/IMC	3A	**10**	10	0	10	10	**ICU/CCU**	3A	0	0	0	0
Other	n/a	**0**	0	0	0	0	**Other**	n/a	0	0	0	0
TOTAL MSGA		**45**	**18**	**20**	**38**	**38**	**TOTAL MSGA**		**0**	**0**	**0**	**0**
Obstetrics	3C - MCH	**0**	3	13	16	29	**Obstetrics**	3C - MCH	0	0	0	0
Pediatrics	n/a	**0**	0	0	0	0	**Pediatrics**	n/a	0	0	0	0
Psychiatric	4A	**16**	3	7	10	17	**Psychiatric**	4A	0	0	0	0
TOTAL ACUTE		**61**	**24**	**40**	**64**	**84**	**TOTAL ACUTE**		**0**	**0**	**0**	**0**
NON-ACUTE CARE							**NON-ACUTE CARE**					
Dedicated Observation**	n/a	**0**	0	**0**	0	0	**Dedicated Observation****	3C	10	**0**	10	10
Rehabilitation	5C	**28**	2	**13**	15	28	**Rehabilitation**	5C	0	**0**	0	0
Chronic Vent Unit	4B	**46**	2	**18**	20	38	**Chronic Vent Unit**	4B	0	**0**	0	0
Chronic Vent Unit (overflow)	3B - IMC	**0**	0	**4**	4	8	**Chronic Vent Unit (overflow)**	3B - IMC	0	**0**	0	0
Sleep Center	5B	**0**	2	**6**	8	14	**Sleep Center**	5B	0	**0**	0	0
TOTAL NON-ACUTE		**74**	**6**	**41**	**47**	**88**	**TOTAL NON-ACUTE**		**10**	**0**	**10**	**10**
HOSPITAL TOTAL		**135**	**30**	**81**	**111**	**172**	**HOSPITAL TOTAL**		**10**	**0**	**10**	**10**

* Include beds dedicated to gynecology and addictions, if unit(s) is separate for acute psychiatric unit

** Include services included in the reporting of the “Observation Center”. Service furnished by the hospital on the hospital's promise, including use of a bed and periodic monitoring by the hospital's nursing or other staff, which are reasonable and necessary to determine the need for a possible admission to the hospital as an inpatient; Must be ordered and documented in writing, given by a medical practitioner.

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

INSTRUCTION: Add or delete rows if necessary. See additional instruction in the column to the right of the table.

DEPARTMENT/FUNCTIONAL AREA	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
Emergency Department		**17,960**			**17,960**
Observation Unit		**6,810**			**6,810**
Imaging		**3,535**			**3,535**
Pharmacy		**260**			**260**
Lab		**1,500**			**1,500**
Outpatient Surgery/SPD		**19,200**			**19,200**
Respiratory Therapy		**230**			**230**
Dietary (includes coffee kiosk)		700			**700**
Psychiatric Day Treatment		3,170			**3,170**
Administration		1,550			**1,550**
Building Services		7,100			**7,100**
Vertical Circulation		780			**780**
Lobby		1,570			**1,570**
General Circulation		7,670			**7,670**
Security		330			**330**
Unregulated Medical Office Suite		3,490			**3,490**
Total		**75,855**			**75,855**

TABLE C. CONSTRUCTION CHARACTERISTICS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table C for each structure.

	NEW CONSTRUCTION	RENOVATION
BASE BUILDING CHARACTERISTICS	**Check if applicable**	
Class of Construction (for renovations the class of the building being renovated)*		
Class A	☑	☐
Class B	☐	☐
Class C	☐	☐
Class D	☐	☐
Type of Construction/Renovation*		
Low	☐	☐
Average	☐	☐
Good	☑	☐
Excellent	☐	☐
Number of Stories		

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Basement		
First Floor	28,420	
Second Floor	47,435	
Third Floor		
Fourth Floor		
Average Square Feet		
Perimeter in Linear Feet	**Linear Feet**	
Basement		
First Floor	716	
Second Floor	1,012	
Third Floor		
Fourth Floor		
Total Linear Feet		
Average Linear Feet		
Wall Height (floor to eaves)	**Feet**	
Basement		
First Floor	15	
Second Floor	15	
Third Floor		
Fourth Floor		
Average Wall Height		
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger		
Freight		
Sprinklers	**Square Feet Covered**	
Wet System		
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project		
Type of Exterior Walls for proposed project		

TABLE D. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table D for each structure.

	NEW CONSTRUCTION COSTS	RENOVATION COSTS
SITE PREPARATION COSTS		
Normal Site Preparation	$240,000	
Utilities from Structure to Lot Line		
Subtotal included in Marshall Valuation Costs	**$240,000**	
Site Demolition Costs	$0	
Storm Drains	$100,000	
Rough Grading	$0	
Hillside Foundation	$0	
Paving	$700,000	
Exterior Signs	$150,000	
Landscaping	$200,000	
Walls	$400,000	
Rock Blasting Allowance	$250,000	
Site Fill	$750,000	
Yard Lighting	$100,000	
MBE Premium	$10,000	
Other *(Specify/add rows if needed)*		
Subtotal On-Site excluded from Marshall Valuation Costs	**$2,660,000**	
OFFSITE COSTS		
Roads		
Utilities		
Jurisdictional Hook-up Fees		
Other *(Specify/add rows if needed)*		
Subtotal Off-Site excluded from Marshall Valuation Costs		
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$2,660,000**	**$0**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$2,900,000**	**$0**

*The combined total site and offsite cost included and excluded from Marshall Valuation Service should typically equal the estimated site preparation cost reported in Application Part II, Project Budget (see Table E. Project Budget). If these numbers are not equal, please reconcile the numbers in an explanation in an attachment to the application.

TABLE E. PROJECT BUDGET

INSTRUCTION: Estimates for Capital Costs (1.a-e), Financing Costs and Other Cash Requirements (2.a-g), and Working Capital Startup Costs (3) must reflect current costs as of the date of application and include all costs for construction and renovation. Explain the basis for construction cost estimates, renovation cost estimates, contingencies, interest during construction period, and inflation in an attachment to the application.

NOTE: Inflation should only be included in the Inflation allowance line A.1.e. The value of donated land for the project should be included on Line A.1.d as a use of funds and on line B.8 as a source of funds

	Hospital Building	Interim Location	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building	$24,700,000		$24,700,000
(2) Fixed Equipment	$480,000		$480,000
(3) Site and Infrastructure	$2,900,000		$2,900,000
(4) Architect/Engineering Fees	$2,060,000		$2,060,000
(5) Permits (Building, Utilities, Etc.)	$100,000		$100,000
SUBTOTAL	**$30,240,000**	**$0**	**$30,240,000**
b. Renovations			
(1) Building		$18,560	$18,560
(2) Fixed Equipment (not included in construction)		$102,295	$102,295
(3) Architect/Engineering Fees			$0
(4) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	**$0**	**$120,855**	**$120,855**
c. Other Capital Costs			
(1) Movable Equipment	$11,780,000	$5,000	$11,785,000
(2) Contingency Allowance	$3,000,000		$3,000,000
(3) Gross interest during construction period	$4,902,000		$4,902,000
(4) Other *(Specify/add rows if needed)*	$300,000		$300,000
SUBTOTAL	***$19,982,000***	***$5,000***	**$19,987,000**
TOTAL CURRENT CAPITAL COSTS	**$50,222,000**	**$125,855**	**$50,347,855**
d. *Land Purchase*			
e. Inflation Allowance	$2,000,000		$2,000,000
TOTAL CAPITAL COSTS	**$52,222,000**	**$125,855**	**$52,347,855**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees	$298,000		$298,000
b. Bond Discount			$0
c CON Application Assistance			
c1. Legal Fees	$150,000		$150,000
c2. Other (Specify/add rows if needed)	$100,000		
d. Non-CON Consulting Fees			
d1. Legal Fees			$0
d2. Other (Specify/add rows if needed)	$330,000		$330,000
e. Debt Service Reserve Fund			$0
f Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$878,000***	***$0***	**$878,000**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$53,100,000***	***$125,855***	***$53,225,855***
B. Sources of Funds			
1. Cash		**$125,855**	$125,855
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds	$38,100,000		$38,100,000
4. Interest Income from bond proceeds listed in #3	$500,000		$500,000
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State	$14,500,000		$14,500,000
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS	***$53,100,000***	***$125,855***	**$53,225,855**
	Hospital Building	***Other Structure***	***Total***
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

* Describe the terms of the lease(s) below, including information on the fair market value of the item(s), and the number of years, annual cost, and the interest rate for the lease.

TABLE F. STATISTICAL PROJECTIONS - UM Capital Region Health

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.					
Indicate CY or FY	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. DISCHARGES									
a. PGHC	7,907	7,865	8,224	8,551	8,928	9,812	10,493	10,544	10,596
b. LRH	2,846	2,846	2,846						
Total MSGA	**10,753**	**10,711**	**11,070**	**8,551**	**8,928**	**9,812**	**10,493**	**10,544**	**10,596**
c. Pediatric									
d. Obstetric	2,450	1,380	1,380	1,380	1,380	1,401	1,443	1,464	1,486
e. PGHC Acute Psychiatric	1,884	1,703	1,703	1,703	1,703	1,752	1,801	1,851	1,903
f. LRH Acute Psychiatric	940	831	831						
Total Acute	**16,027**	**14,625**	**14,984**	**11,634**	**12,011**	**12,965**	**13,737**	**13,860**	**13,985**
g. Rehabilitation	281	237	235	242	248				
h. Chronic Care	148	93	107	78	78				
i. Other (Specify/add rows of needed)									
TOTAL DISCHARGES	**16,456**	**14,955**	**15,326**	**11,953**	**12,337**	**12,965**	**13,737**	**13,860**	**13,985**
2. PATIENT DAYS									
a. PGHC	46,610	47,626	48,630	50,362	52,358	57,136	60,893	61,190	61,488
b. LRH	13,526	13,814	13,814						
Total MSGA	**60,136**	**61,440**	**62,444**	**50,362**	**52,358**	**57,136**	**60,893**	**61,190**	**61,488**
c. Pediatric									
d. Obstetric	5,857	3,589	3,589	3,589	3,589	3,643	3,752	3,809	3,866
e. PGHC Acute Psychiatric	8,801	7,653	7,653	7,653	7,653	7,873	8,094	8,319	8,551
f. LRH Acute Psychiatric	4,389	3,576	3,576						
Total Acute	**79,183**	**76,258**	**77,262**	**61,604**	**63,600**	**68,652**	**72,739**	**73,318**	**73,905**
g. Rehabilitation	2,369	2,319	2,347	2,411	2,477				
h. Chronic Care	6,517	4,595	5,100	3,723	3,723				
i. Other (Specify/add rows of needed)									
TOTAL PATIENT DAYS	**88,069**	**83,172**	**84,709**	**67,738**	**69,800**	**68,652**	**72,739**	**73,318**	**73,905**

TABLE F. STATISTICAL PROJECTIONS - UM Capital Region Health

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.					
Indicate CY or FY	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)									
a. PGHC	5.9	6.1	5.9	5.9	5.9	5.8	5.8	5.8	5.8
b. LRH	4.8	4.9	4.9						
Total MSGA	**5.6**	**5.7**	**5.6**	**5.9**	**5.9**	**5.8**	**5.8**	**5.8**	**5.8**
c. Pediatric									
d. Obstetric	2.4	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6
e. PGHC Acute Psychiatric	4.7	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5
f. LRH Acute Psychiatric	4.7	4.3	4.3						
Total Acute	**4.9**	**5.2**	**5.2**	**5.3**	**5.3**	**5.3**	**5.3**	**5.3**	**5.3**
g. Rehabilitation	8.4	9.8	10.0	10.0	10.0				
h. Chronic Care	44.0	49.4	47.7	47.8	47.9				
i. Other (Specify/add rows of needed)									
TOTAL AVERAGE LENGTH OF STAY	**5.4**	**5.6**	**5.5**	**5.7**	**5.7**	**5.3**	**5.3**	**5.3**	**5.3**
4. NUMBER OF LICENSED BEDS									
a. PGHC	179	183	187	193	201	219	234	235	236
b. LRH	52	53	53						
Total MSGA	**231**	**236**	**240**	**193**	**201**	**219**	**234**	**235**	**236**
c. Pediatric	-	-	-						
d. Obstetric	23	14	14	14	14	14	14	15	15
e. PGHC Acute Psychiatric	34	29	29	29	29	30	31	32	33
f. LRH Acute Psychiatric	17	14	14						
Total Acute	**304**	**293**	**296**	**236**	**244**	**263**	**279**	**281**	**283**
g. Rehabilitation	9	9	9	9	10				
h. Chronic Care	25	18	20	14	14				
i. Other (Specify/add rows of needed)									
TOTAL LICENSED BEDS	**338**	**319**	**325**	**260**	**268**	**263**	**279**	**281**	**283**

TABLE F. STATISTICAL PROJECTIONS - UM Capital Region Health

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.					
Indicate CY or FY	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*									
a. PGHC	71.4%	71.4%	71.4%	71.4%	71.4%	71.4%	71.4%	71.4%	71.4%
b. LRH	71.4%	71.4%	71.4%						
Total MSGA	**71.4%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**
c. Pediatric									
d. Obstetric	71.3%	71.3%	71.3%	71.3%	71.3%	71.3%	71.4%	71.5%	71.6%
e. PGHC Acute Psychiatric	71.3%	71.3%	71.3%	71.3%	71.3%	71.4%	71.5%	71.5%	71.4%
f. LRH Acute Psychiatric	71.6%	71.5%	71.5%						
Total Acute	**71.4%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**
g. Rehabilitation	71.3%	71.4%	71.4%	71.8%	71.4%				
h. Chronic Care	71.4%	71.5%	71.3%	71.3%	71.3%				
i. Other (Specify/add rows of needed)									
TOTAL OCCUPANCY %	**71.4%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**
6. OUTPATIENT VISITS (Includes PGHC, LRH / FMF and BHC									
a. Emergency Department	115,141	66,166	108,821	107,888	106,690	107,663	108,638	109,617	117,529
b. Psych Emergency Department	-	-	-	1,904	1,904	1,904	1,904	1,904	1,904
c. Same-day Surgery	3,990	3,919	3,957	4,031	4,110	4,214	4,318	4,423	4,655
d. Laboratory									
e. Imaging									
f. Intensive Outpatient Psych / Partial Hospitalization Program	254	227	229	331	434	538	588	593	599
g. Clinic	191	191	193	196	199	203	208	212	231
TOTAL OUTPATIENT VISITS	**119,385**	**70,312**	**113,007**	**114,154**	**113,139**	**114,320**	**115,449**	**116,537**	**124,688**
7. OBSERVATIONS**									
a. Number of Patients	5,115	5,224	5,224	5,851	5,746	5,837	5,928	6,019	6,396
b. Hours	137,292	148,057	148,265	177,439	174,093	176,820	179,548	182,275	193,586

* Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

** Services included in the reporting of the "Observation Center", direct expenses incurred in providing bedside care to observation patients; furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, in order to determine the need for a possible admission to the hospitals as an inpatient. Such services must be ordered and documented in writing, given by a medical practitioner; may or may not be provided in a distinct area of the hospital.

TABLE G. REVENUES & EXPENSES, UNINFLATED - Capital Region Health

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial					
Indicate CY or FY	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
1. REVENUE									
a. Inpatient Services	$278,629	$279,142	$289,529	$269,466	$272,109	$280,271	$269,352	$275,968	$282,746
b. Outpatient Services	$ 165,386	$ 164,955	$ 161,767	$ 181,785	$ 182,343	$ 185,439	$ 187,913	$ 190,395	$ 192,931
Gross Patient Service Revenues	***$ 444,015***	***$ 444,097***	***$ 451,296***	***$ 451,250***	***$ 454,452***	***$ 465,709***	***$ 457,265***	***$ 466,362***	***$ 475,677***
c. Deductions	$ 72,297	$ 87,133	$ 76,209	$ 86,214	$ 86,687	$ 88,339	$ 86,253	$ 87,598	$ 88,973
Net Patient Services Revenue	***$ 371,718***	***$ 356,964***	***$ 375,087***	***$ 365,036***	***$ 367,765***	***$ 377,370***	***$ 371,011***	***$ 378,765***	***$ 386,704***
d. Grants	$ 9,828	$ 25,922	$ 39,058	$ 37,127	$ 20,327	$ 20,327	$ 10,327	$ 10,327	$ 10,327
e. Other Operating Revenue	$ 16,118	$ 11,937	$ 13,666	$ 13,358	$ 13,056	$ 12,761	$ 12,474	$ 12,193	$ 11,918
NET OPERATING REVENUE	***$ 397,664***	***$ 394,823***	***$ 427,812***	***$ 415,521***	***$ 401,149***	***$ 410,459***	***$ 393,812***	***$ 401,285***	***$ 408,950***
2. EXPENSES									
a. Salaries & Wages (including benefits)	$ 209,858	$ 218,978	$ 232,195	$ 194,973	$ 178,090	$ 181,114	$ 171,380	$ 175,297	$ 179,320
b. Contractual Services	$ 80,977	$ 77,448	$ 89,642	$ 73,972	$ 68,936	$ 69,538	$ 63,150	$ 64,143	$ 65,160
c. Interest on Current Debt	$ 295	$ 232	$ 249	$ 194	$ 186	$ 5,603	$ 9,289	$ 8,966	$ 9,208
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,525	$ 1,491	$ 1,455
e. Current Depreciation and Ammortization	$ 13,924	$ 14,243	$ 13,714	$ 17,287	$ 18,458	$ 24,478	$ 39,295	$ 40,465	$ 41,636
f. Project Depreciation and Ammortization	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,673	$ 2,788	$ 2,902
g. Supplies	$ 54,991	$ 55,839	$ 55,456	$ 51,550	$ 48,852	$ 50,338	$ 48,414	$ 49,977	$ 51,596
h. Professional Fees	$ 32,734	$ 37,727	$ 41,367	$ 32,207	$ 30,000	$ 30,255	$ 28,856	$ 29,309	$ 29,767
i. Utilities	$ 5,797	$ 5,575	$ 1,617	$ 5,196	$ 5,069	$ 5,027	$ 4,116	$ 4,087	$ 4,058
j. Fixed Cost Additions	$ -	$ -	$ -	$ 32,283	$ 40,039	$ 32,695	$ 23,932	$ 22,759	$ 22,227
TOTAL OPERATING EXPENSES	**$398,576**	**$410,042**	**$434,239**	**$407,661**	**$389,629**	**$399,048**	**$392,631**	**$399,282**	**$407,328**
3. INCOME									
a. Income From Operation	**$ (912)**	**$ (15,218)**	**$ (6,428)**	**$ 7,860**	**$ 11,520**	**$ 11,411**	**$ 1,181**	**$ 2,002**	**$ 1,622**
b. Investment Income	$ 2,146	$ (1,572)	$ 434	$ 2,687	$ 3,047	$ 3,394	$ 4,138	$ 4,237	$ 4,339
SUBTOTAL	***$ 1,234***	***$ (16,790)***	***$ (5,994)***	***$ 10,547***	***$ 14,567***	***$ 14,805***	***$ 5,319***	***$ 6,240***	***$ 5,961***
c. Income Taxes									
NET INCOME (LOSS)	***$ 1,234***	***$ (16,790)***	***$ (5,994)***	***$ 10,547***	***$ 14,567***	***$ 14,805***	***$ 5,319***	***$ 6,240***	***$ 5,961***

TABLE G. REVENUES & EXPENSES, UNINFLATED - Capital Region Health

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial					
Indicate CY or FY	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
4. PATIENT MIX									
a. Percent of Total Revenue									
1) Medicare	31.5%	34.4%	34.4%	31.1%	31.1%	31.1%	32.0%	32.0%	32.0%
2) Medicaid	32.3%	32.8%	32.8%	34.7%	34.7%	34.7%	35.3%	35.3%	35.3%
3) Blue Cross	11.6%	10.3%	10.3%	10.4%	10.4%	10.4%	9.6%	9.6%	9.6%
4) Commercial Insurance	14.5%	13.7%	13.7%	14.3%	14.3%	14.3%	13.9%	13.9%	13.9%
5) Self-pay	8.5%	7.0%	7.0%	7.5%	7.5%	7.5%	7.3%	7.3%	7.3%
6) Other	1.6%	1.8%	1.8%	2.0%	2.0%	2.0%	1.9%	1.9%	1.9%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days									
1) Medicare	39.6%	44.0%	44.0%	44.0%	44.0%	44.0%	44.0%	44.0%	44.0%
2) Medicaid	35.4%	34.1%	34.1%	34.1%	34.1%	34.1%	34.1%	34.1%	34.1%
3) Blue Cross	8.3%	7.4%	7.4%	7.4%	7.4%	7.4%	7.4%	7.4%	7.4%
4) Commercial Insurance	10.2%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%
5) Self-pay	5.5%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%
6) Other	1.0%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table G – Key Financial Projection Assumptions for UM Capital Region Health (Excludes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the Capital Region Health (CRH) FY2017 actual financial performance with assumptions identified below	
Projection period reflects FY2018 – FY2024	
Volumes	- See Table F of the application for volume projections
Patient Revenue • Gross Charges o Update Factor o Demographic Adjustment o Variable Cost Factor o Redistribution of LRH revenue • Revenue Deductions	 - 0.0% annual increase in FY2019 – FY2024 - Remains constant at 0.35% per year - 50% variable cost factor with loss of volumes - 30% variable cost factor with increases in volumes - 50% of $30M of LRH's inpatient GBR will shift to PGHC in FY2019 when LRH IP service are discontinued - $18M of Rehab and Chronic Care revenues will also shift to PGHC in FY2019 – FY2020 as those services are moved to PGHC - Approximately 19.0% of gross revenue per year
Other Revenue • Grants o State o County • Other Operating Revenue	 - $28M support in FY2018, $27M in FY2019, $15M in FY2020-FY2021 and $10M in FY2022-FY2028 - $11.1M in FY2018, 10.1M in FY2019, $5.3M in FY2020-FY2021, and $0.3M in FY2023-FY2024 - Remains relatively constant from FY2018 to FY2024
Investment Income	- Earnings equal 2.5% of projected cash balance
Expenses • Inflation • Expense Variability with Volume Changes o Salaries and Benefits o Professional Fees o Supplies & Drugs	 - 0.0% annual increase - 30%. - 50% - 70%

o Purchased Services o Other Operating Expenses	- 40%. - 0%
• Interest Expense	
o Existing Debt	- CRH has little existing debt and related interest expense
o Project Debt	- In FY2021 and FY2022, the new Prince George's Regional Medical Center and Laurel Medical Center will open and the interest expense associated with these facilities will be recorded at an average interest rate of 5.0%
• Depreciation and Amortization	- Reflects the opening of the Prince George's Regional Medical Center in FY2021 and Laurel Medical Center in FY2022, both of which are depreciated over 30 years - Routine Capital expenditures are depreciated over 10 years
• Performance Improvements	- $11.4M in FY2019 growing to $38.5M in FY2020, $43.5M in FY2021, $64.0M in FY2022, $66.6M in FY2023 and $69.2M in FY2024 with improvements in the following areas: - Reduction in patient billing denials - Improved hospital and physician collections - Achievement of HSCRC quality payment awards - Reduction in average length of stay - Reduction in labor - Reduction in premium and overtime pay - Reduction in supply and drug costs - Reduction in contract services

TABLE H. REVENUES & EXPENSES, INFLATED - UM Capital Region Health

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.					
Indicate CY or FY	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
1. REVENUE									
a. Inpatient Services	$278,629	$279,142	$289,529	$275,933	$285,327	$300,938	$296,156	$310,712	$325,984
b. Outpatient Services	$ 165,386	$ 164,955	$ 161,767	$ 186,147	$ 191,201	$ 199,113	$ 206,612	$ 214,365	$ 222,435
Gross Patient Service Revenues	***$ 444,015***	***$ 444,097***	***$ 451,296***	***$ 462,080***	***$ 476,528***	***$ 500,052***	***$ 502,768***	***$ 525,077***	***$ 548,419***
c. Deductions	$ 72,297	$ 87,133	$ 76,209	$ 88,283	$ 90,898	$ 94,854	$ 94,837	$ 98,626	$ 102,579
Net Patient Services Revenue	***$ 371,718***	***$ 356,964***	***$ 375,087***	***$ 373,797***	***$ 385,630***	***$ 405,198***	***$ 407,931***	***$ 426,451***	***$ 445,840***
d. Grants	$ 9,828	$ 25,922	$ 39,058	$ 37,127	$ 20,327	$ 20,327	$ 10,327	$ 10,327	$ 10,327
e. Other Operating Revenue	$ 16,118	$ 11,937	$ 13,666	$ 13,678	$ 13,690	$ 13,703	$ 13,715	$ 13,728	$ 13,741
NET OPERATING REVENUE	***$ 397,664***	***$ 394,823***	***$ 427,812***	***$ 424,603***	***$ 419,648***	***$ 439,228***	***$ 431,973***	***$ 450,506***	***$ 469,908***
2. EXPENSES									
a. Salaries & Wages (including benefits)	$ 209,858	$ 218,978	$ 232,195	$ 200,241	$ 187,842	$ 196,193	$ 190,664	$ 200,291	$ 210,422
b. Contractual Services	$ 80,977	$ 77,448	$ 89,642	$ 75,970	$ 72,711	$ 75,327	$ 70,256	$ 73,289	$ 76,462
c. Interest on Current Debt	$ 295	$ 232	$ 249	$ 194	$ 186	$ 5,603	$ 9,289	$ 8,966	$ 9,208
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,525	$ 1,491	$ 1,455
e. Current Depreciation and Ammortization	$ 13,924	$ 14,243	$ 13,714	$ 17,287	$ 18,458	$ 24,478	$ 39,295	$ 40,465	$ 41,636
f. Project Depreciation and Ammortization	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,673	$ 2,788	$ 2,902
g. Supplies	$ 54,991	$ 55,839	$ 55,456	$ 52,943	$ 51,527	$ 54,529	$ 53,861	$ 57,102	$ 60,545
h. Professional Fees	$ 32,734	$ 37,727	$ 41,367	$ 33,078	$ 31,642	$ 32,774	$ 32,103	$ 33,487	$ 34,930
i. Utilities	$ 5,797	$ 5,575	$ 1,617	$ 5,336	$ 5,346	$ 5,446	$ 4,579	$ 4,670	$ 4,762
j. Fixed Cost Additions	$ -	$ -	$ -	$ 33,155	$ 42,232	$ 35,417	$ 26,625	$ 26,004	$ 26,082
TOTAL OPERATING EXPENSES	**$398,576**	**$410,042**	**$434,239**	**$418,202**	**$409,945**	**$429,767**	**$430,872**	**$448,554**	**$468,404**
3. INCOME									
a. Income From Operation	**$ (912)**	**$ (15,218)**	**$ (6,428)**	**$ 6,400**	**$ 9,702**	**$ 9,461**	**$ 1,102**	**$ 1,952**	**$ 1,504**
b. Non-Operating Income	$ 2,146	$ (1,572)	$ 434	$ 2,687	$ 3,047	$ 3,394	$ 4,138	$ 4,237	$ 4,339
SUBTOTAL	***$ 1,234***	***$ (16,790)***	***$ (5,994)***	***$ 9,088***	***$ 12,750***	***$ 12,854***	***$ 5,240***	***$ 6,189***	***$ 5,843***
c. Income Taxes									
NET INCOME (LOSS)	***$ 1,234***	***$ (16,790)***	***$ (5,994)***	***$ 9,088***	***$ 12,750***	***$ 12,854***	***$ 5,240***	***$ 6,189***	***$ 5,843***

TABLE H. REVENUES & EXPENSES, INFLATED - UM Capital Region Health

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	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.					
Indicate CY or FY	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
4. PATIENT MIX									
a. Percent of Total Revenue									
1) Medicare	31.5%	34.4%	34.4%	31.1%	31.1%	31.1%	32.0%	32.0%	32.0%
2) Medicaid	32.3%	32.8%	32.8%	34.7%	34.7%	34.7%	35.3%	35.3%	35.3%
3) Blue Cross	11.6%	10.3%	10.3%	10.4%	10.4%	10.4%	9.6%	9.6%	9.6%
4) Commercial Insurance	14.5%	13.7%	13.7%	14.3%	14.3%	14.3%	13.9%	13.9%	13.9%
5) Self-pay	8.5%	7.0%	7.0%	7.5%	7.5%	7.5%	7.3%	7.3%	7.3%
6) Other	1.6%	1.8%	1.8%	2.0%	2.0%	2.0%	1.9%	1.9%	1.9%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days									
Total MSGA									
1) Medicare	39.6%	44.0%	44.0%	44.0%	44.0%	44.0%	44.0%	44.0%	44.0%
2) Medicaid	35.4%	34.1%	34.1%	34.1%	34.1%	34.1%	34.1%	34.1%	34.1%
3) Blue Cross	8.3%	7.4%	7.4%	7.4%	7.4%	7.4%	7.4%	7.4%	7.4%
4) Commercial Insurance	10.2%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%
5) Self-pay	5.5%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%
6) Other	1.0%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table H – Key Financial Projection Assumptions for UM Capital Region Health (Includes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the Capital Region Health (CRH) FY2017 actual financial performance with assumptions identified below	
Projection period reflects FY2018 – FY2024	
Volumes	- See Table F of the application for volume projections
Patient Revenue • Gross Charges o Update Factor o Demographic Adjustment o Variable Cost Factor o Redistribution of LRH revenue • Revenue Deductions	 - 2.4% annual increase in FY2019 – FY2024 - Remains constant at 0.35% per year - 50% variable cost factor with loss of volumes - 30% variable cost factor with increases in volumes - 50% of $30M of LRH's inpatient GBR will shift to PGHC in FY2019 when LRH IP service are discontinued - $18M of Rehab and Chronic Care revenues will also shift to PGHC in FY2019 – FY2020 as those services are moved to PGHC - Approximately 19.0% of gross revenue per year
Other Revenue • Grants o State o County • Other Operating Revenue	 - $28M support in FY2018, $27M in FY2019, $15M in FY2020-FY2021 and $10M in FY2022-FY2028 - $11.1M in FY2018, 10.1M in FY2019, $5.3M in FY2020-FY2021, and $0.3M in FY2023-FY2024 - Remains relatively constant from FY2018 to FY2024
Investment Income	- Earnings equal 2.5% of projected cash balance
Expenses • Inflation o Salaries and Benefits o Professional Fees o Supplies o Drugs o Purchased Services o Other Operating Expenses • Expense Variability with Volume Changes	 - 2.7% weighted average annual increase that reflects the following: - 2.75% - 3.0% - 2.75% - 3.0% - 2.6% - 2.0%

o Salaries and Benefits o Professional Fees o Supplies & Drugs o Purchased Services o Other Operating Expenses	- 30%. - 50% - 70% - 40%. - 0%
• Interest Expense o Existing Debt o Project Debt	- CRH has little existing debt and related interest expense - In FY2021 and FY2022, the new Prince George's Regional Medical Center and Laurel Medical Center will open and the interest expense associated with these facilities will be recorded at an average interest rate of 5.0%
• Depreciation and Amortization	- Reflects the opening of the Prince George's Regional Medical Center in FY2021 and Laurel Medical Center in FY2022, both of which are depreciated over 30 years - Routine Capital expenditures are depreciated over 10 years
• Performance Improvements	- $11.4M in FY2019 growing to $38.5M in FY2020, $43.5M in FY2021, $64.0M in FY2022, $66.6M in FY2023 and $69.2M in FY2024 with improvements in the following areas: - Reduction in patient billing denials - Improved hospital and physician collections - Achievement of HSCRC quality payment awards - Reduction in average length of stay - Reduction in labor - Reduction in premium and overtime pay - Reduction in supply and drug costs - Reduction in contract services

TABLE I. STATISTICAL PROJECTIONS - UM Laurel Regional Hospital (FY2016-FY2018) & UM Laurel Medical Center (FY2019-FY2024)

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.					
Indicate CY or FY	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. DISCHARGES									
a. General Medical/Surgical*	2,846	2,846	2,846						
b. ICU/CCU									
Total MSGA	**2,846**	**2,846**	**2,846**	**-**	**-**	**-**	**-**	**-**	**-**
c. Pediatric									
d. Obstetric	197								
e. Acute Psychiatric	940	831	831						
Total Acute	**3,983**	**3,677**	**3,677**	**-**	**-**	**-**	**-**	**-**	**-**
f. Rehabilitation	281	237	235						
g. Chronic Care									
h. Other (Specify/add rows of needed)									
TOTAL DISCHARGES	**4,264**	**3,914**	**3,912**						
2. PATIENT DAYS									
a. General Medical/Surgical*	13,526	13,814	13,814						
b. ICU/CCU									
Total MSGA	**13,526**	**13,814**	**13,814**	**-**	**-**	**-**	**-**	**-**	**-**
c. Pediatric									
d. Obstetric	458								
e. Acute Psychiatric	4,389	3,576	3,576						
Total Acute	**18,373**	**17,390**	**17,390**						
f. Rehabilitation	2,369	2,319	2,347						
g. Chronic Care									
h. Other (Specify/add rows of needed)									
TOTAL PATIENT DAYS	**20,742**	**19,709**	**19,737**						

TABLE I. STATISTICAL PROJECTIONS - UM Laurel Regional Hospital (FY2016-FY2018) & UM Laurel Medical Center (FY2019-FY2024)

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.					
Indicate CY or FY	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)									
a. General Medical/Surgical*	4.8	4.9	4.9						
b. ICU/CCU									
Total MSGA	**4.8**	**4.9**	**4.9**						
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric	4.7	4.3	4.3						
Total Acute	**4.6**	**4.7**	**4.7**						
f. Rehabilitation	8.4	9.8	10.0						
g. Chronic Care									
h. Other (Specify/add rows of needed)									
TOTAL AVERAGE LENGTH OF STAY	**4.9**	**5.0**	**5.0**						
4. NUMBER OF BEDS									
a. General Medical/Surgical*	52	53	53						
b. ICU/CCU									
Total MSGA	**52**	**53**	**53**						
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric	17	14	14						
Total Acute	**69**	**67**	**67**						
f. Rehabilitation	9	9	9						
g. Chronic Care									
h. Other (Specify/add rows of needed)									
TOTAL BEDS	**78**	**76**	**76**						

TABLE I. STATISTICAL PROJECTIONS - UM Laurel Regional Hospital (FY2016-FY2018) & UM Laurel Medical Center (FY2019-FY2024)

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.					
Indicate CY or FY	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*									
a. General Medical/Surgical*	71.4%	71.4%	71.4%						
b. ICU/CCU									
Total MSGA	**71.4%**	**71.4%**	**71.4%**						
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric	71.6%	71.5%	71.5%						
Total Acute	**73.3%**	**71.4%**	**71.4%**						
f. Rehabilitation	71.3%	71.4%	71.4%						
g. Chronic Care									
h. Other (Specify/add rows of needed)									
TOTAL OCCUPANCY %	**73.0%**	**71.4%**	**71.4%**						
6. OUTPATIENT VISITS									
a. Emergency Department	28,620	26,533	25,863	23,959	21,704	21,704	21,704	21,704	21,704
b. Psych Emergency Department	-	-	-	1,904	1,904	1,904	1,904	1,904	1,904
c. Same-day Surgery	1,986	1,883	1,901	1,948	1,997	2,016	2,035	2,055	2,074
d. Laboratory									
e. Imaging									
f. Intensive Outpatient Psych / Partial Hospitalization Program	254	227	229	331	434	538	588	593	599
TOTAL OUTPATIENT VISITS	**30,860**	**28,643**	**27,993**	**28,142**	**26,040**	**26,163**	**26,232**	**26,256**	**26,281**
7. OBSERVATIONS**									
a. Number of Patients	1,301	1,443	1,407	1,984	1,822	1,822	1,822	1,822	1,822
b. Hours	32,857	34,833	33,953	61,628	56,595	56,595	56,595	56,595	56,595

* Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

** Services included in the reporting of the "Observation Center", direct expenses incurred in providing bedside care to observation patients; furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, in order to determine the need for a possible admission to the hospitals as an inpatient. Such services must be ordered and documented in writing, given by a medical practitioner; may or may not be provided in a distinct area of the hospital.

TABLE J. REVENUES & EXPENSES, UNINFLATED - UM Laurel Medical Center

INSTRUCTION : After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.					
Indicate CY or FY	**FY 2016**	**FY 2017**	**FY 2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
1. REVENUE									
a. Inpatient Services									
b. Outpatient Services				$ 45,184	$ 44,728	$ 44,993	$ 49,687	$ 49,855	$ 50,024
Gross Patient Service Revenues				***$ 45,184***	***$ 44,728***	***$ 44,993***	***$ 49,687***	***$ 49,855***	***$ 50,024***
c. Deductions				$ 10,044	$ 9,942	$ 10,001	$ 11,045	$ 11,082	$ 11,119
Net Patient Services Revenue				***$ 35,140***	***$ 34,785***	***$ 34,992***	***$ 38,642***	***$ 38,773***	***$ 38,904***
d. Grants				$ 4,048	$ 2,200	$ 2,200	$ 1,100	$ 1,100	$ 1,100
e. Other Operating Revenues				$ 464	$ 465	$ 465	$ 512	$ 513	$ 513
NET OPERATING REVENUE				***$ 39,653***	***$ 37,450***	***$ 37,657***	***$ 40,254***	***$ 40,385***	***$ 40,517***
2. EXPENSES									
a. Salaries & Wages (including benefits)				$ 16,095	$ 16,095	$ 16,095	$ 14,890	$ 14,890	$ 14,890
b. Contractual Services				$ 10,411	$ 10,134	$ 10,133	$ 9,605	$ 9,567	$ 9,529
c. Interest on Current Debt				$ 41	$ 41	$ 41	$ -	$ -	$ -
d. Interest on Project Debt				$ -	$ -	$ -	$ 1,525	$ 1,491	$ 1,455
e. Current Depreciation and Amortization				$ 3,247	$ 3,247	$ 3,247	$ -	$ -	$ -
f. Project Depreciation and Amortization				$ -	$ -	$ -	$ 2,673	$ 2,788	$ 2,902
g. Supplies				$ 5,468	$ 5,264	$ 5,290	$ 5,897	$ 5,898	$ 5,899
h. Professional Fees				$ 4,312	$ 4,312	$ 4,312	$ 4,798	$ 4,798	$ 4,798
i. Utilities				$ 1,117	$ 1,117	$ 1,117	$ 426	$ 426	$ 426
TOTAL OPERATING EXPENSES				***$ 40,692***	***$ 40,210***	***$ 40,235***	***$ 39,814***	***$ 39,857***	***$ 39,899***
3. INCOME									
a. Income From Operation				***$ (1,039)***	***$ (2,760)***	***$ (2,578)***	***$ 440***	***$ 529***	***$ 618***
b. Non-Operating Income				$ 16	$ 16	$ 17	$ 17	$ 17	$ 18
SUBTOTAL				***$ (1,023)***	***$ (2,744)***	***$ (2,562)***	***$ 457***	***$ 546***	***$ 636***
c. Income Taxes									
NET INCOME (LOSS)				***$ (1,023)***	***$ (2,744)***	***$ (2,562)***	***$ 457***	***$ 546***	***$ 636***
4. PATIENT MIX									
a. Percent of Total Revenue									
1) Medicare				22.2%	22.2%	22.2%	22.2%	22.2%	22.2%
2) Medicaid				26.2%	26.2%	26.2%	26.2%	26.2%	26.2%
3) Blue Cross				18.7%	18.7%	18.7%	18.7%	18.7%	18.7%
4) Commercial Insurance				19.3%	19.3%	19.3%	19.3%	19.3%	19.3%
5) Self-pay				10.2%	10.2%	10.2%	10.2%	10.2%	10.2%
6) Other				3.4%	3.4%	3.4%	3.4%	3.4%	3.4%
TOTAL				***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days									
Total MSGA									
1) Medicare									
2) Medicaid									
3) Blue Cross									
4) Commercial Insurance									
5) Self-pay									
6) Other									
TOTAL				***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

Table J – Key Financial Projection Assumptions for UM Laurel Medical Center (Excludes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the UM Laurel Regional Hospital (LRH) actual financial performance for the seven months ended January 2018 with assumptions identified below.	
Projection period reflects FY2019 – FY2024	
Volumes	- See Table F and Need Assessment section of the application for volume projections, methodology and assumptions
Patient Revenue	
• GBR Redistribution	- Reflects charges for FMF related services in UM LRH's 2018 HSCRC approved budget
• Gross Charges	
o Update Factor	- 0.0% annual increase in FY2019 – FY2024
o Demographic Adjustment	- Remains constant at 0.35% per year
o Variable Cost Factor	- Laurel FMF volume shifting at 30%
o Other	- Removed assessments and quality from LRH rates and changed the mark-up to reflect LRH's FY2017 payer mix and actual uncompensated care
• Revenue Deductions	
o Contractual Allowances	- Equals 4.8% of gross revenue for FMF related services
o Denials	- Equals 2.1% of gross revenue for FMF related services
o Charity Care	- Equals 4.9% of gross revenue or FMF related services
o Allowance for Bad Debt	- Equals 10.5% of gross revenue for FMF related services
o UCC Payment / Receipt	- No overfunding or underfunding of UCC
Other Revenue	
• Grants	
o State	- 11% allocation, based on LRH revenue, of total CRH $28M support in FY2018, $27M in FY2019, $15M in FY2020-FY2021 and $10M in FY2022-FY2028
o County	- 11% allocation, based on LRH revenue, of $10.8M in FY2018, $9.8M in FY2019, $5.0M in FY2020-FY2021, and elimination in FY2022-FY2024
• Other Operating Revenue	- Remains relatively constant from FY2019 to FY2024
Expenses	
• Basis	- Reflects allocation of LRH's FY2017 direct and variable overhead expenses to FMF related services based on their utilization of ancillary and variable overhead services
• Inflation	- 0.0% annual increases
• Staffing	- See Table L – Workforce Information

• Building Related Expense	- In FY2019-FY2022, expenses are based on a 25% reduction in useable space in the existing hospital - In FY2022, the FMF moves to the new facility with 76,000 square feet
• Physician Expense	- Reflects subsidies of existing practices (Emergency, Hospitalist, Anesthesia, Radiology, Pathology, Mental Health, Wound Care, Orthopedic Surgery) and support for six new clinics
• Ambulance Transport	- Reflects transport of ED visits that need to be admitted
• Expense Variability with Volume Changes	- 55% with changes in volumes
• Other Operating Expenses	- Includes fixed overhead expenses for Administrative and General services, Patient Financial Services and equipment rental
• Interest Expense	- 4.0% interest on $38.6M bonds over 30 years
• Depreciation Expense	- Average life of 25 years on $53.2M of construction project expenditures and 7 years on routine capital expenditures
Routine Capital Expenditures	- $0.3M in FY2022, growing to $1.2M in FY2021 and $2.4M in FY2024

TABLE K. REVENUES & EXPENSES, INFLATED - UM Laurel Medical Center

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.					
Indicate CY or FY	**FY 2016**	**FY 2017**	**FY 2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
1. REVENUE									
a. Inpatient Services									
b. Outpatient Services				$ 46,268	$ 46,900	$ 48,311	$ 49,687	$ 51,051	$ 52,454
Gross Patient Service Revenues				***$ 46,268***	***$ 46,900***	***$ 48,311***	***$ 49,687***	***$ 51,051***	***$ 52,454***
c. Deductions				$ 10,285	$ 10,425	$ 10,739	$ 11,045	$ 11,348	$ 11,660
Net Patient Services Revenue				***$ 35,984***	***$ 36,475***	***$ 37,572***	***$ 38,642***	***$ 39,704***	***$ 40,794***
d. Grants				$ 4,048	$ 2,200	$ 2,200	$ 1,100	$ 1,100	$ 1,100
e. Other Operating Revenues				$ 475	$ 487	$ 500	$ 512	$ 525	$ 538
NET OPERATING REVENUE				***$ 40,507***	***$ 39,162***	***$ 40,272***	***$ 40,254***	***$ 41,328***	***$ 42,432***
2. EXPENSES									
a. Salaries & Wages (including benefits)				$ 16,530	$ 16,977	$ 17,435	$ 14,890	$ 15,292	$ 15,706
b. Contractual Services				$ 10,692	$ 10,689	$ 10,977	$ 9,605	$ 9,825	$ 10,051
c. Interest on Current Debt				$ 41	$ 41	$ 41			
d. Interest on Project Debt				$ -	$ -	$ -	$ 1,525	$ 1,491	$ 1,455
e. Current Depreciation and Ammortization				$ 3,247	$ 3,247	$ 3,247			
f. Project Depreciation and Ammortization				$ -	$ -	$ -	$ 2,673	$ 2,788	$ 2,902
g. Supplies				$ 5,616	$ 5,552	$ 5,730	$ 5,897	$ 6,058	$ 6,222
h. Professional Fees				$ 4,429	$ 4,549	$ 4,672	$ 4,798	$ 4,927	$ 5,060
i. Utilities				$ 1,147	$ 1,178	$ 1,210	$ 426	$ 437	$ 449
TOTAL OPERATING EXPENSES				***$ 41,702***	***$ 42,232***	***$ 43,311***	***$ 39,814***	***$ 40,818***	***$ 41,845***
3. INCOME									
a. Income From Operation				***$ (1,195)***	***$ (3,070)***	***$ (3,040)***	***$ 440***	***$ 510***	***$ 587***
b. Investment Income				$ 16	$ 16	$ 17	$ 17	$ 17	$ 18
SUBTOTAL				***$ (1,179)***	***$ (3,054)***	***$ (3,023)***	***$ 457***	***$ 528***	***$ 604***
c. Income Taxes									
NET INCOME (LOSS)				***$ (1,179)***	***$ (3,054)***	***$ (3,023)***	***$ 457***	***$ 528***	***$ 604***
4. PATIENT MIX									
a. Percent of Total Revenue									
1) Medicare				22.2%	22.2%	22.2%	22.2%	22.2%	22.2%
2) Medicaid				26.2%	26.2%	26.2%	26.2%	26.2%	26.2%
3) Blue Cross				18.7%	18.7%	18.7%	18.7%	18.7%	18.7%
4) Commercial Insurance				19.3%	19.3%	19.3%	19.3%	19.3%	19.3%
5) Self-pay				10.2%	10.2%	10.2%	10.2%	10.2%	10.2%
6) Other				3.4%	3.4%	3.4%	3.4%	3.4%	3.4%
TOTAL				***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days									
1) Medicare									
2) Medicaid									
3) Blue Cross									
4) Commercial Insurance									
5) Self-pay									
6) Other									
TOTAL				***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

Table K – Key Financial Projection Assumptions for Laurel Medical Center (Includes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the UM Laurel Regional Hospital (LRH) actual financial performance for the seven months ended January 2018 with assumptions identified below.	
Projection period reflects FY2019 – FY2024	
Volumes	- See Table F and Need Assessment section of the application for volume projections, methodology and assumptions
Patient Revenue	
• GBR Redistribution	- Reflects charges for FMF related services in UM LRH's 2018 HSCRC approved budget
• Gross Charges	
o Update Factor	- 2.4% annual increase in FY2019 – FY2024
o Demographic Adjustment	- Remains constant at 0.35% per year
o Variable Cost Factor	- Laurel FMF volume shifting at 30%
o Other	- Removed assessments and quality from LRH rates and changed the mark-up to reflect LRH's FY2017 payer mix and actual uncompensated care
• Revenue Deductions	
o Contractual Allowances	- Equals 4.8% of gross revenue for FMF related services
o Denials	- Equals 2.1% of gross revenue for FMF related services
o Charity Care	- Equals 4.9% of gross revenue or FMF related services
o Allowance for Bad Debt	- Equals 10.5% of gross revenue for FMF related services
o UCC Payment / Receipt	- No overfunding or underfunding of UCC
Other Revenue	
• Grants	
o State	- 11% allocation, based on LRH revenue, of total CRH $28M support in FY2018, $27M in FY2019, $15M in FY2020-FY2021 and $10M in FY2022-FY2028
o County	- 11% allocation, based on LRH revenue, of $10.8M in FY2018, $9.8M in FY2019, $5.0M in FY2020-FY2021, and elimination in FY2022-FY2024
• Other Operating Revenue	- Remains relatively constant from FY2019 to FY2024
Expenses	
• Basis	- Reflects allocation of LRH's FY2017 direct and variable overhead expenses to FMF related services based on their utilization of ancillary and variable overhead services

• Inflation	- 2.7% weighted average annual increase that reflects the following: - 2.75% - 3.0% - 2.75% - 3.0% - 2.6% - 2.0%
• Staffing	- See Table L – Workforce Information
• Building Related Expense	- In FY2019-FY2022, expenses are based on a 25% reduction in useable space in the existing hospital - In FY2022, the FMF moves to the new facility with 76,000 square feet
• Physician Expense	- Reflects subsidies of existing practices (Emergency, Hospitalist, Anesthesia, Radiology, Pathology, Mental Health, Wound Care, Orthopedic Surgery) and support for six new clinics
• Ambulance Transport	- Reflects transport of ED visits that need to be admitted
• Expense Variability with Volume Changes	- 55% with changes in volumes
• Other Operating Expenses	- Includes fixed overhead expenses for Administrative and General services, Patient Financial Services and equipment rental
• Interest Expense	- 4.0% interest on $38.6M bonds over 30 years
• Depreciation Expense	- Average life of 25 years on $53.2M of construction project expenditures and 7 years on routine capital expenditures
Routine Capital Expenditures	- $0.3M in FY2022, growing to $1.2M in FY2021 and $2.4M in FY2024

TABLE L. WORKFORCE INFORMATION

INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables F and G.

UM LRH	*CURRENT ENTIRE FACILITY - FMF IN EXISTING FACILITY (2018 DOLLARS)*			*PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)*			*OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)*			*PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (2018 DOLLARS) **		
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees												
Administration *(List general categories, add rows if needed)*												
Division Administrative Support Coordinator (DASC) - nursing	1.1	$45,122	$49,634		$45,122	$0		$45,122	$0	1.1	$ 45,122	$49,634
Billing/Scheduler - OR	1.0	$48,506	$48,506		$48,506	$0		$48,506	$0	1.0	$ 48,506	$48,506
Director of Nursing	1.0	$156,000	$156,000		$156,000	$0		$156,000	$0	1.0	$ 156,000	$156,000
Nurse Manager - ED/OBS	1.0	$98,280	$98,280		$98,280	$0		$98,280	$0	1.0	$ 98,280	$98,280
Nurse Manager - OR	1.0	$110,427	$110,427		$110,427	$0		$110,427	$0	1.0	$ 110,427	$110,427
Nurse Manager - PHP	0.5	$110,365	$55,183		$110,365	$0		$110,365	$0	0.5	$ 110,365	$55,183
Nursing Supervisor (OR)	1.0	$100,000	$100,000		$100,000	$0		$100,000	$0	1.0	$ 100,000	$100,000
Nursing Supervisor (ED/OBS)	3.3	$100,000	$330,000		$100,000	$0		$100,000	$0	3.3	$ 100,000	$330,000
Nurse Educator	1.0	$110,000	$110,000		$110,000	$0		$110,000	$0	1.0	$ 110,000	$110,000
HIM - Clinical Coding Outpatient	0.0	$110,000	$0		$110,000	$0		$110,000	$0	0.0	$ 110,000	$0
HIM - D/C Process/Prep/Scan/ QC/Validation/Analysis/Mgmt	0.0	$110,000	$0		$110,000	$0		$110,000	$0	0.0	$ 110,000	$0
HIM - MPI Merger	0.0	$110,000	$0		$110,000	$0		$110,000	$0	0.0	$ 110,000	$0
HIM - Supervisor	0.0	$110,000	$0		$110,000	$0		$110,000	$0	0.0	$ 110,000	$0
HIM - ROI (contracted)	0.0	$110,000	$0		$110,000	$0		$110,000	$0	0.0	$ 110,000	$0
Quality Improvement Coordinator	0.0	$93,000	$0		$93,000	$0		$93,000	$0	0.0	$ 93,000	$0
Infection Preventionist	0.0	$100,000	$0		$100,000	$0		$100,000	$0	0.0	$ 100,000	$0
Risk Management	0.5	$100,000	$50,000		$100,000	$0		$100,000	$0	0.5	$ 100,000	$50,000
Insurance Specialist	0.0	$54,000	$0		$54,000	$0		$54,000	$0	0.0	$ 54,000	$0
Executive Office	1.0	$53,000	$53,000		$53,000	$0		$53,000	$0	1.0	$ 53,000	$53,000
Medical Staff Office	1.0	$75,000	$75,000		$75,000	$0		$75,000	$0	1.0	$ 75,000	$75,000
Patient Financial Office			$0		$0	$0		$0	$0	0.0	$ -	$0
Corporate Allocation	0.0	$0	$0		$0	$0		$0	$0	0.0	$ -	$0

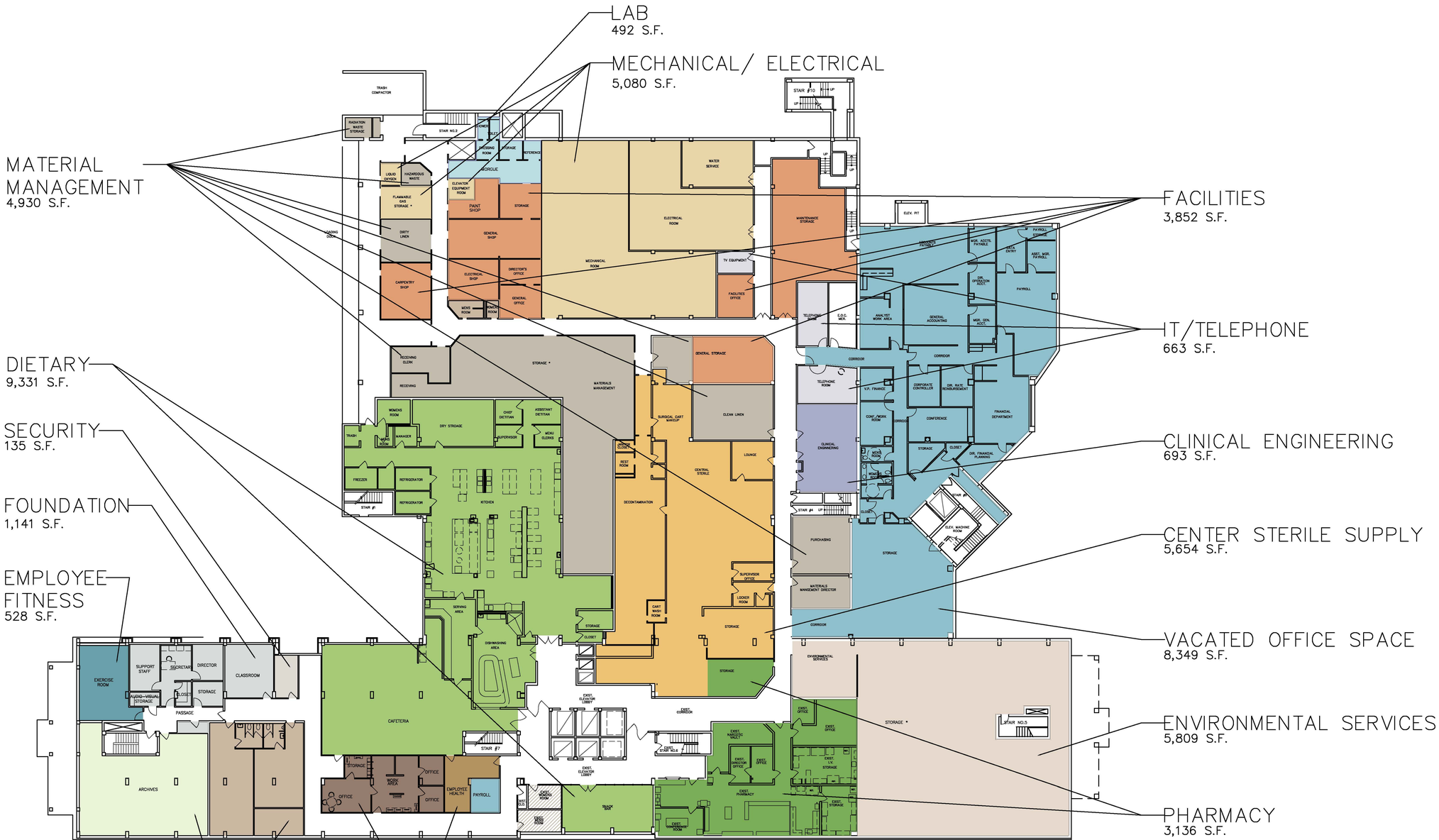
UM LRH	*CURRENT ENTIRE FACILITY - FMF IN EXISTING FACILITY (2018 DOLLARS)*			*PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)*			*OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)*			*PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (2018 DOLLARS) **		
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G)*
Total Administration	13.4	$92,241	$1,236,030	0.0	$0	$0	0.0	$0	$0	13.4	$92,241	$1,236,030
Direct Care Staff *(List general categories, add rows if needed)*												
RN - ED	26.3	$74,154	$1,950,250		$74,154	$0		$74,154	$0	26.3	$ 74,154	$1,950,250
Patient Care Tech - ED	4.6	$40,000	$184,000		$40,000	$0		$40,000	$0	4.6	$ 40,000	$184,000
RN - OBS (current Med/Surg)	8.7	$74,154	$645,140		$74,154	$0		$74,154	$0	8.7	$ 74,154	$645,140
Patient Care Tech - OBS (old M/S)	4.2	$49,500	$207,900		$49,500	$0		$49,500	$0	4.2	$ 49,500	$207,900
Monitor Tech - OBS	0.0	$0	$0		$0	$0		$0	$0	0.0	$ -	$0
RN - OR	5.0	$74,154	$370,770		$74,154	$0		$74,154	$0	5.0	$ 74,154	$370,770
RN - OR Pre-OP	3.0	$74,154	$222,462		$74,154	$0		$74,154	$0	3.0	$ 74,154	$222,462
RN - OR PACU	4.0	$74,154	$296,616		$74,154	$0		$74,154	$0	4.0	$ 74,154	$296,616
OR Tech	3.5	$61,000	$213,500		$61,000	$0		$61,000	$0	3.5	$ 61,000	$213,500
PA	2.1	$128,000	$268,800		$128,000	$0		$128,000	$0	2.1	$ 128,000	$268,800
Equipment Tech	0.5	$63,250	$31,625		$63,250	$0		$63,250	$0	0.5	$ 63,250	$31,625
RN - PHP	0.5	$74,154	$37,077		$74,154	$0		$74,154	$0	0.5	$ 74,154	$37,077
Social Worker - PHP	3.0	$77,757	$233,271		$77,757	$0		$77,757	$0	3.0	$ 77,757	$233,271
RN Case Manager - house	3.0	$88,000	$264,000		$88,000	$0		$88,000	$0	3.0	$ 88,000	$264,000
Radiology - Tech	5.3	$62,400	$330,720		$62,400	$0		$62,400	$0	5.3	$ 62,400	$330,720
Radiology - Midnight Rad/CT	0.6	$36,000	$21,600		$36,000	$0		$36,000	$0	0.6	$ 36,000	$21,600
Radiology - OR support (days)	1.1	$30,000	$33,000		$30,000	$0		$30,000	$0	1.1	$ 30,000	$33,000
Radiology - clerical (days)	1.0	$40,000	$40,000		$40,000	$0		$40,000	$0	1.0	$ 40,000	$40,000
Radiology - supervisor	0.6	$100,000	$60,000		$100,000	$0		$100,000	$0	0.6	$ 100,000	$60,000
Radiology - Director	0.3	$143,000	$42,900		$143,000	$0		$143,000	$0	0.3	$ 143,000	$42,900
Radiology - RIS/PACS/Quality	0.4	$98,872	$39,549		$98,872	$0		$98,872	$0	0.4	$ 98,872	$39,549
Radiology - US (24/7)	4.5	$91,500	$411,750		$91,500	$0		$91,500	$0	4.5	$ 91,500	$411,750
Radiology - CT (24/7)	5.1	$72,800	$371,280		$72,800	$0		$72,800	$0	5.1	$ 72,800	$371,280
Radiology - Nuc Med	1.5	$102,667	$154,000	-1.5	$102,667	-$154,000		$102,667	$0	0.0	$ 102,667	$0
LAB - medical technologist (24/7)	5.5	$55,000	$302,500		$55,000	$0		$55,000	$0	5.5	$ 55,000	$302,500
LAB - Sr Tech (days)	1.0	$60,000	$60,000		$60,000	$0		$60,000	$0	1.0	$ 60,000	$60,000
LAB - Mannager (3 days/week)	0.6	$110,000	$66,000		$110,000	$0		$110,000	$0	0.6	$ 110,000	$66,000
LAB - Technical Specialist	0.4	$39,000	$15,600		$39,000	$0		$39,000	$0	0.4	$ 39,000	$15,600

UM LRH	*CURRENT ENTIRE FACILITY - FMF IN EXISTING FACILITY (2018 DOLLARS)*			*PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)*			*OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)*			*PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (2018 DOLLARS) **		
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G)*
LAB - System Director	0.2	$135,000	$27,000		$135,000	$0		$135,000	$0	0.2	$ 135,000	$27,000
LAB - Manager, Transfusion srvcs	0.1	$110,000	$11,000		$110,000	$0		$110,000	$0	0.1	$ 110,000	$11,000
LAB - LIS Supervisor Analyst	0.2	$83,000	$16,600		$83,000	$0		$83,000	$0	0.2	$ 83,000	$16,600
LAB - Quality Coordinator	0.1	$88,000	$8,800		$88,000	$0		$88,000	$0	0.1	$ 88,000	$8,800
CSP	2.0	$65,000	$130,000		$65,000	$0		$65,000	$0	2.0	$ 65,000	$130,000
PHP Coordinator	1.0	$87,381	$87,381		$87,381	$0		$87,381	$0	1.0	$ 87,381	$87,381
Pharmacy	3.1	$121,345	$376,170		$121,345	$0		$121,345	$0	3.1	$ 121,345	$376,170
Pharmacy Tech	2.7	$60,500	$163,350		$60,500	$0		$60,500	$0	2.7	$ 60,500	$163,350
Respiratory	6.9	$87,000	$600,300		$87,000	$0		$87,000	$0	6.9	$ 87,000	$600,300
Wound Care	5.9	$62,352	$367,877		$62,352	$0		$62,352	$0	5.9	$ 62,352	$367,877
Physical Therapist	0.6	$95,000	$57,000		$95,000	$0		$95,000	$0	0.6	$ 95,000	$57,000
Occupational Therapy	0.3	$88,000	$26,400		$88,000	$0		$88,000	$0	0.3	$ 88,000	$26,400
Cardiovascular Tech	1.2	$80,000	$96,000		$80,000	$0		$80,000	$0	1.2	$ 80,000	$96,000
Total Direct Care	120.6	$73,318	$8,842,187	(1.5)	$102,667	-$154,000	0.0	$0	$0	119.1	$72,949	$8,688,187
Support Staff *(List general categories, add rows if needed)*												
Unit Clerk - ED	4.2	$34,000	$142,800		$34,000	$0		$34,000	$0	4.2	$ 34,000	$142,800
Unit Clerk - OBS	1.0	$34,000	$34,000		$34,000	$0		$34,000	$0	1.0	$ 34,000	$34,000
Unit Clerk - PHP	1.0	$34,000	$34,000		$34,000	$0		$34,000	$0	1.0	$ 34,000	$34,000
EVS - OR	16.0	$30,000	$480,000		$30,000	$0		$30,000	$0	16.0	$ 30,000	$480,000
Maintenance	8.2	$70,213	$575,750	-7.2	$70,611	-$508,400		$70,213	$0	1.0	$ 70,213	$70,213
Storeroom	0.0	$30,000	$0		$30,000	$0		$30,000	$0	0.0	$ 30,000	$0
Food Services	10.7	$35,328	$378,006	-1.9	$89,214	-$169,507		$35,328	$0	8.8	$ 35,328	$310,883
Communications	5.7	$35,000	$199,500	-5.7	$35,000	-$199,500		$35,000	$0	0.0	$ 35,000	$0
Registration	12.4	$36,000	$446,400		$36,000	$0		$36,000	$0	12.4	$ 36,000	$446,400
Total Support	59.2	$38,690	$2,290,456	-14.8	$59,284	-$877,407		$0	$0	44.4	$34,196	$1,518,297
REGULAR EMPLOYEES TOTAL	***193.2***	$64,020	$12,368,673	***-16.3***	$63,277	-$1,031,407	***0.0***	$0	$0	***176.9***	$64,684	$11,442,514
Benefits *(State method of calculating benefits below)* **:**			**3,726,628**			**-310,758**			**0**			**3,447,580**

UM LRH	*CURRENT ENTIRE FACILITY - FMF IN EXISTING FACILITY (2018 DOLLARS)*			*PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)*			*OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)*			*PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (2018 DOLLARS) **		
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G)*
30.13%												
TOTAL COST	***193.2***		***$16,095,301***	***-16.3***		***-$1,342,165***	***0.0***		***$0***			***$14,890,094***

EXHIBIT 2

PHASE I



PHASE 1

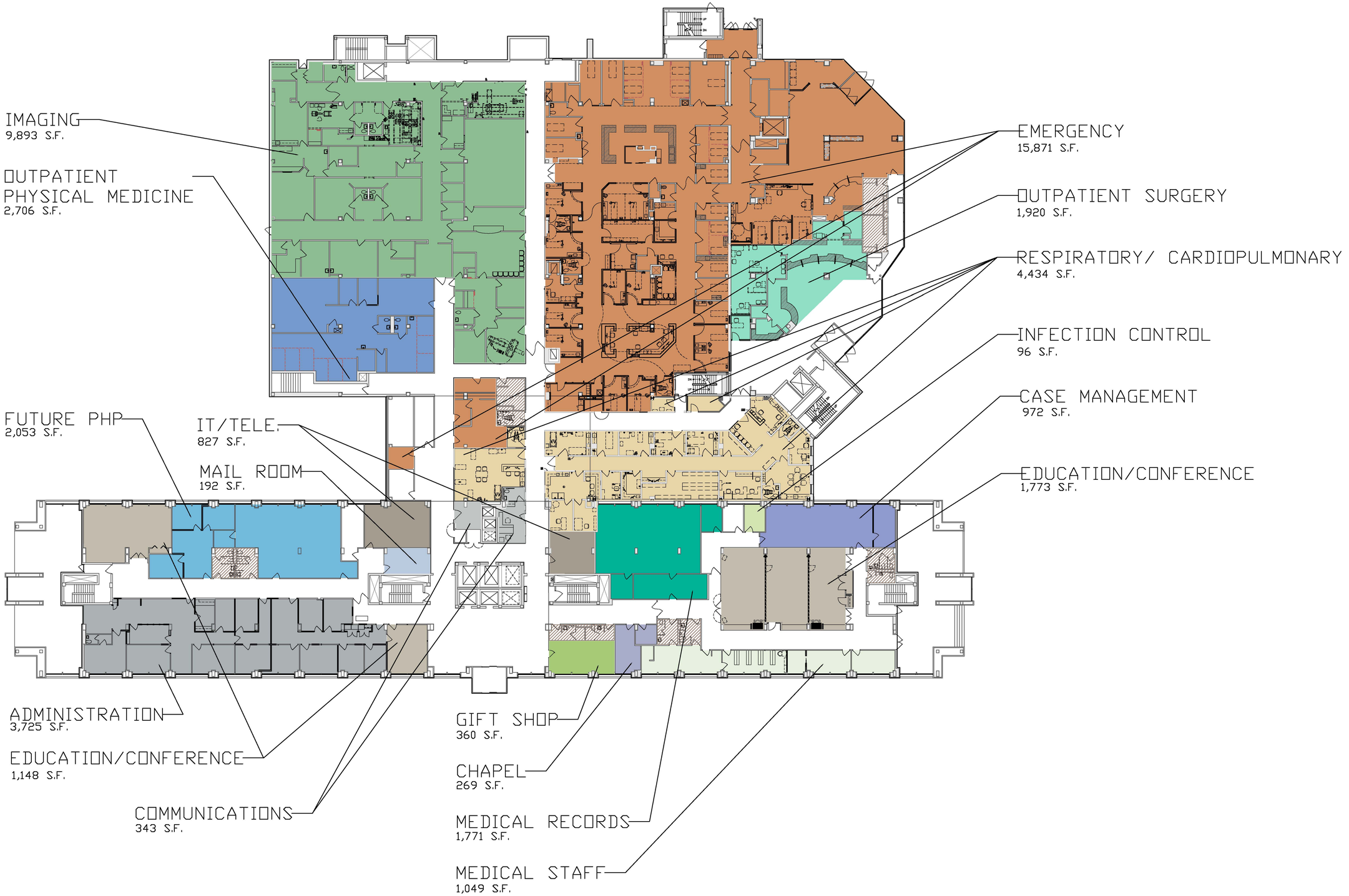
LAUREL MEDICAL CENTER

LEVEL 1 LAUREL, MD 1/16" = 1'-0"

February 21,2018

UNIVERSITY of MARYLAND MEDICAL SYSTEM

WILMOTSANZ ARCHITECTURE PLANNING



PHASE 1

UNIVERSITY of MARYLAND MEDICAL SYSTEM

LAUREL MEDICAL CENTER

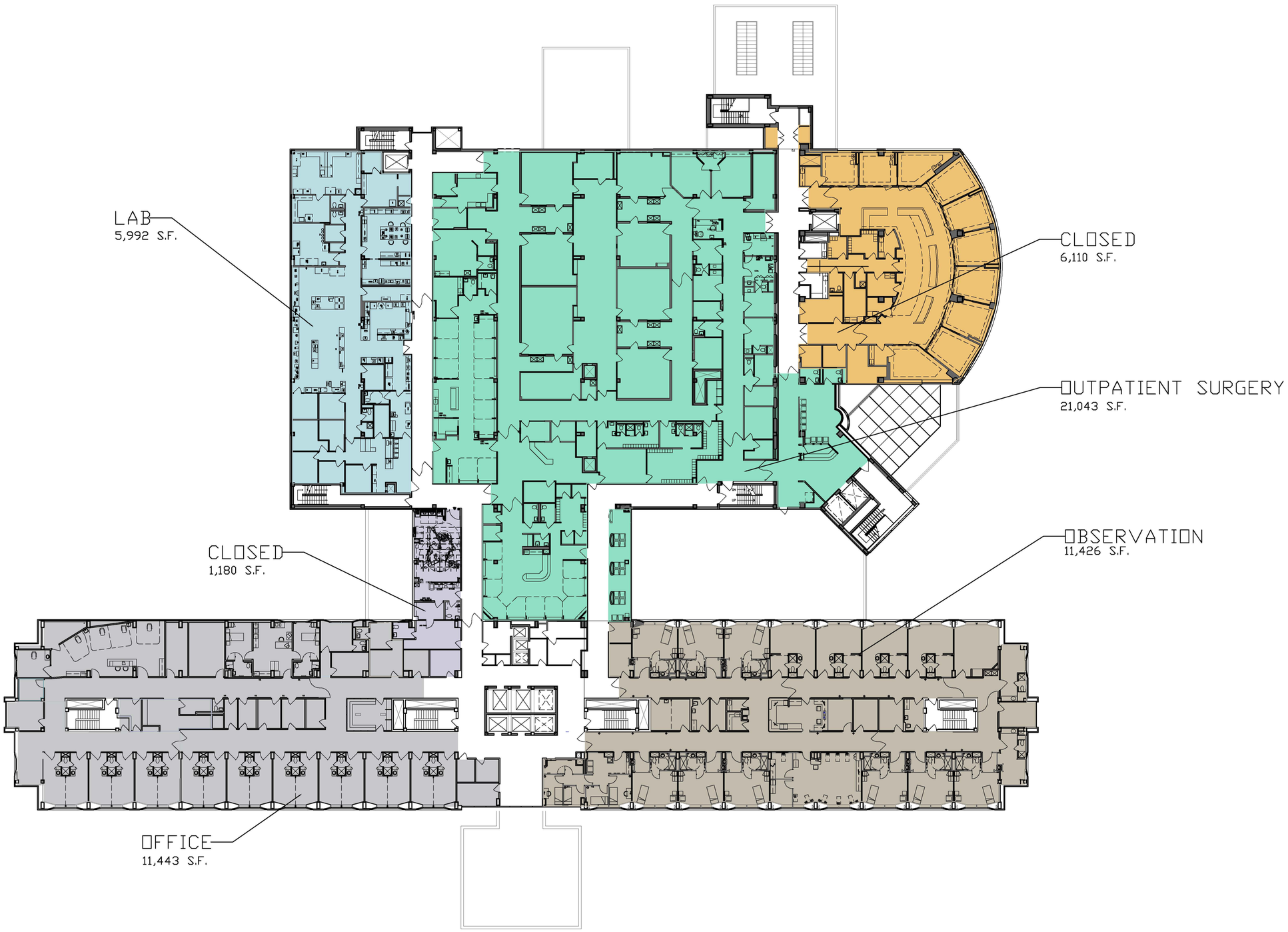
LEVEL 2

LAUREL, MD

1/16" = 1'-0"

February 21,2018

WILMOTSANZ
ARCHITECTURE
PLANNING



PHASE 1

LAUREL MEDICAL CENTER

LEVEL 3

LAUREL, MD

1/16" = 1'-0"

February 21,2018

UNIVERSITY of MARYLAND MEDICAL SYSTEM

WILMOTSANZ
ARCHITECTURE
PLANNING

PHASE 1

LAUREL MEDICAL CENTER

LEVEL 4

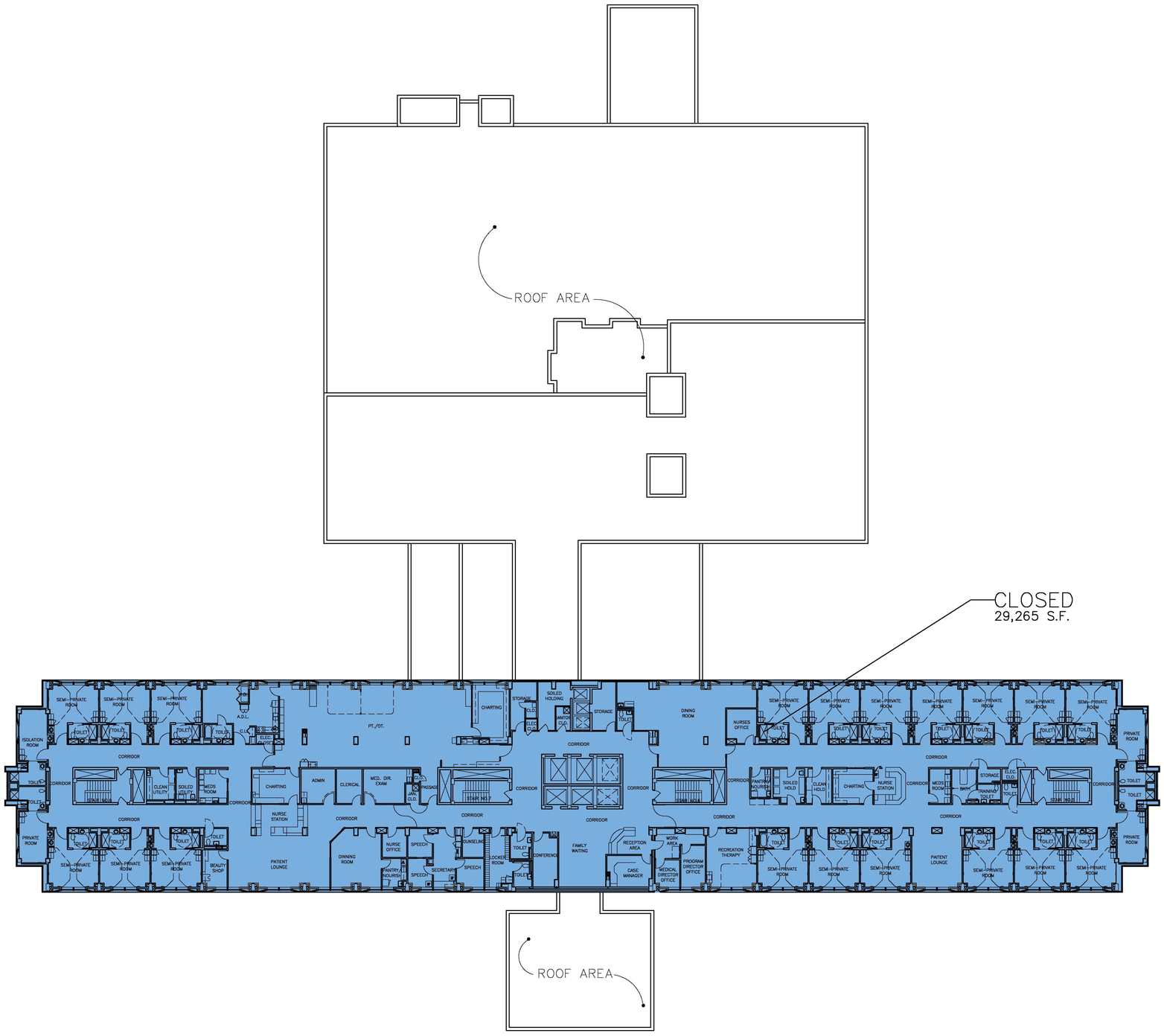
LAUREL, MD

1/16" = 1'-0"

February 21,2018

UNIVERSITY of MARYLAND MEDICAL SYSTEM

WILMOTSANZ
ARCHITECTURE
PLANNING



PHASE 1

LAUREL MEDICAL CENTER

LEVEL 5 — LAUREL, MD — 1/16" = 1'-0"

February 21,2018

UNIVERSITY of MARYLAND MEDICAL SYSTEM

WILMOTSANZ
ARCHITECTURE
PLANNING

PHASE II

LAUREL MEDICAL CENTER

LEVEL 01 — LAUREL, MD — 1/8" = 1'-0"

March 7, 2018

UNIVERSITY of MARYLAND MEDICAL SYSTEM

WILMOTSANZ ARCHITECTURE PLANNING

UNIVERSITY of MARYLAND MEDICAL SYSTEM

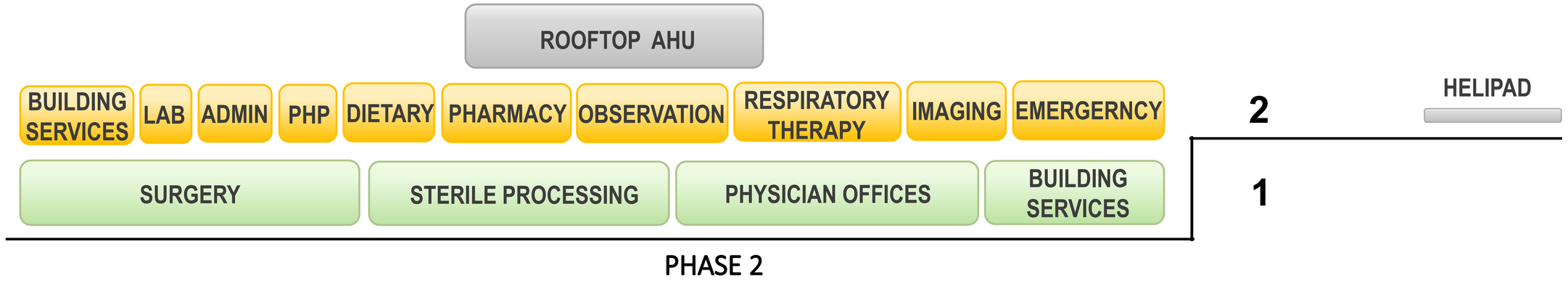
LAUREL MEDICAL CENTER

LAUREL, MD

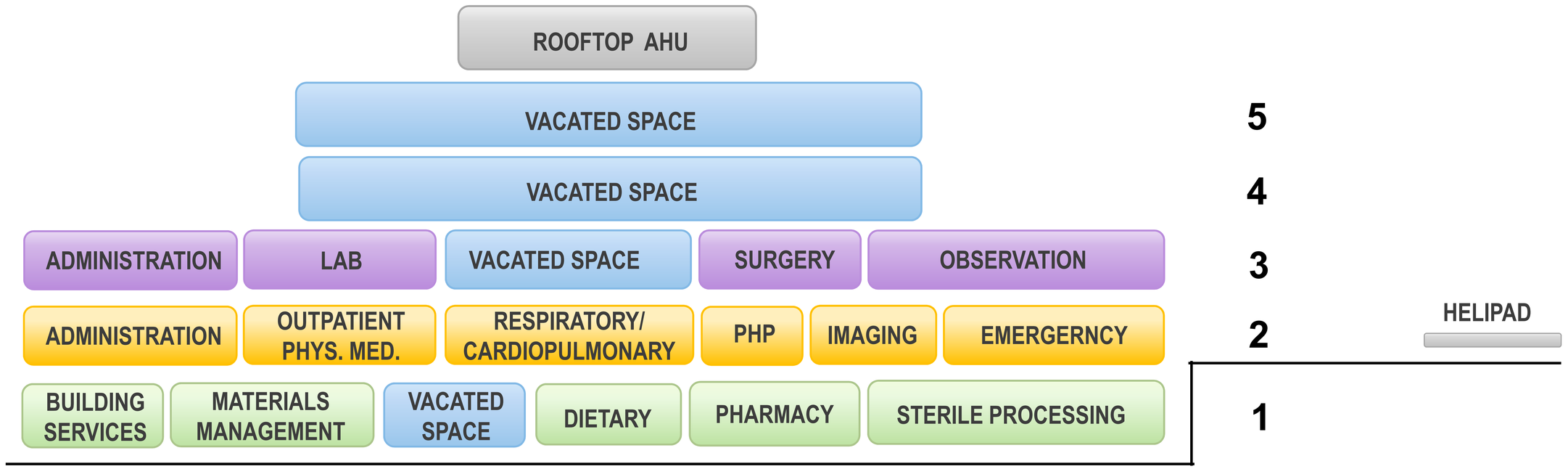
OBSERVATION
OBS. 1
OBS. 2
OBS. 3 (BARIATRIC)
OBS. 4
OBS. 5
OBS. 6 (BARIATRIC)
OBS. 7
OBS. 8
OBS. 9
OBS. 10
ELEC
EVS
MEDS
CASE MGT.
CLEAN SUPPLY
STAFF TLT
PHYS. DICT.
EQUIP ALCOVE
EQUIP ALCOVE
CONFERENCE
POTENTIAL CONNECTING CORRIDOR
EQUIP. STOR.
SOIL HOLD
TLT/ SHWR
STAFF LOUNGE
NOUR.
FAMILY CONSULT
EQUIP. STORAGE
TLT
TREAT. 12
TREAT. 11
CLEAN SUPPLY
SOIL. HOLD
TREAT. 13
TREAT. 14
TREAT. 15
PHYS. WORK ROOM
ELEC.
EQUIP ALCOVE
TREAT. 10
TREAT. 9
TREAT. 8
TREAT. 7
TREAT. 6
TREAT. 5
TREAT. 4
FUTURE EXPANSION
A2-03
1
A2-03
2
BUILDING SERVICES STORAGE
SERVICE
SERVICE LOBBY
BODY HOLD
FACILITIES OFFICE
STERI CYCLE
HOUSE KEEPING
O2
DIETARY
STAFF TLT
PHAR-MACY STOR-AGE
PHARMACY WORK ROOM
NURSE MGR.
SOILED HOLDING
MED DIR.
CLEAN LINEN
VICE CHAIR
ON-CALL
ON-CALL
LAB
STAFF LOUNGE
OFFICE
OFFICE
TLT
STOR.
STAFF TLT
TECH
OFFICE
OFFICE
READ
ULTRASOUND
IMAGING
ELEC
X-RAY
X-RAY
CONT.
CT
EQUIP.
EVS
TLT.
STAFF TLT
TLT
MEDS
NOURISH
TREAT. 16
TREAT. 17
TREAT. 18
TREAT. 19
DECON.
TLT
VEST.
EQ ALCOVE
ISOL. 3
TREAT. 2
AMBULANCE
TRAUMA/ RESUS. 1
BEREAVE
EQUIP ALCOVE
SEC
EMERGENCY
ELECTRIC ROOM
ELECTRIC ROOM
OFFICE
OFFICE
OFFICE
OFFICE
OFFICE
OFFICE
TLT
OFFICE 1
OFFICE 2
OFFICE 3
OFFICE 4
STAFF TLT
TLT
RESP. THERAPY
OFFICE 5
OFFICE 6
PSYCHIATRIC DAY TREATMENT
STAFF LOUNGE
GROUP 1
GROUP 2
GROUP 3
WAITING
REC.
TLT
GOWN
PATIENT HOLDING
SUB WAITING
EQUIP ALCOVE
DATA
SECURITY OFFICE
SECURITY MONITOR
LOBBY
VEST
CAFE KIOSK
RESULTS WAITING
EVS
TLT
TLT
TREAT. 20
LAB
TLT
ATM
CASHIER
REC.
REG.
INTAKE
EMS
VEST
TRIAGE 2
INTAKE
TRIAGE 1
EVS
WAITING
SEC
TLT
VENDING
TLT
VEST
PEDS WAITING
SEC. HOLD
CLEAN SUPPLY
SOIL. HOLD.
NOURISH
STAFF TLT
MEDS
PAT. STOR.
TEAM STATION
TV
TLT/ SHWR
PSYCH E.D.
TREAT. 1
TREAT. 2
TREAT. 3
TREAT. 4

LEVEL 02
1/8" = 1'-0"
February 21, 2018

WILMOTSANZ
ARCHITECTURE
PLANNING

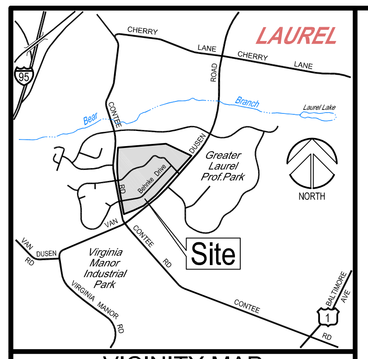


PHASE 2

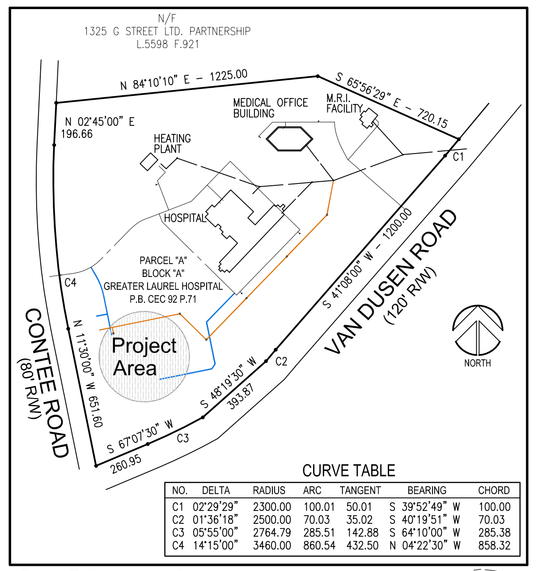


PHASE 1

STACKING DIAGRAMS



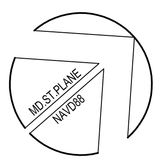
VICINITY MAP
SCALE: 1:=2000'
P.G. CO. ADC MAP #5168 GRID: J/K-6/7
W.S.S.C. 200' SHEET 218 NE 6 & 7



CURVE TABLE

NO.	DELTA	RADIUS	ARC	TANGENT	BEARING	CHORD
C1	02°29'29"	2300.00	100.01	50.01	S 39°52'49" W	100.00
C2	01°36'18"	2500.00	70.03	35.02	S 40°19'51" W	70.03
C3	05°55'00"	2764.79	285.51	142.88	S 64°10'00" W	285.38
C4	14°15'00"	3460.00	860.54	432.50	N 04°22'30" W	858.32

Overall Property Map
Scale: 1"=400'



North
Plan Scale: 1"=40'
40 0 40 80 120
Graphic Scale

Contee Road
80' R/W
EX. 8"S
EX. 10"W
Possible Future Medical Office Building Pad Site
Prop 8"W
Prop 8"S
Loading/Service
PROPOSED
2 Story
Ambulatory Care Facility
72,000 GFA
FF = 278.10
LL= 264.10
Limits of Level One
Prop. Facility
MRI Facility
5400 GFA
FF = xxx.10
LL = xxx.10
Slab=274.0
N 41°30'00" W – 550.60'
6' LANDSCAPE BUFFER
15' HIKER-BIKER EASEMENT
25' BRL
Proposed Signage Feature
N 67°07'30" E – 260.95'
EX. 12" W
L=285.51'
R=2764.79'
Van Dusen Road
120' R/W
25' BRL
15' HIKER-BIKER EASEMENT
6' LANDSCAPE BUFFER
N 48°19'30" E – 393.87'
L=70.03'
R=2500.00'
EX. 12" W
EXISTING MULTI-LEVEL SENIOR ACTIVITY CENTER
EXISTING COOLING TOWER
EXISTING HEATING PLANT
EX. 8" SD
EX. 8" S
Fire Hyd
EXISTING HELECOPTER PAD
EX. 10" W
EX. 24" SD
EX. 30" RCP
EX STEAM
EX. 8" W
EX. 10"W
EX. 8"S
EX. 4" SD
EX. 6" W
EX TRASH COMPACTER
EX TRASH TANK
EX CANOPY
Siamese Conn.
EX. 8"W
EXISTING 3 STORY
EXISTING 4 STORY
EXISTING 3 STORY
EXISTING 4 STORY
EX. 15" RCP
EX. 12" RCP
EX. 8" W
EXISTING 4 STORY
EXISTING 5 STORY LAUREL REGIONAL HOSPITAL F.F.=260.4
EX CONC SIDEWALK
EX. 8" W
Fire Hyd
Behnke Drive
Prop 8"S
(see Overall Map for Continuation)
EX. 18" RCP
Prop 8"W
Prop 8"S
Prop 8"W
Prop 8"W
Prop 8"S
Prop 8"S
Prop 8"S
Prop 8"W
Prop 8"W
Prop 8"S

Developer/Applicant:

Howard Patrick [Pat] Barry, AIA MELP JD
Senior Manager/Project Executive
University of Maryland Medical System
Corporate Facilities
Planning | Design | Construction
6th Floor | 6-N-604
110 South Paca Street
Baltimore, MD 21201
Phone: 410-3289707
Email: howard.barry@umm.edu

Certificate of Need Plan
Parcel "A" Block "A"
Laurel Regional Hospital
Plat Book: CEC 92 Plat No. 71
Laurel Regional Hospital
Laurel Election District Number 10
Prince George's County, Maryland

I hereby certify that these documents were prepared or approved by me, and that I am a duly licensed professional engineer under the laws of the State of Maryland.
License No: 12243 Type: PROFESSIONAL Exp Date: 12.17.18

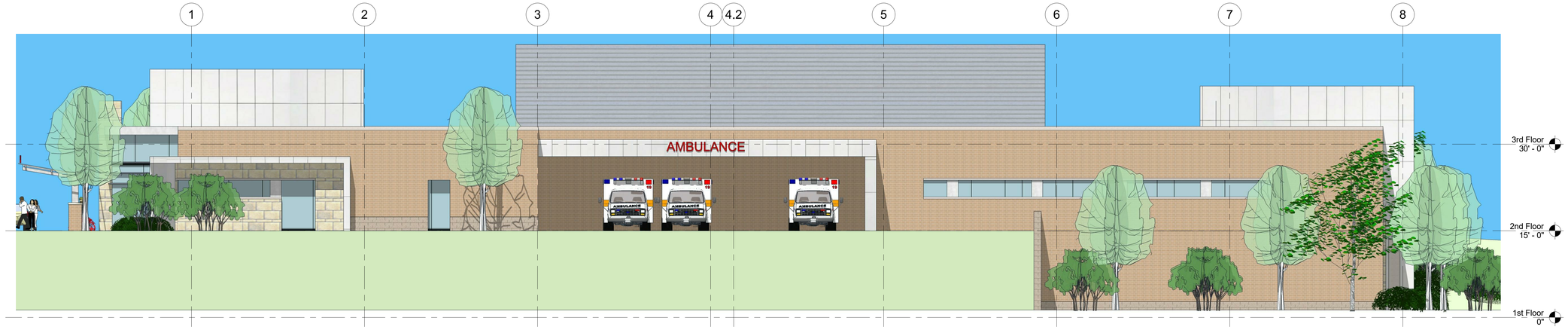
REVISIONS:

JOYCE ENGINEERING CORPORATION
CIVIL ENGINEERING LAND SURVEYING LAND PLANNING CONSTRUCTION MANAGEMENT
10754 BALTIMORE AVENUE • BELTSVILLE, MARYLAND 20705
TEL: (301) 595-6333 FAX: (301) 309-6630 WEB: www.joyceeng.com

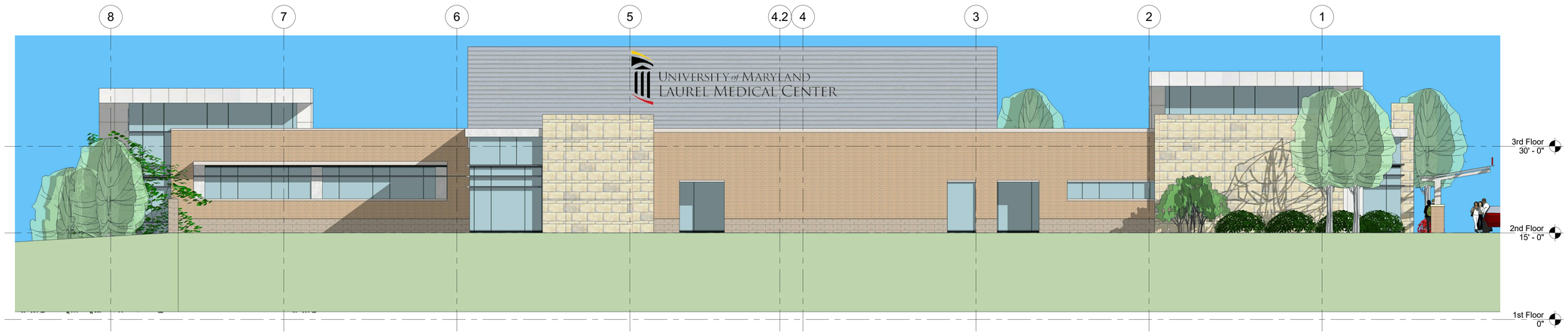
DESIGN: WAJ	DATE: June 2017	JOB No.: 93002FMF	
DRAFT: HAL	COMP: JEC	SCALE: 1"=40'	
CHECK: JEC ☐	SURVEY: CW-JR-MM	SHEET: 1 OF 1	

CN-1

Drawing name: R:\Land Projects\93022 - Greater Laurel Hospital\dwg\Ambulatory Care Center\93022-CON-1.Phase1.dwg
Plotted: Mar 01, 2018 - 9:31am



1 EAST ELEVATION
SCALE: 1/8" = 1'-0"



2 WEST ELEVATION
SCALE: 1/8" = 1'-0"

UNIVERSITY of MARYLAND
MEDICAL SYSTEM

LAUREL MEDICAL CENTER

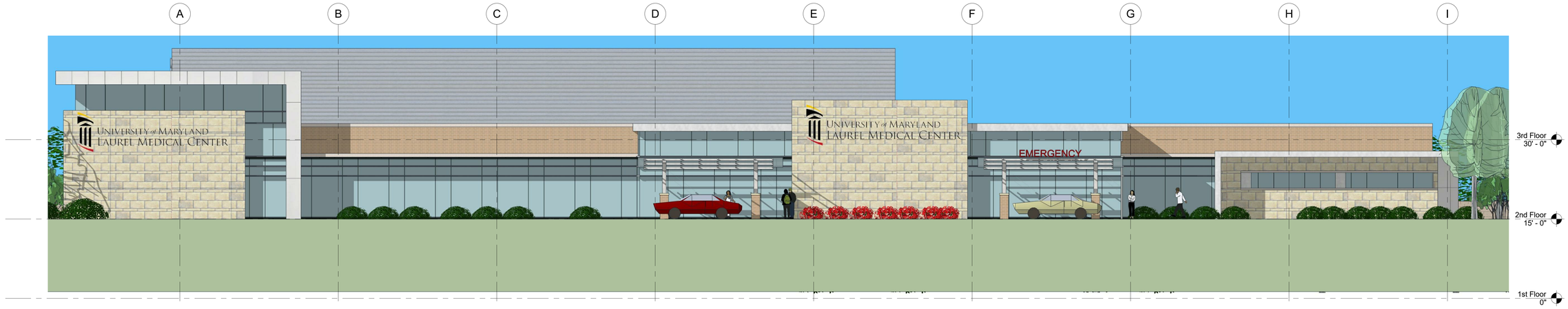
EXTERIOR
ELEVATIONS

LAUREL, MD

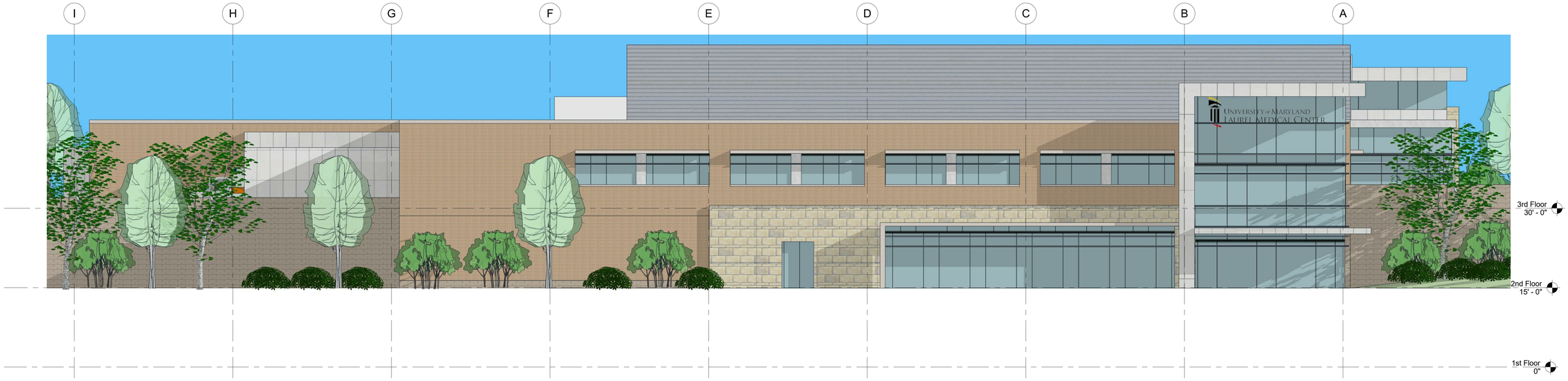
February 21,2018

1/8" = 1'-0"

WILMOTSANZ
ARCHITECTURE
PLANNING



1 SOUTH ELEVATION
SCALE: 1/8" = 1'-0"



2 NORTH ELEVATION
SCALE: 1/8" = 1'-0"

UNIVERSITY of MARYLAND
MEDICAL SYSTEM

LAUREL MEDICAL CENTER

EXTERIOR
ELEVATIONS

LAUREL, MD

1/8" = 1'-0"

February 21,2018

WILMOTSANZ
ARCHITECTURE
PLANNING

EXHIBIT 3

U□ □S - Capital Region □ealth

Laurel Regional □ospital Service Area - Population by Age Cohort

2010 - 202□

	2010	2011	2012	201□	201□	201□	201□	201□	201□	201□	2020	2021	2022	202□	202□	Cumulative 2010-201□	Cumulative 201□ - 202□
Ages 0-44	684,698	686,340	687,985	689,634	691,288	692,945	694,606	696,272	697,941	698,168	698,396	698,623	698,850	699,078	699,306		
□ *Change*		*0*.2□	*0*.2□	*0*.2□	*0*.2□	*0*.2□	*0*.2□	*0*.2□	*0*.2□	*0*.0□	*0*.0□	*0*.0□	*0*.0□	*0*.0□	*0*.0□	*1*□□	*0*.2□
Ages 45-64	272,737	275,520	278,332	281,172	284,041	286,940	289,868	292,826	295,814	297,718	299,634	301,563	303,504	305,457	307,423		
□ *Change*		*1*.0□	*1*.0□	*1*.0□	*1*.0□	*1*.0□	*1*.0□	*1*.0□	*1*.0□	*0*.6□	*0*.6□	*0*.6□	*0*.6□	*0*.6□	*0*.6□	*8*.5□	*3*.□□
Ages 65-74	60,154	63,262	66,530	69,967	73,582	77,383	81,381	85,585	90,007	93,909	97,979	102,226	106,658	111,281	116,105		
□ *Change*		*5*.2□	*5*.2□	*5*.2□	*5*.2□	*5*.2□	*5*.2□	*5*.2□	*5*.2□	*4*.3□	*4*.3□	*4*.3□	*4*.3□	*4*.3□	*4*.3□	*4*□*6*□	*2*□*0*□
Ages 75□	48,452	49,826	51,239	52,693	54,187	55,724	57,304	58,930	60,601	62,943	65,375	67,900	70,524	73,249	76,079		
□ *Change*		*2*.8□	*2*.8□	*2*.8□	*2*.8□	*2*.8□	*2*.8□	*2*.8□	*2*.8□	*3*.□□	*3*.□□	*3*.□□	*3*.□□	*3*.□□	*3*.□□	*25*.*1*□	*25*.*5*□
□otal Population	**1,0□□,0□1**	**1,0□□,□□□**	**1,0□□,0□□**	**1,0□□,□□□**	**1,10□,0□□**	**1,112,□□2**	**1,12□,1□0**	**1,1□□,□1□**	**1,1□□,□□□**	**1,1□2,□□□**	**1,1□1,□□□**	**1,1□0,□1□**	**1,1□□,□□□**	**1,1□□,0□□**	**1,1□□,□1□**		
□ *Change*		*0*.8□	*0*.□□	*0*.□□	*0*.□□	*0*.□□	*0*.□□	*0*.□□	*0*.□□	*0*.□□	*0*.8□	*0*.8□	*0*.8□	*0*.8□	*0*.8□	□.*3*□	*4*.8□

Source: Environics (Spotlight)

EXHIBIT 4

Current Status: *Active*

PolicyStat ID: *4598699*

Effective:	*02/2018*
Approved:	*02/2018*
Last Reviewed:	*02/2018*
Review:	*02/2021*
Owner:	*Bill Broslus: CFO*
Policy Area:	*Finance*
References:	
Applicability:	*UM Capital Region Health* *UM Laurel Regional Hospital* *UM Prince George's County Hospital*

UNIVERSITY of MARYLAND CAPITAL REGION HEALTH

Public Information Regarding Charges

PURPOSE:

This policy is intended to provide information to the public regarding estimated charges for services at acute care hospitals owned and operated by University of Maryland Capital Region Health in compliance with COMAR l0.24.10A (1).

POLICY:

Information regarding hospital services and charges shall be made available to the public upon request, and on the internet site of each acute care hospital in University of Maryland Capital Region Health.

PROCEDURE:

A representative list of services and estimated charges will be available to the public in written form upon request , and via the health system website.

A. Patient Financial Services Department shall be responsible for maintaining and updating the list of estimated charges on a quarterly basis.

    1. The list shall include estimated charges for the most commonly used inpatient and outpatient charges. The published charges will be consistent with hospital rates as approved by the Maryland Health Services Cost Review Commission (HSCRC).

        a. The Patient Access Department shall be responsible for ensuring that the written information is made available to the financial counselors and Patient Financial Services Customer Service area.

        b. The Marketing and Communications Department shall be responsible for ensuring that the information is available to the public on the UM Capital Region Health website.

        c. The Patient Access and Patient Financial Services Departments shall be responsible for distribution of patient information on **estimated charges**.

The Directors of the Patient Access Department and the Patient Financial Services Department shall ensure that appropriate education and training is provided to their staff related to charge estimates and the Charge Description Master.

OWNER:

Patient Financial Services

Patient Access Services

Information Management

Attachments:

Estimated Average Charge for Common Procedures - Nov 2017.pdf
UMCRH Sliding Fee Scale 2018 FAP Program.pdf

Approval Signatures : William A Brosius Date: 3/1/2018

Approver	Date
Bill Brosius: CFO	02/2018

EXHIBIT 5

Estimated Average Charge for Common Inpatient & Outpatient Procedures (updated February 2018)

The tables below provide estimated average charges for common inpatient and outpatient procedures at UM Capital Region Health. These tables are updated quarterly and are based on the patient charges actually incurred for these services during the previous twelve months. They may be used by patients to estimate the charge for services that they may incur. Please note that these are only estimates and are subject to change without notice. The actual cost of a procedure may be higher or lower based on factors unique to each patient's case, including the length of stay and medical complexity of the care provided. Questions regarding an estimated charge can be directed to a Financial Counselor at (301) 618-3100.

These estimates reflect hospital charges only. They do not include physician or other provider fees that are billed separately from the hospital fees. These other providers may include an anesthesiologist, hospitalist, pathologist, radiologist, cardiologist, emergency room physician and other specialists who may have participated in the care of the patient. Questions regarding a bill from one of these providers should be directed to that provider's billing office.

Most Frequent Inpatient Medical/Surgical Cases	Estimated Average Charge
Acute Embolism & Thrombosis	$11,620.91
Acute Kidney Failure	$11,595.00
Acute Respiratory Failure	$29,633.31
Anemia	$8,743.27
Chronic Obstructive Pulmonary Disease	$14,328.73
Diabetes	$10,990.62
Heart Disease	$36,422.66
Heart Failure	$14,391.75
Knee & Lower Leg Procedures	$46,209.81
Pneumonia	$13,304.03
Renal Failure	$16,936.04
Seizure	$10,541.52
Septicemia	$21,422.42
Syncope & Collapse	$8,285.36
CVA precerebral occlusion with Infarction	$19,507.22

Most Frequent Inpatient Obstetric and Newborn Cases	Estimated Average Charge
Vaginal Delivery	$7,395.18
Cesarean Delivery	$9,150.86
Labor& Delivery w Complications	$8,041.00
Abnormal Fetal Heart Rate Comp L & D	$11,063.31

Most Frequent Inpatient Psychiatric Cases	Estimated Average Charge
Schizophrenia	$12,007.92
Major Depressive Disorders	$5,619.03
Bipolar Disorders	$8,829.68
Alcohol Abuse	$10,816.91
Acute Anxiety & Delirium States	$9,726.81
Other Drug Abuse & Dependencies	$11,708.87

Most Frequent Outpatient Surgical Cases	Estimated Average Charge
EGD with Closed Biopsy	$1,808.32
Endoscopic Polypectomy of Large Intestine	$1,958.51
Colonoscopy	$1,685.48
Lap/Chole	$4,152.58
Other Excision of lesion of Uterus	$3,722.40
Ultrasonography of Left & Right Heart	$6,345.94
Urinary Filtration	$6,258.07

Most Frequent Laboratory Services	Estimated Average Charge
Drug Screen each drug	$16.24
CBC W/AUTO DIFF	$20.69
URINALYSIS WITH MICORSCOPIC IF	$8.28
BASISC METABOLIC PANEL	$22.76
COMP METABOLIC PANEL	$31.04
URINALYSIS MICROSCOPIC	$10.38
GLUCOMETER	$16.54
TROPONIN T	$51.65
TOTAL CK	$12.43
U BETA HCG GL	$20.69

Most Frequent Outpatient Diagnostic Imaging Services	Estimated Average Charge
MRI 3D Reconstruction	$60.82
X Ray Chest 2 views	$77.44
X Ray Chest 1 view frontal	$61.96
CT head or Brain w/o contrast	$56.94
CT Spine Cervical w/o contrast	$100.33
CT ABD & Pelvis w contrast	$162.13
X ray pelvis 1 or 2 views	$92.93
Ultrasound Obstetric Sonogram 1st Trimester< 14 weeks	$325.25
CT Maxillofacial without contrast	$73.22
CT Thorax w Contrast	$127.45

EXHIBIT 6

Current Status: *Active* **PolicyStat ID:** *4635463*

Effective:	*04/2013*
Approved:	*02/2018*
Last Reviewed:	*02/2018*
Review:	*02/2021*
Owner:	*Bill Brosius: CFO*
Policy Area:	*Finance*
References:	
Applicability:	*UM Capital Region Health* *UM Laurel Regional Hospital* *UM Prince George's County Hospital*

Financial Assistance Program, 210-01

PURPOSE:

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

POLICY:

Capital Region Health (CRH) is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for emergent and medically necessary care based on their individual financial situation.

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

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

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

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

PROGRAM ELIGIBILITY

Consistent with their mission to deliver compassionate and high quality healthcare services and to advocate

for those who do not have the means to pay for medically necessary care, CRH hospitals strive to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

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

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

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

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

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

4. Patient convenience items

5. Patient meals and lodging

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

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

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

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

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

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

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

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

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

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

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

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

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

Presumptive Financial Assistance

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

a. Active Medical Assistance pharmacy coverage

b. SLMB coverage

c. PAC coverage

d. Homelessness

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

f. Medical Assistance spend down amounts

g. Eligibility for other state or local assistance programs

h. Patient is deceased with no known estate

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

j. Non-US Citizens deemed non-compliant

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

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

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

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

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

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

PROCEDURE:

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

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

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

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

    c. Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance. Determination of Probable Eligibility will be provided within

two business days following a patient's request for charity care services, application for medical assistance, or both

d. Upon receipt of the patient's application, they will have thirty (30) days to submit the required documentation to be considered for eligibility. If no data is received within the 30 days, a denial letter will be sent notifying that the case is now closed for lack of the required documentation. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to. The Financial Assistance application process will be open up to at least 240 days after the first post-discharge patient bill is sent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Once a patient is approved for Financial Assistance, Financial Assistance coverage may be effective for the month of determination, up to 3 years prior, and up to six (6) calendar months in to the future. However, there are no limitations on the Financial Assistance eligibility period. Each eligibility period will be determined on a case-by-case basis. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance. In addition, changes to the patient's income, assets, expenses or family status are expected to be communicated to the Financial Assistance Program Department. All Extraordinary Collections Action activities, as defined below, will be terminated once the patient is approved for financial assistance and all the patient responsible balances are paid.

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

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

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

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

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

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

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

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

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

Financial Hardship

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

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

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

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

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

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

Once a patient is approved for Financial Hardship Assistance, coverage will be effective starting the month of the first qualifying date of service and up to the following twelve (12) calendar months from the application evaluation completion date. Each patient will be evaluated on a case-by-case basis for the eligibility time frame according to their spell of illness/episode of care. It will cover the patient and the immediate family members living in the household for the approved reduced cost and eligibility period for medically necessary treatment.

Coverage shall not apply to elective or cosmetic procedures. However, the patient or guarantor must notify the hospital of their eligibility at the time of registration or admission. In order to continue in the program after the expiration of each eligibility approval period, each patient must reapply to be reconsidered. In addition, patients who have been approved for the program must inform the hospitals of any changes in income, assets, expenses, or family (household) status within 30 days of such change(s).

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

Appeals

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

Judgments

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

Attachments:

Financial Assistance Application
Financial Assistance Program Sliding Fee Scale - 2017

Approval Signatures

Approver	Date
Bill Brosius: CFO	02/2018

EXHIBIT 7

University of Maryland Prince George's Hospital Center

University of Maryland Laurel Regional Hospital

University of Maryland Bowie Heath Center

Patient Information Sheet

Hospital Financial Assistance Policy:

- This hospital provides emergency or urgent care to all patients regardless of ability to pay.
- You are receiving this information sheet because under Maryland law, this hospital must have a financial assistance policy and must inform you that you may be entitled to receive financial assistance with the cost of medically necessary hospital services if you have a low income, do not have insurance, or your insurance does not cover your medically-necessary hospital care and you are low-income.
- This hospital meets or exceeds the legal requirement by providing financial assistance based on: medically necessary services, family size, income, eligibility to sliding fee scale discounts up to 300% of the current Federal Poverty Guidelines. (Update financial information must be provided every six months.)
- **Patients' Rights and Obligations**
    - Those patients that meet the financial assistance policy criteria described above may receive assistance from the hospital in paying their bill.
    - If you believe you have wrongly been referred to a collection agency, you have the right to contact the hospital to request assistance (see contact information below).
    - You may be eligible for Maryland Medical Assistance. Medical Assistance is a program funded jointly by the state and federal governments that pays the full cost of health coverage for low-income individuals who meet certain criteria (see contact information below).

Patients' Obligations

- For those patients with the ability to pay their bill, it is the obligation of the patient to pay the hospital in a timely manner.
- This hospital makes every effort to see that patient accounts are properly billed, and patients may expect to receive a uniform summary statement within 30 days of discharge. It is your responsibility to provide correct insurance information.
- If you do not have health coverage, we expect you to pay the bill in a timely manner. If you believe that you may be eligible under the hospital's financial assistance policy, or if you cannot afford to pay the bill in full, you should contact the business office promptly **301-618-3100**, to discuss this matter.
- If you fail to meet the financial obligations of this bill, you may be referred to a collection agency. In determining whether a patient is eligible for free, reduced cost care, or a payment plan, it is the obligation of the patient to provide accurate and complete financial information. If your financial position changes, you have an obligation to promptly contact the business office to provide updated/corrected information.

Contacts:

- If you have questions about your bill, please contact the hospital Customer Service Department: **301-618-3100**. A hospital representative will be glad to assist you with any questions you may have.
- If you wish to get more information about or apply for the hospital's financial assistance plan, you may call **301-618-3250** or download the uniform financial assistance application from the following link: http://www.hscrc.state.md.us/consumers_uniform.cfm
- If you wish to get more information about or apply for Maryland Medical Assistance you may contact one of our hospitals CAC (Certified Application Counselors – 301-618-3250) or your local Department of Social Services by phone 1-800-332-6347; TTY: 1-800-925-4434; or internet www.dhr.state.md.us .

Physician Services:

Physician services provided during your stay will be billed separately and are *not* included on your hospital billing statement.

For Medicare discharge and appeal rights:

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

For mental and behavioral health services:

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

For medication concerns:

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

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

Financial Information

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

You may receive a bill from UM Capital Region Health for facility fees and from individual physicians for professional fees.

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

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

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

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

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
Life and Health / Appeals and Grievances
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: (410) 468-2000 or (800) 492-6116
TTY: (800) 735-2258
Fax: (410) 468-2270 or (410) 468-2260

WHAT YOU SHOULD KNOW AS A PATIENT

UNIVERSITY of MARYLAND CAPITAL REGION HEALTH

UM Bowie Health Center
UM Capital Surgery Center
UM Family Health
UM Laurel Regional Hospital
UM Prince George's Hospital Center
Rachel H. Pemberton Senior Health Center

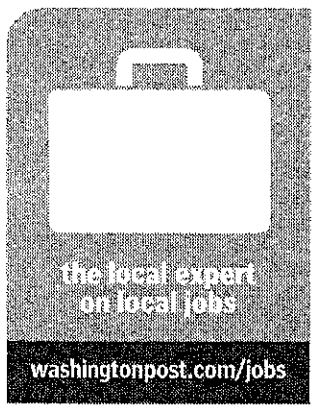
EXHIBIT 8

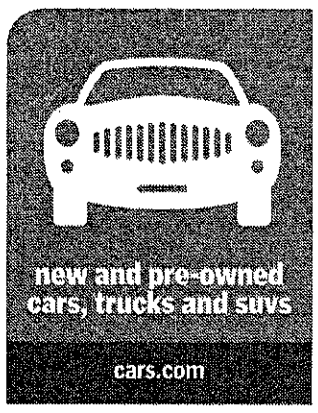
The Washington Post

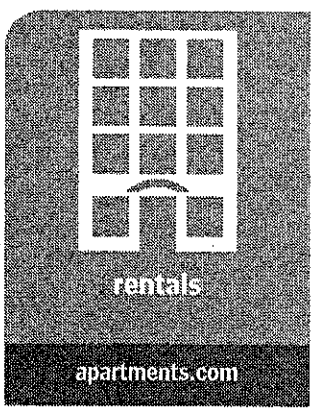
CLASSIFIED

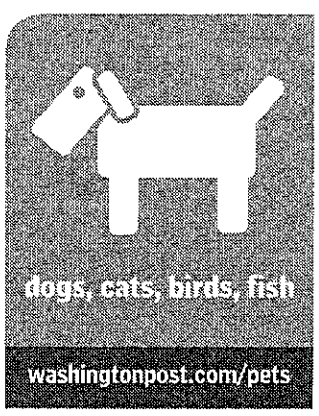
washingtonpost.com/classifieds

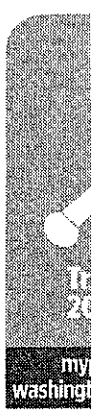
THURSDAY, FEBRUARY 1, 2018











For Jobs advertisements, go to **washingtonpost.com/recruit** or call 202-334-4100 (toll free 1-800-765-3675)

To place an ad, go to **washingtonpostads.com** or call 202-334-6200
Non-commercial advertisers can now place ads 24/7 by calling 202-334-6200

Legal Notices - 202-334-7007
Auctions, Estate Sales, Furniture - 202-334-7029
Biz Ops/Services - 202-334-5787

FREE UNDER $
If the merchandise you're selling is priced under $250, your
Go to washingtonpostads.com for complete details and

205 Antiques

BUY RECORD COLLECTIONS!—I drive to you, pay CASH, and haul them away. Call 571-830-5871

208 Appliances

Kirby Sentria Vacuum Cleaner—$249 Looks and works like new. Cost $1800 new. 571-606-0319

THERMAL COFFEE MAKER—$26, B & D, CM 1609. New, unopened box. Laurel, MD, 301-498-8019

225 Collectibles

AURORA SLOT CARS Wanted—$100 & up, cars/sets, +Atlas, AFX, Tyco, AMT, Revell, K&B. 703-960-3594

BUY RECORD COLLECTIONS!—I drive to you, pay CASH, and haul them away. Call 571-830-5871

SMALL COLLECTOR PAYS CASH FOR COINS/COLLECTIONS. Call Al, 301-807-3266. Will Come to you!

WANTED: $ FOR MILITARY: WWI, WWII, VN. Jackets, Hats, Knives, Medals, ETC. $100/MORE FOR SOME OLD HELMETS, 301-657-8994

229 Clothing, Shoes & Accessories

New luggage— $50, Washington, DC, 630-220-4114

245 Electronics

Therapy Lamp—32 NatureBright Light and Ion Therapy Lamp $32, Alexandria, VA, 571-431-1501

260 Furniture

NEW QUEEN PILLOWTOP MATT. SET—150.00 Sykesville, MD, CALL 240-426-0699

Showcases Display locking—$240, Olney, MD, 301-750-4164

Student Desk & Chair—$45 Metal 24x40 top with 2 drawers, v/good cond. roller chair, 301-345-1693

265 Home & Garden

BRICK—$249 New 10 Hole Bldg Size, less or more if need (apprx 2000) .45 each 301-345-1693

Car Seats—33 Generic Infant $33 or Graco child car seat $44 (70 both) Alexandria, VA 571431-1501

Solid Hardwood Brazilian Cherry Flooring - 3600 S.F., $2.50 per SF. 301-860-1190

275 Merchandise Wanted

Buy Chinese furniture,jewelry, painting, porcelain, jade — 249 c: 703 966 9935, sharonantique@ gmail.com

Freon R12 WANTED—Certified buyer will pick up, pay CASH for cylinders and cases of cans. 312-291-9169 RefrigerantFinders.com

BUY RECORD COLLECTIONS!—I drive to you, pay CASH, and haul them away. Call 571-830-5871

Old Bottles Of Bourbon—$0 Seeking full/sealed bottles of vintage bourbon and rye. Alex 443-223-7669

Radio tubes—249 WANTED ham radios huge speakers tube hif amps 202 527 9501, vcvdc@msn.com

RECORDS - I pay cash for 50s, 60s, & 70s. Categories: Jazz, Soul, R&R, R&B. Call 703-865-6050

VINTAGE HI-FI TUBE AMPS—1 TUBES BIG SPKRS MCINTOSH AMPS MOST CASH 410-740-5222 50's 60's 70's

291 Sporting Goods & Services

Bicycles—$20, McLean, VA, 703-356- 0170, Kids and adult bikes ready to roll

FOLDING BIKE—$65 20" Silver Unis folding bike in good shape, liv mes- sage, 301-345-1693

Nordic Track Exercise Slider—$195 MD-Folds up easy to fit in car. Cost $800 new. 571-606-0319

SCUBAGEAR Large—$249 Wet- suit,Fins,Gloves,Boots,Mask/Snrkl, Wght belt/wghts, 301-345-1693

355 Garage Sales, VA

SPRINGFIELD- 8000 Forbes Pl. Ste# 102. Sat 02/03, 9am-3pm, School Closing Sale! Desks, tables, chairs, computer monitors, file cabinets, bookshelves, kitchenware, Xmas decorations & so much more!

360 Estate Sales

5143 15th St N. Arlington, VA
TM SALES Thurs - Sun, 9-4
Mid century furniture, antiques, zenith radio, sterling jewelery, oriental rugs, paintings and prints, housewares. For more info see www.estatesales.net

610 Dogs for Sale

Bichon/ShihTzu—Fuzzywuzzy Teddy bear pups! Adorable real life puppy dogs. Truly sweet & special little pups. Shichon 8/9wks $675 Call our home: 703-397-6141

BOXER PUPPIES - AKC, champion blood line, 5 males, 2 females. Ready for new home 2/28. Shots and vet checked. Call 304-229-5300

Bulldog mix, Yorkies & more—Pup- pies for Sale. 304-904-6289, Cash, CC, Easy Finance, wvpuppy.com, 59 East Rd, Martinsburg WV, exit16E

Cavachon—Cava Chon Puppies ready & wagging! Cavachon pups in our home and raised with TLC 9wks 703-577-1069 $950-1150.00 www.DCDogFinders.com

Cockapoo & Labradoodle—FAMILY

622 Adopt Cats

4Paws—Adopt fr 30+ cat & kitten $v Sat 1-5 Fairfax Petco www.fourpaws.org 703-352-3300 CFC #34517

815 Legal Notices

BEFORE THE PUBLIC SERVICE COMMISSION OF MARYLAND

IN THE MATTER OF THE APPLICATION OF ENERGY VENTURES IPP, LLC FOR A CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY TO CONSTRUCT A 10 MW SOLAR PHOTOVOLTAIC GENERATING FACILITY IN PRINCE GEORGE'S COUNTY, MARYLAND

CASE NO. 9469

NOTICE OF HEARING

A prehearing conference in the above-entitled matter is scheduled for Monday, February 5, 2018, beginning at 11:00 a.m., concerning Energy Ventures IPP, LLC's application for a Certificate of Public Convenience and Necessity (CPCN) from the Maryland Public Service Commission. The prehearing conference will be held in the Maryland Public Service Commission's 19th floor hearing room, located in William Donald Schaefer Tower, 6 St. Paul Street, Baltimore, Maryland 21202-6806. Energy Ventures IPP, LLC has proposed to construct a 10 MW solar photovoltaic generating facility in Prince George's County, Maryland.

Hearing topics may include:

*Any preliminary matters, including the consideration of any petitions to intervene; and

*The establishment of a procedural schedule.

Persons who seek to intervene in this proceeding are directed to file petitions to intervene with the Commission's Executive Secretary, David J. Collins, at William Donald Schaefer Tower, 6 St. Paul Street, Baltimore, Maryland 21202-6806. Petitions must reference Case No. 9469 and be filed by close of business February 2, 2018.

IN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MD

IN THE MATTER OF ANDREA CECILIA FUENTES-AGUILAR FOR CHANGE OF NAME TO: ANDREA CECILIA FUENTES - ALVARENGA FAMILY LAW: 150511FL
Blance Cecilia Alvarenga Aguilar Petitioner

PUBLICATION NOTICE

The above Petitioner has filed a Petition for change of Name of a Minor in which he/she seeks to change his/her name from Andrea Cecilia Fuentes-Aguilar to Andrea Cecilia Fuentes-Alvarenga. The petitioner is seeking a name change because: there was an error on the minor child's last name. The mother's maternal last name (Aguilar) paternal last name (Alvarenga).
Any person may file an objection to the Petition on or before the 16th day of February, 2018. The objection must be supported by an affidavit and served upon the Petitioner in accordance with Maryland Rule 1-321. failure to file an objection or affidavit within the time allowed my result in a judgement by default or the grant of the relief sought.
This Notice is to be published the the Washington Post newspaper of general circulation in Montgomery County, Maryland, one successive week on or before the 1st day of February, 2018.

/s/ Barbara H. Meiklejohn
CLERK, Circuit Court
Montgomery County, Maryland

IN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MD

IN THE MATTER OF AJAYDEEP S. BIAN FOR CHANGE OF NAME TO: AJAYDEEP SINGH BAINS FAMILY LAW: 150493FL

PUBLICATION NOTICE

The above Petitioner has filed a Petition for change of Name in which he/she seeks to change his/her name from Ajaydeep S. Bian to Ajaydeep Singh Bains. The petitioner is seeking a name change because: Incorrect spelling.
Any person may file an objection to the Petition on or before the 16th day of February, 2018. The objection must be supported by an affidavit and served upon the Petitioner in accordance with Maryland Rule 1-321. failure to file an objection or affidavit within the time allowed my result in a judgement by default or the grant of the relief sought.
This Notice is to be published the the Washington Post newspaper of general circulation in Montgomery County, Maryland, one successive week on or before the 1st day of February, 2018.

/s/ Barbara H. Meiklejohn
CLERK, Circuit Court
Montgomery County, Maryland

IN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MD

IN THE MATTER OF INDER SINGH BIAN FOR CHANGE OF NAME TO: INDER SINGH BAINS FAMILY LAW: 150498FL

PUBLICATION NOTICE

The above Petitioner has filed a Petition for change of Name in which he/she seeks to change his/her name from Inder Singh Bian to Inder Singh Bains. The petitioner is seeking a name change because: Incorrect spelling.
Any person may file an objection to the Petition on or before the 16th day of February, 2018. The objection must be supported by an affidavit and served upon the Petitioner in accordance with Maryland Rule 1-321. failure to file an objection or affidavit within the time allowed my result in a judgement by default or the grant of the relief sought.
This Notice is to be published the the Washington Post newspaper of general circulation in Montgomery County, Maryland, one successive week on or before the 1st day of February, 2018.

/s/ Barbara H. Meiklejohn
CLERK, Circuit Court
Montgomery County, Maryland

IN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MD

IN THE MATTER OF GURPREET SINGH BIAN FOR CHANGE OF NAME TO: GURPREET SINGH BAINS FAMILY LAW: 150492FL

PUBLICATION NOTICE

The above Petitioner has filed a Petition for change of Name in which he/she seeks to change his/her name from Gurpreet Singh Bian to Gurpreet Singh Bains. The petitioner is seeking a name change because: Incorrect spelling.
Any person may file an objection to the Petition on or before the 16th day of February, 2018. The objection must be supported by an affidavit and served upon the Petitioner in accordance with Maryland Rule 1-321. failure to file an objection or affidavit within the time allowed my result in a judgement by default or the grant of the relief sought.
This Notice is to be published the the Washington Post newspaper of general circulation in Montgomery County, Maryland, one successive week on or before the 1st day of February, 2018.

/s/ Barbara H. Meiklejohn
CLERK, Circuit Court
Montgomery County, Maryland

IN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MD

IN THE MATTER OF JULIO ELOM-TSATSU TAMAKLOE FOR CHANGE OF NAME TO:

815 Legal Notices

321. failure to file an objection or affidavit within the time allowed my result in a judgement by default or the grant of the relief sought.
This Notice is to be published the the Washington Post newspaper of general circulation in Montgomery County, Maryland, one successive week on or before the 1st day of February, 2018.

/s/ Barbara H. Meiklejohn
CLERK, Circuit Court
Montgomery County, Maryland

IN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MD

IN THE MATTER OF SUDARAT NGUYEN FOR CHANGE OF NAME TO: SUDARAT BOWORNPHAKDI FAMILY LAW: 150615FL

PUBLICATION NOTICE

The above Petitioner has filed a Petition for change of Name in which he/she seeks to change his/her name from Sudarat Nguyen to Sudarat Bowornphakdi. The petitioner is seeking a name change because: Divorce.
Any person may file an objection to the Petition on or before the 16th day of February, 2018. The objection must be supported by an affidavit and served upon the Petitioner in accordance with Maryland Rule 1-321. failure to file an objection or affidavit within the time allowed my result in a judgement by default or the grant of the relief sought.
This Notice is to be published the the Washington Post newspaper of general circulation in Montgomery County, Maryland, one successive week on or before the 1st day of February, 2018.

/s/ Barbara H. Meiklejohn
CLERK, Circuit Court
Montgomery County, Maryland

IN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MD

IN THE MATTER OF GURPREET SINGH BIAN FOR CHANGE OF NAME TO: GURPREET SINGH BAINS FAMILY LAW: 150492FL

PUBLICATION NOTICE

The above Petitioner has filed a Petition for change of Name in which he/she seeks to change his/her name from Gurpreet Singh Bian to Gurpreet Singh Bains. The petitioner is seeking a name change because: Incorrect spelling.
Any person may file an objection to the Petition on or before the 16th day of February, 2018. The objection must be supported by an affidavit and served upon the Petitioner in accordance with Maryland Rule 1-321. failure to file an objection or affidavit within the time allowed my result in a judgement by default or the grant of the relief sought.
This Notice is to be published the the Washington Post newspaper of general circulation in Montgomery County, Maryland, one successive week on or before the 1st day of February, 2018.

/s/ Barbara H. Meiklejohn
CLERK, Circuit Court
Montgomery County, Maryland

IN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MD

IN THE MATTER OF AJAYDEEP S. BIAN FOR CHANGE OF NAME TO: AJAYDEEP SINGH BAINS FAMILY LAW: 150493FL

PUBLICATION NOTICE

The above Petitioner has filed a Petition for change of Name in which he/she seeks to change his/her name from Ajaydeep S. Bian to Ajaydeep Singh Bains. The petitioner is seeking a name change because: Incorrect spelling.
Any person may file an objection to the Petition on or before the 16th day of February, 2018. The objection must be supported by an affidavit and served upon the Petitioner in accordance with Maryland Rule 1-321. failure to file an objection or affidavit within the time allowed my result in a judgement by default or the grant of the relief sought.
This Notice is to be published the the Washington Post newspaper of general circulation in Montgomery County, Maryland, one successive week on or before the 1st day of February, 2018.

/s/ Barbara H. Meiklejohn
CLERK, Circuit Court
Montgomery County, Maryland

IN THE CIRCUIT COURT FOR MONTGOMERY COUNTY, MD

IN THE MATTER OF FABIO DELAEFUI TAMAKLOE FOR CHANGE OF NAME TO: FABIO DELAYAO BAXTER FAMILY LAW: 150549FL

PUBLICATION NOTICE

The above Petitioner has filed a Petition for change of Name in which he/she seeks to change his/her name from Fabio Delaefui Tamakloe to Fabio Delayao Baxter. The petitioner is seeking a name change because: He would like to take on the name of his stepfather, a person that he has a close bond and relationship with.
Any person may file an objection to the Petition on or before the 16th day of February, 2018. The objection must be supported by an affidavit and served upon the Petitioner in accordance with Maryland Rule 1-321. failure to file an objection or

815 Legal Notices

LEGAL NOTICE

In the Court of Common Pleas, Division of Domestic Relations, Lake County, Ohio located at 25 North Park Place, Painesville, Ohio 44077, and pursuant to Civil Rule 4.4 Legal Notice is hereby issued in the matter of Cecilia Calderon-Mayen v. Otto Rene Mayen Cordova upon:

Otto Rene Mayen Cordova, whose last known address was 11721 Emack Road, Beltsville, Maryland 20705, otherwise whose place of residence is unknown and cannot by reasonable diligence be ascertained, will take notice on the 26th day of December, 2017, the plaintiff, Cecilia Calderon-Mayen filed a Complaint for Divorce against him in the Court of Common Pleas of Lake County, Ohio, the same being Case No. 17 DR 000742 in said Court, praying therein for an Absolute Divorce from the Defendant; orders regarding a division of property, debts, distributive award and spousal support consistent with the evidence; for an order of fees and costs consistent with the evidence; and for such other and further relief as the Court deems equitable and necessary.

Said party is required to answer with 28 days after last publication, which shall be conspicuously published once a week for six (6) successive weeks pursuant to Civil Rule and Local Rule. Service is complete on the date of last publication.

NOTICE TO OLIVIER JAVAUDIN

IN THE UNITED STATES BANKRUPTCY COURT FOR THE EASTERN DISTRICT OF VIRGINIA ALEXANDRIA DIVISION

IN RE:
CASSANDRA L. JOHNSON
Debtor Case No. 17-11893-BFK

JANET M. MEIBURGER, Trustee,
Plaintiff,
v. Adv. Pro. No. 17-01117-BFK
OLIVIER JAVAUDIN
Defendant.

NOTICE OF ADVERSARY PROCEEDING

Please take notice that a lawsuit has been filed against you in the bankruptcy case of Cassandra L. Johnson, Case No. 17-11893. The Complaint requests approval to sell 3908 Woodley Drive, Alexandria, VA 22309. A copy of the Complaint has been mailed to you at 3908 Woodley Drive, Alexandria, VA 22309. You are required to submit a motion or answer to the Complaint. If you fail to respond to the Complaint, your failure will be deemed to be your consent to entry of a judgment by the Bankruptcy Court and judgment by default may be taken against you for the relief demanded in the Complaint. **You may obtain a copy of the Complaint and related documents from the Bankruptcy Court, 200 South Washington Street, Alexandria, VA 22314 or by contacting the Trustee, Janet M. Meiburger, The Meiburger Law Firm, P.C. (703) 556-9404, 1493 Chain Bridge Road, Suite 201, McLean, Virginia 22101.**

STATE OF CONNECTICUT
Superior Court at Bridgeport
Docket: FA11-4037815
NOTICE TO: DENNIS F. HIGHTOWER.

You are named as a defendant in a motion filed in the above named court seeking orders of contempt. To respond to this application, you must appear at the court, 1061 MAIN STREET, BRIDGEPORT, CONNECTICUT, on MARCH 1, 2018 at 9:30 A.M.
This notice is published pursuant to an ORDER OF NOTICE dated 1/19/2018.
attest:/s/ Jon Gallup
Constable

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA PROBATE DIVISION WASHINGTON, D.C. 20001-2131 2017 ADM 001470

DAVID ALLEN LYON PRO SE

NOTICE OF APPOINTMENT, NOTICE TO CREDITORS AND NOTICE TO UNKNOWN HEIRS

G. Don Westfall, whose address is 124 Sawmill Creek Dr., Nellysford, VA 22958 was appointed Personal Representative of the estate of David Allen Lyon who died on August 8, 2017 without a will and will serve without Court supervision. All unknown heirs and heirs whose whereabouts are unknown shall enter their appearance in this proceeding. Objections to such appointment shall be filed With the Register of Wills, D.C., Building A, 515 5th Street, N.W., 3rd Floor, Washington, D.C. 20001, on or before July 18, 2018. Claims against the decedent shall be presented to the undersigned with a copy to the Register of Wills or filed with the Register of Wills with a copy to the undersigned, on or before July 18, 2018, or be forever barred. Persons believed to be heirs or legatees of the decedent who do not receive a copy of this notice by mail within 25 days of its first publication shall so inform the Register of Wills, including name, address and relationship.

G. Don Westfall
PERSONAL REPRESENTATIVE
Anne Meister
REGISTER OF WILLS

VIRGINIA:
IN THE CIRCUIT COURT OF FAUQUIER COUNTY
GENERAL LEE WHITE, JR.
Plaintiff,
v. CASE NO. CL15-528
STEPHEN DAVIS, et al.
Defendants

820 Official Notices

MARYLAND DEPARTMENT OF THE ENVIRONMENT
WATER AND SCIENCE ADMINISTRATION
NOTICE OF APPLICATION RECEIVED
Montgomery County
Application for State Discharge Permit 16DP2754, NPDES Permit MD0064777:
The International Monetary Fund, Bretton Woods Recreation Center, 15700 River Rd., Germantown, MD 20874 applied for renewal of the permit to discharge an average of 15,000 gallons per day of treated domestic wastewater from the Bretton Woods Wastewater Treatment Plant located at 15700 River Road, Germantown, MD 20874 to the Potomac River.
If a written request is received by **February 15, 2018**, an informational meeting can be held to discuss the application and permitting process. Requests should be forwarded to the **Maryland Department of the Environment, Water and Science Administration, 1800 Washington Blvd., Baltimore, Maryland 21230-1708, Attn: Mr. Yen-Der Cheng, Chief, Municipal Permits Division**. Hearing-impaired persons may request an interpreter at the informational meeting by contacting Mr. Cheng at (410) 537-3363 or 1-800-633-6101, or at the above address, at least ten working days prior to the scheduled meeting.
Any person wishing to review the application should contact Mr. Cheng at the above telephone number to schedule an appointment. Copies may be obtained at a cost of $0.36 per page.

NOTICE OF JOINT PUBLIC HEARING

The Mayor and City Council and Planning Commission of the City of Gaithersburg, Maryland, will conduct a joint public hearing on Master Plan Amendment Application MP-1-17 on

TUESDAY
FEBRUARY 20, 2018
AT 7:30 P.M.

or as soon thereafter as this matter can be heard in the Council Chambers at 31 South Summit Avenue, Gaithersburg, Maryland.
This amendment includes the Historic Preservation Element of the 2018 Master Plan Update. Gaithersburg, as an incorporated city, is subject to the Land Use Article of the Annotated Code of Maryland. Land Use Division 1, §3-301(a) Plan Revisions requires the City's comprehensive master plan to be reviewed and if necessary revised and amended at least once every 10 years. Land Use Division I, §3-102(b)(1) Elements-Municipal Corporations permits the City to include additional plan elements beyond what is required, such as Historic Preservation.

Historic Preservation is the first element of the 2018 Master Plan Update to be reviewed.

Historic Preservation will present recommendations for the City's continued stewardship of its historic resources while being consistent with the State and City visions. Public comment is invited prior to and at the joint public hearing on the Historic Preservation Element.

Further information may be obtained from the Planning and Code Administration Department at City Hall, 31 South Summit Avenue, between the hours of 8 a.m. and 5 p.m., Monday through Friday, or on the City's website at http://www.gaithersburgmd.gov/services/planning-services/city-master-plan.

Rob Robinson, Long Range Planning Manager
Planning and Code Administration # 1194

Statement of Charity Care

University of Maryland Capital Region Health offers a reasonable amount of care at no charge or reduced rates to eligible persons who do not have insurance, Medicare or Medical Assistance. In addition, qualifying patients may be able to participate in an extended payment plan without interest. Eligibility for free care, reduced rates and extended payment plans will be determined on a case-by-case basis for those who cannot afford to pay for care. If you think that you may be eligible for uncompensated care, you can receive further information from the University of Maryland Capital Region Health Customer Service Department at 301-618-3100.

825 Bids & Proposals

Brazilian Naval Commission
Public Bid No. 02/18

Object: Acquisition of medical supply; audio, video and photo equipments; maneuvering and patrolling equipments and machinery and equipment, for the use of the Command of Material of the Brazilian Marine Corps (Brazilian Navy).
Documentation: The Bid with the detailed object, dates and Bid's Requirements can be downloaded from www.marinha.mil.br/cnbw/.
Proposals: Electronic Proposal with "Qualification Documents" and "Price Proposal" must be submitted via email at cnbw.bid@marinha.mil.br until February 9th/2018. Opening of Proposals will be on February 12th/2018 at the following address: Brazilian Naval Commission in Washington, 5130 MacArthur Blvd, NW, Washington DC 20016.

815 Legal Notices

LUSHA SALES
MELODY SALES
JOEY EMBREY
WILLIAM EMBREY
TAMMY EMBREY
YVETTE EMBREY
SHARRON WALLER
JOSEPH EMBREY, JR.
JUANITA THOMAS JOHNSON
WESLEY G. WASHINGTON
SYLVIA JOHNSON
OLIVER B. JOHNSON
NANCY JOHNSON
ALICE L. LEWIS JONES
GWENDOLYN LEWIS
SHARON PITCHER
ALEX PITCHER
RHODA PITCHER MENSON
MICHAEL PITCHER
DONALD RODGERS
MARY WASHINGTON FIELDS
BEVERLY PITCHER
BEVERLY CRAY
ALVIN D. CRAY
GLADYS BLACKWELL
CLARA PARKER THOMAS
ESTHER THOMAS ROBERTSON
GENEVA WEBSTER THOMAS
RUBY A. THOMAS
WALTER THOMAS
JOHN THOMAS
DENETRA THOMAS SMITH
MARIAN JOHNSON DECOSTA
JANICE E. PRESSEY ODUM
LINDA MAE LEWIS
WILLIAM H. LEWIS, JR.
GERALDINE PITCHER
KATHLYN JONES MOORE
VINCENT JONES
if living, and their heirs, stepchildren, devisees and grantees, if any there be,
PARTIES UNKNOWN
Defendants.
ORDER OF PUBLICATION
Defendants.

820 Official Notices

Notice is hereby given that the following named company at the address listed herewith has made application to engage in the business of loaning money for the license year ending December 31, 2018 as provided by the Act of Congress, approved February 14, 1913. Anyone desiring to protest against the issuance of this license should do so in writing to the Commissioner of the Department of Insurance, Securities and Banking, 810 First Street, NE, Suite 701, Washington DC 20002, in the manner prescribed by said Act: See DC Code Title 26, Chapter 9 and 16 DCMR 2.
CarFinance.com LLC
7525 Irvine Center Drive,
Suite 250, Irvine, CA 92618

The Wah Luck Senior Medical Adult Day Care Center will be located at **800 6th Street NW, Washington DC 20001.** It will be open to Senior Citizens approximately in May of 2018.

The facility will address the unmet health and social needs of participants in a day setting. The services will include: individual and group activities; cognitive memory games; field trips; and nutritious meals and snacks. Its hours will be 7:30 am to 6 pm weekdays. All services will be provided by qualified licensed professionals. The facility will work closely with the D.C. Department of Health and other health care and social service providers.

Dr. Hon Yuen Wong, Director of this Project is authorized to respond to

820 Official Notices

NOTICE TO THE PUBLIC OF AN APPLICATION BY ATLANTIC BROADBAND ENTERPRISE, LLC, FOR CERTIFICATES OF PUBLIC CONVENIENCE AND NECESSITY TO PROVIDE LOCAL EXCHANGE AND INTEREXCHANGE TELECOMMUNICATIONS SERVICES IN THE COMMONWEALTH OF VIRGINIA
CASE NO. PUR-2017-00169

On December 12, 2017, Atlantic Broadband Enterprise, LLC ("Atlantic Broadband" or "Company") filed an application with the State Corporation Commission ("Commission") for certificates of public convenience and necessity to provide local exchange and interexchange telecommunications services throughout the Commonwealth of Virginia ("Application"). The Company also requested authority to price its interexchange telecommunications services on a competitive basis pursuant to § 56-481.1 of the Code of Virginia.

Copies of the Application are available for public inspection between the hours of 8:15 a.m. and 5 p.m., Monday through Friday, excluding holidays, in the Commission's Document Control Center located on the first floor of the Tyler Building, 1300 East Main Street, Richmond, Virginia 23219. Copies of the Application also may be downloaded from the Commission's website: http://www.scc.virginia.gov/case, or may be ordered from Atlantic Broadband's counsel: Douglas D. Orvis II, Esquire, or Brett P. Ferenchak, Esquire, Morgan, Lewis & Bockius LLP, 1111 Pennsylvania Avenue, NW, Washington, D.C. 20004.

On or before February 26, 2018, any person desiring to comment on Atlantic Broadband's Application may do so by directing such comments in writing to the Clerk of the Commission at the address set forth below. Interested persons desiring to submit comments electronically may do so by following the instructions found on the Commission's website: http://www.scc.virginia.gov/case. A hard copy of the comments, whether submitted in writing or electronically, shall be served on Atlantic Broadband's counsel at the address set forth above.

On or before February 26, 2018, any person may request a hearing on Atlantic Broadband's Application. If not filed electronically, an original and fifteen (15) copies of the request for hearing shall be submitted to the Clerk of the Commission at the address set forth below. Requests shall include: (i) a precise statement of the interest of the filing party; (ii) a statement of the specific action sought to the extent then known; (iii) a statement of the legal basis for such action; and (iv) a precise statement why a hearing should be conducted in the matter. Persons filing a request for hearing shall serve a copy of their request upon Atlantic Broadband's counsel at the address set forth above.

All written communications to the Commission concerning Atlantic Broadband's Application shall be directed to Joel H. Peck, Clerk, State Corporation Commission, c/o Document Control Center, P.O. Box 2118, Richmond, Virginia 23218-2118, and shall refer to Case No. PUR 2017 00169.

ATLANTIC BROADBAND ENTERPRISE, LLC

840 Trustees Sale - DC

840 Trustees Sale - DC

Samuel I. White, P.C.
611 ROCKVILLE PIKE,
SUITE 100
ROCKVILLE, MARYLAND 20852

SUBSTITUTE TRUSTEE'S SALE OF VALUABLE RESIDENTIAL DWELLING KNOWN AS:

3129 38TH STREET NW
WASHINGTON, DC 20016

By virtue of Deed of Trust recorded in the land records of the District of Columbia recorded on January 16, 2007, as Instrument Number 2007006267, and in accordance Judgment filed on March 10, 2017 in case 2015 CA 003595 R(RP) and at the request of the party secured thereby, the undersigned Substitute Trustees will offer to sell at public auction, within the office of HARVEY WEST AUCTIONEERS, INC., 5335 WISCONSIN AVENUE, NW, SUITE 440, WASHINGTON, DC 20015-2034 on,

FEBRUARY 27, 2018 at 3:00 PM

the land and premises situated in the District of Columbia and more particularly described in the above referenced Deed of Trust and as of the date hereof designated on the Records of the Assessor of the District of Columbia for assessment purposes as:

3129 38TH STREET NW, WASHINGTON, DC 20016, LOT NUMBERED FIFTY (50) IN THE SUBDIVISION MADE BY THOMAS J. LANE, JR. OF LOT NUMBERED TWENTY-ONE (21) IN BLOCK NUMBERED ONE (1)

The property will be sold in an "AS IS WHERE IS" condition without either express or implied warranty or representation, including but not limited to the description, fitness for a particular purpose or use, structural integrity, physical condition, construction, extent of construction, workmanship, materials, liability, zoning, subdivision, environmental condition, merchantability, compliance with building or housing codes or other laws, ordinances or regulations, the ability of the purchaser to obtain title insurance or other similar matters, and subject to easements, agreements and restrictions of record which affect the same, if any. The property will be sold subject to any assessments including assessment pursuant to D.C. Code Section 42-1903.13.

TERMS OF SALE: A deposit of $20,000.00 cash or certified funds shall be required at the time of sale. The balance of the purchase price with interest on the unpaid purchase money at the current rate contained in the Deed of Trust Note (3.375% per annum) from the date of sale to the date funds are received by the Trustees, payable in cash or certified funds within TEN

840 Trustees Sale - DC

Trustees Sale - DC
Pardo & D
Jason A. Par
4400 Jenifer St
Washingtor
202-22

TRUSTE
OF REAL

107 Rhode Island Avenu
(Lot 100 in S

Under a power of sale contain
Deed of Trust and Security Ag
and Rents ("Deed of Trust") in
$1,595,000.00 dated June 1
21, 2017 as Instrument No.
Records of the District of Colu
NW, LLC, as Grantor, to Jason
as Trustees, for the benefit o
Beneficiary ("Deed of Trust"),
the terms thereof, and followin
the Land Records of an Affida
Foreclosure, and a Notice of F
or Condominium Unit, at the re
the Trustee will sell at public au
Auctioneers, Inc., 5335 Wisc
Washington, DC 20015, on

FEBRUARY 6, 2

ALL THAT LOT OF GROUN
THEREON situated in the City o
bia, known as 107 Rhode Isl
D.C. (Lot 100 in Square 3113)
Deed of Trust.

The property will be sold in
warranty of any kind, and sub
agreements, liens, and encum
same – except those encumbran
operation of District of Columbi
of the Deed of Trust.

Purchaser will take title to the p
and sewer charges, and other
assumes the risk of loss or da
date of sale forward. Purchaser
physical possession of the prope

TERMS OF SALE: A deposi
cashier's check will be required
place of sale. Purchaser shall
sale. TIME SHALL BE OF THE
SETTLEMENT BY PURCHASER
to be paid in cash or certified
be paid on the unpaid purchas
to the date of settlement at th
debt instrument secured by the
be responsible for payment of al

The noteholder and its affiliates,
to post a deposit or to pay intere

In the event that purchaser do
reason, purchaser shall be in
deposit shall be forfeited to the
of this sale (including attorneys'
gross sale price) shall be charg
forfeited deposit. Trustee may re
expense of the defaulting purch
shall not be entitled to any surp
from any resale of the property.

If the Trustee does not settle as
remedy at law and in equity sh
deposit and the sale shall be co
effect whatsoever.

The Trustee reserves the right,
any and all bids, to withdraw th
before or at the auction, to ext
waive or modify the deposit requ
requirement that interest be paid
and/or to extend the period of tir

Additional terms may be announ
bidder will be required to exec
a memorandum or contract of
bidding.

Jason A. Pardo and Rus

HARVEY W E S T
AUC
5335 Wisconsin A
Washington
202-46
www.hwestA

JANUARY 24, 26, 30, FEBRUAR

IS Y
OLD
HOLDIN

IN RE:
CASSANDRA L. JOHNSON
Debtor Case No. 17-11893-BFK

JANET M. MEIBURGER, Trustee,
Plaintiff,
v. Adv. Pro. No. 17-01117-BFK
OLIVIER JAVAUDIN
Defendant.

NOTICE OF ADVERSARY PROCEEDING

Please take notice that a lawsuit has been filed against you in the bankruptcy case of Cassandra L. Johnson, Case No. 17-11893. The Complaint requests approval to sell 3908 Woodley Drive, Alexandria, VA 22309. A copy of the Complaint has been mailed to you at 3908 Woodley Drive, Alexandria, VA 22309. You are required to submit a motion or answer to the Complaint. If you fail to respond to the Complaint, your failure will be deemed to be your consent to entry of a judgment by the Bankruptcy Court and judgment by default may be taken against you for the relief demanded in the Complaint. **You may obtain a copy of the Complaint and related documents from the Bankruptcy Court, 200 South Washington Street, Alexandria, VA 22314 or by contacting the Trustee, Janet M. Meiburger, The Meiburger Law Firm, P.C. (703) 556-9404, 1493 Chain Bridge Road, Suite 201, McLean, Virginia 22101.**

STATE OF CONNECTICUT
Superior Court at Bridgeport
Docket: FA11-4037815
NOTICE TO: DENNIS F. HIGHTOWER.

You are named as a defendant in a motion filed in the above named court seeking orders of contempt. To respond to this application, you must appear at the court, 1061 MAIN STREET, BRIDGEPORT, CONNECTICUT, on MARCH 1, 2018 at 9:30 A.M.
This notice is published pursuant to an ORDER OF NOTICE dated 1/19/2018.
attest: /s/ Jon Gallup
Constable

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
PROBATE DIVISION
WASHINGTON, D.C. 20001-2131
2017 ADM 001470

DAVID ALLEN LYON
PRO SE

NOTICE OF APPOINTMENT, NOTICE TO CREDITORS AND NOTICE TO UNKNOWN HEIRS

G. Don Westfall, whose address is 124 Sawmill Creek Dr., Nellysford, VA 22958 was appointed Personal Representative of the estate of David Allen Lyon who died on August 8, 2017 without a Will and will serve without Court supervision. All unknown heirs and heirs whose whereabouts are unknown

This amendment includes the Historic Preservation Element of the 2018 Master Plan Update. Gaithersburg, as an incorporated city, is subject to the Land Use Article of the Annotated Code of Maryland. Land Use Division 1, §3-301(a) Plan Revisions requires the City's comprehensive master plan to be reviewed and if necessary revised and amended at least once every 10 years. Land Use Division I, §3-102(b)(1) Elements-Municipal Corporations permits the City to include additional plan elements beyond what is required, such as Historic Preservation.

Historic Preservation is the first element of the 2018 Master Plan Update to be reviewed.

Historic Preservation will present recommendations for the City's continued stewardship of its historic resources while being consistent with the State and City visions. Public comment is invited prior to and at the joint public hearing on the Historic Preservation Element.

Further information may be obtained from the Planning and Code Administration Department at City Hall, 31 South Summit Avenue, between the hours of 8 a.m. and 5 p.m., Monday through Friday, or on the City's website at http://www.gaithersburgmd.gov/services/planning-services/city-master-plan.

Rob Robinson, Long Range Planning Manager
Planning and Code Administration # 1194

Statement of Charity Care

University of Maryland Capital Region Health offers a reasonable amount of care at no charge or reduced rates to eligible persons who do not have insurance, Medicare or Medical Assistance. In addition, qualifying patients may be able to participate in an extended payment plan without interest. Eligibility for free care, reduced rates and extended payment plans will be determined on a case-by-case basis for those who cannot afford to pay for care. If you think that you may be eligible for uncompensated care, you can receive further information from the University of Maryland Capital Region Health Customer Service Department at 301-618-3100.

825 Bids & Proposals

825 Bids & Proposals

Brazilian Naval Commission
Public Bid No. 02/18

Object: Acquisition of medical supply; audio, video and photo equipments; maneuvering and patrolling equipments and machinery and equipment, for the use of the Command of Material of the Brazilian Marine Corps (Brazilian Navy).
Documentation: The Bid with the detailed object, dates and Bid's Requirements can be downloaded from www.marinha.mil.br/cnbw/.
Proposals: Electronic Proposal with "Qualification Documents" and "Price Proposal" must be submitted via email at cnbw.bid@marinha.mil.br until February 9th/2018. Opening of Proposals will be on February 12th/2018 at the following address: Brazilian Naval Commission in Washington, 5130 MacArthur Blvd. NW, Washington DC 20016.

815 Legal Notices

LUSHA SALES
MELODY SALES
JOEY EMBREY
WILLIAM EMBREY
TAMMY EMBREY
YVETTE EMBREY
SHARRON WALLER
JOSEPH EMBREY, JR.
JUANITA THOMAS JOHNSON
WESLEY G. WASHINGTON
SYLVIA JOHNSON
OLIVER B. JOHNSON
NANCY JOHNSON
ALICE L. LEWIS JONES

820 Official Notices

Notice is hereby given that the following named company at the address listed herewith has made application to engage in the business of loaning money for the license year ending December 31, 2018 as provided by the Act of Congress, approved February 14, 1913. Anyone desiring to protest against the issuance of this license should do so in writing to the Commissioner of the Department of Insurance, Securities and Banking,

website. http://www.scc.virginia.
the comments, whether submitted
ly, shall be served on Atlantic Br
address set forth above.

On or before February 26, 2018, a
hearing on Atlantic Broadband's
electronically, an original and fi
request for hearing shall be subn
Commission at the address set
shall include: (i) a precise statem
filing party; (ii) a statement of th
to the extent then known; (iii) a
basis for such action; and (iv) a
hearing should be conducted in th
request for hearing shall serve a c
Atlantic Broadband's counsel at th

All written communications to the
Atlantic Broadband's Application s
Peck, Clerk, State Corporation Co
Control Center, P.O. Box 2118, R
2118, and shall refer to Case No. PU

ATLANTIC BROADBAND F

840 Trustees Sale - DC

840

Samuel I. Whit
611 ROCKVILLE
SUITE 10
ROCKVILLE, MARYLA

SUBSTITUTE TRUSTE
VALUABLE RESIDENTIAL DW

3129 38TH STRE
WASHINGTON, D

By virtue of Deed of Trust recorde
the District of Columbia recorded
Instrument Number 2007006267, a
filed on March 10, 2017 in case 20
at the request of the party secured
Substitute Trustees will offer to sel
the office of HARVEY WEST AU
WISCONSIN AVENUE, NW, SUITE
20015-2034 on,

FEBRUARY 27, 2018

the land and premises situated in th
more particularly described in the
Trust and as of the date hereof desig
Assessor of the District of Columbia f

3129 38TH STREET NW, WASHI
NUMBERED FIFTY (50) IN THE
THOMAS J. LANE, JR. OF LOT NUM

UNIVERSITY of MARYLAND CAPITAL REGION HEALTH

Statement of Charity Care

University of Maryland Capital Region Health offers a reasonable amount of care at no charge or reduced rates to eligible persons who do not have insurance, Medicare or Medical Assistance. In addition, qualifying patients may be able to participate in an extended payment plan without interest. Eligibility for free care, reduced rates and extended payment plans will be determined on a case-by-case basis for those who cannot afford to pay for care. If you think that you may be eligible for uncompensated care, you can receive further information from the University of Maryland Capital Region Health Customer Service Department at 301-618-3100.
Thank you.

EXHIBIT 9

UM Prince George's Hospital Center (UM PGHC)
Plans of Correction for Quality Measures Scored "Below Average"

Quality Measure	Corrective Action Plan
Practice Patterns	
Newborn deliveries scheduled 1-3 weeks earlier than medically necessary	UM PGHC has implemented several corrective actions, including: 1. Residents, Interns, and Nurses received education regarding the significance of health risk associated with early delivery absent a clinical indication. (December 2016) 2. Acceptable clinical indications for early delivery were agreed upon by the department medical staff. (December 2016) 3. A process was implemented that requires approval by the Corporate Medical Director of OB/GYN Services for early delivery without a clinical indication. (December 2016) The rate for this indicator has been 0% for CY 2017. UM PGHC will continue to monitor this measure.

UM Prince George's Hospital Center (UM PGHC)
Plans of Correction for Quality Measures Scored "Below Average"

Communication	
How often did nurses always communicate well with patients?	UM PGHC has implemented several corrective actions, including: 1. Implemented patient rounding on the Post-Partum and Medical Surgical nursing units beginning in July 2017. 2. Nursing unit staff was trained on effective communication with patients and family members. (November 2, 2017) 3. Use of Patient Personalization Poster that encourages individualized care with a personal touch on Medical Surgical Unit. (August 2017) 4. Hospital-wide implementation of initiative to improve interactions between staff and patient/families. The initiative is called *Communications is Key* and focuses on three behaviors: **Smile:** a simple smile makes everyone feel human. **Listen:** a shared vision is best created when we listen with both our ears and with our heart. **Explain:** take the time to explain in a way that the patient/family can understand. (February 2018) This measure trended positive in FY 2017 to 65%, and 69.8% by Q2 in FY 2018. UM PGHC will continue to monitor this measure.

UM Prince George's Hospital Center (UM PGHC)
Plans of Correction for Quality Measures Scored "Below Average"

How often did doctors always communicate well with patients?	UM PGHC has implemented several corrective actions, including: 1. Conducted physician education on effective communication. (September - October 2017) 2. Hospital-wide implementation of initiative to improve interactions between staff and patient/families. The initiative is called *Communications is Key* and is described above. This measure was trending positive in FY 2017 to 77.8 and sustained in Q2 FY 2018 at 77.6. UM PGHC will continue to monitor this measure.
How often did staff always explain about medicines before giving them to patients?	UM PGHC has implemented several corrective actions, including: 1. Engaged Clinical Pharmacist in patient education regarding medication use. (August 2017) 2. Hospital-wide implementation of initiative to improve interactions between staff and patient/families. The initiative is called *Communications is Key* and is described above. 3. The Pharmacy Department has developed simplified versions of medication educational materials for a select group of medications to improve patient understanding of how to manage their medicine(s) after discharge. This measure was trended positive in FY 2017 to 53.6%, and 57.1 by Q2% in FY 2018. UM PGHC will continue to monitor this measure.

UM Prince George's Hospital Center (UM PGHC)
Plans of Correction for Quality Measures Scored "Below Average"

Were patients always given information about what to do during their recovery at home?	UM PGHC has implemented several corrective actions, including: 1. Incorporating patient education in daily workflow versus educating only at the time of discharge. 2. Hospital-wide implementation of initiative to improve interactions between staff and patient/families. The initiative is called *Communications is Key* and is described above. This measure trended positive in FY 2017 to 79.0%, and 80% YTD in FY 2018. UM PGHC will continue to monitor this measure.
How well do patients understand their care when they leave the hospital?	1. UM PGHC instituted an initiative to incorporate patient education in daily work-flow, beginning in July 2017. 2. Beginning in March 2018 the case management model was re-designed. The model is now service-based. In this model, the case manager rounds with physicians on the service and is a part of the ongoing process of preparing the patient for a safe discharge. This measure increased to 42.12% for FY 2017 and YTD 2018 is 41.77%. UM PGHC will continue to monitor this measure.

UM Prince George's Hospital Center (UM PGHC)
Plans of Correction for Quality Measures Scored "Below Average"

Environment	
How often were the patients' rooms and bathrooms always kept clean?	UM PGHC has implemented several corrective actions, including: 1. Implementation of patient rounding with electronic tool- Alert sent to EVS if room has any cleaning concern. (July - September 2017) 2. Implemented a rotating floor cleaning schedule. (February 2018) The score has ranged from 54.4% to 65.7% for CY 2017, higher than the score in the Commission's measures. UM PGHC will continue to monitor this measure.
How often did patients always receive help quickly from hospital staff?	UM PGHC implemented patient rounding with electronic tool, which included surveying staff responsiveness. (July - September 2017) This measure trended positive in FY 2017 to 48.28%, and 54.5% by Q2 FY 2018. UM PGHC will continue to monitor this measure.
How often was patients' pain always well-controlled?	Nurse managers conduct daily patient rounds to assess patient perception of pain management. Concerns are managed in real-time. June 2017 The percentage of patients who gave top box rating increased to 62% in FY 2017, and to 68.5% YTD in Q2 FY 2018. UM PGHC will continue to monitor this measure.

UM Prince George's Hospital Center (UM PGHC)
Plans of Correction for Quality Measures Scored "Below Average"

Satisfaction Overall	
How do patients rate the hospital overall?	UM PGHC has implemented several corrective actions, including: 1. Implemented Leader Round Teams. Key leaders sent for training in improving patient experience. Unit-based staff training implemented by Director of Patient Engagement. 2. Hospital-wide implementation of initiative to improve interactions between staff and patient/families. The initiative is called *Communications is Key* and is described above. (February 2018) This measure is trended positive in FY 2017 to 49.35%, and 51.3% in FY 2018. UM PGHC will continue to monitor this measure.
Would patients recommend the hospital to friends and family?	UM PGHC has implemented several corrective actions, including: 1. Implemented Leader Round Teams. Key leaders sent for training in improving patient experience. Unit-based staff training implemented by Director of Patient Engagement. 2. Hospital-wide implementation of initiative to improve interactions between staff and patient/families. The initiative is called *Communications is Key* and is described above. This measure trended positive in FY 2017 to 47.96%, and 52.8% in FY 2018. UM PGHC will continue to monitor this measure.

Wait Times	
How long patients spent in the emergency department before leaving for their hospital room	To improve the flow of patients through the emergency department, a number of interventions have been explored and employed: 1. As the second busiest trauma center in the state of Maryland, the efficient movement of patients through the ED is paramount to organizational success. An inter-professional team was created to focus on ED throughput. The Team is co-led by four physicians and the Chief Nursing Officer. (June 16, 2017) 2. Physician Assistant hours were flexed up. (September 30, 2017) 3. Point of Care Testing has been implemented in the ED for chemistry, troponin, & pregnancy testing. (September 21, 2017) 4. The number of rolling computers has been increased to facilitate bedside registration. (September 30, 2017) 5. Provide better staffing levels downstream for psychiatric and telemetry units to prevent delays in transfers from the ED. (August 30, 2017) 6. Transport Staff dedicated to the ED (October 13, 2017) 7. Housekeeping staff to report the availability of individual rooms rather than "batching" multiple rooms before reporting availability. (August 21, 2017) 8. Case Manager Dedicated to ED to determine severity of illness and eligibility for admission vs. treat and release. (September 30, 2017) 9. Beginning in March 2018 the case management model was re-designed. The model is now service-based. In this model, the case manager rounds with physicians on the service and is a part of the ongoing process of preparing the patient for a safe discharge. This

	practice also facilitates improved patient flow which will make beds available sooner. The median time for FY 2017 is 712.48, and down to 671.86 YTD by Q2. UM PGHC will continue to improve on this measure.
How long patients spent in the emergency department after the doctor decided the patient would stay in the hospital before leaving for their hospital room	To improve the flow of patients through the ED a number of interventions have been explored and employed: 1. Physician Assistant hours are flexed up. (September 30, 2017) 2. Point of Care Testing has been implemented in the ED for chemistry, troponin, & pregnancy testing. (September 21, 2017) 3. The number of rolling computers have been increased to facilitate bedside registration. (September 30, 2017) 4. Provide better staffing levels downstream for psychiatric and telemetry units to prevent delays in transfers from the ED. (August 30, 2017) 5. Transport Staff dedicated to the ED. (October 13, 2017) 6. Housekeeping staff to report the availability of individual rooms rather than "batching" multiple rooms before reporting availability. (August 21, 2017) 7. Case Manager Dedicated to ED to determine severity of illness and eligibility for admission vs. treat and release. (September 30, 2017) The median time for FY 2017 is 712.48 and down YTD by Q2 to 403.86. UM PGHC will continue to improve on this measure.
How long patients who came to the emergency department with broken bones had to wait before receiving pain medication.	To improve the flow of patients through the ED, a number of interventions have been explored and employed:

	1. Physician Assistant hours are flexed up. (September 30, 2017) 2. Point of Care Testing has been implemented in the ED for chemistry, troponin, & pregnancy testing. (September 21, 2017) 3. The number of rolling computers have been increased to facilitate bedside registration. (September 30, 2017) 4. Provide better staffing levels downstream for psychiatric and telemetry units to prevent delays in transfers from the ED. (August 30, 2017) 5. Transport Staff dedicated to the ED. (October 13, 2017) 6. Housekeeping staff to report the availability of individual rooms rather than "batching" multiple rooms before reporting availability. (August 21, 2017) 7. Case Manager dedicated to ED to determine severity of illness and eligibility for admission vs. treat and release. (September 30, 2017) This metric has been trending down in CY 2017 from 167.26 minutes to 91.8 minutes by Q4. UM PGHC will continue to improve on this measure.

Patients who left the emergency department without being seen	To improve the flow of patients through the ED a number of interventions have been explored and employed: 1. Physician Assistant hours are flexed up. (September 30, 2017) 2. Point of Care Testing has been implemented in the ED for chemistry, troponin, & pregnancy testing. (September 21, 2017) 3. The number of rolling computers have been increased to facilitate bedside registration. (September 30, 2017) 4. Provide better staffing levels downstream for psychiatric and telemetry units to prevent delays in transfers from the ED. (August 30, 2017) 5. Transport Staff dedicated to the ED. (October 13, 2017) 6. Housekeeping staff to report the availability of individual rooms rather than "batching" multiple rooms before reporting availability. (August 21, 2017) 7. Case Manager dedicated to ED to determine severity of illness and eligibility for admission vs. treat and release. (September 30, 2017) 8. Significant work has been completed to decrease the amount of time that patients wait before being seen by a provider. Currently, the hospital is better than average for this metric For CY 2017 the average for Left without Being Seen is 3.83%. UM PGHC will continue to improve on this measure.

UM Prince George's Hospital Center (UM PGHC)
Plans of Correction for Quality Measures Scored "Below Average"

Recommended Care—Outpatient	
Patients with a heart attack who received aspirin on arrival to the hospital	The hospital has employed a full-time Chest Pain Coordinator who works with internal and external stakeholders to improve the care of patient who present with chest pain. (July 1, 2017) FY 2017 results averaged 95.45%. FYI 2018 YTD is 100%. UM PGHC will continue to monitor this measure.
How long patients who come to the hospital with chest pain or possible heart attack waited to get a test that detects heart damage after a heart attack	The hospital has employed a full-time Chest Pain Coordinator who works with internal and external stakeholders to improve the care of patient who present with chest pain. (July 1, 2017) FY 2017 results averaged 45 minutes, non-risk adjusted. FYI 2018 YTD is 12 minutes, non-risk adjusted. UM PGHC will continue to monitor this measure.
Practice Patterns	
Contrast material (dye) used during thorax CT scan	By January 2019, UM PGHC plans to implement an Imaging Clinical Decision Support System designed to facilitate "appropriate use" when ordering CT scans.
Patients who came to the hospital for a scan of their brain and also got a scan of their sinuses.	By January 2019, UM PGHC plans to implement an Imaging Clinical Decision Support System designed to facilitate "appropriate use" when ordering CT scans.

UM Prince George's Hospital Center (UM PGHC)
Plans of Correction for Quality Measures Scored "Below Average"

Results of Care—Death	
How often patients die in the hospital after fractured hip	The risk-adjusted mortality rate for death after a fractured hip is well within the confidence interval and should not be categorized as "below average." UM PGHC has a Mortality Prevention Workgroup that reviews mortality by product line and explores opportunity to decrease the risk of mortality. CY 2017 data shows there were no deaths following orthopedic surgery from January through July. For CY 2017 there have been no patient deaths associated with hip fractures. UM PGHC will continue to monitor this measure.
Results of Care	
How often patients in the hospital had to use a breathing machine after surgery because they could not breathe on their own	1. A workgroup has been convened to identify opportunities to decrease the post-operative ventilator length of stay. 2. Data is being collected in 6 hour segments to identify the patients with the greatest opportunity to decrease the time patients spend on the ventilator post surgically. 3. This metric will be added to the quality indicators collected by the Respiratory Department and will be integrated in to the hospital quality management system. Maryland Hospital Compare Data shows a LOS that is 30.6295.
Central Line-Associated Blood Stream Infections (CLABSI)	As of November 2, 2017 the following interventions have been implemented: 1. Admission central line checklist for history of line(s) inserted (when, why, who). 2. Implementation of the use of Curos caps. 3. Infection Prevention & Control rounds on patients with central line access to evaluate dressing care, bags and lines dated, timed and labeled and Curos caps in use.

	4. Conduct a timely Apparent Cause Analysis of all infections. 5. Action Plan was developed to implement the following best practices when obtaining blood cultures: Oral temps on patients that could hold a thermometer appropriately versus axillary temps, no routine use of lines for blood culture, blood cultures from central lines only as last alternative. 6. Daily CHG bath. 7. Staff education on CHG bathing The SIR is trending down from 4.38 in FY 2017 to 3.37 in FY 2018 Q2. UM PGHC will continue to monitor this measure.

EXHIBIT 10

2016

PRINCE GEORGE'S COUNTY

COMMUNITY HEALTH NEEDS ASSESSMENT

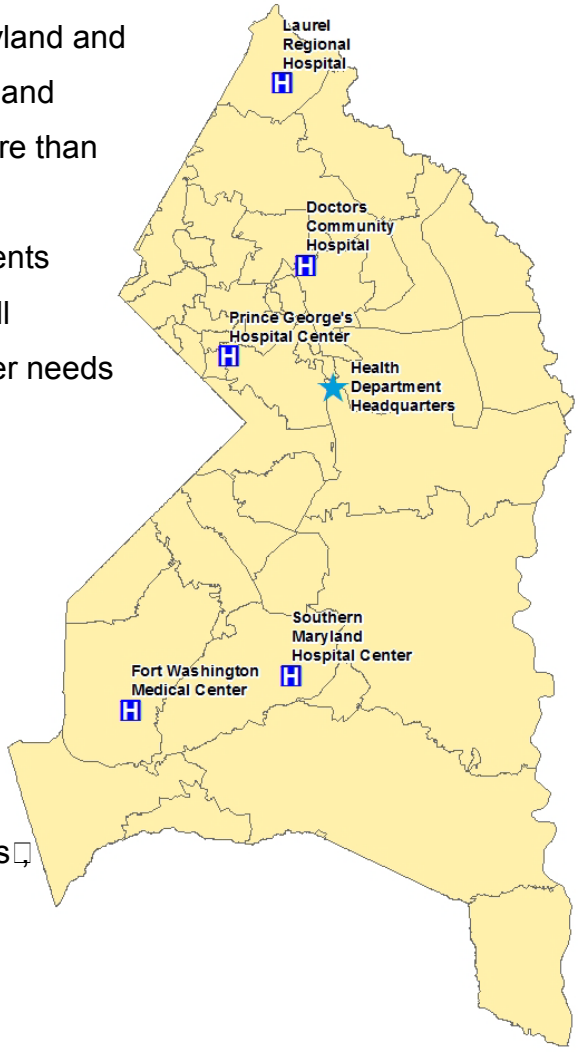
Prepared by:
Prince George's County
Health Department

Rushern L. Baker, III
County Executive

HEALTH DEPARTMENT
Prince George's County

INTRODUCTION

Prince George's County is located in the state of Maryland and borders Montgomery, Howard, Anne Arundel, Calvert and Charles Counties, and Washington, D.C. Home to more than 900,000 diverse residents, the county includes urban, suburban, and rural areas; one out of every five residents in the county are immigrants. The county, while overall considered affluent, has many communities with higher needs and poor health outcomes.



In 2015, the Prince George's County government and Maryland-National Capital Parks and Planning Commission conducted a special study to develop a Primary Healthcare Strategic Plan[1] in preparation for enhancing the healthcare delivery network. A key recommendation from the plan was to build collaboration among Prince George's County hospitals, which included conducting a joint community health needs assessment (CHNA) with the Prince George's County Health Department.

C□□A Core □eam

Doctors Community □ospital
Fort □ ashington □edical Center
Laurel Regional □ospital
□edStar Southern □aryland □ospital Center
Prince □eorge□s County □ealth Department
Prince □eorge□s □ospital Center

There are five hospitals located within the county: Doctors Community Hospital; Fort Washington Medical Center; Laurel Regional Hospital, MedStar Southern Maryland Hospital Center; and Prince George's Hospital Center. All five hospitals and the Health Department appointed staff (the core team) to facilitate the CHNA process. The core team began meeting in December 2015 to develop the first inclusive CHNA for the county.

[1] http://www.pgplanning.org/Resources/Publications/PHSP.htm

PROCESS OVERVIEW

The CHNA Process was developed to 1) maximize community input, 2) learn from the community experts, 3) utilize existing data, and 4) ensure a comprehensive community prioritization process. The Health Department staff led the CHNA process in developing the data collection tools and analyzing the results with input from the hospital representatives. The process included:

- A community resident survey available in both English and Spanish distributed by the hospitals and health department;
- Secondary data analyses that included the county demographics and population description through socioeconomic indicators, and a comprehensive health indicator profile;
- Hospital Service Profiles to detail the residents served by the core team;
- A community-based organization survey and key informant interviews;
- A comprehensive collection of community resources and assets; and
- An inclusive community prioritization process that included forty representatives from across the county.

While the core team led the data gathering process, there was recognition that there **must be shared ownership of the county□s health**. The community data collection strategies and the prioritization process were intentionally developed with this in mind, and set the foundation for community inclusion moving forward. The prioritization process resulted in a community focus on:

- behavioral health,
- metabolic syndrome, and
- cancer,

while acknowledging that any strategies to address these issues in the county would have to include a consideration of the disparate social determinants of health. The results of this process will be used to guide the health department and hospitals in addressing the health needs of the county, with the insight and support of the CHNA participants.

KEY FINDINGS

Drivers of Poor □ealth Outcomes:

- **Poor social determinants of health drive many of our health disparities□**
    - Poverty, food insecurity, access to healthy food, affordable housing, employment, lack of educational attainment, inadequate financial resources, and a disparate built environment result in poorer health outcomes.
    - Resources may be available in communities with greater needs, but are of poorer quality. For example, a recent study in access to healthy foods in an urban area of the county show that there are many grocery stores, but they lack quality healthy food options.[2]
- **Access to health insurance through the Affordable Care Act has not helped everyone□**
    - Many residents still lack health insurance (some have not enrolled, some are not eligible).
    - Those with health insurance cannot afford healthcare (co-pays).
- **Residents lac□ □nowledge of or how to use available resources□**
    - The healthcare system is challenging to navigate, and providers and support services need more coordination.
    - There are services available, but they are perceived as underutilized because residents do not know how to locate or use them.
    - Low literacy and low health literacy contribute to poor outcomes.
- **□he county does not have enough healthcare providers to serve the residents□**
    - There is a lack of behavioral health providers, dentists, specialists, and primary care providers (also noted in the 2015 Primary Healthcare Strategic Plan for the county[3]).

[2] Prince George's County Food System Study, November 2015, http://www.mncppcapps.org/planning/Publications/PDFs/304/Cover%20page,%20Introduction%20and%20Executive%20summary.pdf

[3] Primary Healthcare Strategic Plan, 2015, http://www.pgplanning.org/Resources/Publications/PHSP.htm

- There is a lack of providers who accept public insurance.

- **The county lacks quality healthcare providers**
  - Surrounding jurisdictions are perceived to have better quality providers.
  - There is a lack of culturally competent and bilingual providers.
- **Lack of ability to access healthcare providers**
  - There are limited transportation options available, and the supply does not meet the need. There is also a lack of transportation for urgent but non-emergency needs that cannot be scheduled in advance.

Leading Health Challenges

- **Chronic conditions such as heart disease, diabetes, and stroke continue to lead in poor outcomes for many county residents**
  - Residents have not adopted behaviors that promote good health, such as healthy eating and active living.
  - An estimated two-thirds of residents are obese or overweight.
  - The lack of physical activity and increased obesity is closely related to residents with **metabolic syndrome**[4], which increases the risk for heart disease, diabetes, and stroke.
- **Behavioral health affects entire families and communities, not just individuals**
  - The ambulance crews, hospitals, police, and criminal justice system see many residents needing behavioral health services and treatment.
  - The county lacks adequate resources needed to address residents with significant behavioral health issues.
  - The stigma around behavioral health is an ongoing problem in the county.
- **While the trend for many health issues has improved in the county, we still have significant disparities. For example:**

[4] Metabolic Syndrome is a group of risk factors that raises the risk of heart disease and other health problems such as diabetes and stroke. The risk factors include: a large waist; high triglycerides (fat in the blood); low HDL or "good" cholesterol; high blood pressure, and high blood glucose (sugar). Source: NIH, accessed on 6/1/16, http://www.nhlbi.nih.gov/health/health-topics/topics/ms

- **Cancer:** By cancer site, Black residents in the county had higher incidence and mortality rates for breast, colorectal, and prostate cancers. However, overall, White non-Hispanic residents had a higher cancer mortality rate (2014).
- **HIV:** Prince George's County had the second highest rate of HIV diagnoses in the state in 2013, and had the highest number of actual cases in the state.
- **Asthma:** For adults, Black county residents have an age-adjusted hospitalization rate due to asthma that is more than twice as high as White, non-Hispanic residents (2010-2012).

Recommendations

- **More partnership and collaborative efforts are needed**
  - Current coordinated efforts in the county were recognized as improving outcomes through care coordination and by and addressing systemic issues in the county.
- **More funding and resource for health**
  - Successful efforts to improve resident health in the county are often limited in scope and effect due to lack of funding. Building public health capacity in the county requires the necessary resources.
  - Funding is needed to strengthen the health safety net and build capacity of local non-profits.
- **Increase community-specific outreach and education**
  - More outreach and education is needed, and should be tailored at a community-level to be culturally sensitive and reach residents.
  - Residents need education about the available resources, and how to utilize and navigate them.

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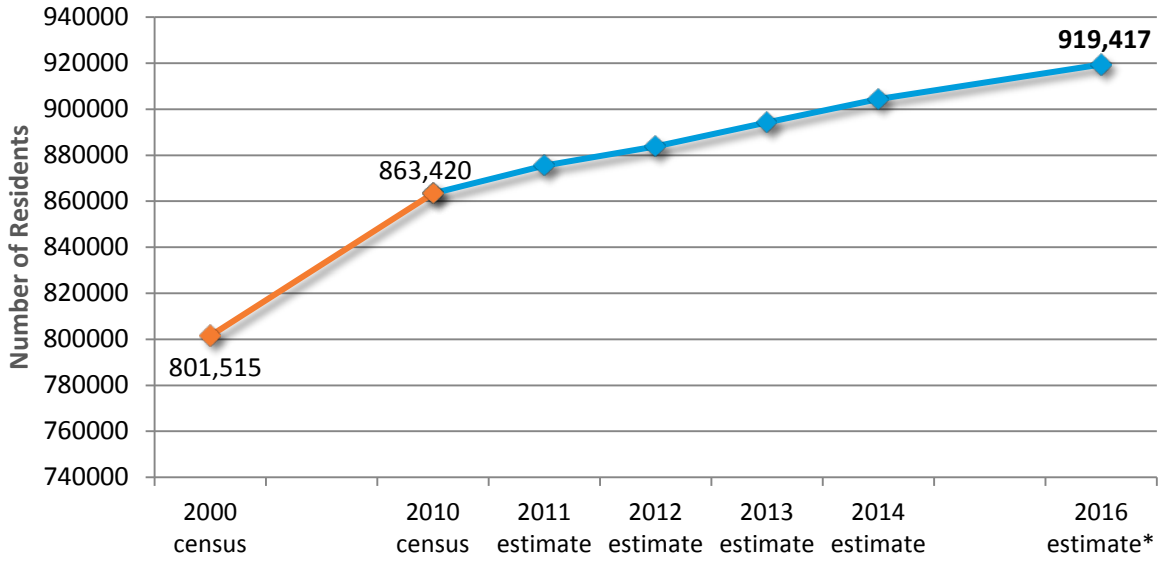
POPULATION PROFILE

Overall Population

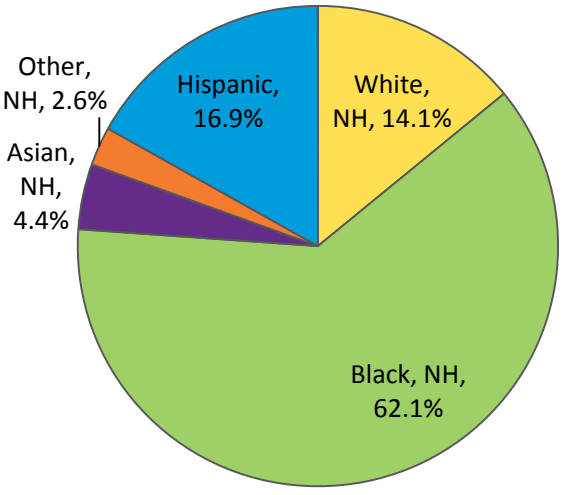
From 2000 to 2010, Prince George□s County population grew by 7.7% to 863,420. The county is currently on track to surpass the growth of the previous decade with a 6.5% increase in population from 2010 to 2016.

Prince □eorge□s County Population, 2000-201□



Data Source: U.S. Census, Annual Population Estimates; * 2016 estimate provided by Claritas

Prince □eorge□s County by Race and Ethnicity, 201□



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

Data Source: 2014 American Community Survey 1-Year Estimates, Table DP05

Population Demographics, 201

2014 Estimates	Prince George's	Maryland	United States
Population			
Total Population	904,430	5,976,407	318,857,056
Male	435,891 (48%)	2,896,033 (48%)	156,890,101 (49%)
Female	468,539 (52%)	3,080,374 (52%)	161,966,955 (51%)
Race and Hispanic Origin			
White, Non-Hispanic (NH)	127,383 (14%)	3,133,653 (52%)	197,409,353 (62%)
Black, NH	561,215 (62%)	1,744,971 (29%)	39,267,149 (12%)
Asian, NH	39,434 (4%)	367,948 (6%)	16,513,652 (5%)
Other, NH	23,837 (3%)	173,656 (3%)	10,387,450 (3%)
Hispanic (any race)	152,561 (17%)	556,179 (9%)	55,279,452 (17%)
Age			
Under 5 Years	60,169 (7%)	369,754 (6%)	19,876,883 (6%)
5-17 Years	145,001 (16%)	980,790 (16%)	53,706,735 (17%)
18-24 Years	97,019 (11%)	562,215 (9%)	31,464,158 (10%)
25-44 Years	260,385 (29%)	1,598,270 (27%)	84,029,637 (26%)
45-64 Years	240,550 (27%)	1,643,118 (27%)	83,536,432 (26%)
65 Years and Over	101,306 (11%)	822,260 (14%)	46,243,211 (15%)
Median Age (years)	36.1	38.2	37.7

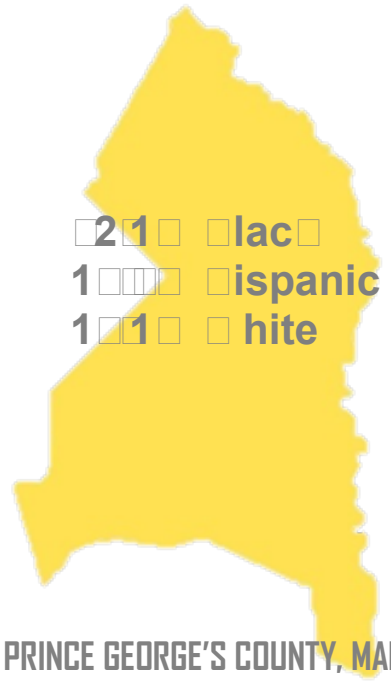
Data Source: 2014 American Community Survey 1-Year Estimates, Table DP05; U.S. Census Population Estimates

Prince eorge s County, edian Age by Race and Ethnicity, 201

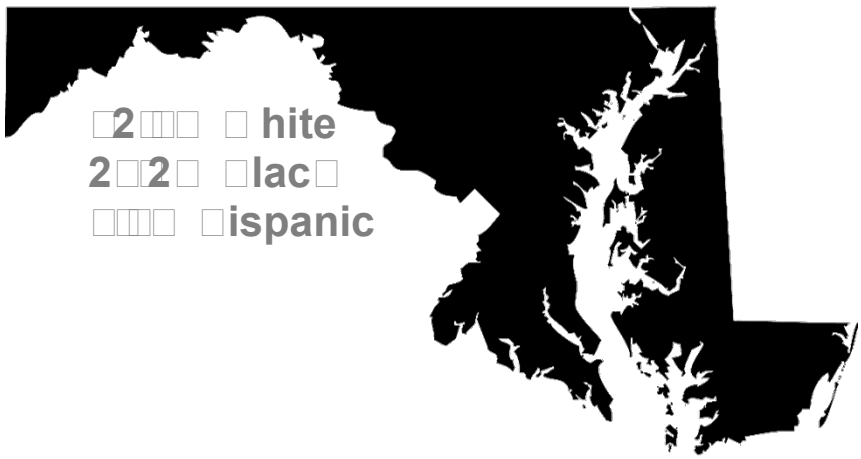
Race and Ethnicity	Median Age (yrs.)
White, NH	44.6
Black	38.6
Hispanic, Any Race	28.4
Asian	36.1

Data Source: 2014 American Community Survey 1-Year Estimates, Table B01002

Overall, the demographics of Prince George's County differ from the state of Maryland. While Maryland has a majority White, Non-Hispanic (NH) population, Prince George's County has a majority Black, NH population. Prince George's County also has a higher proportion of Hispanics than the state.



PRINCE GEORGE'S COUNTY, MARYLAND



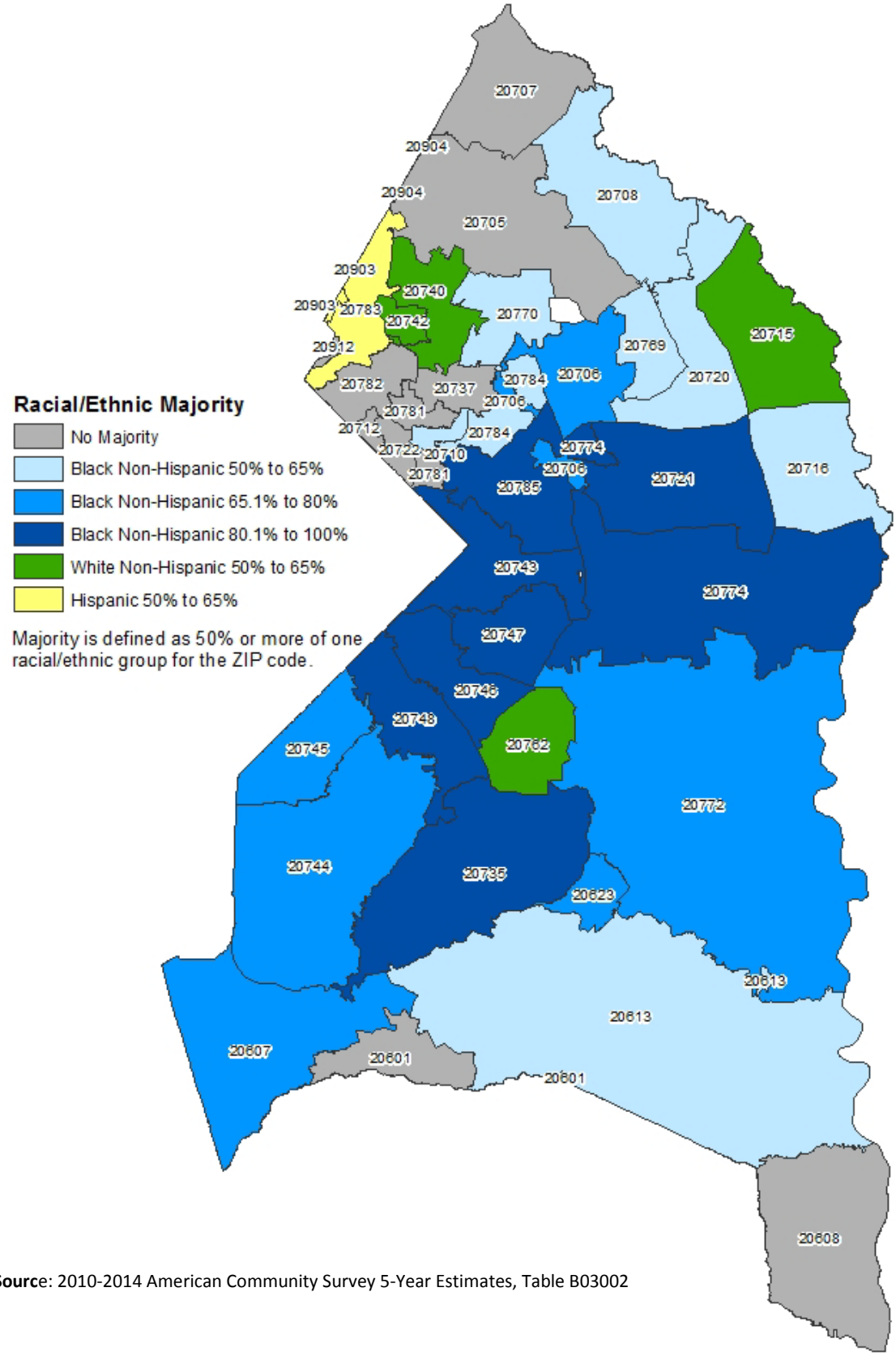
STATE OF MARYLAND

Overall, Prince George's County has a younger population compared to Maryland and the U.S. The median age in the county is 36.1 years, while the state is at 38.3 and the U.S. is at 37.7. This can also be seen by the age groups in Table 1; a larger percent of the County's population is under 45 years of age.

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

By □IP code, most of the county has a Black, Non-Hispanic majority as seen in Map 1. However, the northern part of the county is more diverse, with no majority population in many areas, and a few □IP codes with a Hispanic or White, Non-Hispanic majority.

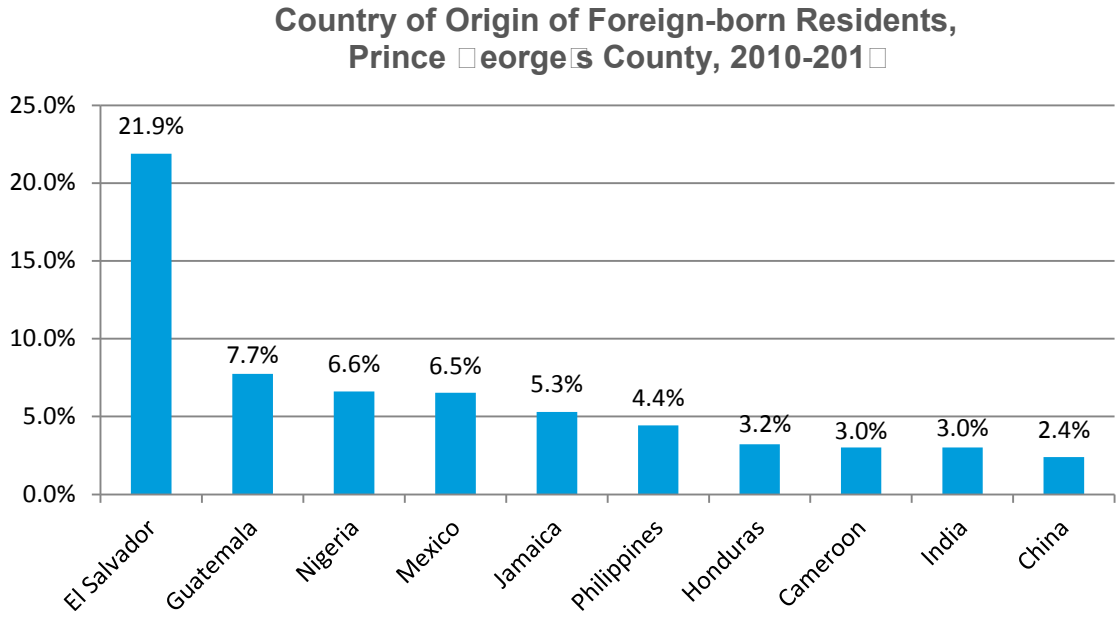
□IP Codes by Population Racial and Ethnic □a□ority, Prince □eorge□s County, 2010-201□



Data Source: 2010-2014 American Community Survey 5-Year Estimates, Table B03002

Foreign □orn Residents

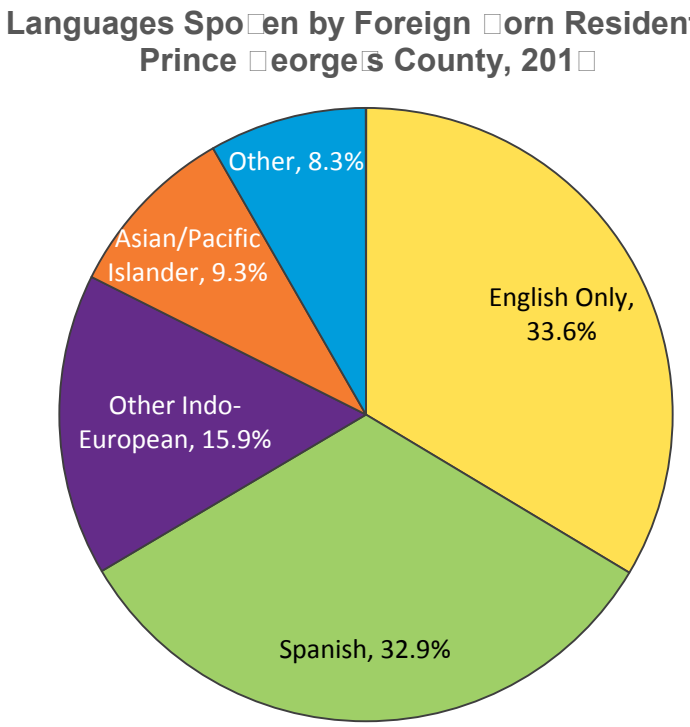
In Prince George□s County, 1 out of every 5 residents (21.8%)[1] are born outside the United States. The countries that contribute the most to the foreign-born population include El Salvador, Guatemala, Nigeria, Mexico, and □amaica: these five countries account for nearly half of the total foreign-born population. Of the nearly 200,000 foreign born residents in the County, 40% are naturalized U.S. citizens with a median household income of $72,093, compared to $56,274 for the 60% who are not U.S. citizens.



Data Source: 2010-2014 American Community Survey 5-Year Estimates, Table B05006

The majority of county foreign-born residents speak English (33.6%) or Spanish (32.9%). For those that speak languages other than English, 45% report speaking English □very well□; of those who do not speak English well, most (66.2%) are Spanish-speaking[2], which translates to approximately 47,000 residents.

[1] American Community Survey 1-year estimates, 2014, Table S0501
[2] American Community Survey 1-year estimates, 2014, Table C16005



Data Source: 2014 American Community Survey 1-year estimates, Table C16005

Poverty

Over 10% of people in Prince George's County lived in poverty in 2014, which is similar to Maryland at 10.1% and lower than the United States at 15.5%. There are noticeable differences in poverty by gender with more women in poverty than men, and by age with 14% of children living in poverty. Racial and ethnic disparities also exist in the county: approximately 17% of Hispanic and Latino residents live in poverty, compared to 9.3% among the county's White non-Hispanic population and 8.6% among the county's Black population. Residents with more education had lower levels of poverty, while those without a high school degree had the highest level of poverty at 15.7%.

Individual Poverty Status in the Past 12 Months, Prince George's County, 2012

Indicators	Prince Georges County		Maryland	U.S.
	N	% Poverty	% Poverty	% Poverty
Total individuals in poverty	89,672	10.2%	10.1%	15.5%
Male	39,168	9.2%	9.1%	14.2%
Female	50,504	11.0%	11.1%	9.5%
Age				
Under 18 years	28,051	14.0%	13.0%	21.7%
18 to 64 years	55,609	9.6%	9.6%	14.6%
65 years and over	6,012	6.0%	7.4%	9.5%
Race & Ethnicity				
White, non-Hispanic	11,024	9.3%	6.9%	10.8%
Black	47,902	8.6%	14.6%	27.0%
Asian	3,212	8.6%	9.0%	12.5%
Hispanic (of any race)	25,684	17.1%	14.2%	24.1%
Educational Attainment (population 25 years+)				
Less than high school	13,596	15.7%	21.3%	27.8%
High school graduate (or equivalent)	14,566	9.3%	11.3%	14.7%
Some college, associate's degree	11,231	6.6%	7.4%	10.6%
Bachelor's degree and higher	8,091	4.3%	3.3%	4.7%

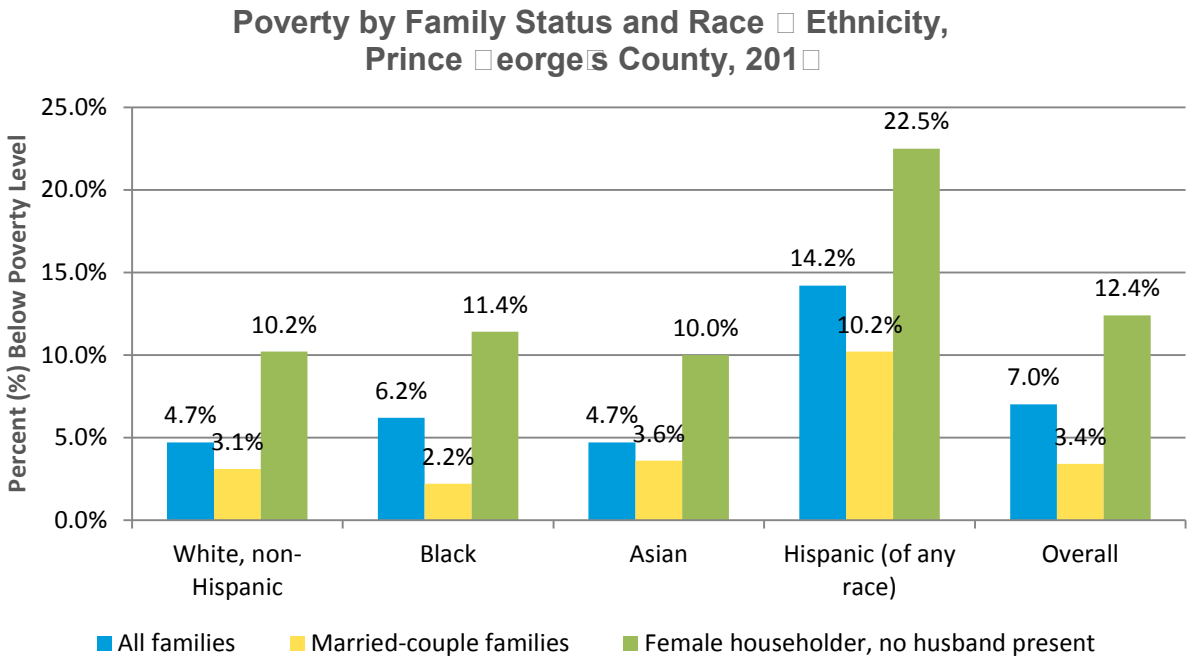
Data Source: American Community Survey 1-Year Estimates, 2014, Table S1701

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

Family Poverty Status in the Past 12 □onths, 201□

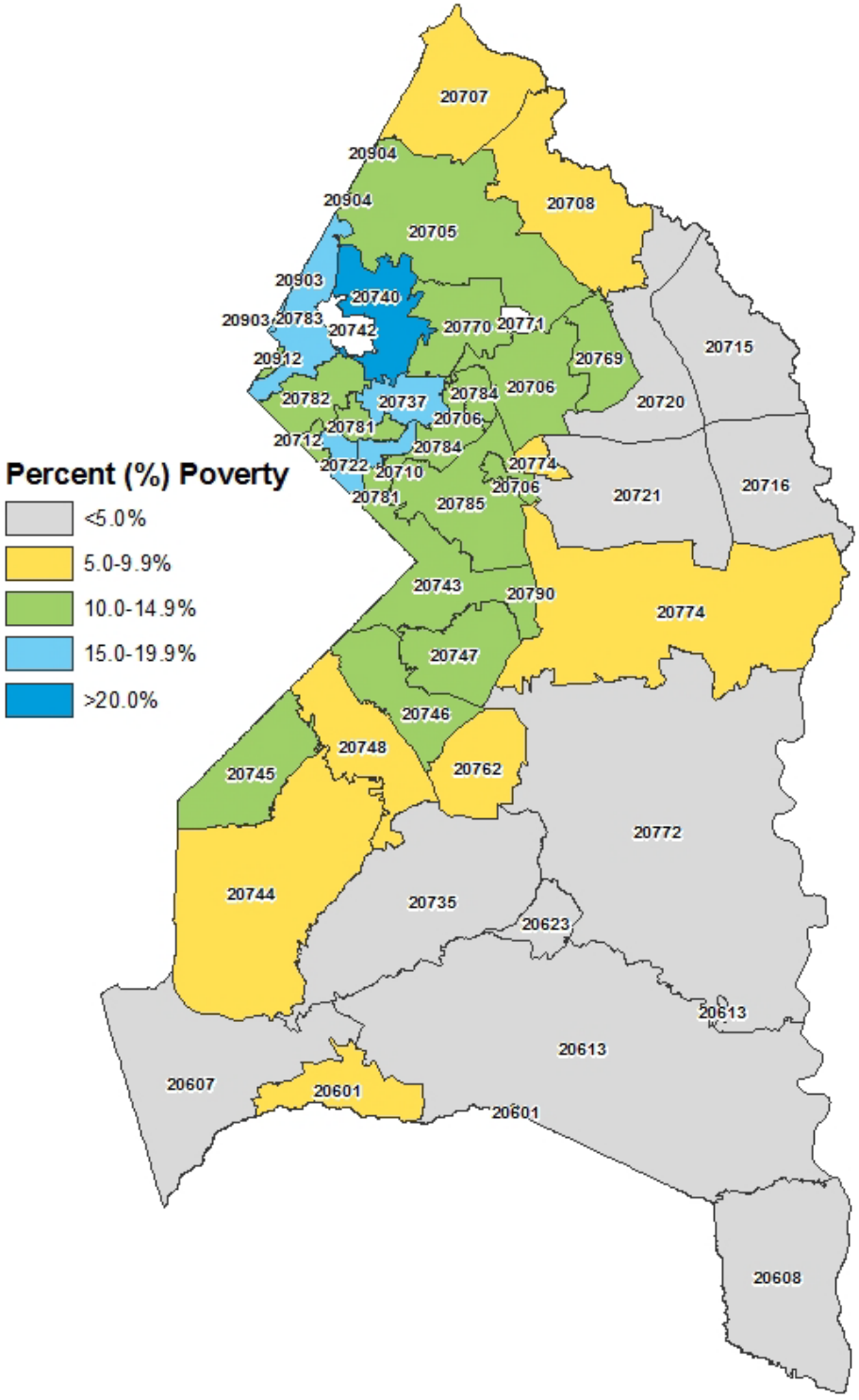
	Prince George's County % Poverty	Maryland % Poverty	United States % Poverty
All families	7.0%	7.1%	11.3%
With related children under 18 years	11.2%	10.8%	18.0%
Married couple families	3.4%	3.1%	5.6%
With related children under 18 years	5.7%	4.1%	8.2%
Families with female householder, no husband present	12.4%	18.5%	30.5%
With related children under 18 years	17.6%	25.4%	40.6%

Data Source: 2014 American Community Survey 1-Year Estimates, Table S1702



Data Source: 2014 American Community Survey 1-Year Estimates, Table S1702

Percent of Residents Living in Poverty by ZIP Code, Prince George's County, 2010-2014



Data Source: 2010-2014 American Community Survey 5-Year Estimates, Table S1701

Percent of Residents Living in Poverty by ZIP Code, Prince George's County, 2010 - 2014

ZIP	Area	Poverty Percentage
20601	Waldorf	5.6%
20607	Accokeek	1.8%
20608	Aquasco	3.2%
20613	Brandywine	3.5%
20623	Cheltenham	4.5%
20705	Beltsville	10.4%
20706	Lanham	10.4%
20707	Laurel	7.7%
20708	Laurel	7.1%
20710	Bladensburg	18.1%
20712	Mount Rainier	14.8%
20715	Bowie	2.9%
20716	Bowie	3.8%
20720	Bowie	3.3%
20721	Bowie	4.8%
20722	Brentwood	15.1%
20735	Clinton	4.9%
20737	Riverdale	16.5%
20740	College Park	25.8%
20743	Capitol Heights	12.3%
20744	Fort Washington	6.3%
20745	Oxon Hill	13.4%
20746	Suitland	11.0%
20747	District Heights	10.4%
20748	Temple Hills	8.4%
20762	Andrews Air Force Base	7.7%
20769	Glenn Dale	10.1%
20770	Greenbelt	11.7%
20772	Upper Marlboro	3.5%
20774	Upper Marlboro	6.0%
20781	Hyattsville	12.2%
20782	Hyattsville	13.9%
20783	Hyattsville	16.6%
20784	Hyattsville	10.0%
20785	Hyattsville	12.5%
20903	Silver Spring	18.3%
20904	Silver Spring	9.4%
20912	Takoma Park	10.1%

Data Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates, Table DP03

Food Stamp Supplemental utrition Assistance Program S AP enefits

Prince George s County had a higher percent of households that received food stamps/ SNAP benefits in 2014 (12.4%) compared to Maryland (11.6%), but was lower than the United States at 13.2%. In the County, over half (54.6%) of households receiving food stamps/SNAP include children under 18 years of age. An additional 27.1% of households receiving food stamps/SNAP included people over 60 years of age.

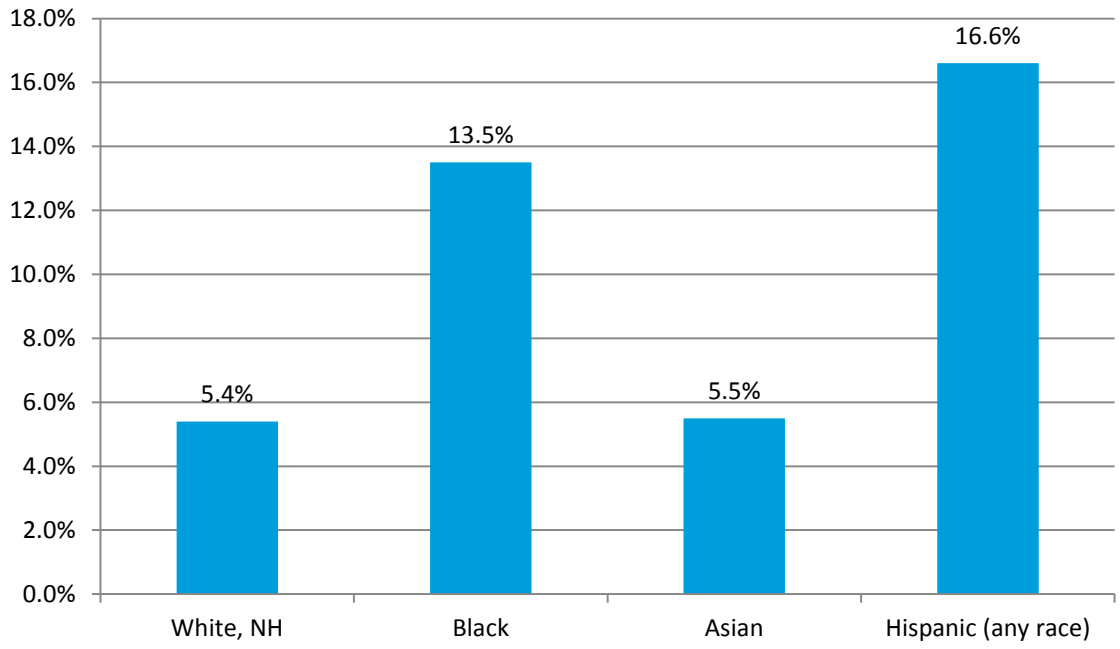
Percent of ousehold with Food Stamp S AP enefits, 201

	Prince George's County	Maryland	United States
Households Receiving Food Stamps/SNAP	12.4%	11.6%	13.2%

Data Source: 2014 American Community Survey 1-Year Estimates, Table S2201

For household s by race and ethnicity, a low percent of White, Non-Hispanic (NH) and Asian households received food stamps/SNAP in 2014 (5.4% and 5.5%, respectively). In contrast, 13.5% of Black households and 16.6% of Hispanic households received food stamps/SNAP.

Percent of ouseholds Receiving Food Stamps S AP by Race and Ethnicity, Prince eorge s County, 201



Data Source: 2014 American Community Survey 1-Year Estimates, Table B2205

Percentage of □ouseholds with Food Stamp□S□AP □enefits by □IP Code, Prince □eorge□s County, 2010-201□

ZIP	Area	Percent of Households on SNAP
20601	Waldorf	8.8%
20607	Accokeek	2.8%
20608	Aquasco	9.1%
20613	Brandywine	4.2%
20623	Cheltenham	0.7%
20705	Beltsville	9.7%
20706	Lanham	10.1%
20707	Laurel	8.5%
20708	Laurel	8.2%
20710	Bladensburg	20.3%
20712	Mount Rainier	11.3%
20715	Bowie	2.4%
20716	Bowie	3.1%
20720	Bowie	3.3%
20721	Bowie	4.8%
20722	Brentwood	14.8%
20735	Clinton	6.3%
20737	Riverdale	15.7%
20740	College Park	5.4%
20743	Capitol Heights	19.0%
20744	Fort Washington	7.6%
20745	Oxon Hill	21.5%
20746	Suitland	13.4%
20747	District Heights	14.3%
20748	Temple Hills	12.6%
20762	Andrews Air Force Base	4.0%
20769	Glenn Dale	11.1%
20770	Greenbelt	9.5%
20772	Upper Marlboro	5.5%
20774	Upper Marlboro	7.5%
20781	Hyattsville	10.7%
20782	Hyattsville	9.7%
20783	Hyattsville	11.6%
20784	Hyattsville	14.2%
20785	Hyattsville	15.7%
20903	Silver Spring	13.1%
20904	Silver Spring	8.5%
20912	Takoma Park	9.5%

Data Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates, Table DP03

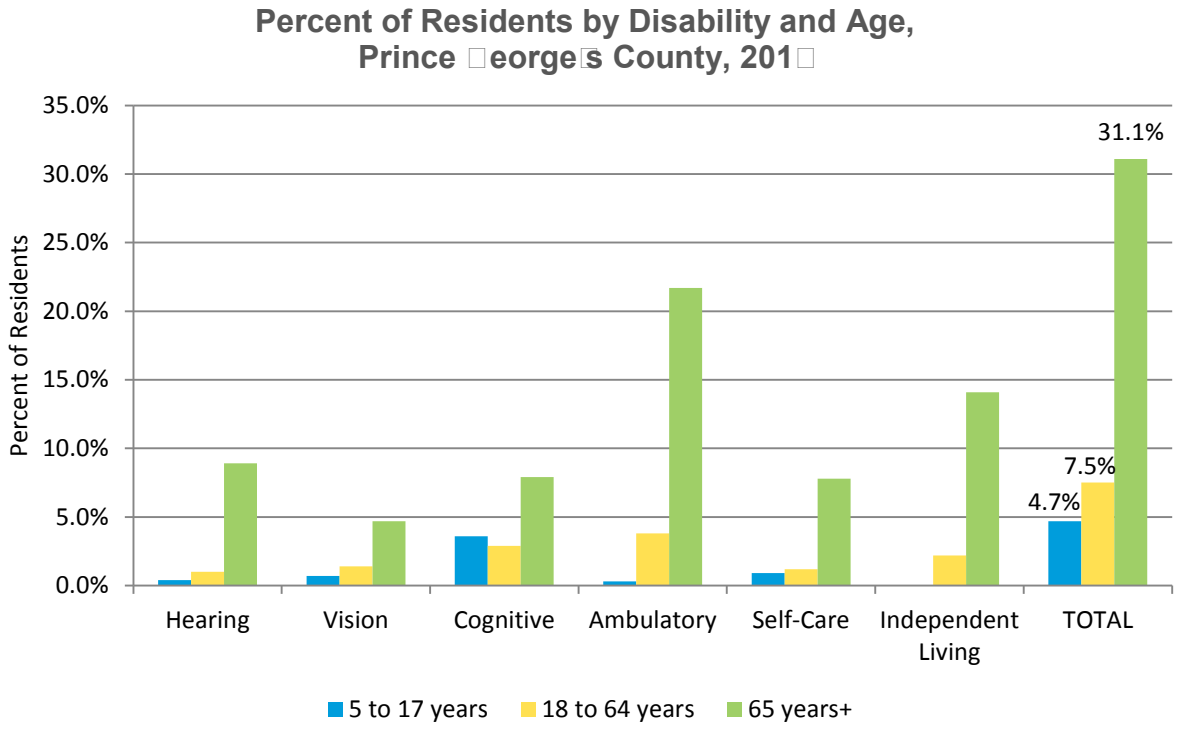
Disability

In 2014, an estimated 9.2% of the County's population lives with a disability. Some disabilities may occur with age, while others may be from birth, or from disease or accident. By race and ethnicity, the White, Non-Hispanic population is estimated to have the highest proportion of County residents with a disability at 12.9%. Over 31% of residents age 65 years and older have a disability; of those approximately two-thirds have an ambulatory disability.

Percent of Residents with a Disability, 201

	Prince George's County	Maryland	United States
With a Disability	9.2%	10.6%	12.6%

Data Source: 2014 American Community Survey 1-Year Estimates, Table S1810



Data Source: 2014 American Community Survey 1-Year Estimates, Table S1810

Education

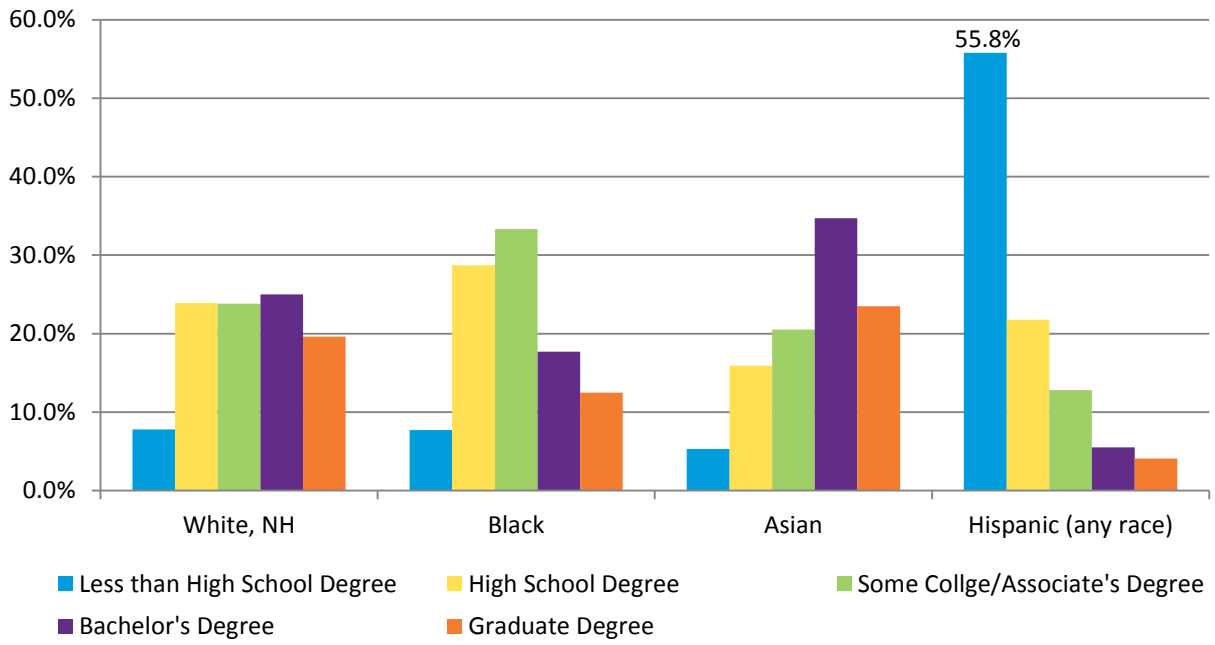
Approximately 85% of County residents age 25 years and older have at least a high school degree, which is lower than Maryland (90%) and the U.S. (87%).

Percent of Residents 2□ Years and Older by Education, 201□

	Prince George's County (n=602,567)	Maryland (n=4,062,813)	United States (n=213,725,624)
Less than 9th Grade	7.4%	4.1%	5.6%
9th to 12th Grade, No Diploma	7.1%	6.3%	7.5%
High School Graduate	26.1%	25.7%	27.7%
Some College, No Degree	22.5%	19.1%	21.0%
Associate's Degree	5.9%	6.5%	8.2%
Bachelor's Degree	18.1%	20.7%	18.7%
Graduate or Professional Degree	12.9%	17.5%	11.4%

Data Source: 2014 American Community Survey 1-Year Estimates, Table S1501

Percent of Residents 2□ Years and Older by Education and Race□Ethnicity, Prince □eorge□s County, 201□

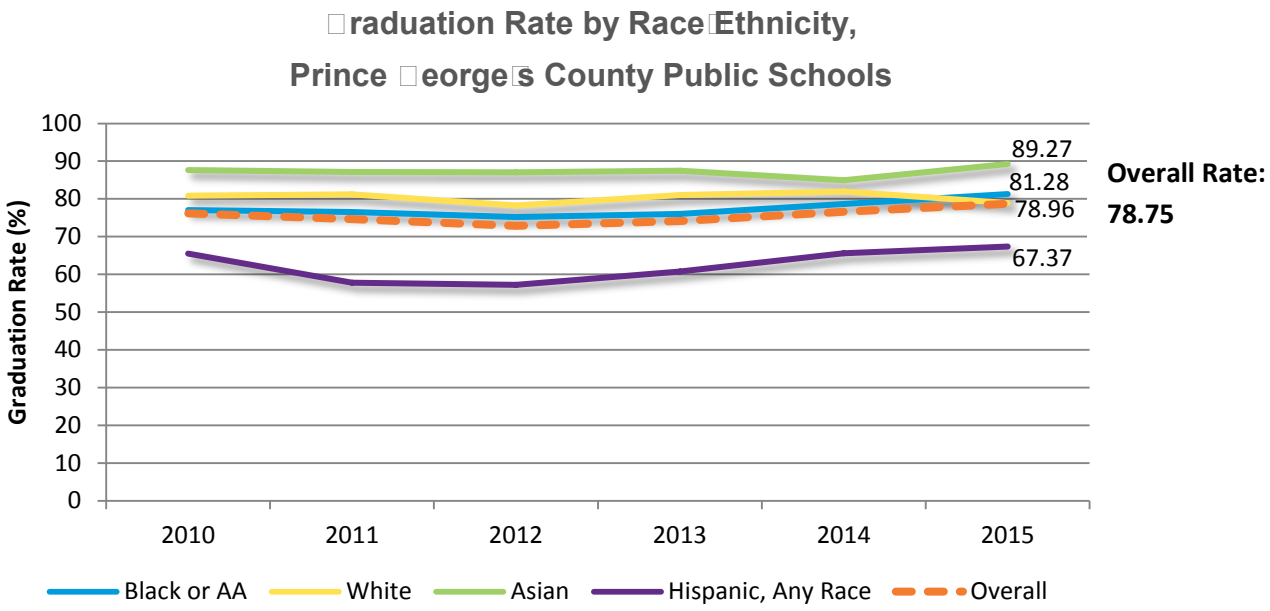


Data Source: 2014 American Community Survey 1-Year Estimates, Table B15002

While Prince George□s County is similar to the U.S. (see Table 7) for those with Bachelor□s Degrees and higher (31% and 30%), the County falls behind when compared to Maryland (38%). There is more of disparity when comparing the County to the neighboring jurisdiction of Washington, D.C., which has 55% of residents with a Bachelor□s Degree or higher.

There are noticeable differences within the County by race and ethnicity (see Graph 6), with Asian residents having high educational attainment, followed by White, Non-Hispanic (NH) residents. Most Black residents do have a High School Degree, but fewer have a college degree compared to Asian and White, NH residents. The County□s Hispanic residents have the most significant disparity, with over 50% lacking a High School Degree or equivalent, and less than 10% having a Bachelor□s Degree or higher.

In 2015, 127,576 County children and adolescents enrolled in public schools. While the overall graduation rate has increased since 2012 (see Graph 7), Hispanic students are still less likely to complete high school in the County. Overall, Prince George□s County has a lower graduation rate (78.75%) compared to Maryland (86.98%) in 2015. Part of that difference may be due to the graduation rate for Hispanic students in Maryland being over 10 percent higher (76.89% compared to 67.37% for the County).



Data Source: Maryland Report Card http://reportcard.msde.maryland.gov/

Percentage of Residents □ ithout □igh School or E□uivalent Education by □IP Code, Prince □eorge□s County, 2010-201□

ZIP	Area	Percent Without High School or Equivalent
20601	Waldorf	16.4%
20607	Accokeek	17.8%
20608	Aquasco	4.0%
20613	Brandywine	14.5%
20623	Cheltenham	24.6%
20705	Beltsville	9.2%
20706	Lanham	15.7%
20707	Laurel	10.5%
20708	Laurel	7.1%
20710	Bladensburg	17.7%
20712	Mount Rainier	19.8%
20715	Bowie	4.2%
20716	Bowie	5.5%
20720	Bowie	2.1%
20721	Bowie	3.7%
20722	Brentwood	19.4%
20735	Clinton	8.7%
20737	Riverdale	27.9%
20740	College Park	2.6%
20743	Capitol Heights	17.3%
20744	Fort Washington	10.1%
20745	Oxon Hill	24.5%
20746	Suitland	19.8%
20747	District Heights	14.0%
20748	Temple Hills	15.1%
20762	Andrews Air Force Base	0.2%
20769	Glenn Dale	26.5%
20770	Greenbelt	15.7%
20772	Upper Marlboro	17.1%
20774	Upper Marlboro	5.9%
20781	Hyattsville	35.7%
20782	Hyattsville	16.7%
20783	Hyattsville	37.2%
20784	Hyattsville	19.3%
20785	Hyattsville	16.2%
20903	Silver Spring	33.6%
20904	Silver Spring	10.8%
20912	Takoma Park	14.2%

Data Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates, Table S1501

Employment

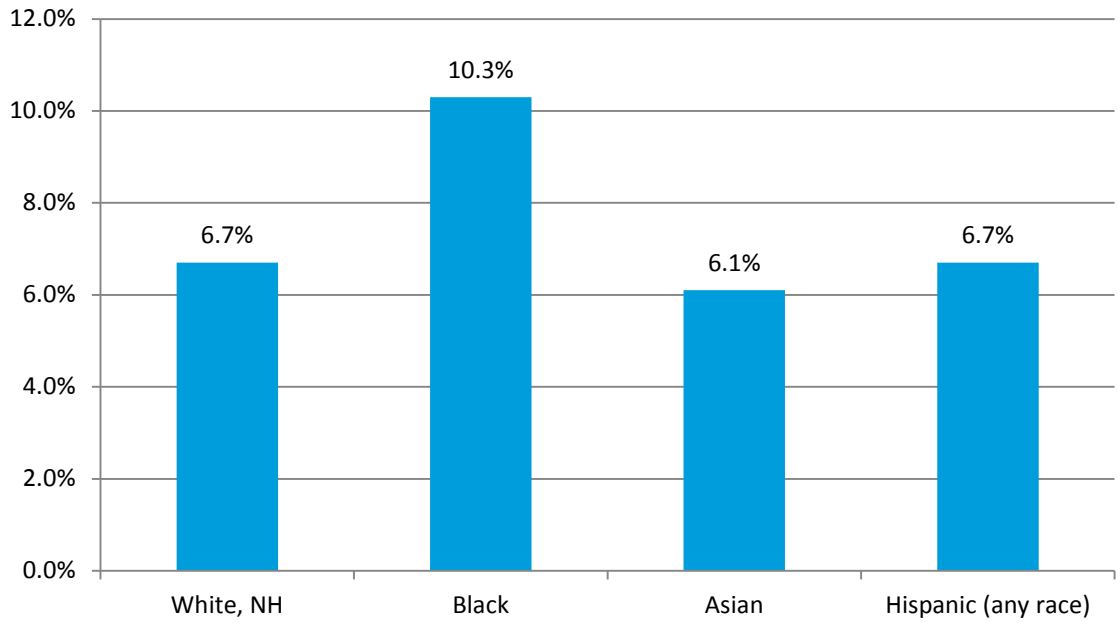
In 2014, 9.1% of Prince George□s County residents were unemployed, which is higher than both Maryland and the U.S. at 7.2%. The county unemployment rate varies by education, disability status, and by race and Hispanic ethnicity. Overall, one-third of residents age 16 and older living in poverty are unemployed.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

Unemployment Rate for Residents 1□ Years and Older, 201□

	Prince George's County	Maryland	United States
Population 16 years and older	9.1%	7.2%	7.2%
Below Poverty Level	32.8%	30.5%	25.0%
With Any Disability	17.1%	16.0%	14.9%
Educational Attainment (Ages 25-64 Years)			
Less than High School	9.2%	12.7%	10.8%
High School Graduate	8.9%	8.1%	7.7%
Some College or Associate's Degree	8.4%	6.6%	6.1%
Bachelor's Degree or Higher	4.8%	3.4%	3.4%

Data Source: 2014 American Community Survey 1-Year Estimates, Table S2301

Unemployment Rate, Prince □eorge□s County, 201□

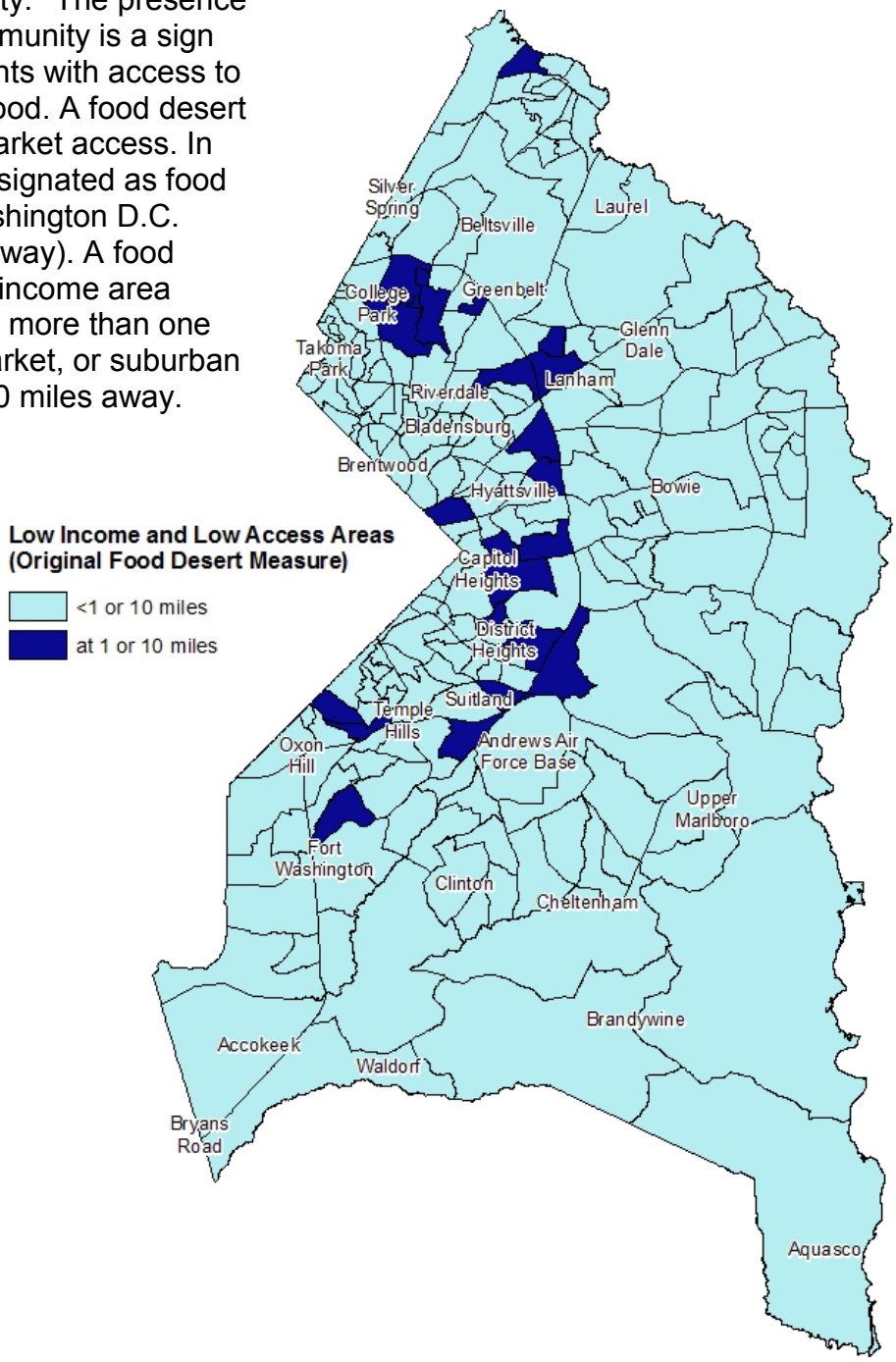


Data Source: 2014 American Community Survey 1-Year Estimates, Table S2301

Access to Food

Access to healthy food has been shown to increase fruit and vegetable consumption and lower the risk of obesity.[3] The presence of a supermarket in a community is a sign health by providing residents with access to affordable and nutritious food. A food desert is an area lacking supermarket access. In the county, most areas designated as food deserts are within the Washington D.C. metro area (inside the beltway). A food desert is defined as a low income area where urban residents are more than one mile away from a supermarket, or suburban residents are more than 10 miles away.

Food Deserts: Low Income and Low Access, Prince George's County, 2010



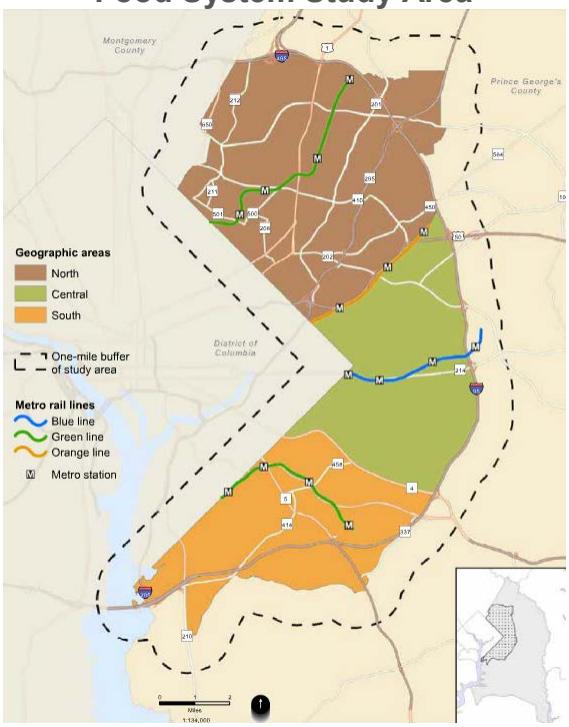
Data Source: United States Department of Agriculture, Economic Research Service, Food Access Research Atlas

[3] Robert Wood Johnson Foundtation, http://www.rwjf.org/en/library/research/2012/12/do-all-americans-have-equal-access-to-healthy-foods-.html

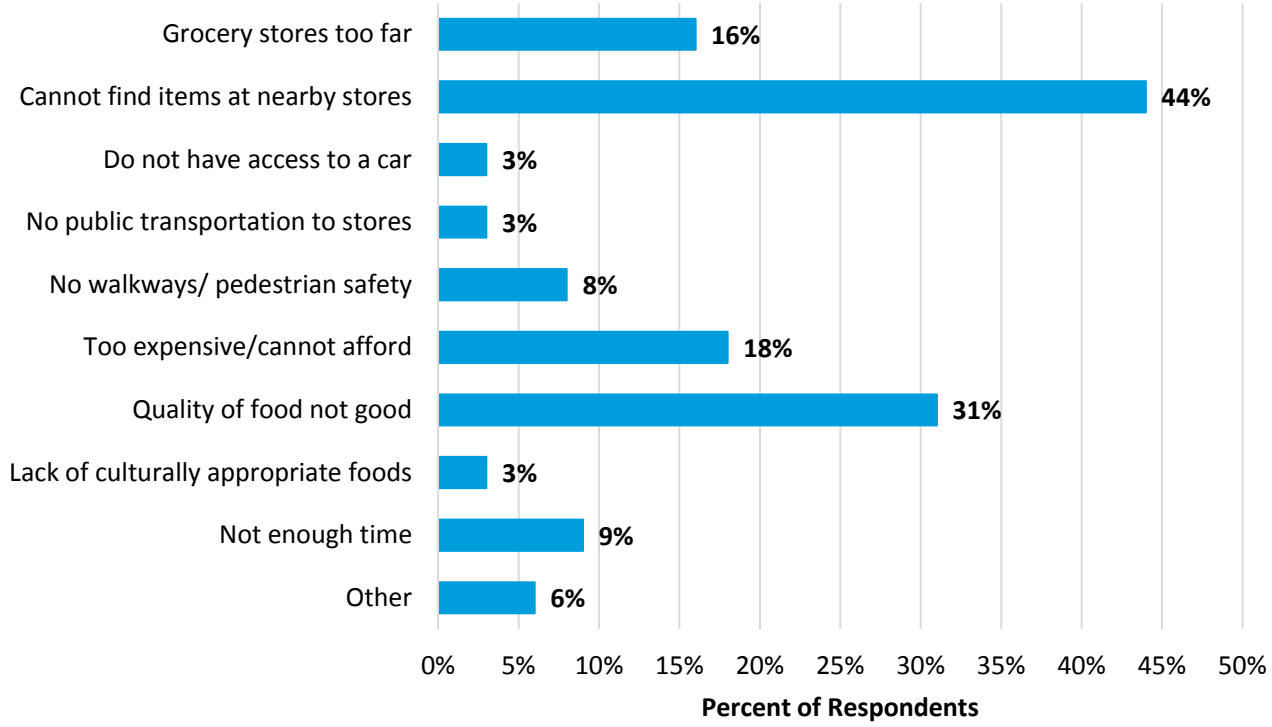
Prince □eorge□s County Food System Study, 201□

A 2015 food system study of the area of Prince George□s County adjacent to Washington, DC, found that many residents had food access challenges □related to the quality of local stores and what they carry than the physical access to food outlets. Many residents do not patronize nearby supermarkets but travel elsewhere, even to other jurisdictions, where more variety and better quality food are sold for less□[4] This finding was confirmed by a survey of the local food outlets that indicated small markets had limited healthy food alternative available. The study area was noted to have numerous supermarkets, but that the quality and availability of food even within the same retailer varied.

Food System Study Area



Food Access Challenges



[4] Healthy Food for all Prince George's County, Maryland National Park and Planning Commission, Prince George's County Planning Department, 2015

□ousing

There are fewer housing vacancies in Prince George□s County (7.1%) compared to both Maryland (10.6%) and the U.S. (12.5%). The County has more single-family households (21%) compared to Maryland (14.7%) and the U.S. (13%).[5] The median value of homes in Prince George□s County is $247,600 which is lower than the overall state ($280,220) but higher than the national value ($173,900).[6]

□ousing Characteristics, 201□

Indicators	Prince George's		Maryland		U.S.	
	N	%	N	%	N	%
Total Housing Units	**330,514**		**2,422,317**		**133,962,970**	
Vacancy						
Occupied Housing Units	307,022	92.9%	2,165,438	89.4%	117,259,427	87.5%
Vacant Housing Units	23,492	7.1%	256,879	10.6%	16,703,543	12.5%
For Rent	10,033		54,918		2,963,407	
Occupied Housing Units						
Owner-occupied	185,502	60.4%	1,426,748	65.9%	73,991,995	63.1%
Renter-occupied	121,520	39.6%	738,690	34.1%	43,267,432	36.9%
Owner-Occupied Units Household Type						
Married couple family		48.9%		58.4%		60.0%
Male householder, no wife present		5.7%		4.2%		4.1%
Female householder, no husband present		16.7%		10.9%		9.2%
Nonfamily household		28.8%		26.5%		26.7%
Renter-Occupied Units Household Type						
Married couple family		23.0%		25.5%		27.1%
Male householder, no wife present		9.8%		6.3%		6.3%
Female householder, no husband present		25.6%		21.9%		19.6%
Nonfamily household		41.7%		46.3%		47.0%
Average Household Size						
Owner-occupied	2.97		2.77		2.71	
Renter-occupied	2.76		2.54		2.55	

Data Source: 2014 American Community Survey 1-Year Estimates, Tables B25004, S2501, S2502, B25010

[5] Census.gov Table S1101
[6] Census.gov Table DP04

Fair □ar□et Rent

Approximately 40% of occupied housing units in Prince George□s County are rentals (Table 8). The estimated median income for renters in the County is $50,792, which is 30% lower than the overall County median household income of $72,290. Based on the Fair Market Rent values, affordable housing can be a challenge in the County. When limited income has to be used for rent, these households may affect their ability to purchase other necessities, such as food, transportation and medical expenses. While the rental income in Prince George□s County is greater than Maryland, the rental costs are also higher.

Fair □ar□et Rent, 201□

	Prince George's County	Maryland
Fair Market Rent by Unit		
Efficiency	$1,167	$936
One bedroom	$1,230	$1,049
Two bedroom	$1,458	$1,281
Three bedroom	$1,951	$1,677
Four bedroom	$2,451	$1,957
Income Needed to Afford Fair Market Rent by Unit		
Efficiency	$46,680	$37,448
One bedroom	$49,200	$41,942
Two bedroom	$58,320	$51,249
Three bedroom	$78,040	$67,074
Four bedroom	$98,040	$78,299
Income of Renter		
Estimated renter median income	$50,792	$46,697
Rent affordable for households earning the renter median income	$1,270	$1,167

Data Source: National Low Income Housing Coalition, www.nlihc.org

Income

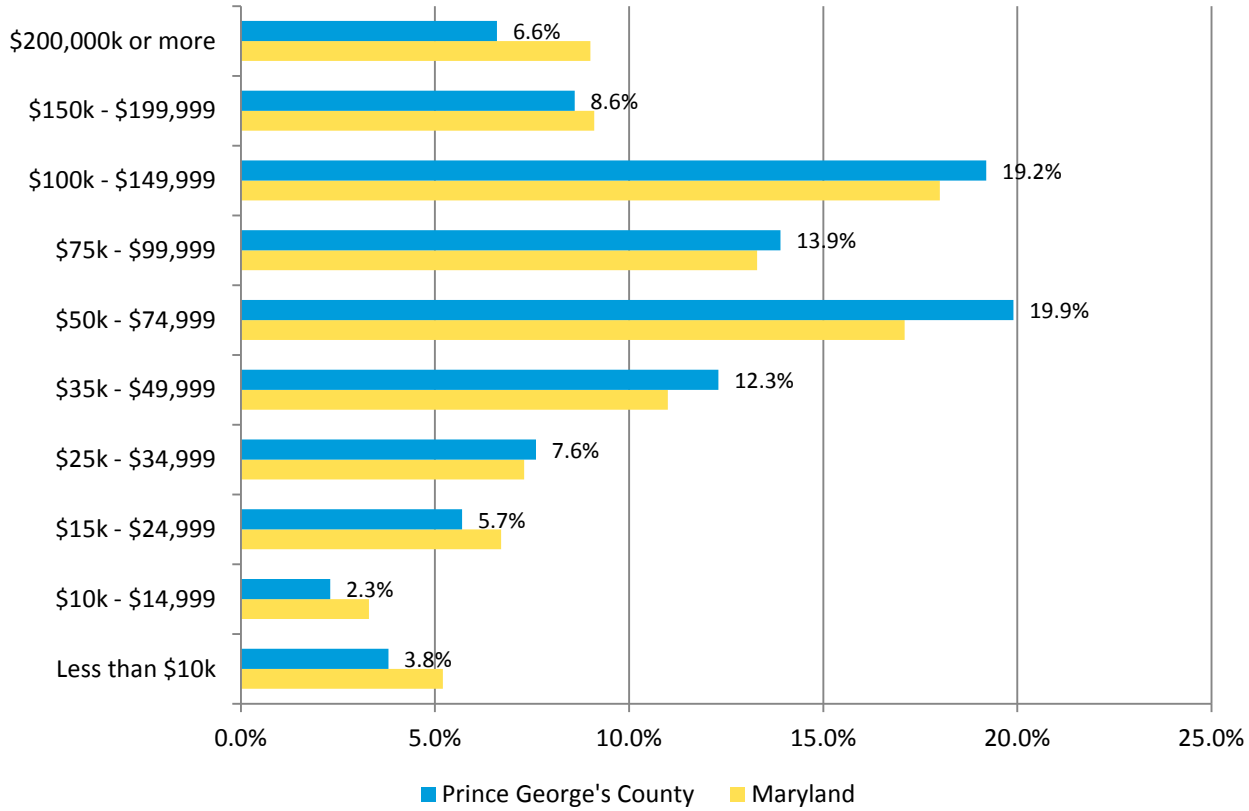
The median household income in the County is $72,290 which is lower than Maryland ($73,971), but is higher than the U.S. When looking at income by groups (Graph 8), Maryland has more residents making below $25,000 compared to Prince George's County; however, Maryland also has more residents making above $150,000 compared to Prince George's County, which helps to explain the higher mean and median income for the state.

Income in the Past 12 Months in 2015 Inflation-Adjusted Dollars

	Prince George's County	Maryland	United States
Median household income	$72,290	$73,971	$53,657
Mean household income	$89,171	$97,016	$75,591
Median family income	$83,167	$89,678	$65,910
Mean family income	$99,201	$112,887	$88,394

Data Source: 2014 American Community Survey 1-Year Estimates, Table S1901

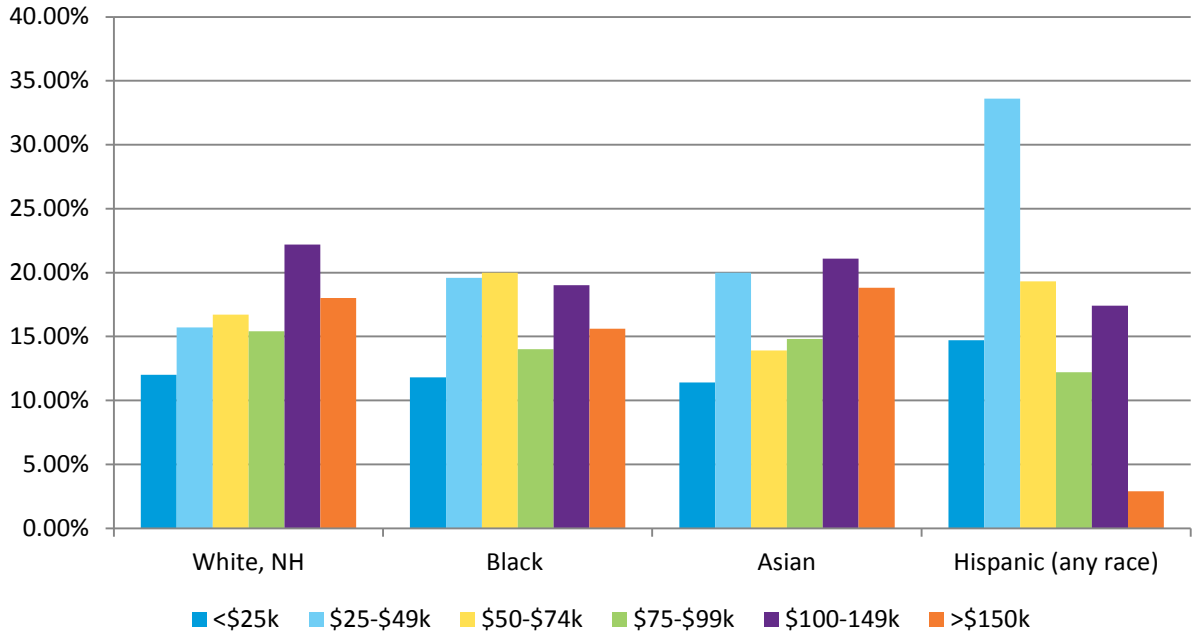
Household Income in 2015 Inflation-Adjusted Dollars



Data Source: 2014 American Community Survey 1-Year Estimates, Table S1901

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

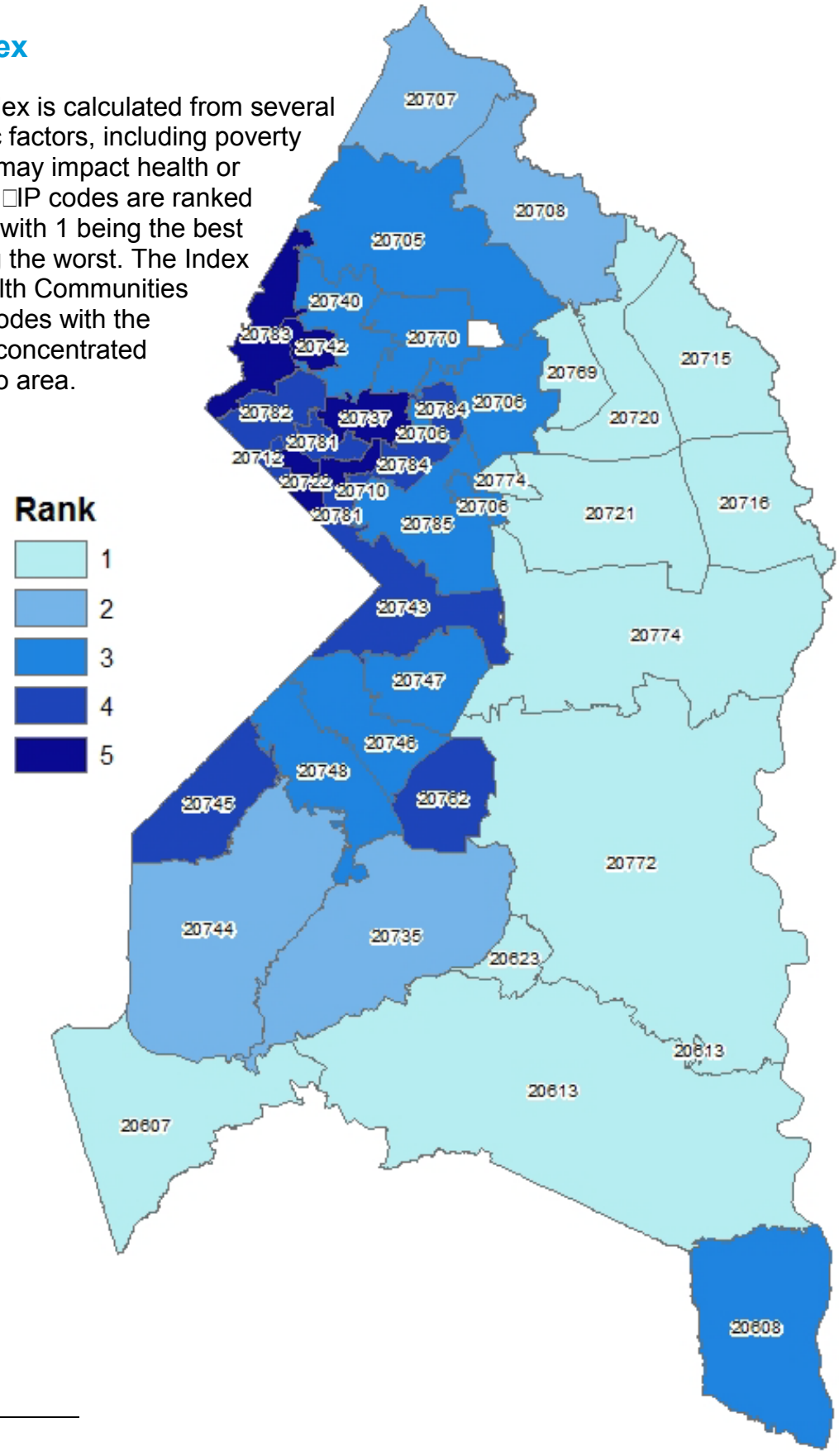
□ousehold Income □In 201□ Inflation-Ad□usted Dollars□by Race and Ethnicity, Prince □eorge□s County



Data Source: 2014 American Community Survey 1-Year Estimates, Table B19001

Socio□eeds Index

The SocioNeeds Index is calculated from several social and economic factors, including poverty and education, that may impact health or access to care. The □IP codes are ranked based on the index, with 1 being the best ranking, and 5 being the worst. The Index is calculated by Health Communities Institute[7]. The □IP codes with the highest ranking are concentrated within the D.C. metro area.



[7] www.pgchealthzone.org

HEALTH INDICATORS REPORT

Introduction

The following report includes existing health data for Prince George's County, compiled using the most current local, state, and national sources. This report was developed to inform and support a joint Community Health Needs Assessment for the Health Department and area hospitals, and was used as part of the Prioritization Process that included resident representation from across the county.

ethods

Much of the information in this report is generated through a variety of sources, including: Maryland Health Services Cost Review Commission; Maryland ital Statistics Annual Reports, Maryland Department of Health and Mental Hygiene's (DHMH) Annual Cancer Reports, Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention's CDC WONDER Online Database, Centers for Medicare and Medicaid Services, National ital Statistics Reports, Maryland SHIP, and the Prince George's County Health Department data website: www.pgchealthzone.org. Some of the data presented, specifically some birth and death data as well as some emergency room and hospitalization data, were analyzed by the Health Department using data files provided by Maryland DHMH. The specific data sources used are listed throughout the report.

When available, state (noted as MD SHIP) and national (noted as HP 2020) comparisons were provided as benchmarks. Most topics were analyzed by gender, race and ethnicity, age group and IP Code level to study the burden of health conditions, determinants of health and health disparities.

Limitations

While efforts were made to include accurate and current data, data gaps and limitations exist. One major limitation is that Prince George's County residents sometimes seek services in Washington, D.C.; because this is a different jurisdiction the data for these services may be unavailable (Emergency Room isits) or older (hospitalizations). Another major limitation is that the diversity of the county is often not captured through traditional race and ethnicity. The county has a large immigrant population, but data specific to this population is often not available related to health issue. Data with small numbers can also be difficult to analyze and interpret and should be viewed carefully. Current events can also affect data, such as the implementation of the Affordable Care Act (ACA). While the ACA has increased health insurance coverage, the data that is needed to fully understand how this has affected our residents is not yet available.

Definitions

Crude Rate - The total number of cases or deaths divided by the total population at risk. Crude rate is generally presented as rate per population of 1,000, 10,000 or 100,000. It is not adjusted for the age, race, ethnicity, sex, or other characteristics of a population.

Age-Ad□usted Rate - A rate that is modified to eliminate the effect of different age distributions in the population over time, or between different populations. It is presented as a rate per population of 1,000, 10,000 or 100,000.

Fre□uency - Often denoted by the symbol □n□, frequency is the number of occurrences of an event.

□**ealth Disparity -** Differences in health outcomes or health determinants that are observed between different populations. The terms health disparities and health inequalities are often used interchangeably.

□**ealth People 2020** □□**P 2020**□□ Healthy People 2020 is the nation□s goals and objectives to improve citizens□health. HP2020 goals are noted throughout the report as a benchmark.

Incidence Rate - A measure of the frequency with which an event, such as a new case of illness, occurs in a population over a period of time.

Infant □ortality Rate - Defined as the number of infant deaths per 1,000 live births per year. Infant is defined as being less than one year of age.

□**aryland S□IP** □□**D S□IP**□□ Maryland□s State Health Improvement Plan is focused on improving the health of the state; measures for the SHIP areas are included throughout the report as a benchmark.

Prevalence Rate - The proportion of persons in a population who have a particular disease or attribute at a specified point in time (point prevalence) or over a specified period of time (period prevalence).

Racial and Ethnic □roups:

□ **hite -** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

□**lac□ or African American** - A person having origins in any of the black racial groups of Africa.

Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, □apan, □orea, Malaysia, Pakistan, the Philippine Islands, Thailand, □ietnam etc.

American Indian or Alas□a □ative - A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

□**ispanic or Latino** - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

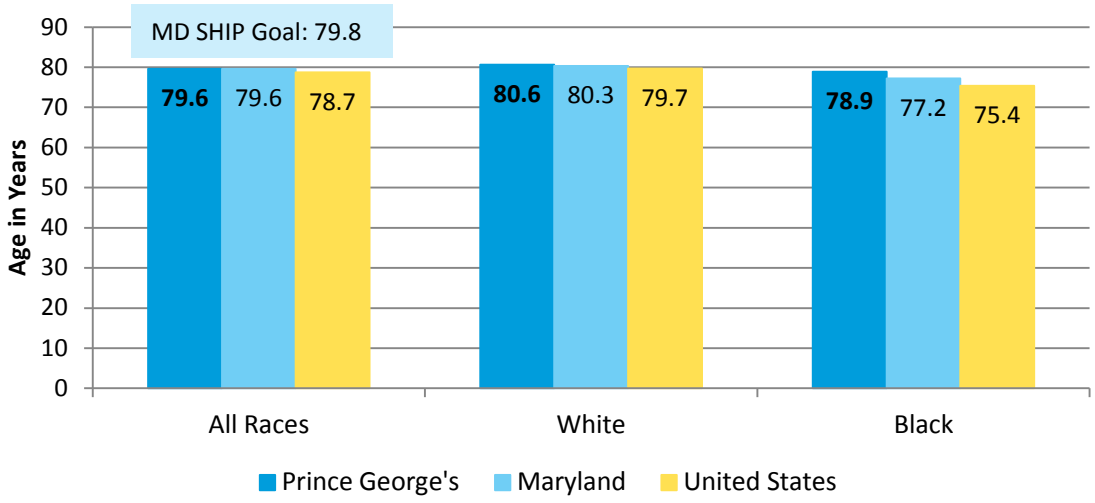
□able of Contents

□ealth Status Indicators

Life Expectancy

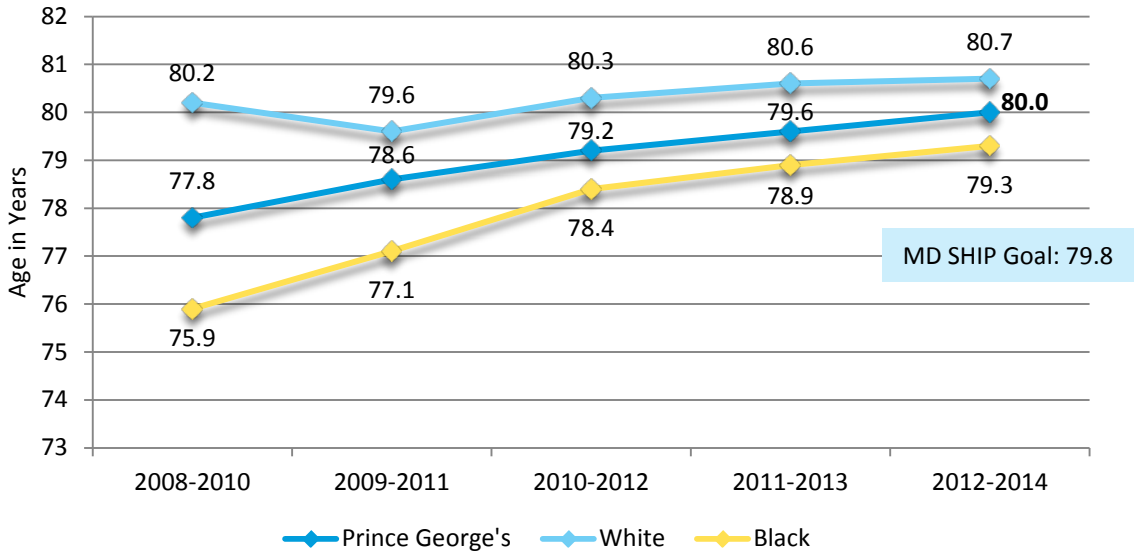
Prince George□s County has a life expectancy about the same as Maryland and above the U.S. Life expectancy has steadily increased in the county, and the Maryland SHIP Goal of 79.8 years was met as of 2014. However, there is still a disparity in life expectancy by race, with White residents living longer on average than Black residents.

Life Expectancy at □irth by Race, 2011-201□



Data Source: National Vital Statistics Report, CDC http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf; Maryland Vital Statistics Annual Report 2014, Maryland Department of Health and Mental Hygiene

Life Expectancy at □irth by Race, Prince □eorge□s County, 200□-201□



Data Source: Maryland Vital Statistics Annual Report 2014, Maryland Department of Health and Mental Hygiene

□ortality

From 2012-2014, 16,585 deaths occurred to Prince George□s County residents. The leading two causes of death in the county, heart disease and cancer, account for half of all resident deaths. Overall, the age-adjusted death rate for the county is higher than Maryland, but lower than the U.S. for 2012-2014. For the leading causes of death, the county□s age-adjusted mortality rates are higher than Maryland and the U.S. for heart disease, cancer, stroke, diabetes, septicemia, nephritis, homicide, hypertension, and perinatal conditions.

Leading Causes of Death, 2012-201□

Cause of Death	Prince George's County Deaths		Age-Adjusted Death Rates per 100,000 Population			Healthy People 2020 Target	Maryland SHIP 2017 Goal
	Number	Percent	Prince George's	Maryland	U.S.		
All Causes	16,585	100%	720.3	706.3	729.7	---	---
Heart Disease	4,182	25.2%	185.8	171.6	169.1	---	166.3
Cancer	4,056	24.5%	166.4	163.3	163.6	161.4	147.4
Stroke	823	5.0%	37.8	36.9	36.5	34.8	---
Diabetes	683	4.1%	29.4	19.4	21.1	66.6	---
Accidents	667	4.0%	26.5	27.4	39.7	36.4	---
CLRD*	458	2.8%	21.0	31.4	41.4	---	---
Septicemia	370	2.2%	16.1	15.1	10.6	---	---
Influenza and Pneumonia	318	1.9%	15.0	16.2	15.2	---	---
Nephritis	305	1.8%	13.8	11.4	13.2	---	---
Alzheimer's	273	1.6%	14.5	14.5	24.3	---	---
Homicide	213	1.3%	7.8	7.0	5.2	10.2	9.0
Hypertension	199	1.2%	9.0	7.1	8.3	5.5	---
Perinatal Conditions	183	1.1%	7.2	5.2	4.2	3.3	---

*CLRD=Chronic Lower Respiratory Disease, includes both chronic obstructive pulmonary disease and asthma
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Overall, White non-Hispanic (NH) male residents have the highest age-adjusted death rate in the county, followed by Black NH males. White, NH, Asian NH, and Hispanic residents all have higher age-adjusted death rates than in Maryland.

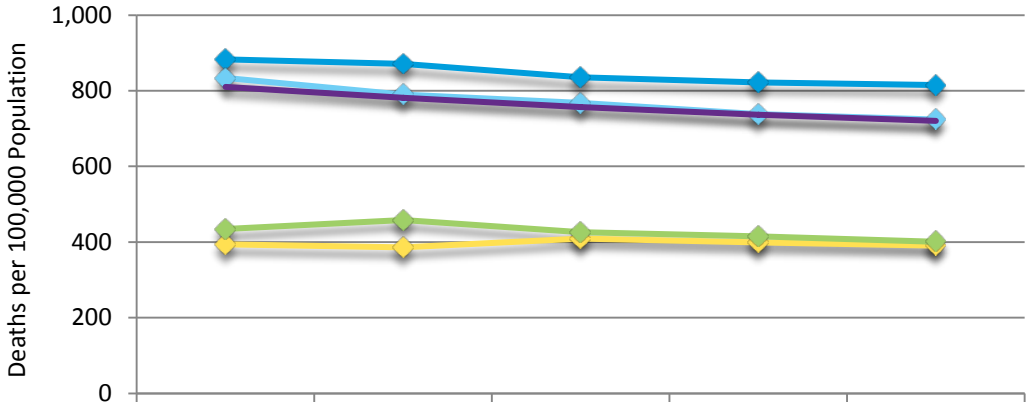
Age-Adjusted Death Rate per 100,000 by Race, Ethnicity, and Sex, 2012-2014

Race and Ethnicity	Prince George's County	Maryland	U.S.
White, Non-Hispanic	815.1	707.7	745.2
Male	953.4	832.1	875.0
Female	701.1	607.8	636.6
Black, Non-Hispanic	723.9	806.1	880.8
Male	888.7	1,002.4	1,076.4
Female	608.5	671.5	737.8
Hispanic, Any Race	390.8	323.6	532.2
Male	460.3	362.5	636.4
Female	330.2	285.4	445.9
Asian, Non-Hispanic	400.8	343.3	402.1
Male	*	390.4	479.6
Female	*	305.5	342.7
All Races and Ethnicities	720.3	706.3	729.7
Male	871.1	838.9	861.2
Female	609.6	603.4	621.6

*Rates unavailable due to low death counts

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

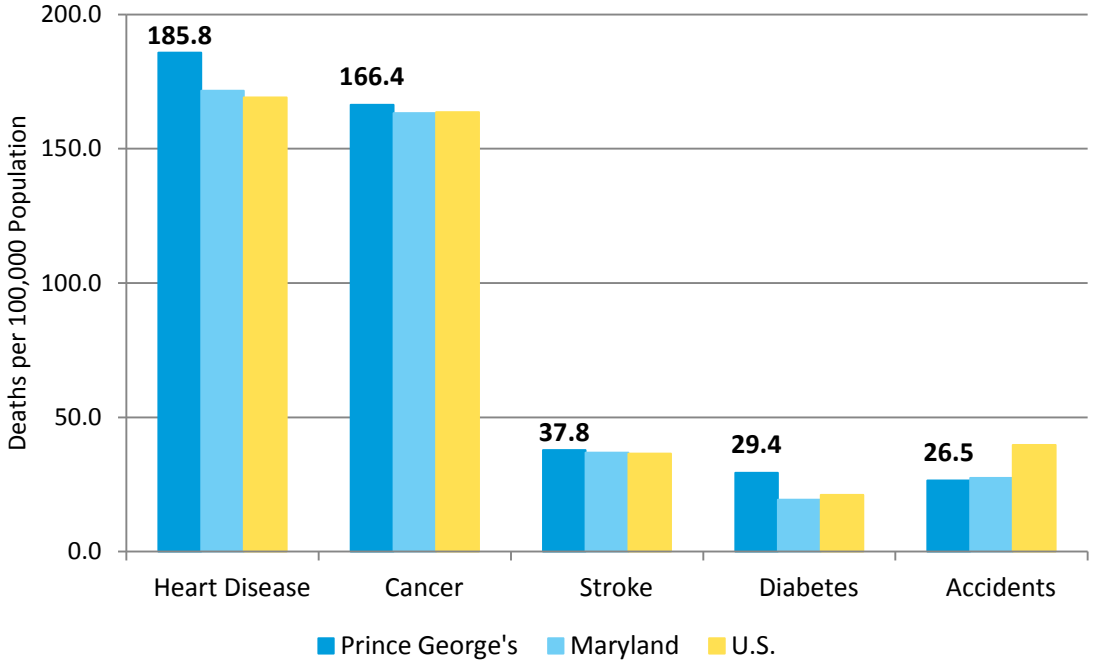
Age-Adjusted Death Rate per 100,000 for All Causes of Death by Race and Ethnicity, Prince George's County, 2008-2014



	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
White NH	882.8	871.4	835.3	822.2	815.1
Black NH	833.6	790.0	767.6	738.2	723.9
Hispanic, Any Race	393.9	386.0	409.0	398.8	390.8
Asian NH	434.3	458.2	425.9	414.8	400.8
Prince George's	810.0	781.6	756.9	736.3	720.3

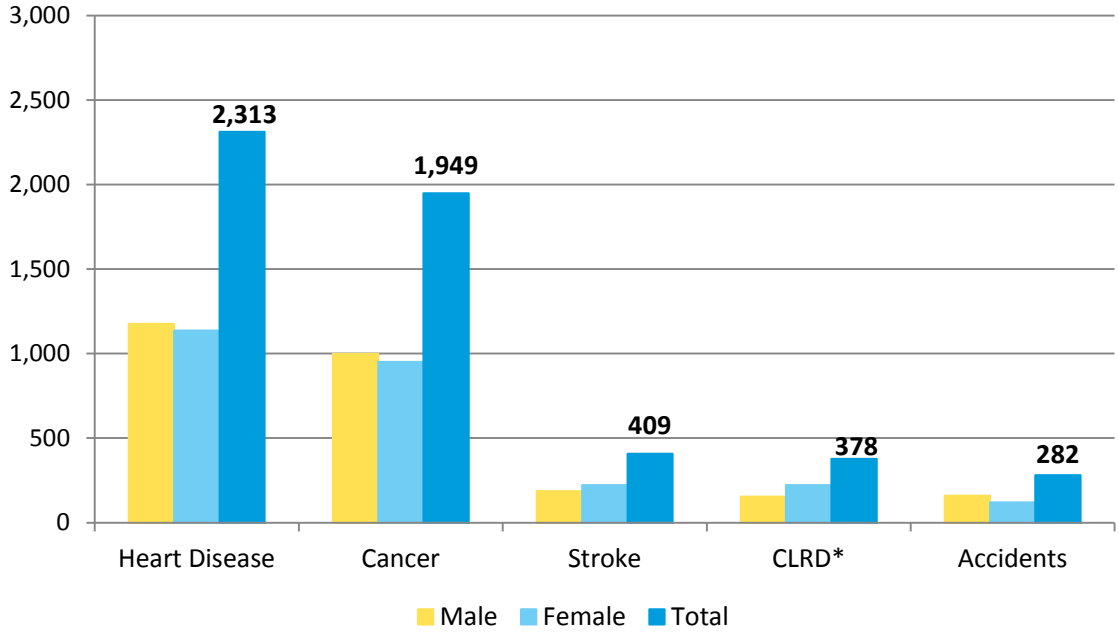
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Leading Causes of Death, Age-Adjusted Rates, 2012-2014



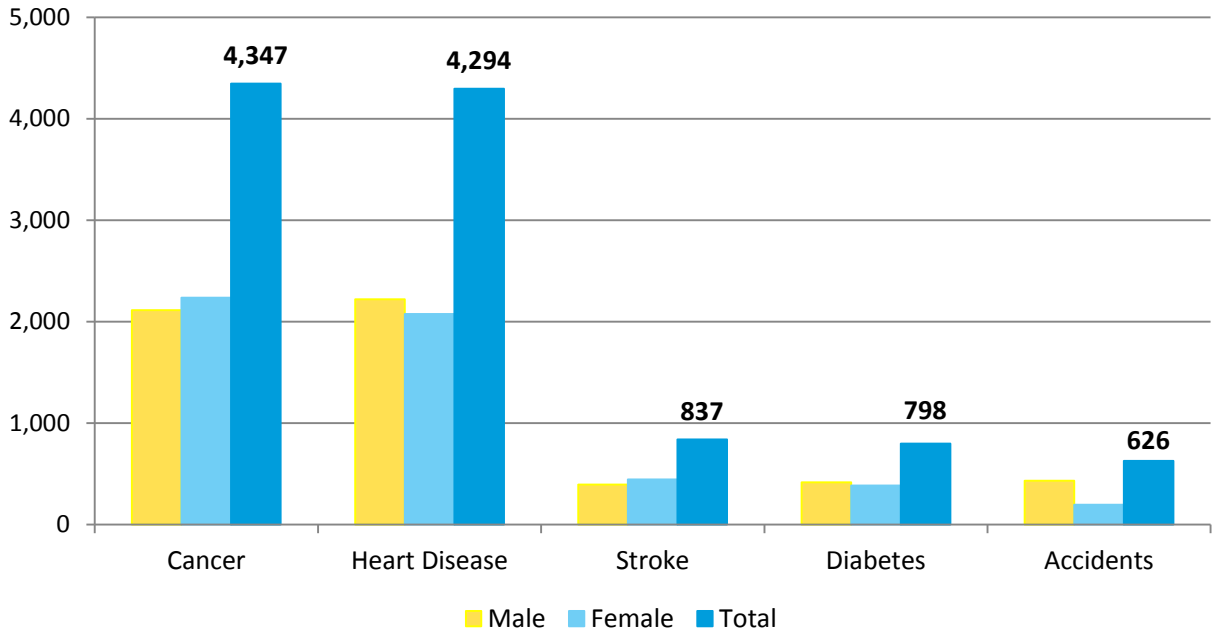
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Leading Causes of Death for White Non-Hispanic Residents, Prince George's County, 2010-2014 Annual Average



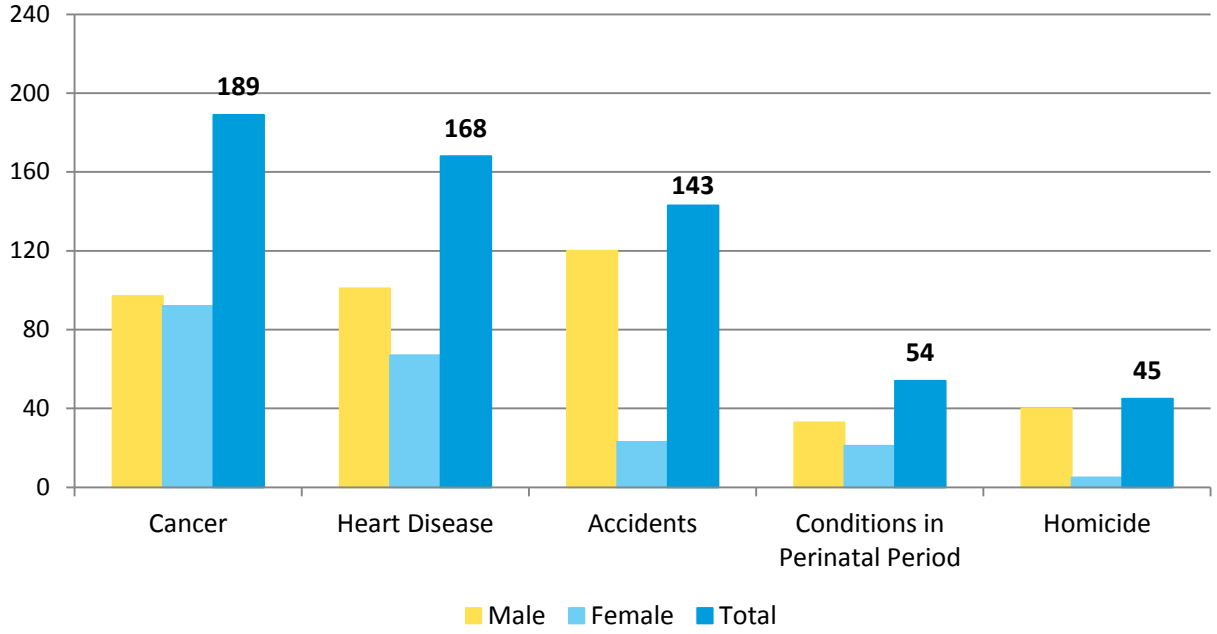
*CLRD=Chronic Lower Respiratory Disease, includes both chronic obstructive pulmonary disease and asthma
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Leading Causes of Death for □lac□ □on-□ispanic Residents, Prince □eorge□s County, 2010-201□ □□ □1□,1□□□



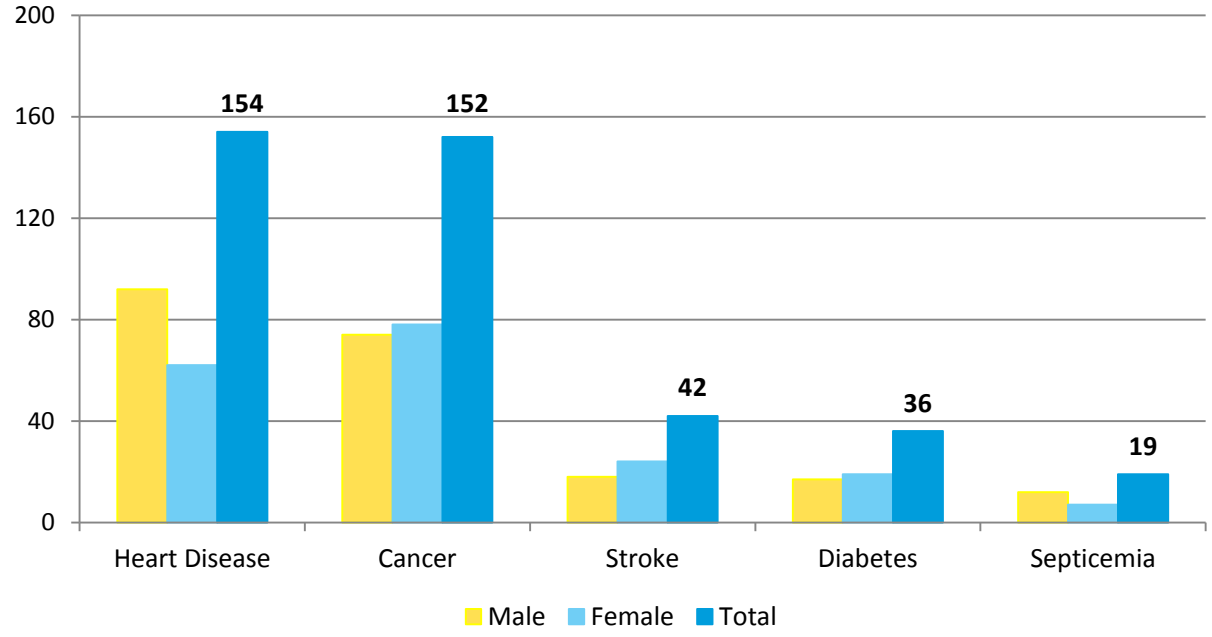
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Leading Causes of Death for □ispanic Residents of Any Race, Prince □eorge□s County, 200□-201□ □□ □1,01□□



Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Leading Causes of Death for Asian □on-□ispanic Residents, Prince □eorge□s County, 2010-201□ □□ □□□1□



Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

While the leading cause of death by race and Hispanic ethnicity is consistently heart disease and cancer, there is variation for the remaining causes. For White non-Hispanic (NH), Black NH, and Asian NH residents the third leading cause of death is stroke, but for Hispanic residents it is accidents. Diabetes is a leading cause of death for both Black NH and Asian NH residents, while both perinatal period conditions and homicide are included in the five leading causes of death for Hispanic residents.

Emergency Department □isits

Emergency Department □isits□, Prince □eorge□s County, 201□

	Number of ED Visits	Age-Adjusted Rate per 1,000 Population
Race/Ethnicity		
White, non-Hispanic	27,761	206.9
Black, non-Hispanic	180,973	314.9
Asian, non-Hispanic	2,402	58.2
Hispanic	25,779	167.6
Sex		
Male	101,805	234.6
Female	149,605	315.9
Age		
Under 18 Years	40,508	197.4
18 to 39 Years	98,331	421.5
40 to 64 Years	82,942	227.4
65 Years and Over	29,630	292.5
Total	**251,411**	**276.2**

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Outpatient Discharge Data File 2014, Maryland Health Services Cost Review Commission; Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Emergency Department □isits□by Diagnosis, Prince □eorge□s County, 201□

	Principal Diagnosis	Frequency	Percent of Visits
1	Respiratory Symptoms	17,356	6.9%
2	Abdominal Pain	12,085	4.8%
3	General Symptoms	11,013	4.4%
4	Sprains and Strains	8,156	3.2%
5	Unspecified Back Pain	6,931	2.8%
6	Head and Neck Pain	6,689	2.7%
7	Upper Respiratory Infections	5,796	2.3%
8	Urinary Tract Infections	5,255	2.1%
9	Asthma	4,717	1.9%
10	Digestive System Symptoms	4,519	1.8%

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Outpatient Discharge Data File 2014, Maryland Health Services Cost Review Commission

□ospital Admissions

□ospital Inpatient □isits□□Admissions□, Prince □eorge□s County, 201□

	Number of ED Visits	Age-Adjusted Rate per 1,000 Population
Race/Ethnicity		
White, non-Hispanic	11,610	72.7
Black, non-Hispanic	42,359	76.1
Asian, non-Hispanic	1,250	31.3
Hispanic	6,782	51.6
Sex		
Male	26,558	66.5
Female	40,331	85.0
Age		
Under 18 Years	9,613	46.9
18 to 39 Years	16,776	57.1
40 to 64 Years	20,920	69.0
65 Years and Over	19,581	191.7
Total		

* Inpatient Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Inpatient Data File 2014, Maryland Health Services Cost Review Commission

□ospital Inpatient □isits□□Admissions□by Diagnosis, Prince □eorge□s County, 201□

	Principal Diagnosis	Frequency	Percent
1	Live Birth	9,655	14.4%
2	Hearing loss	2,174	3.2%
3	Pneumonia	1,241	1.9%
4	Cerebral Infarction	1,034	1.6%
5	Congestive Heart Failure	946	1.4%
6	Acute Kidney Failure	848	1.3%
7	Post-term Pregnancy, Delivered	751	1.1%
8	Urinary Tract Infection	735	1.1%
9	Obstructive Chronic Bronchitis	626	0.9%
10	Subendocardial Infarction	616	0.9%

* Inpatient Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Source: Inpatient Discharge Data File 2014, Maryland Health Services Cost Review Commission

Access to □ealth Care

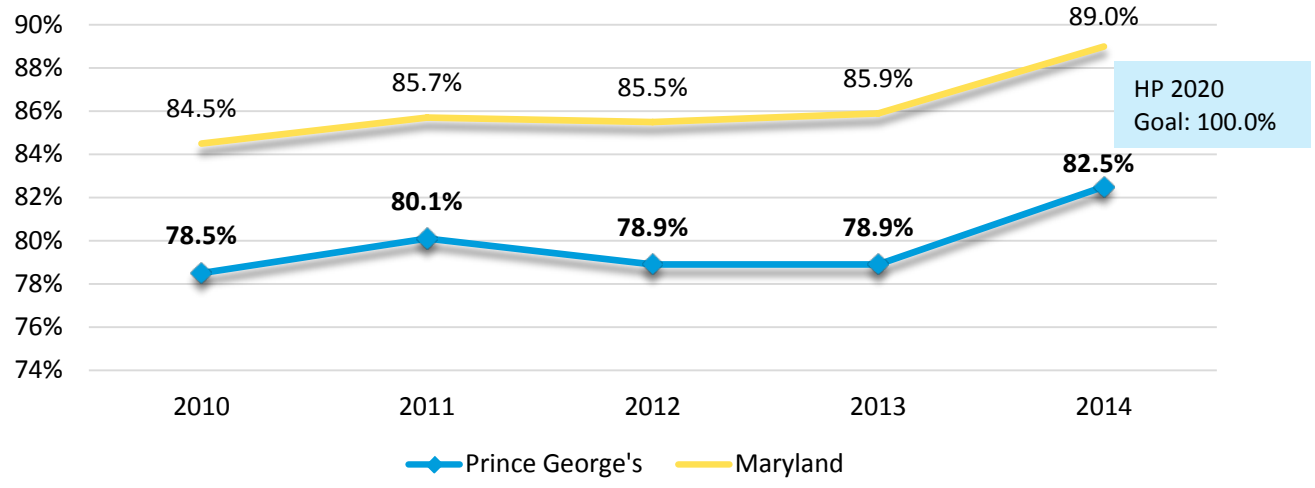
Access to quality, comprehensive health care services leads to an overall better quality of life through prevention and timely treatment for health issues. The implementation of the Affordable Care Act has resulted in an increase of county residents with health insurance, which is a key component to accessing care; however, the results are still being collected and will be reflected starting in 2015 data. Access to care goes beyond insurance, and includes provider proximity, ability to get an appointment with a medical provider, transportation, and ability to pay co-pays or fees.

Adults with □ealth Insurance, 201□

HP 2020 Goal: 100.0%	Prince George's	Maryland
Race/Ethnicity		
White, non-Hispanic	91.8%	93.5%
Black, non-Hispanic	89.5%	89.0%
Asian	84.6%	89.3%
Hispanic	47.1%	63.1%
Sex		
Male	78.9%	87.0%
Female	85.9%	90.9%
Age Group		
18 to 24 Years	84.2%	87.1%
25 to 34 Years	74.3%	84.8%
35 to 44 Years	77.9%	87.8%
45 to 54 Years	87.3%	91.3%
55 to 54 Years	90.9%	93.4%
Total	**82.5%**	**89.0%**

Data Source: American Community Survey

Adults with □ealth Insurance, 2010 to 201□



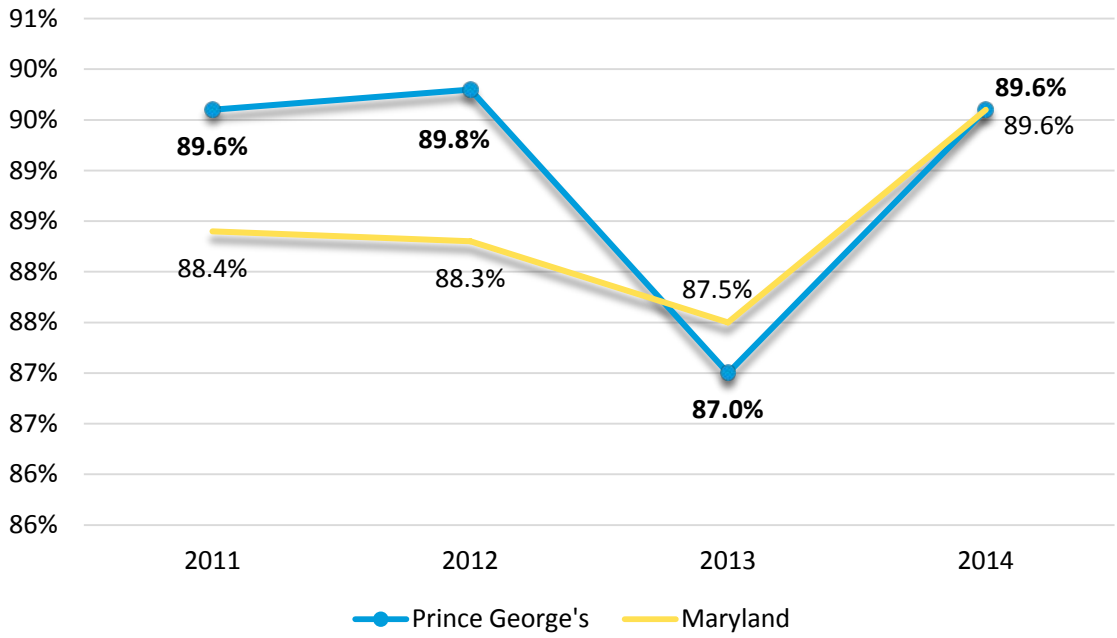
Data Source: American Community Survey

Adults who had a Routine Chec up ithin the Last 2 Years, 201

Demographic	Prince George's	Maryland
Race/Ethnicity		
White, non-Hispanic	88.4%	89.0%
Black, non-Hispanic	92.3%	93.5%
Hispanic	77.4%	77.9%
Sex		
Male	87.1%	86.2%
Female	91.9%	92.6%
Age Group		
18 to 44 Years	84.0%	84.2%
45 to 64 Years	95.2%	93.1%
Over 65 Years	96.3%	96.6%
Total	**89.6%**	**89.6%**

Data Source: 2014 Maryland BRFSS

Adults who had a Routine Chec up ithin the Last 2 Years, 2011 to 201



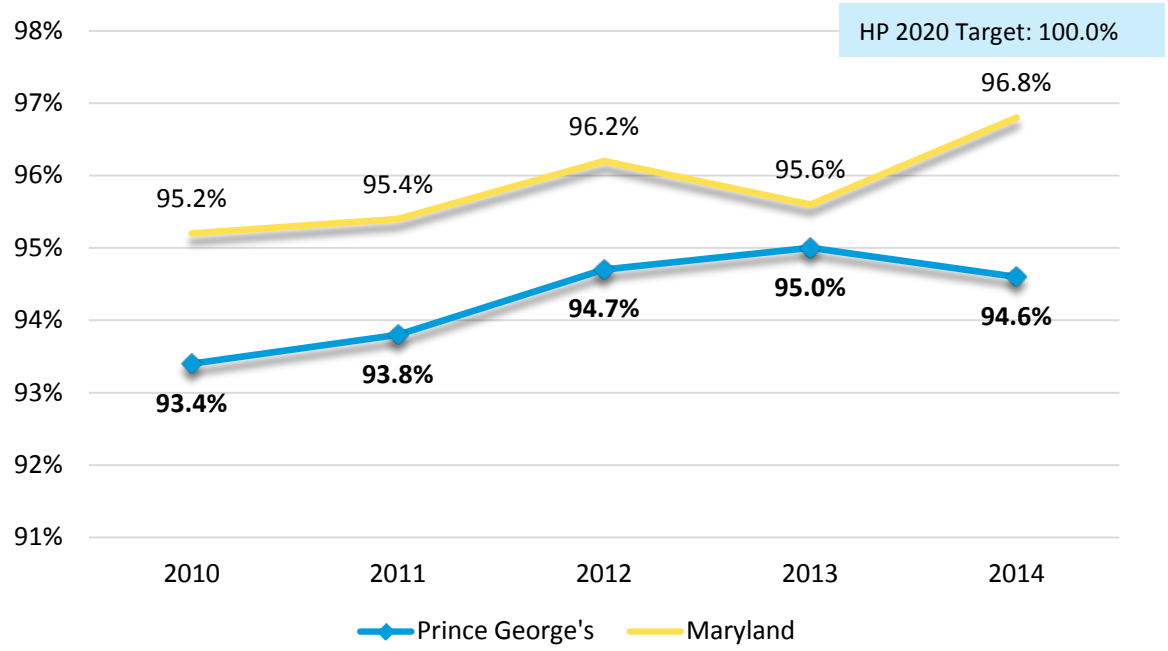
Data Source: MD BRFSS

Children with □ealth Insurance, 201□

HP 2020 Target: 100.0%	Prince George's	Maryland
Race/Ethnicity		
White, non-Hispanic	98.6%	97.9%
Black, non-Hispanic	97.0%	97.3%
Asian	98.3%	96.8%
Hispanic	86.1%	91.6%
Sex		
Male	94.9%	96.9%
Female	94.2%	96.8%
Age Group		
Under 6 Years	96.2%	97.4%
6 to 17 Years	93.7%	96.6%
Total	**94.6%**	**96.8%**

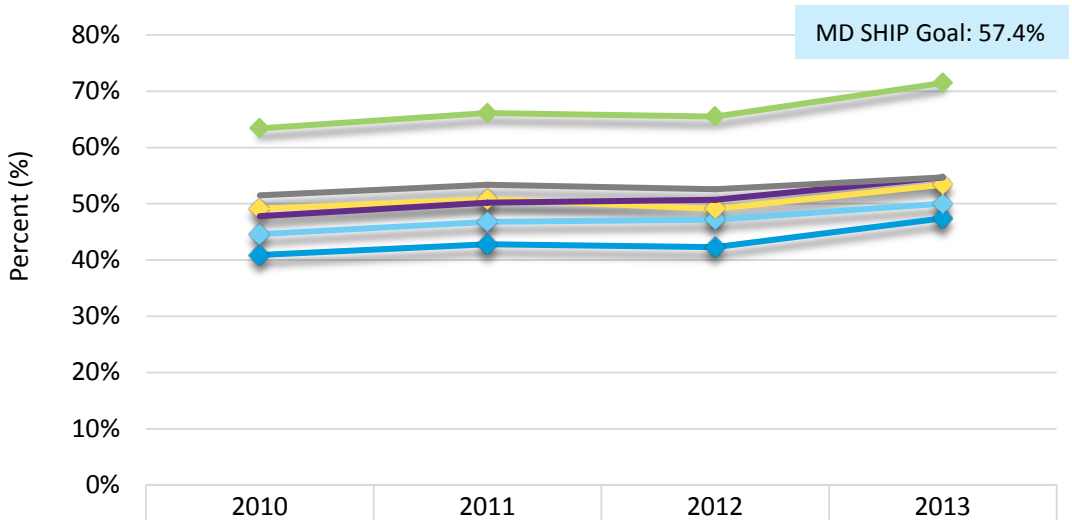
Data Source: American Community Survey

Children with □ealth Insurance, 2010 to 201□



Data Source: American Community Survey

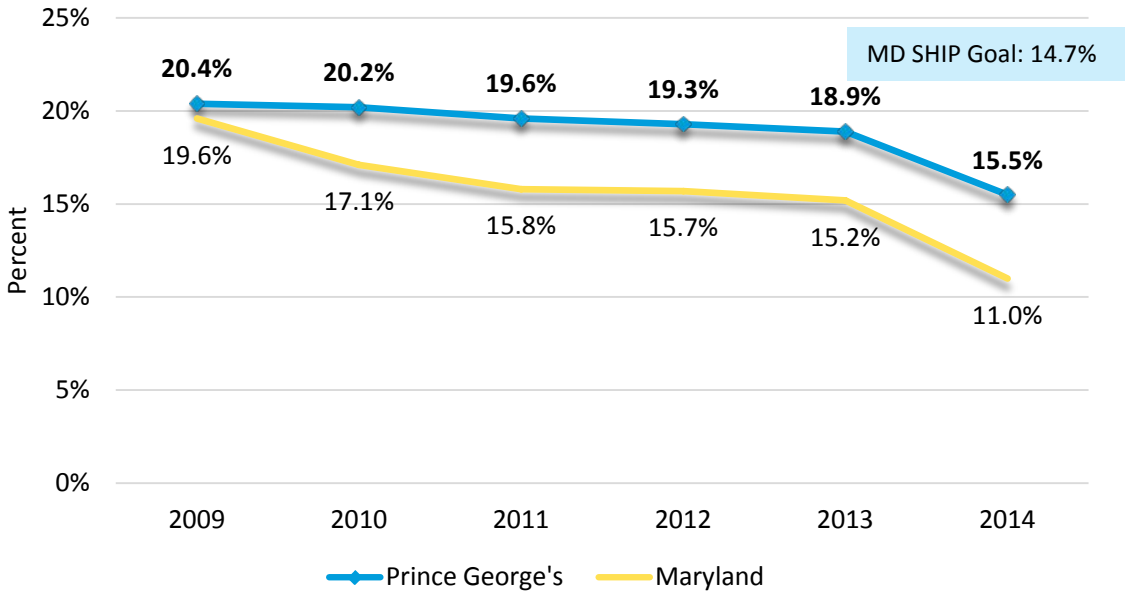
Adolescents Enrolled In □edicaid□□ ho Received a □ ellness Chec□up in the Last Year, 2010 to 201□



	2010	2011	2012	2013
PGC White NH	40.9%	42.8%	42.3%	47.4%
PGC Black NH	44.6%	46.8%	47.2%	50.0%
PGC Asian	49.1%	50.8%	49.2%	53.4%
PGC Hispanic	63.4%	66.1%	65.5%	71.5%
PGC	47.8%	50.2%	50.7%	54.7%
Maryland	51.5%	53.4%	52.6%	54.7%

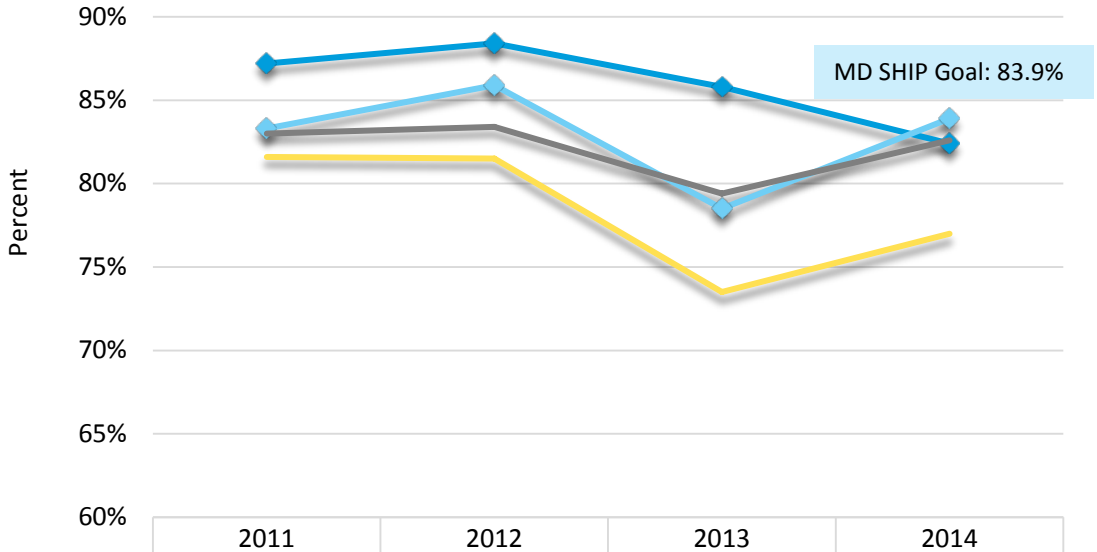
*Number of adolescents aged 13 to 20 years enrolled in Medicaid for at least 320 days
Data Source: Maryland Medicaid Service Utilization

Uninsured Emergency Department □isits, 200□-201□



Data Source: Maryland Health Services Cost Review Commission (HSCRC) Research Level Statewide Outpatient Data Files

Residents with a Usual Primary Care Provider, 2011 to 201



	2011	2012	2013	2014
PGC White NH	87.2%	88.4%	85.8%	82.4%
PGC Black NH	83.3%	85.9%	78.5%	83.9%
PGC	81.6%	81.5%	73.5%	77.0%
Maryland	83.0%	83.4%	79.4%	82.6%

Data Source: Maryland DHMH BRFSS

Resident to Provider Ratios

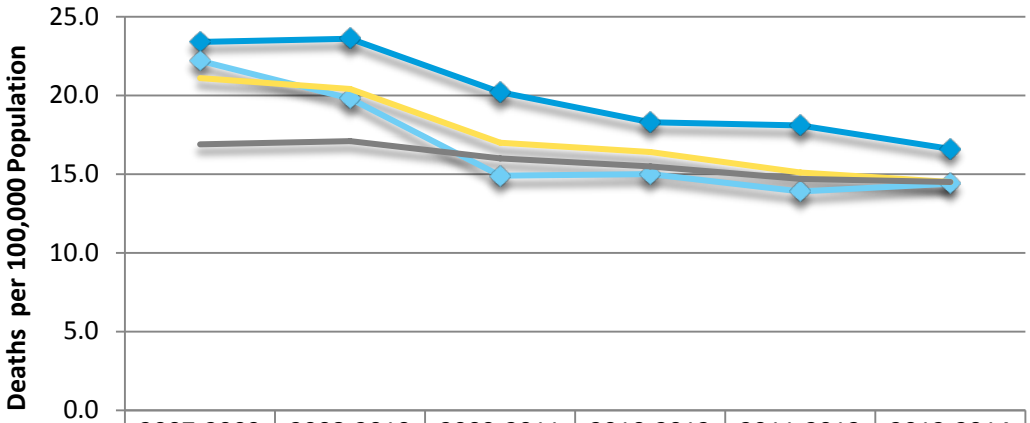
	Prince George's County Ratio	Maryland Ratio	Top U.S. Counties (90th percentile)
Primary Care Physicians (2013)	1,860:1	1,120:1	1,040:1
Dentists (2014)	1,680:1	1,360:1	1,340:1
Mental Health Providers (2015)	860:1	470:1	370:1

Data Source: 2016 County Health Rankings, www.countyhealthrankings.org

Diseases and Conditions

Al□heimer□s Disease

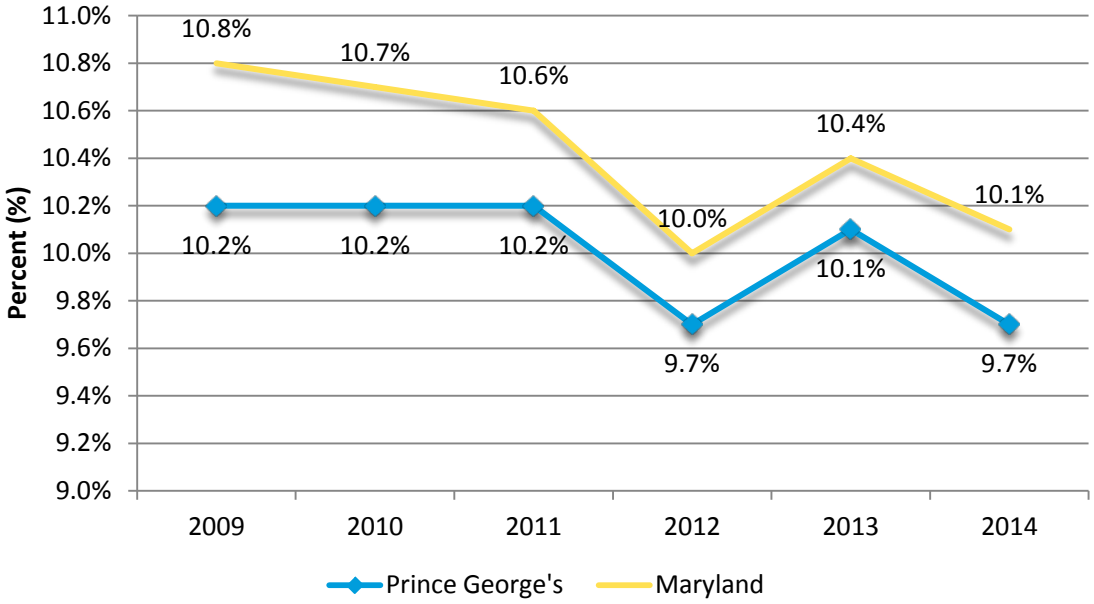
Age-Ad□usted Death Rate per 100,000 for Al□heimer□s Disease 200□-201□



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PGC White NH	23.4	23.6	20.2	18.3	18.1	16.6
PGC Black NH	22.2	19.8	14.9	15.0	13.9	14.4
PGC	21.1	20.4	17.0	16.4	15.1	14.5
Maryland	16.9	17.1	16.0	15.5	14.7	14.5

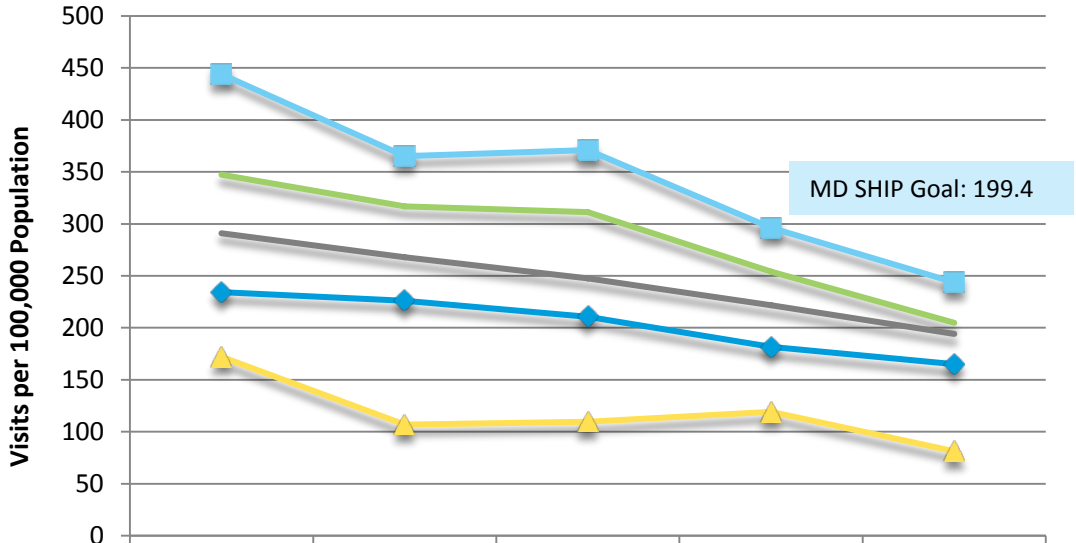
***** Residents of Hispanic Origin and Asian/Pacific Islanders were not included due to insufficient numbers
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Percentage of □edicare □eneficiaries who were □reated for Al□heimer□s Disease or Dementia, 200□ to 201□



Data Source: Centers for Medicare and Medicaid Services

Age-Ad□usted □ospital Inpatient□□isit Rate Related to Al□heimer□s and Other Dementias, 2011 to 201□



	2010	2011	2012	2013	2014
PGC White NH	234.2	226.0	210.7	181.5	165.0
PGC Black NH	444.1	365.3	370.9	296.1	243.7
Hispanic	172.0	106.7	109.5	119.1	81.2
PGC	347.4	316.8	311.2	254.0	204.8
Maryland	291.1	267.8	247.6	221.6	194.1

* Includes visits to Maryland and Washington, D.C. hospitals

Asian/Pacific Island Residents were not included due to insufficient numbers

Data Source: Maryland Health Services Cost Review Commission (HSCRC), Research Level Statewide Inpatient Data Files

Cancer

Overview	
What is it?	Cancer is a term used for diseases in which abnormal cells divide without control and can invade other tissues; there are more than 100 kinds of cancer.
Who is affected?	In 2011, 3,235 residents were diagnosed with cancer in the county, and the cancer incidence rate was 390.0 per 100,000 residents. In 2014, there were 1,417 deaths from cancer in the county, which accounted for one out of every four deaths. Prostate and breast cancer are the most common types of cancer in the county, and in 2011 accounted for 36% of all new cancer cases. Overall, Black residents have the highest age-adjusted rate for new cancer cases, while White non-Hispanic residents have the highest age-adjusted death rate for cancer. By site, lung and bronchus cancer has the highest age-adjusted death rate for county residents, followed by breast cancer.
Prevention and Treatment	According to the CDC, there are several ways to help prevent cancer: • Healthy choices can reduce cancer risk, like avoiding tobacco, limiting alcohol use, protecting your skin from the sun and avoiding indoor tanning, eating a diet rich in fruits and vegetables, keeping a healthy weight, and being physically active. • The human papillomavirus (HPV) vaccine helps prevent most cervical cancers and several other kinds of cancer; the hepatitis B vaccine can lower liver cancer risk. • Screening for cervical and colorectal cancers helps prevent these diseases by finding precancerous lesions so they can be treated before they become cancerous. Screening for cervical, colorectal, and breast cancers also helps find these diseases at an early stage, when treatment works best. Cancer treatment can involve surgery, chemotherapy, radiation therapy, targeted therapy, and immunotherapy.
What are the outcomes?	Remission (no cancer signs or symptoms); long-term treatment and care; death.
Disparity	Overall, men had a higher age-adjusted cancer incidence rate per 100,000 (475.5) than women (333.1), and Black residents had a higher rate (393.4) compared to White and Asian residents in 2011. In 2014, men had a higher cancer mortality rate at 199.4 compared to women (149.6), and White non-Hispanic (NH) residents had a higher mortality rate (208.3) compared to Black NH residents (167.7). By cancer site, Black residents in the county had higher incidence and mortality rates for breast, colorectal, and prostate cancers.
How do we compare?	Prince George's County 2011 age-adjusted cancer incidence rate was 390.0 per 100,000 residents, much lower than the state at 440.7; other Maryland counties range from 387.4 to 553.7 (2014 MD Cancer Report). The age-adjusted death rate for the county from 2012-2014 was 166.4, compared to Maryland at 163.3 with a range of 121.7 to 208.5 across Maryland counties. The county is similar to the state for cancer screening.

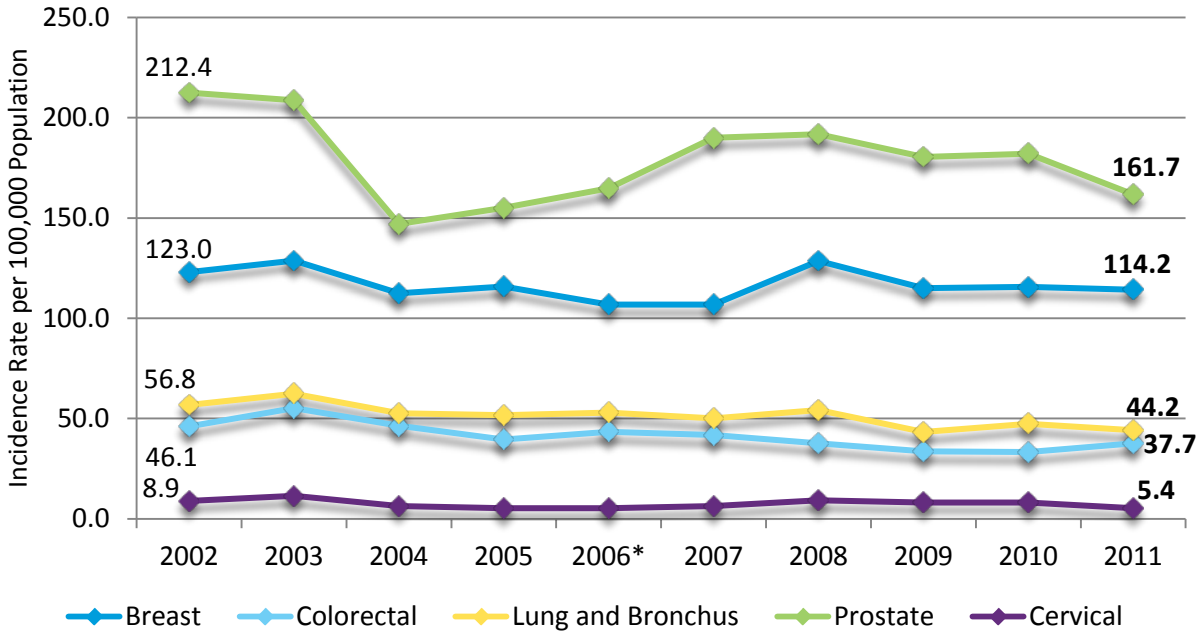
Overall, Prince George's County Age-Adjusted Cancer Incidence Rate is less than Maryland and the U.S, and for most leading types of cancer. An exception to this is Prostate Cancer with a county rate of 180.4 compared to Maryland at 148.7 and the nation at 143.6.

Cancer Age-Adjusted Incidence Rates per 100,000 Population by Site, 2007-2011

Site	Prince George's	Maryland	United States	HP 2020 Goal
All Sites	403.5	451.8	470.6	---
Breast (Female)	116.1	127.8	123.2	---
Colorectal	36.7	39.3	43.5	39.9
Male	42.0	45.1	50.3	---
Female	32.9	34.8	38.0	---
Lung and Bronchus	47.7	59.9	65.2	---
Male	59.8	69.9	79.0	---
Female	39.5	52.8	54.9	---
Prostate	180.4	148.7	143.6	---
Cervical	7.4	6.7	7.9	7.2

Data Source: Maryland Department of Health and Mental Hygiene, Annual Cancer Report, 2014; CDC National Center for Health Statistics, CDC WONDER Online Database

Cancer Age-Adjusted Incidence Rates by Site, Prince George's County, 2002-2011



*2006 incidence rates are lower than actual due to case underreporting

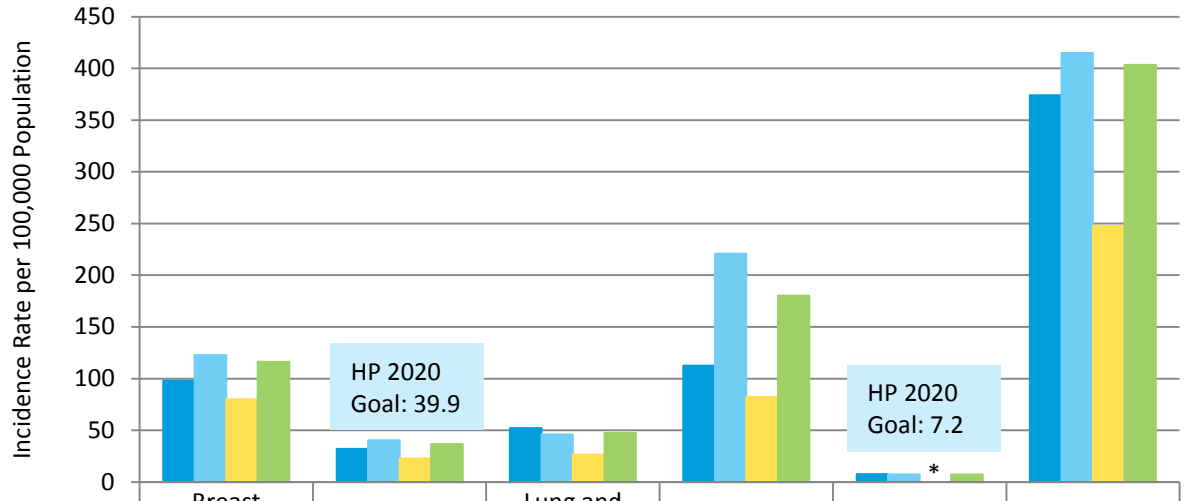
Data Source: Maryland Department of Health and Mental Hygiene, Annual Cancer Reports

Cancer Age-Adjusted Incidence Rates by Site, Prince George's County, 2002-2011

Year	All Sites	Breast	Colon	Lung and Bronchus	Prostate	Cervical
2002	**435.0**	123.0	46.1	56.8	212.4	8.9
2003	**463.0**	128.7	55.1	62.4	208.7	11.4
2004	**386.3**	112.4	46.4	52.6	147.0	6.4
2005	**386.3**	115.8	39.5	51.7	155.0	5.3
2006*	**364.4**	106.8	43.4	53.0	164.7	5.3
2007	**409.8**	106.8	41.7	50.1	189.9	6.3
2008	**429.1**	128.6	37.7	54.2	191.7	9.2
2009	**387.6**	115.0	33.7	43.3	180.4	8.2
2010	**403.5**	115.6	33.3	47.4	182.0	8.2
2011	**390.0**	114.2	37.7	44.2	161.7	5.4

*2006 incidence rates are lower than actual due to case underreporting
Data Source: Maryland Department of Health and Mental Hygiene, Annual Cancer Reports

Cancer Age-Adjusted Incidence Rates by Race, Prince George's County, 2002-2011

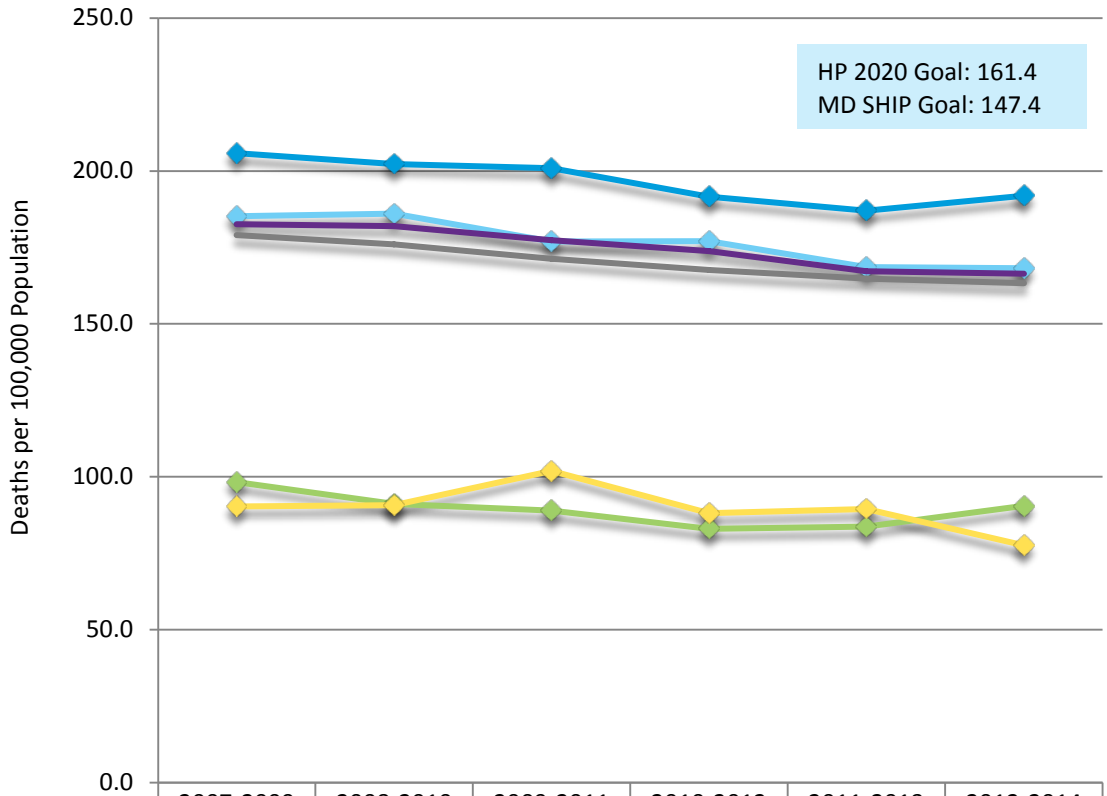


	Breast (Female)	Colorectal	Lung and Bronchus	Prostate	Cervical	All Sites
White	98.1	32.0	52.3	112.4	7.5	374.1
Black	122.7	40.4	45.9	220.8	7.4	415.0
Asian/PI	80.1	22.9	26.6	82.2	*	247.4
All Races	116.1	36.7	47.7	180.4	7.4	403.5

*Cervical cancer age-adjusted incidence rate unavailable for Asian/PI due to small number of cases
Data Source: Maryland Department of Health and Mental Hygiene, Annual Cancer Report, 2014
Individuals of Hispanic origin were included within the White or Black estimates and are not listed separately

Deaths due to cancer decreased in the county by nearly 10% from 2007-2009 to 2012-2014; the county is nearing the Healthy People 2020 Goal to reduce the cancer death rate to 161.4. White, non-Hispanic (NH) residents have the highest age-adjusted death rate due to cancer at 191.9, followed by Black NH residents at 168.2.

Age-Adjusted Death Rate per 100,000 for Cancer by Race and Ethnicity, Prince George's County, 2007-2014



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PGC White NH	205.8	202.3	200.9	191.6	187.0	191.9
PGC Black NH	185.2	186.0	176.9	177.0	168.6	168.2
PGC Asian NH	98.3	91.2	89.0	83.0	83.7	90.5
PGC Hispanic	90.3	90.7	101.9	88.1	89.5	77.6
PGC	182.6	182.0	177.4	173.8	167.2	166.4
Maryland	179.0	176.0	171.3	167.6	164.8	163.3

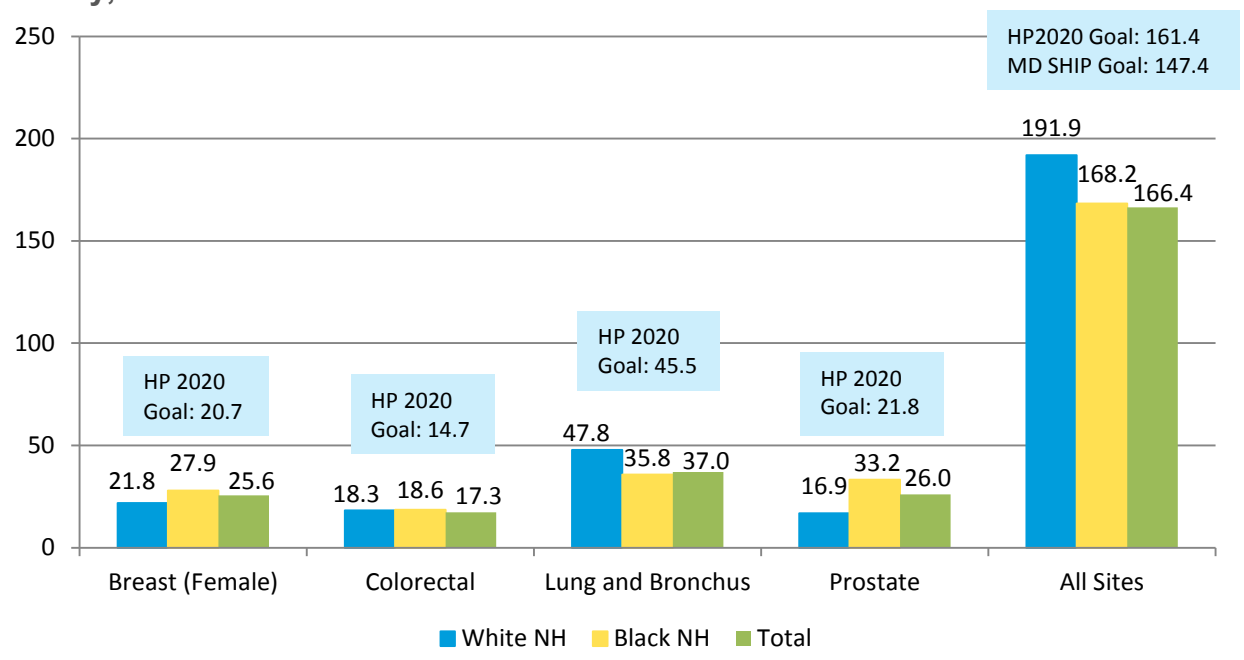
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Cancer Age-Adjusted Death Rates per 100,000 by Site and Sex, 2012-2016

Site	Prince George's	Maryland	United States	HP 2020 Goal	MD SHIP 2017 Goal
All Sites	**166.4**	163.3	163.6	161.4	147.4
Breast (Female)	**25.6**	22.7	20.9	20.7	
Colorectal	**17.3**	14.4	14.4	14.5	
Male	**22.1**	17.6	17.3	---	
Female	**13.6**	12.0	12.2	---	
Lung and Bronchus	**37.0**	41.9	43.4	45.5	
Male	**46.8**	50.5	53.8	---	
Female	**30.6**	35.7	35.5	---	
Prostate	**26.0**	19.6	19.2	21.8	
Cervical	**2.5**	1.9	2.3	2.2	

Source: Maryland Department of Health and Mental Hygiene, Annual Cancer Report, 2014; Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database; DHMH Maryland SHIP http://dhmh.maryland.gov/ship/Pages/home.aspx; Healthy People 2020 https://www.healthypeople.gov/

Cancer Age-Adjusted Death Rates by Race and Hispanic Origin, Prince George's County, 2012-2016



***** Individuals of Hispanic origin and Asian/Pacific Islanders were not included due to insufficient numbers; Cervical cancer age-adjusted rates not shown by race due to insufficient numbers

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

.

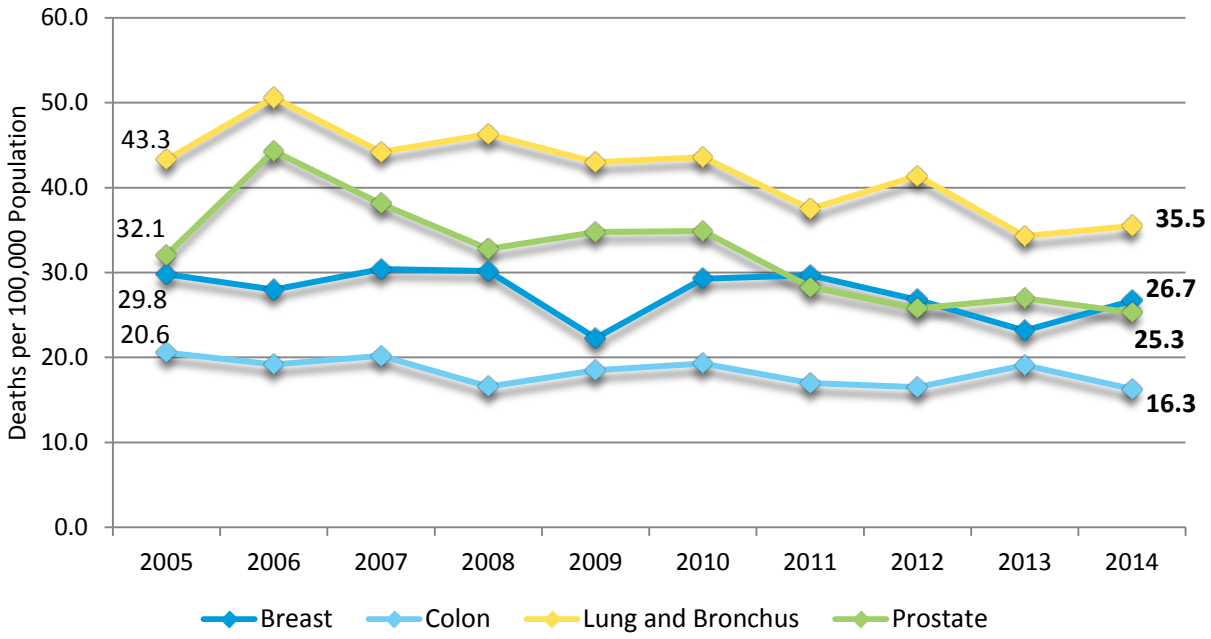
Cancer Age-Adjusted Death Rates per 100,000 by Site, Prince George's County, 2005-2014

Year	All Sites	Breast (Female only)	Colon	Lung and Bronchus	Prostate
2005	189.4	29.8	20.6	43.3	32.1
2006	199.4	28.0	19.2	50.6	44.3
2007	184.5	30.4	20.2	44.2	38.1
2008	184.9	30.2	16.6	46.3	32.8
2009	178.8	22.3	18.5	43.0	34.8
2010	182.4	29.3	19.3	43.6	34.9
2011	171.3	29.7	17.0	37.5	28.3
2012	168.4	26.8	16.5	41.4	25.8
2013	162.1	23.2	19.1	34.3	27.0
2014	168.4	26.7	16.3	35.5	25.3

* Cervical cancer statistics not included due to insufficient numbers.

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Cancer Age-Adjusted Death Rates by Site, Prince George's County, 2005-2014

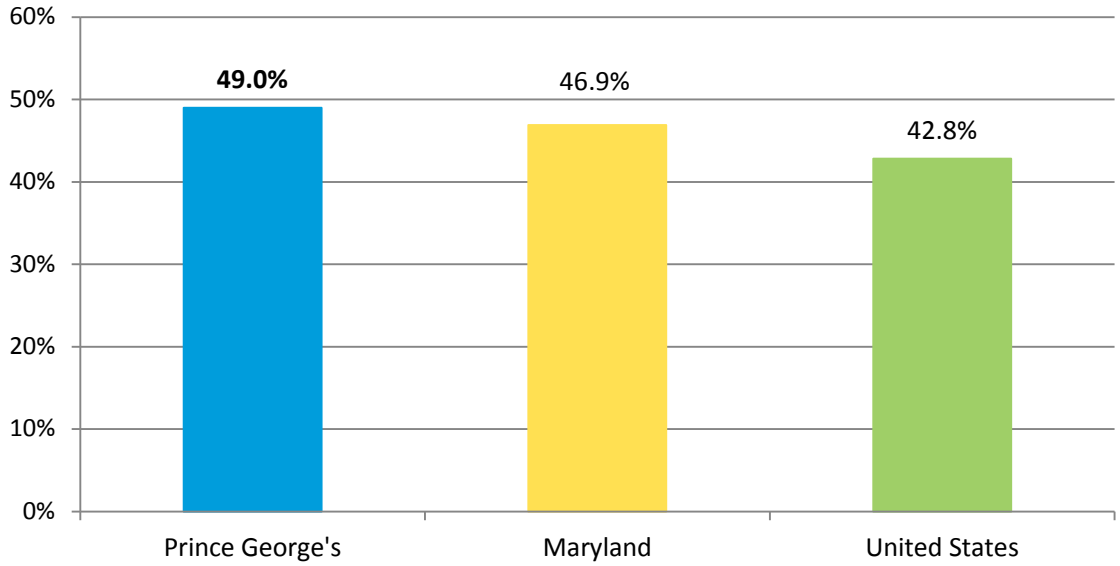


Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Cancer Screening

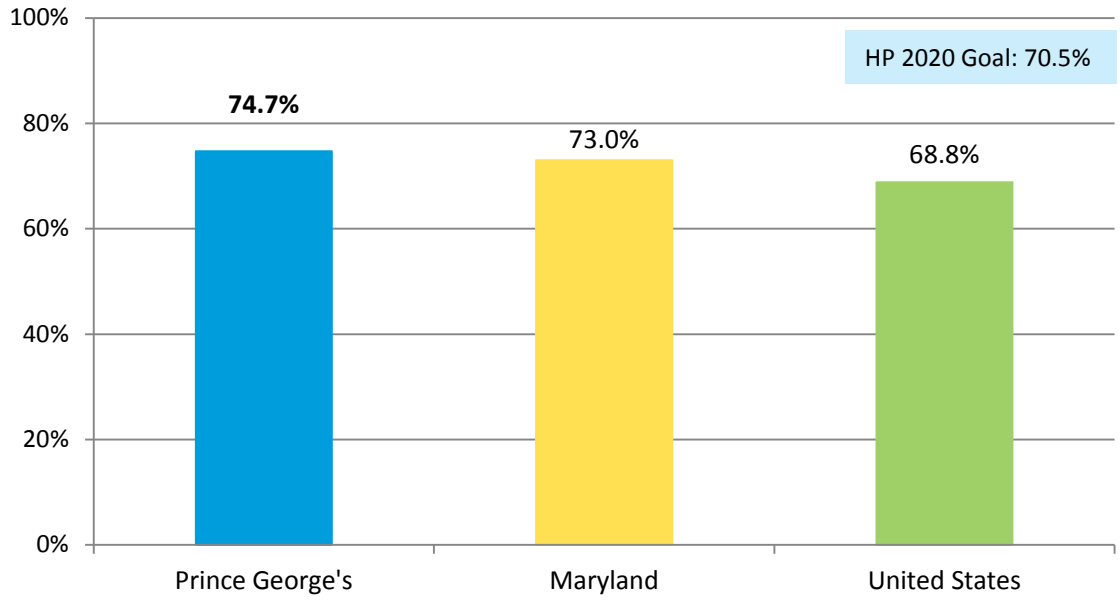
In 2014, Prince George□s County had slightly higher cancer screening rates compared to the state and nation for prostate, colorectal, and breast cancers, and slightly lower screening rates for cervical cancer.

□en □□0 years□□□ ith a Prostate-Specific Antigen □est in the Past □wo Years, 201□



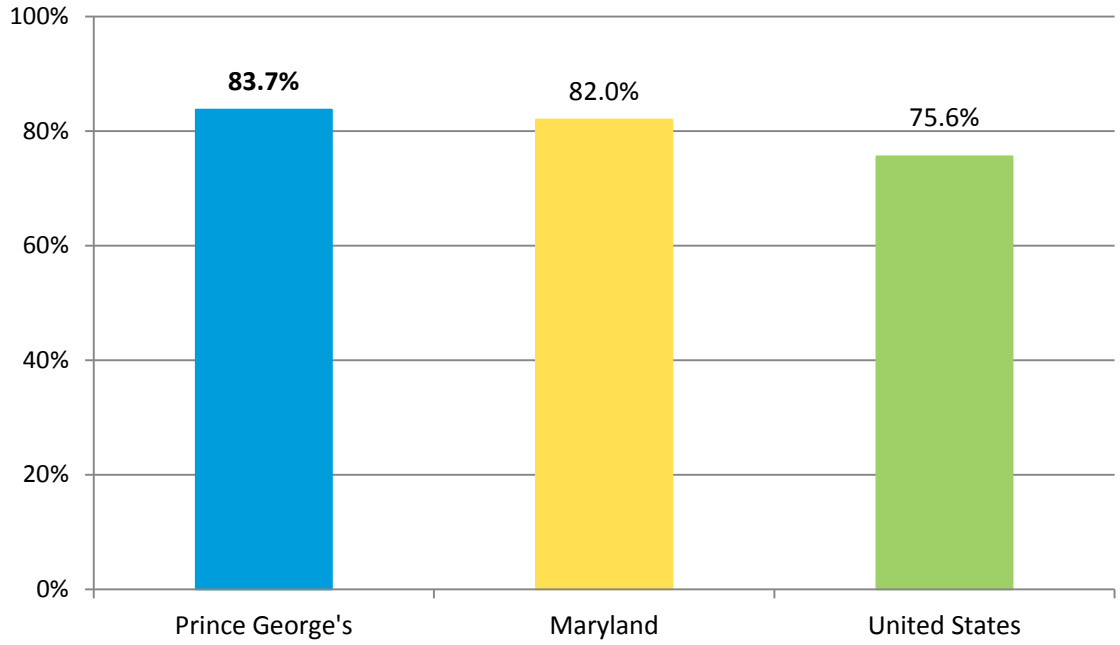
Data Source: 2014 Maryland BRFSS, DHMH; CDC National Center for Chronic Disease Prevention Health Promotion, Division of Public Health, BRFSS

□en and □ omen □□0 years□□who ever had a Colorectal Cancer Screening, 201□



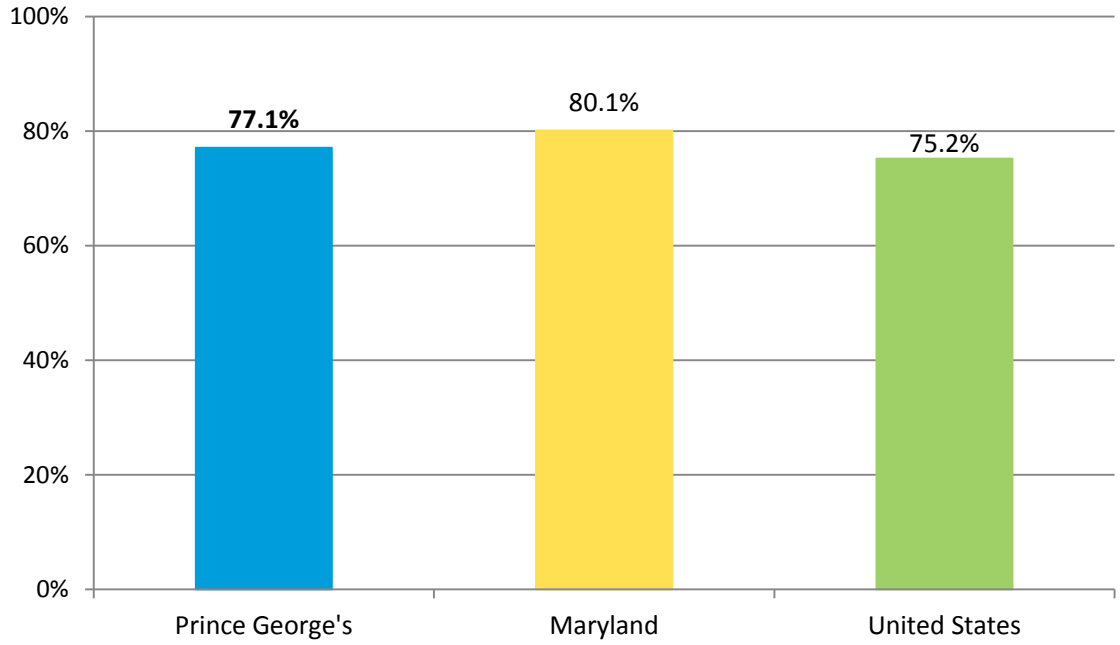
Data Source: 2014 Maryland BRFSS, DHMH; CDC National Center for Chronic Disease Prevention Health Promotion, Division of Public Health, BRFSS

□ omen □□0 years□□who had a □ammography in the Past 2 Years, 201□



Data Source: 2014 Maryland BRFSS, DHMH; CDC National Center for Chronic Disease Prevention Health Promotion, Division of Public Health, BRFSS

□ omen □1□ years□□who had a Pap Smear in the Past □hree Years, 201□



Data Source: 2014 Maryland BRFSS, DHMH; CDC National Center for Chronic Disease Prevention Health Promotion, Division of Public Health, BRFSS

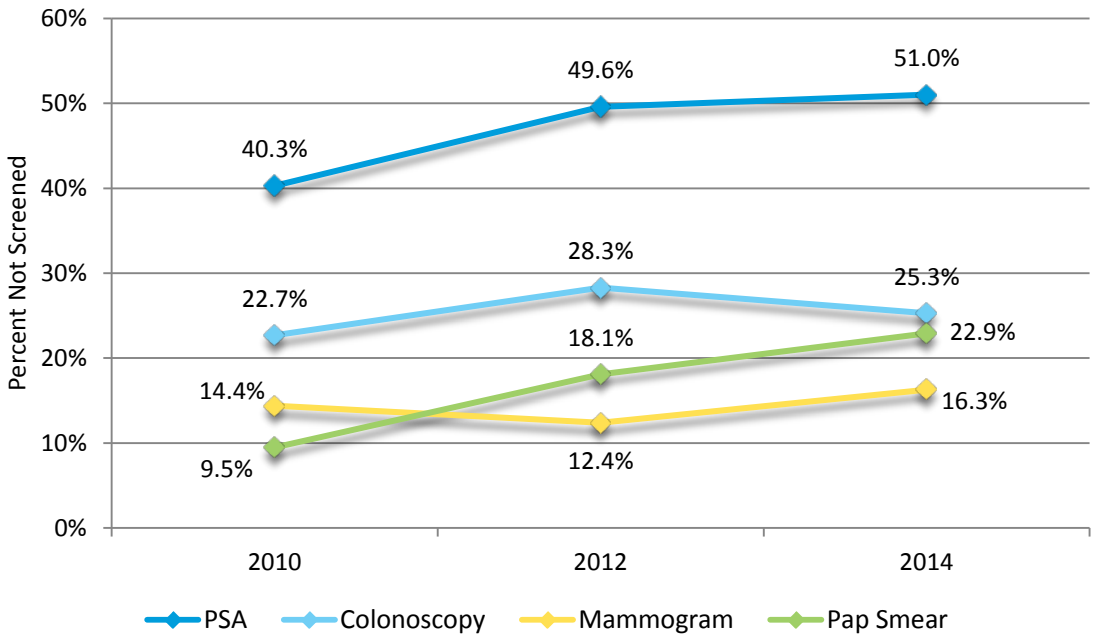
Cancer screening is important to find cancers early, when treatment is likely to work best. Many Prince George□s County residents do not receive the recommended cancer screenings, which can result in cancer that progresses before it is detected.

Population □ot Screened for Selected Cancer, Prince □eorge□s County, 201□

Cancer Screening	Target Group	Total Population	Percentage not Screened	Estimated Population not Screened
Prostate Specific Antigen (PSA) in past 2 years	Men 40 years and above	183,641	**51.0%**	**93,657**
Colorectal Cancer Screening	Men and women 50 years and above	277,992	**25.3%**	**70,332**
Mammography in past 2 years	Women 50 years and above	155,596	**16.3%**	**25,362**
Pap Smear in past 3 years	Women 18 years and above	368,450	**22.9%**	**84,375**

Data Source: 2014 Maryland BRFSS, DHMH; 2014 1-Year Estimates, U.S. Census Bureau, Table B01001 www.census.gov

Population □ot Screened for Selected Cancers, Prince □eorge□s County, 2010-201□



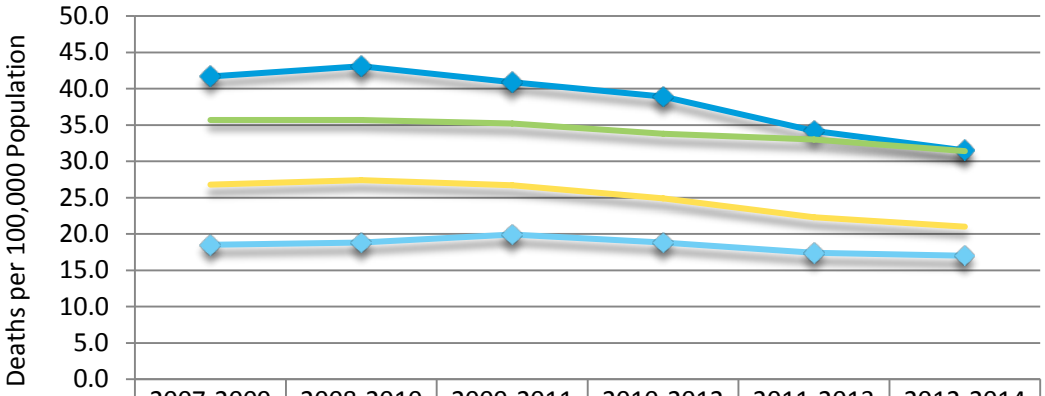
Data Source: 2010, 2012, 2014 Maryland BRFSS, DHMH www.marylandbrfss.org

Chronic Lower Respiratory Disease (CLRD)

CLRD are diseases that affect the lungs, which includes COPD (chronic obstructive pulmonary disease) and asthma. COPD consists of emphysema which means the air sacs in the lungs are damaged, and chronic bronchitis where the lining of the lungs are red and swollen and become clogged with mucus. Cigarette smoking is the main cause of COPD, and is strongly associated with lunch cancer. Asthma is a disease that also affects the lungs that is commonly is diagnosed in childhood. Asthma is described further below:

Asthma Overview	
What is it?	Asthma is a chronic disease involving the airways that allow air to come in and out of the lungs. Asthma causes airways to always be inflamed; they become even more swollen and the airway muscles can tighten when something triggers your symptoms: coughing, wheezing, and shortness of breath.
Who is affected?	14.3% (99.459) of adults are estimated to have asthma (MD 2014 BRFSS) and 13.9% (33,294) of children are estimated to have asthma (MD 2013 BRFSS).
Prevention and Treatment	Asthma cannot be prevented and there is no cure, but steps can be taken to control the disease and prevent symptoms: use medicines as your doctor prescribes and try to avoid triggers that make asthma worse. (NHLBI.NIH.gov; AAAAI.org)
What are the outcomes?	People with asthma are at risk of developing complications from respiratory infections like influenza and pneumonia. Asthma complications can be severe and include decreased ability to exercise, lack of sleep, permanent changes in lung function, persistent cough, trouble breathing, and death (NIH.gov).
Disparity	16.7% of Black, non-Hispanic (NH) adults are estimated to have asthma compared to 10.0% of White, NH adults. More females (18.5%) than males (9.6%) are estimated to have asthma and females have a higher rate of Emergency Department visits due to asthma. More younger adults are estimated to have asthma (16.2%) compared to adults ages 45 to 64 (11.4%) and 65 and older (13.1%). (2014 MD BRFSS). For adults, Black, NH county residents have an age-adjusted hospitalization rate due to asthma that is more than twice as high as White, NH residents. For children, American Indian and Alaskan Native residents have the highest age-adjusted hospitalization rate per 100,000 (33.6) followed by Black NH (18.5). Higher hospitalization rates are mostly concentrated around the Washington, D.C. border.
How do we compare?	While 14.3% of adult county residents have asthma, other Maryland counties range from 9.3% to 24.1%; the state overall is 13.5% (2014 MD BRFSS) and the U.S. is at 13.8% (BRFSS). Maryland has a slightly higher rate of Emergency Department visits due to asthma (ED visits to Washington D.C. are not included, which could affect county estimates).

Age-Adjusted Death Rate per 100,000 for Chronic Lower Respiratory Disease (CLRD) by Race and Ethnicity, 2007-2014



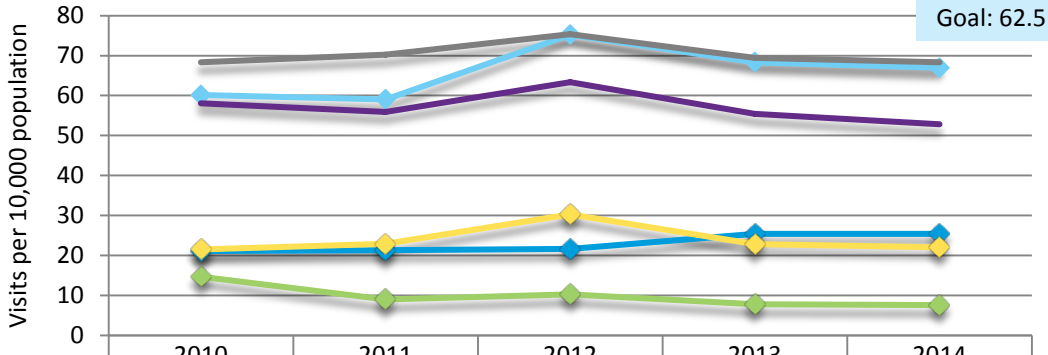
	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PGC White NH	41.7	43.1	40.9	38.9	34.2	31.5
PGC Black NH	18.5	18.8	19.9	18.8	17.4	17.0
PGC	26.8	27.4	26.7	24.9	22.3	21.0
Maryland	35.7	35.7	35.2	33.8	33.0	31.4

***** Residents of Hispanic Origin and Asian/Pacific Islanders were not included due to insufficient numbers

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Age-Adjusted Emergency Department Visit Rate per 10,000 Population due to Asthma, 2010-2014

MD SHIP Goal: 62.5



	2010	2011	2012	2013	2014
PGC White NH	21.1	21.3	21.6	25.4	25.4
PGC Black NH	60.1	59.0	75.2	68.3	66.9
PGC Hispanic	21.5	22.9	30.3	22.8	22.0
PGC Asian NH	14.7	9.0	10.3	7.8	7.6
Prince George's	58.0	55.9	63.3	55.4	52.8
Maryland	68.3	70.2	75.3	69.4	68.3

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Maryland Health Services Cost Review Commission Outpatient File, Maryland SHIP

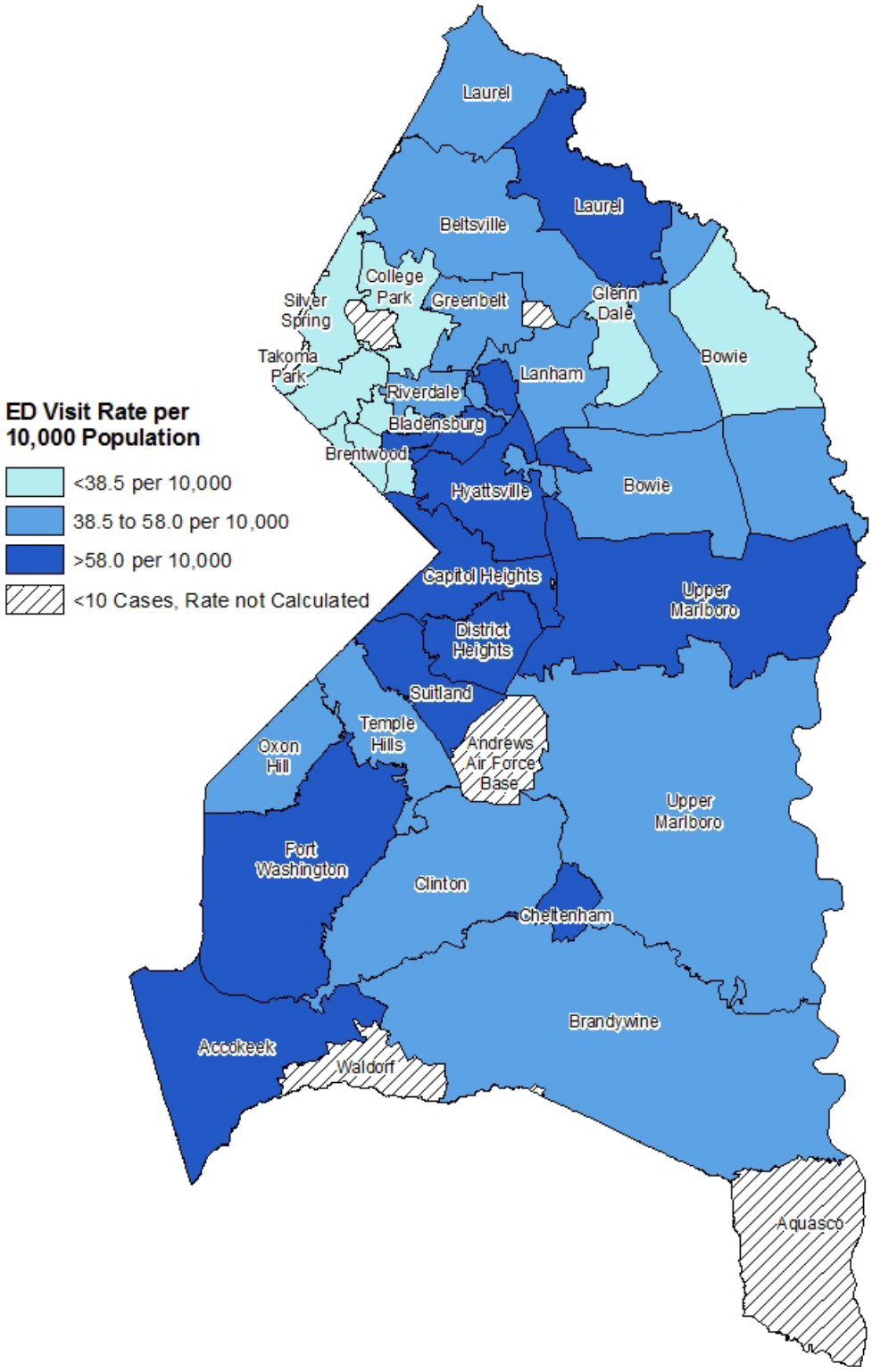
Emergency Department□□isits for Asthma, 201□

		Age-Adjusted Visit Rate per 10,000 Population	
	Number of ED Visits	Prince George's	Maryland
Race/Ethnicity			
White, non-Hispanic	297	25.4	26.7
Black, non-Hispanic	3,769	66.9	108.5
Asian, non-Hispanic	32	7.6	7.2
Hispanic	363	22.0	30.5
Sex			
Male	2,094	47.5	---
Female	2,623	56.5	---
Age			
Under 18 Years	1,580	77.0	---
18 to 39 Years	1,554	66.6	---
40 to 64 Years	1,315	36.1	---
65 Years and Over	268	26.5	---
Total	**4,717**	**52.8**	**68.3**

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Outpatient Discharge Data File 2014, Maryland Health Services Cost Review Commission; DHMH Maryland SHIP; Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Emergency Department□□isit Rate per 100,000 Population, Asthma as Primary Discharge Diagnosis, Prince □eorge□s County, 201□

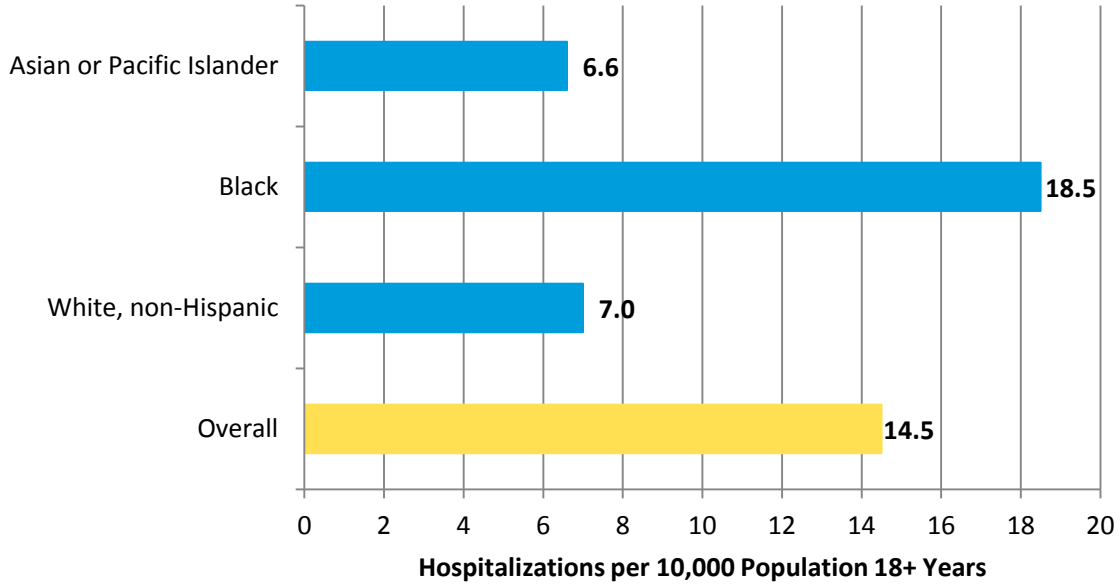


* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Outpatient Discharge Data File 2014, Maryland Health Services Cost Review Commission

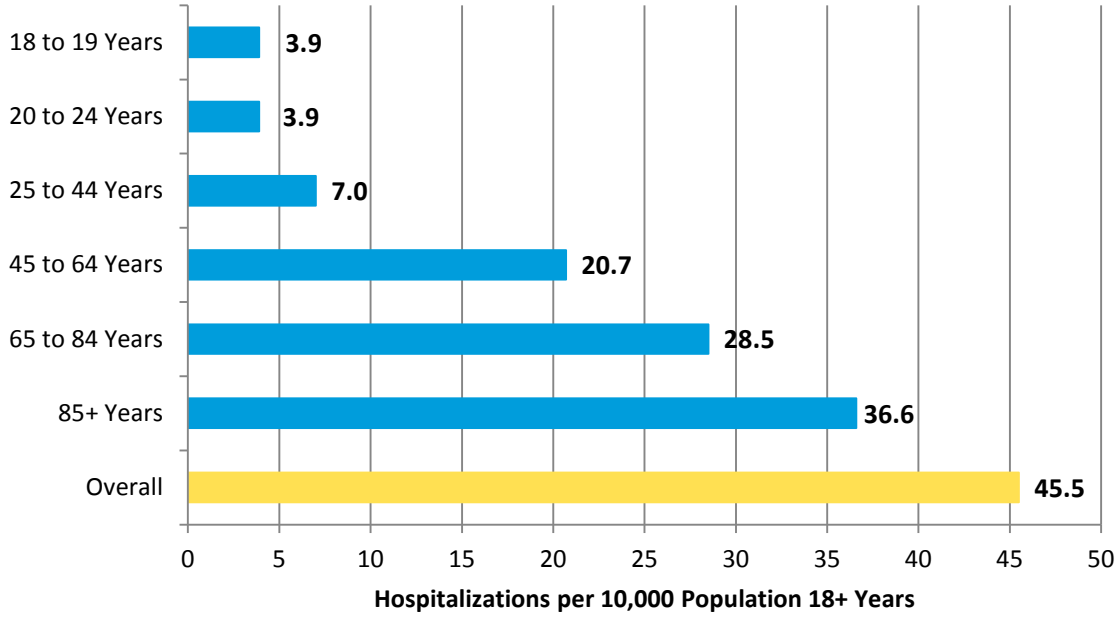
Adult Asthma

Age-Adjusted Hospital Inpatient Visit Rate due to Adult Asthma by Race and Ethnicity, Prince George's County, 2010-2012



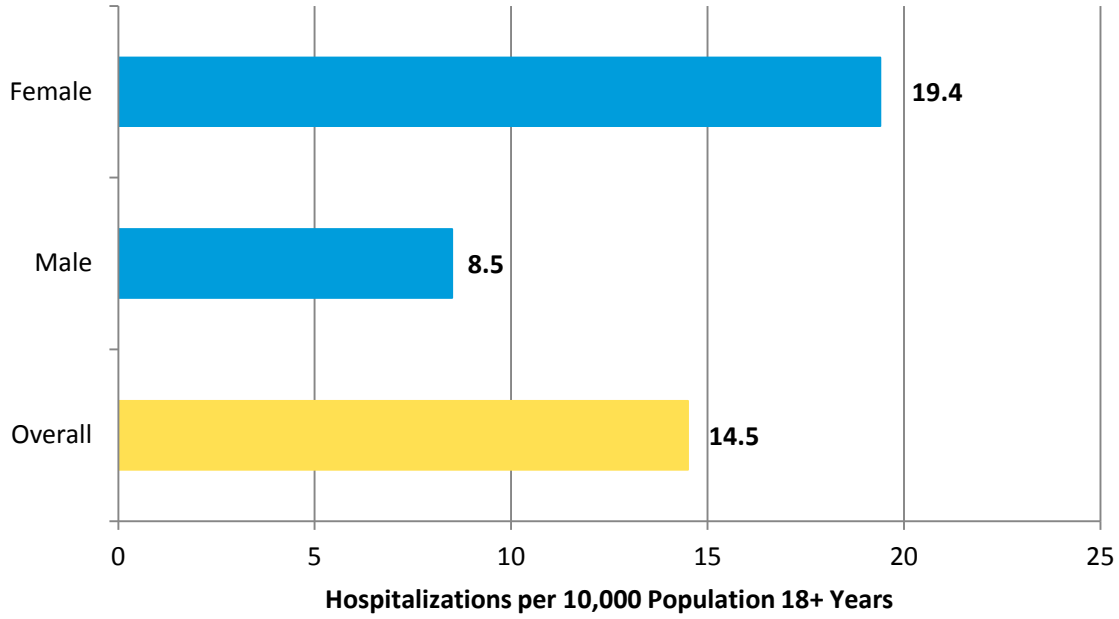
* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient Visit Rate due to Adult Asthma by Age Group, Prince George's County, 2010-2012



* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

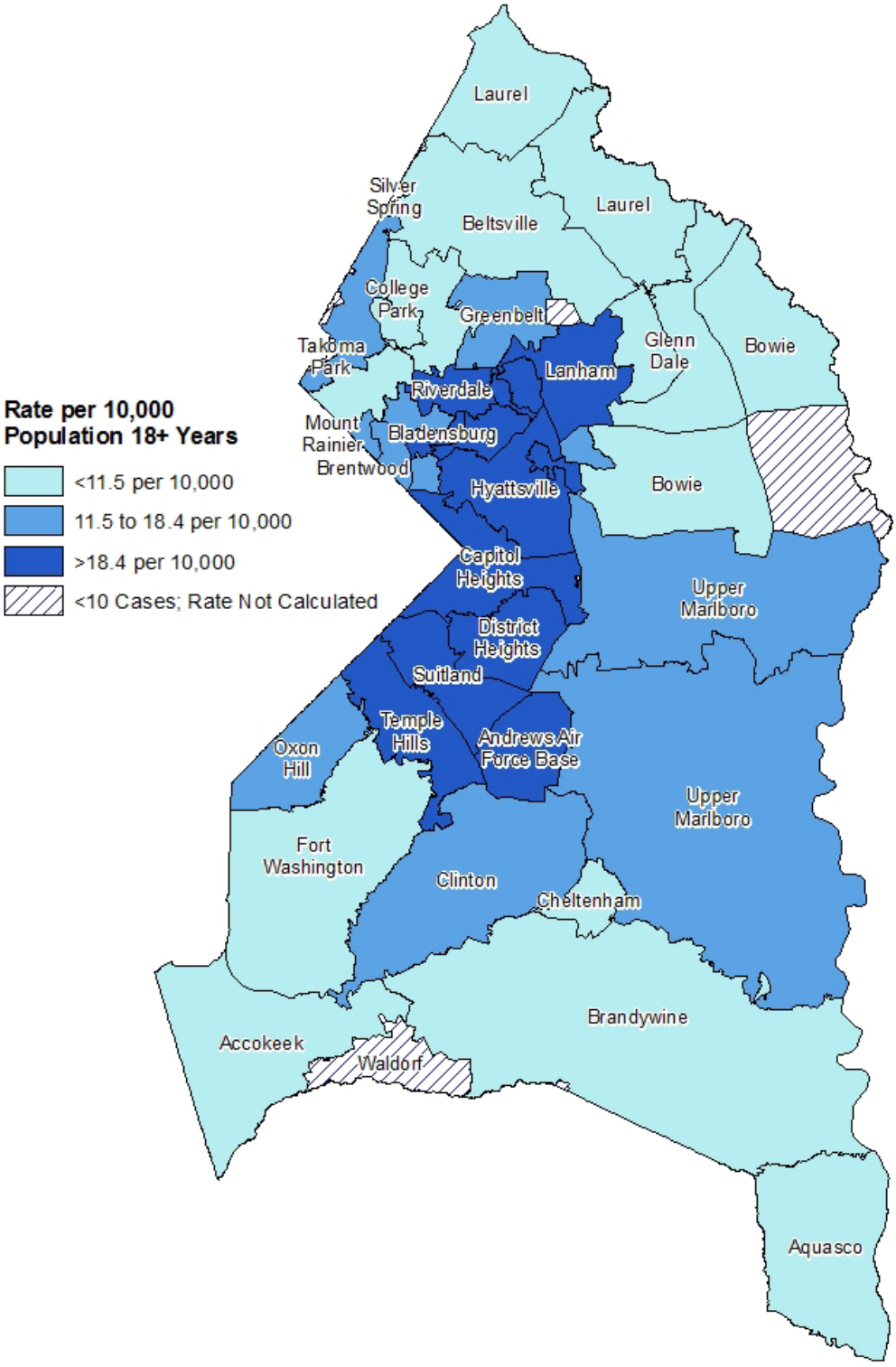
Age-Adjusted Hospital Inpatient Visit Rate due to Adult Asthma by Sex, Prince George's County, 2010-2012



* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient Visit Rate due to Adult Asthma, Prince George's County, 2010-2012

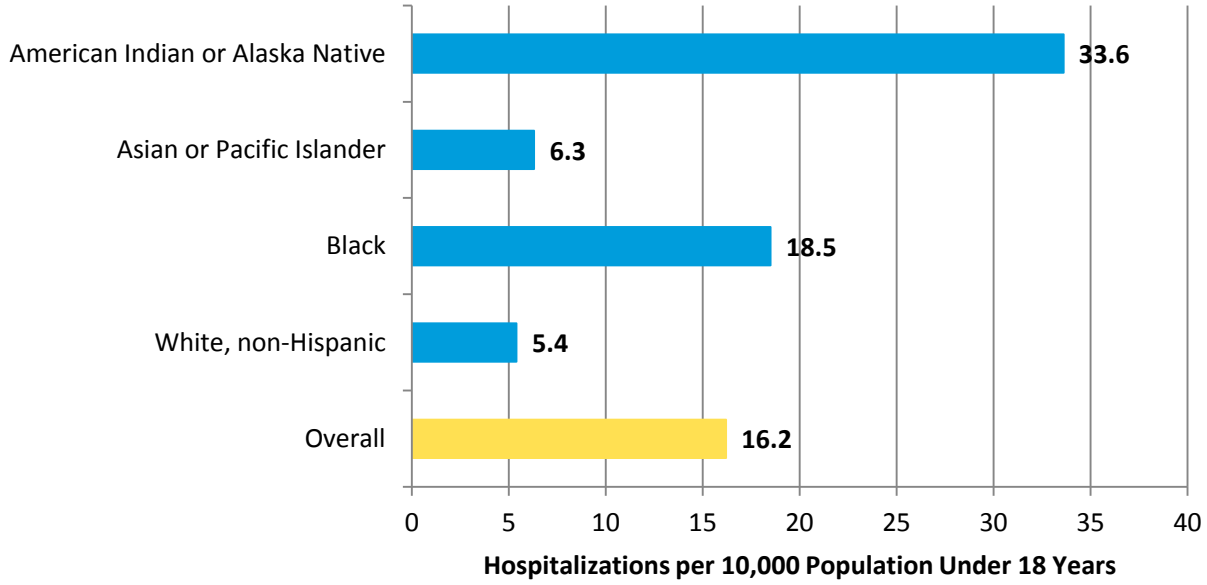


* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

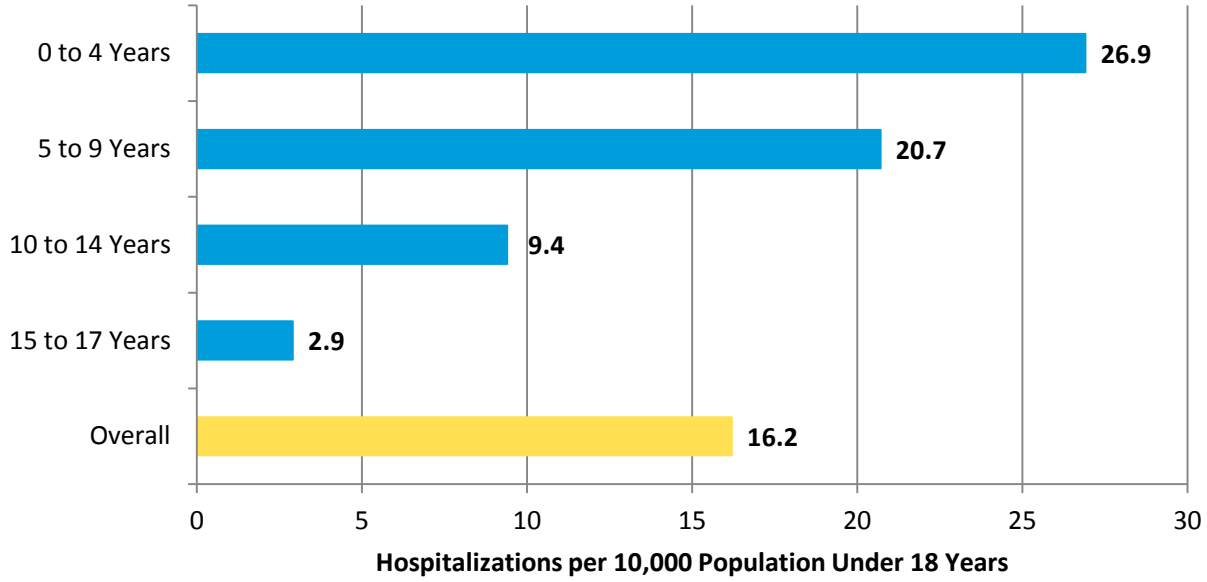
Pediatric Asthma

Age-Adjusted Hospital Inpatient Visit Rate due to Pediatric Asthma Under 1 Years by Race and Ethnicity, Prince George's County, 2010-2012



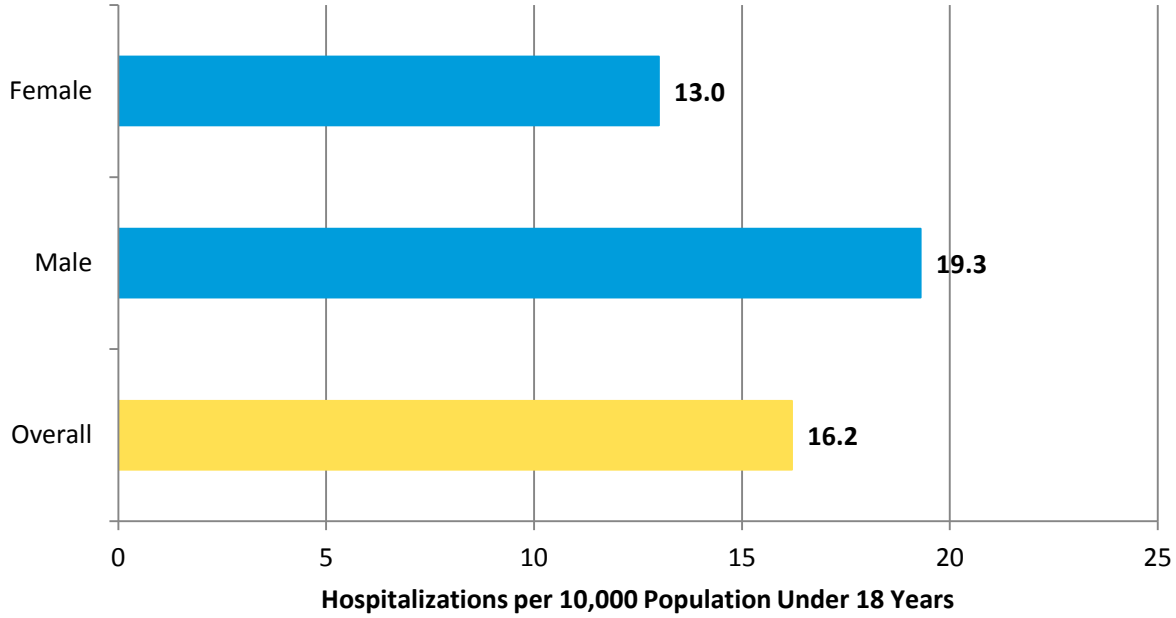
* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient Visit Rate due to Pediatric Asthma Under 1 Years by Age, Prince George's County, 2010-2012



* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

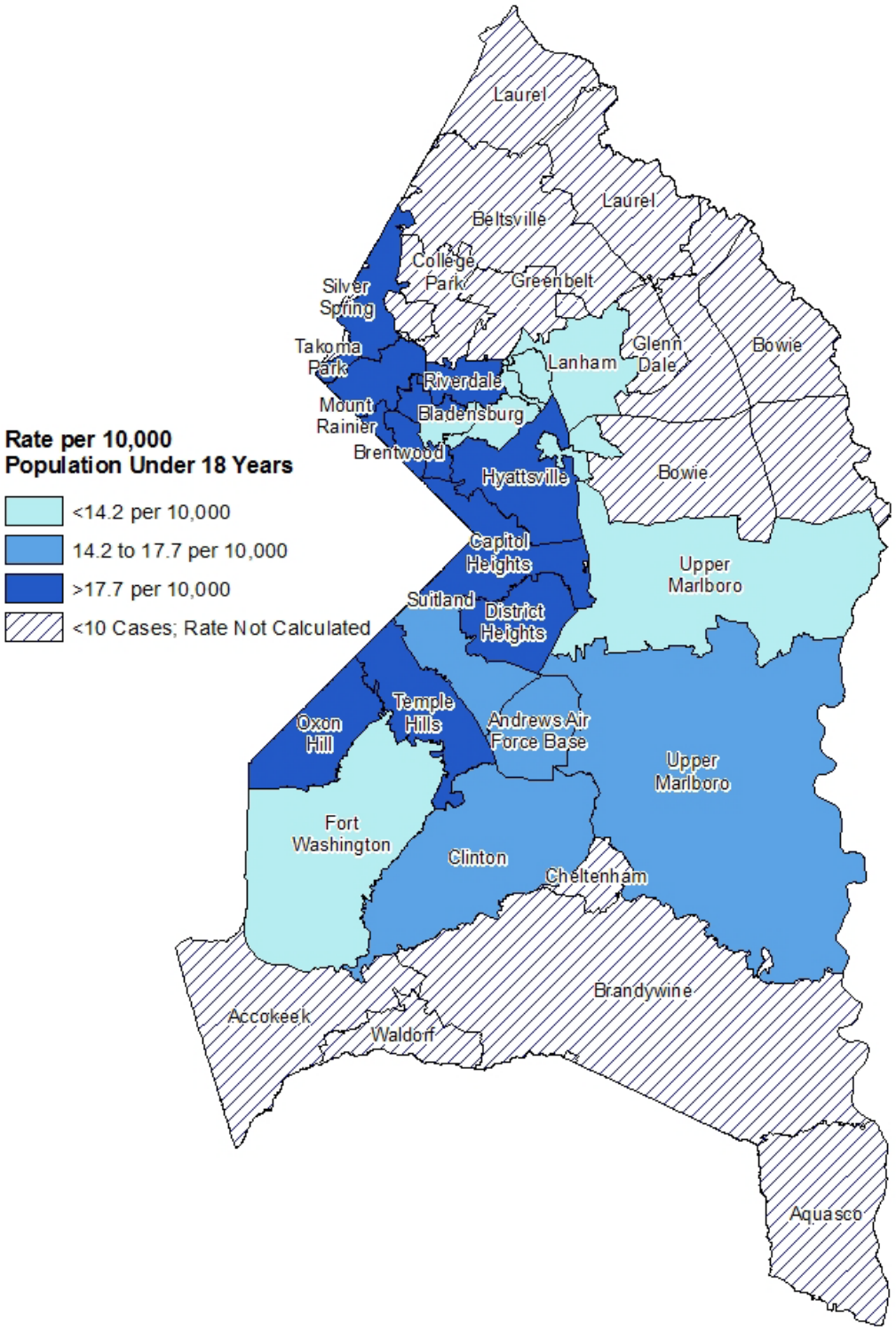
Age-Adjusted Hospital Inpatient Visit Rate due to Pediatric Asthma Under 18 Years by Sex, Prince George's County, 2010-2012



* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient Visit Rate due to Pediatric Asthma (Under 18 Years), Prince George's County, 2010-2012

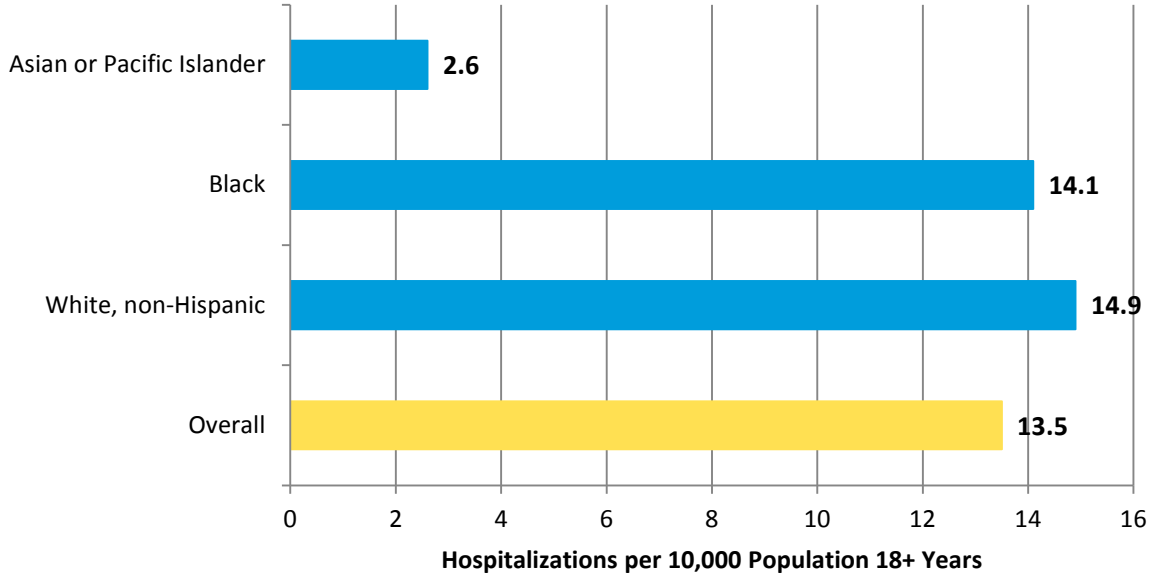


* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

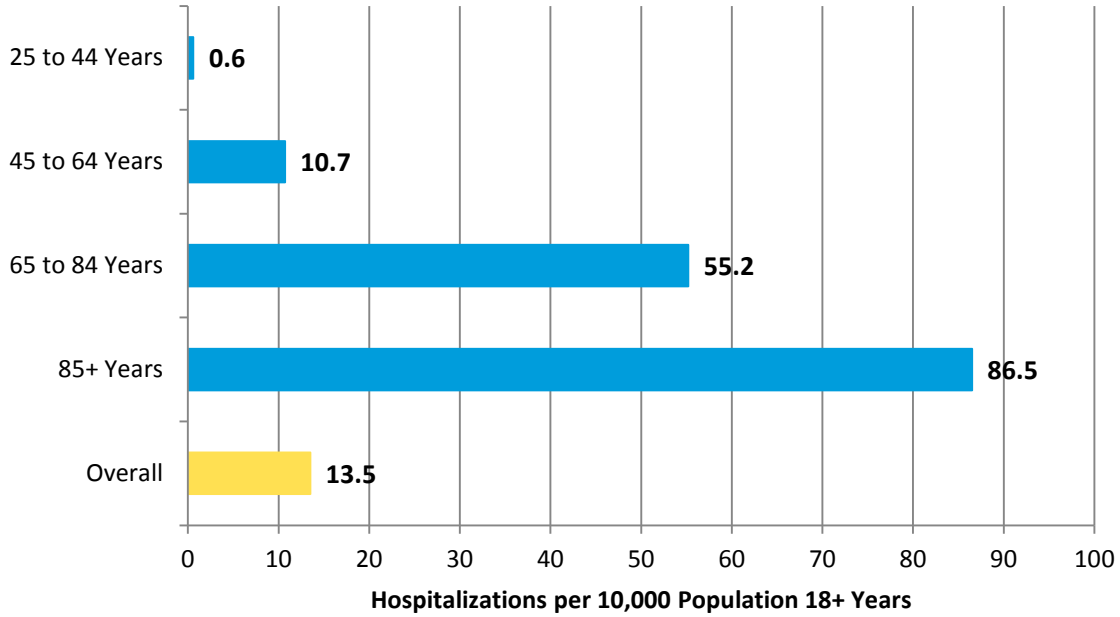
Chronic Obstructive Pulmonary Disease (COPD)

Age-Adjusted Hospital Inpatient Visit Rate due to COPD by Race and Ethnicity, Prince George's County, 2010-2012



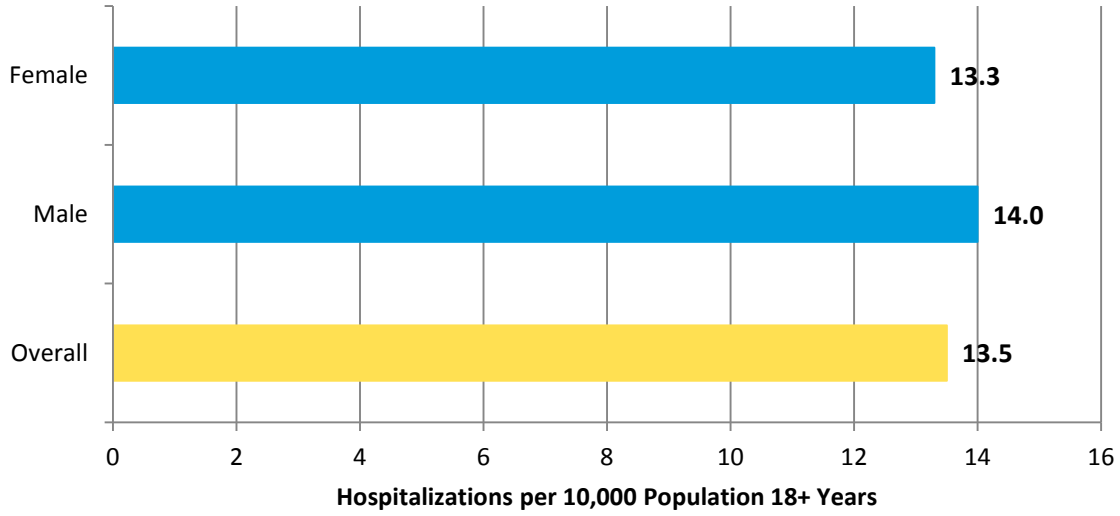
* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient Visit Rate due to COPD by Age Group, Prince George's County, 2010-2012



* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

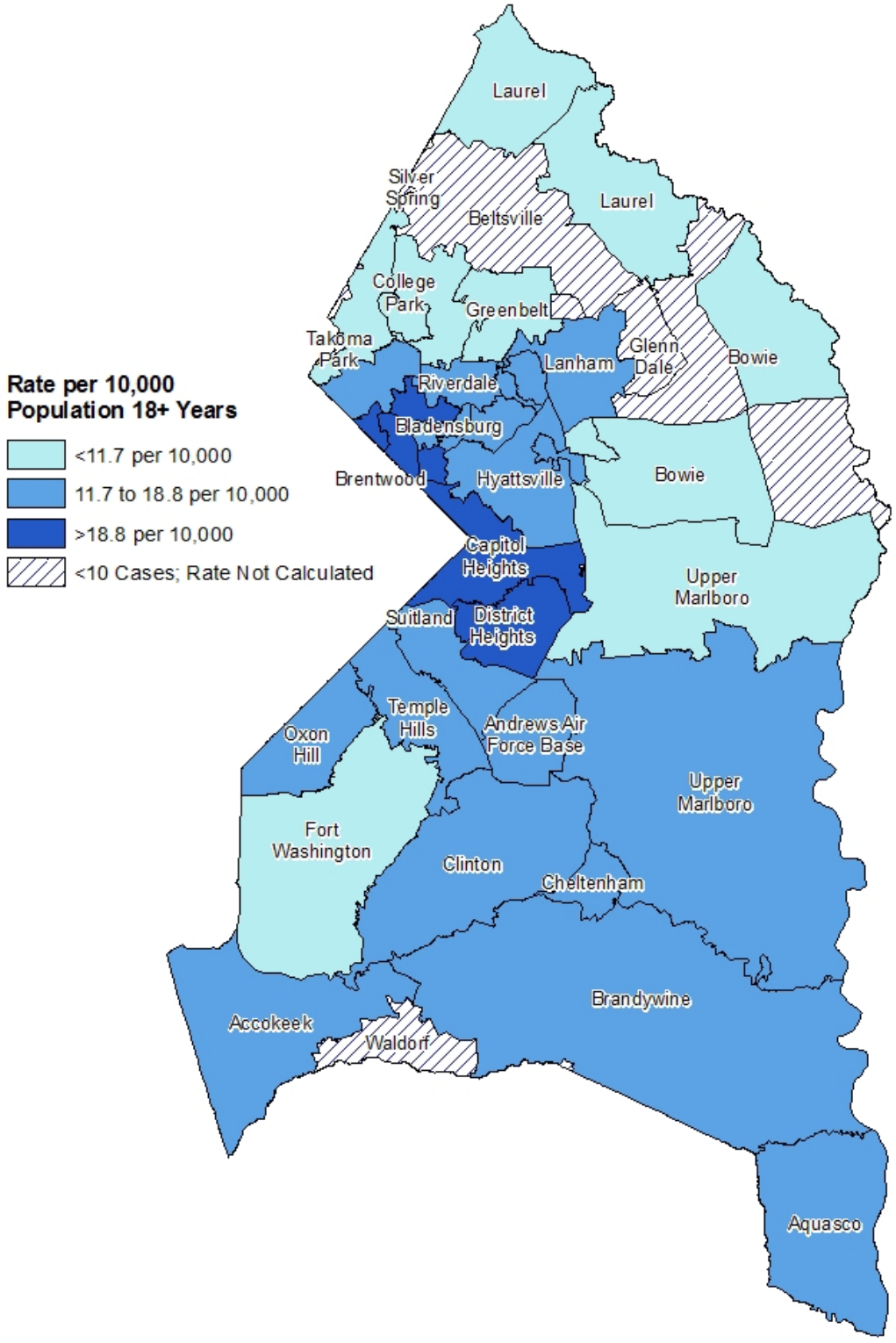
Age-Adjusted Hospital Inpatient Visit Rate due to COPD by Sex, Prince George's County, 2010-2012



* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient Visit Rate due to COPD, Prince George's County, 2010-2012



* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Diabetes

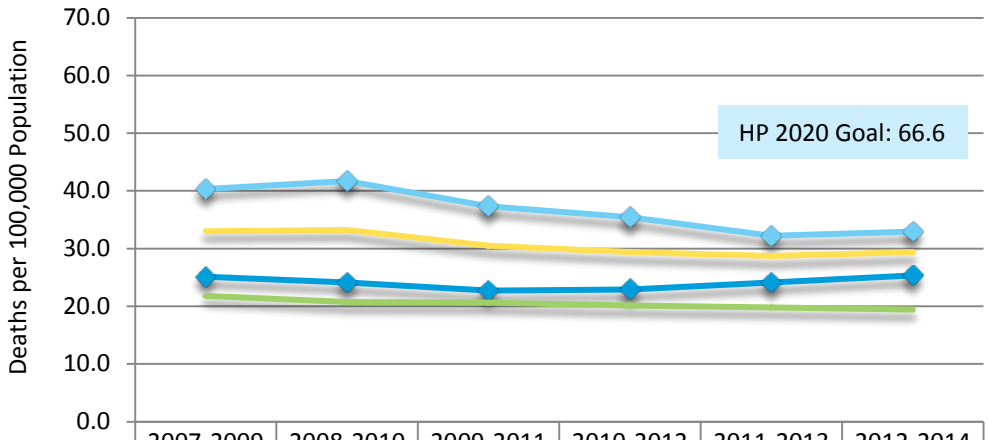
Overview	
What is it?	Diabetes is a condition in which the body either doesn't make enough of a hormone called insulin or can't use its own insulin, which is needed to process glucose (sugar) (Source: CDC).
Who is affected?	11.5% (78,525) of adults in the county are estimated to have diabetes, with an additional 71,065 with prediabetes. (2014 MD BRFSS). In 2014, 245 county residents died from diabetes.
Prevention and Treatment	• Diabetes can be prevented or delayed by losing a small amount of weight (5 to 7 percent of total body weight) through 30 minutes of physical activity 5 days a week and healthier eating. (Source: CDC Diabetes Prevention Program) • The goals of diabetes treatment are to control blood glucose levels and prevent diabetes complications by focusing on: nutrition, physical activity, and medication. (source: Joslin Diabetes Center)
What are the outcomes?	Complications from diabetes include: heart disease, kidney failure, lower-extremity amputation, and death
Disparity	13.7% of White, non-Hispanic (NH) and 13.4% of Black NH residents are estimated to have diabetes; Black NH residents have a higher age-adjusted death rate due to diabetes compared to White NH residents. More women (12.5%) are estimated to have diabetes compared to men (10.4%), but men have a higher rate of Emergency Department visits due to diabetes. Over one-third of residents aged 65+ (35.8%), and 13.8% of adults ages 45-64 are estimated to have diabetes. (2014 MD BRFSS).
How do we compare?	While 11.5% of county residents have diabetes, other Maryland counties range from 6.2% to 18.2%; the state overall is 10.2% (2014 MD BRFSS), and the U.S. is at 10.0% (BRFSS). Prince George's County has a much higher rate of deaths due to diabetes compared to the state.

Percent of Adults □ ho □ave Ever □een □old □y a □ealth Professional □hat □hey □ave Diabetes, 201□ □Excludes Diabetes During Pregnancy□

	Prince George's County	Maryland
Sex		
Male	10.4%	10.4%
Female	12.5%	10.0%
Race/Ethnicity		
White, non-Hispanic	13.7%	10.0%
Black, non-Hispanic	13.4%	12.9%
Hispanic	2.0%	3.9%
Age Group		
18 to 34 Years	1.5%	1.5%
35 to 49 Years	5.4%	5.5%
50 to 64 Years	16.4%	15.1%
Over 65 Years	35.8%	23.2%
TOTAL	**11.5%**	**10.2%**

Data Source: Maryland BRFSS 2014

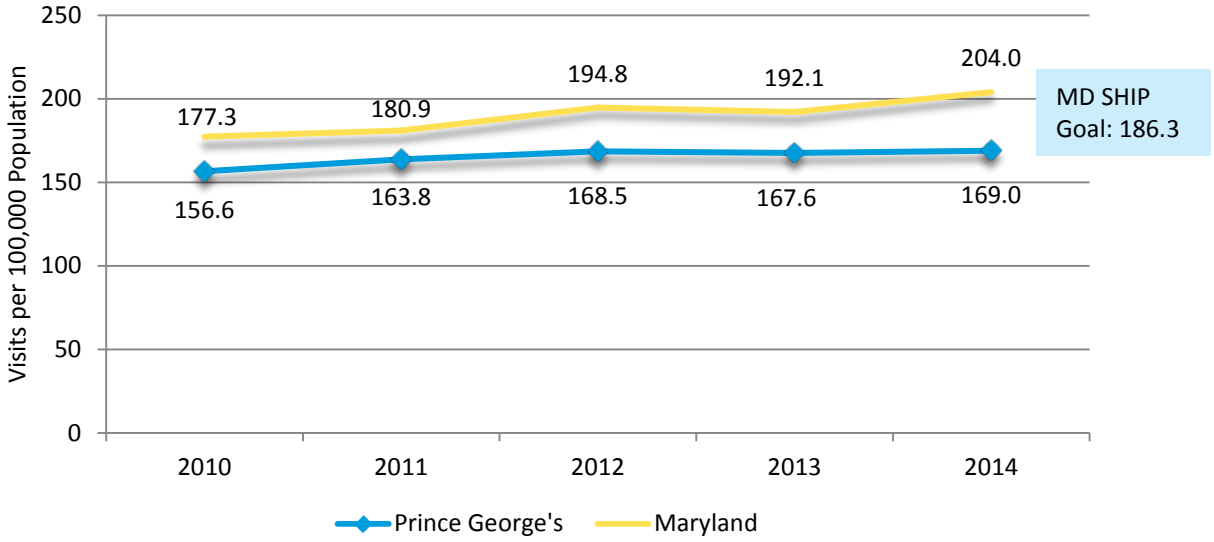
Age-Ad□usted Death Rate per 100,000 for Diabetes, 200□-201□



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PGC White NH	25.1	24.1	22.7	22.9	24.1	25.3
PGC Black NH	40.3	41.7	37.3	35.4	32.2	32.9
PGC	33.0	33.2	30.5	29.4	28.7	29.4
Maryland	21.8	20.7	20.6	20.1	19.8	19.4

***** Individuals of Hispanic origin and Asian/Pacific Islanders were not included due to insufficient numbers
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database;

Age-Adjusted Emergency Department Visits per 100,000 Population due to Diabetes, 2010-2014



* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Maryland Health Services Cost Review Commission Outpatient File

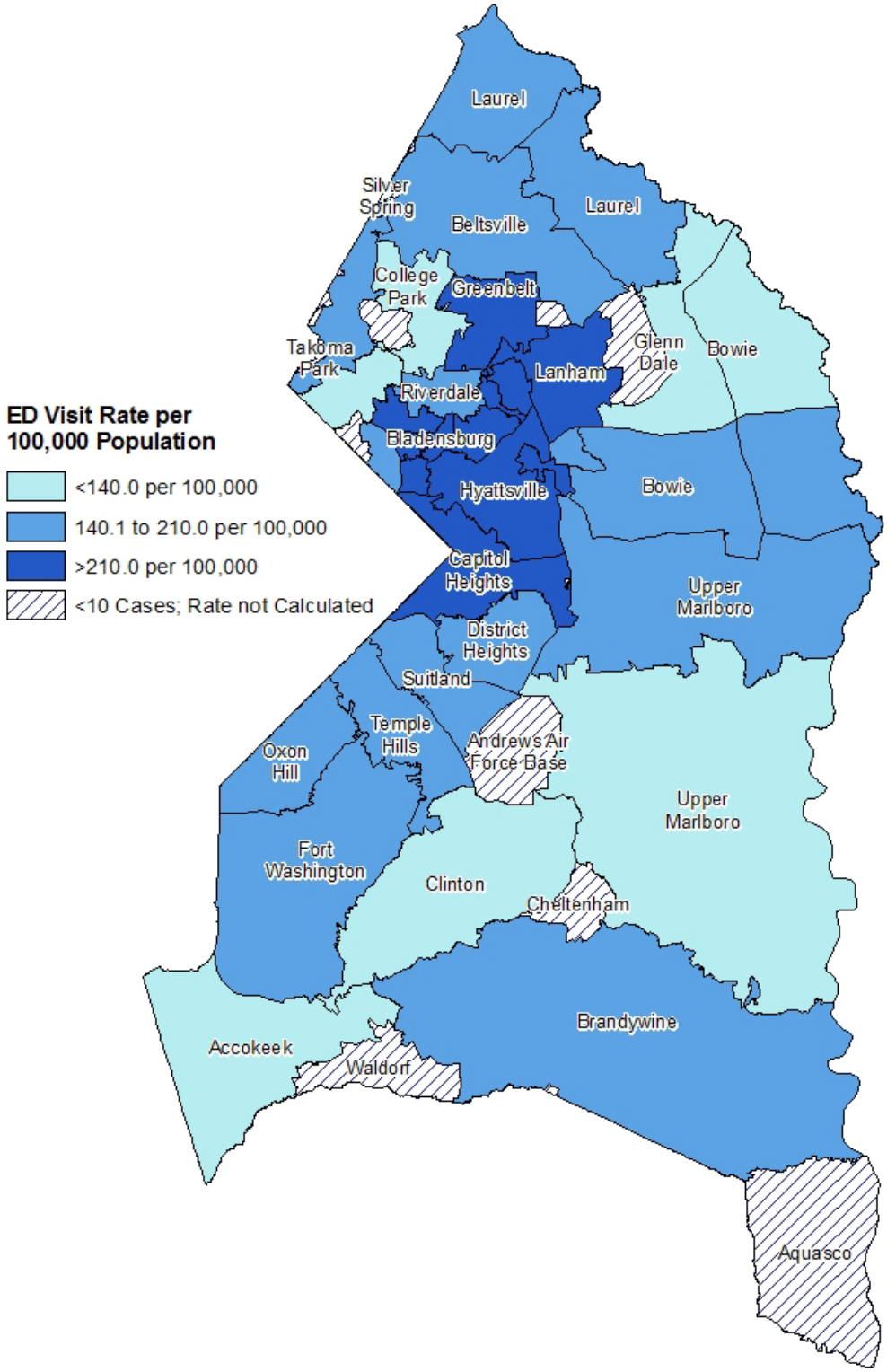
Emergency Department Visits for Diabetes, 2014

	Number of ED Visits	Age-Adjusted Visit Rate per 100,000 Population	
		Prince George's	Maryland
Race/Ethnicity			
White, non-Hispanic	137	86.1	107.9
Black, non-Hispanic	1,198	200.2	309.4
Asian, non-Hispanic	<10	---	28.6
Hispanic	128	129.6	116.1
Sex			
Male	766	180.6	---
Female	800	159.8	---
Age			
Under 18 Years	46	22.4	
18 to 39 Years	321	137.6	
40 to 64 Years	827	226.8	
65 Years and Over	372	367.2	
Total	**1,566**	**169.0**	**204.0**

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Outpatient Discharge Data File 2014, Maryland Health Services Cost Review Commission; DHMH Maryland SHIP http://dhmh.maryland.gov/ship/; Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

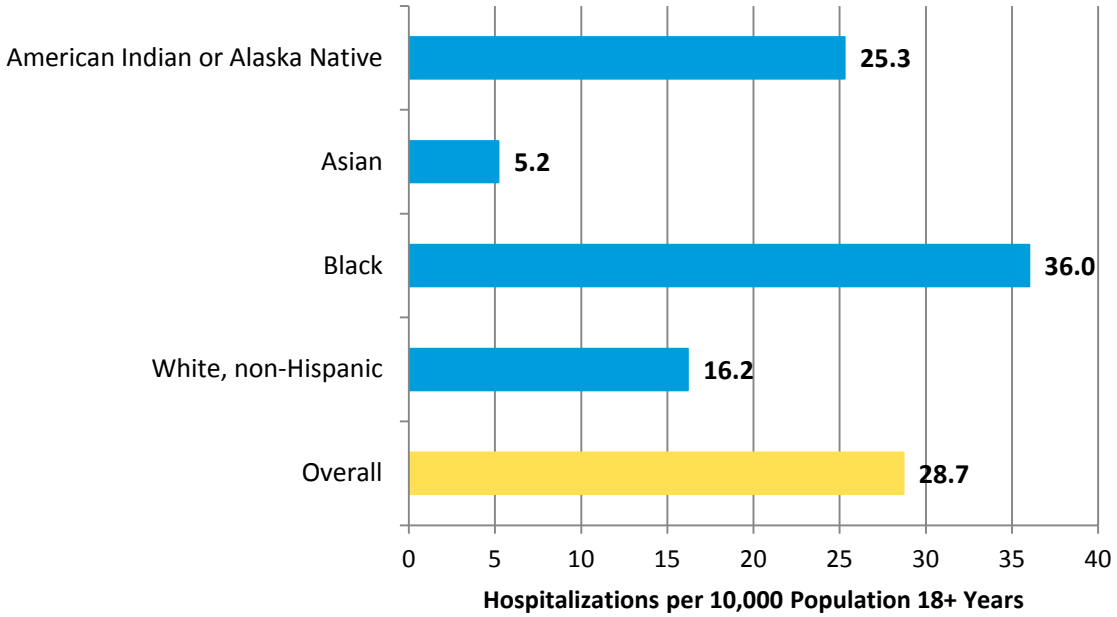
Emergency Department □isit Crude Rate per 100,000 Population, Diabetes as Primary Discharge Diagnosis, Prince □eorge□s County, 201□



* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

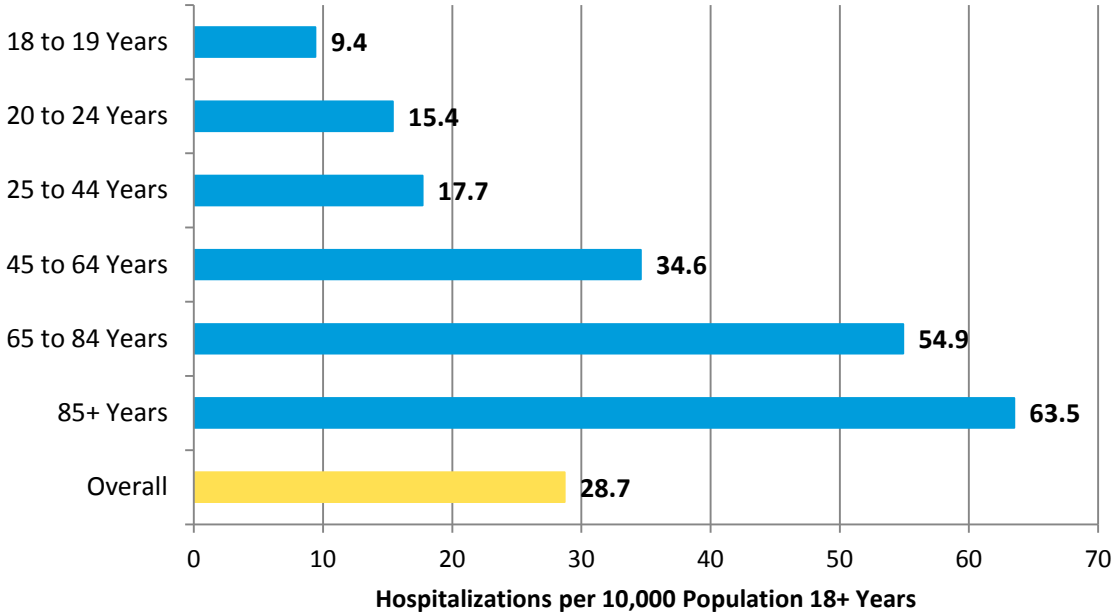
Data Source: Outpatient Discharge Data File 2014, Maryland Health Services Cost Review Commission

Age-Adjusted Hospital Inpatient Visit Rate due to Diabetes by Race and Ethnicity, Prince George's County, 2010-2012



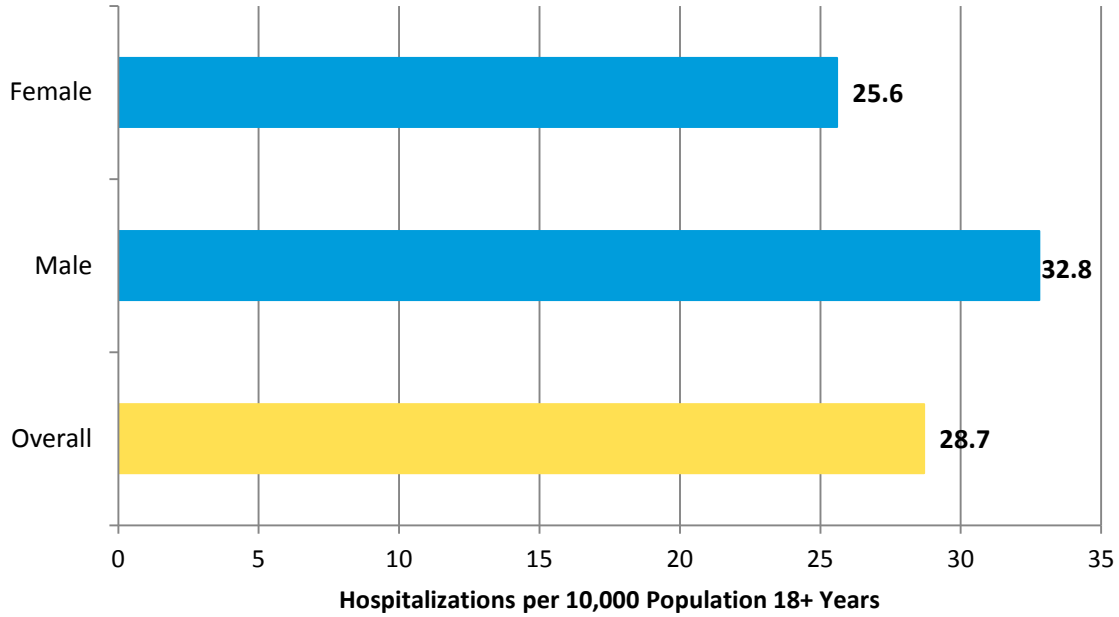
* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient Visit Rate due to Diabetes by Age Group, Prince George's County, 2010-2012



* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

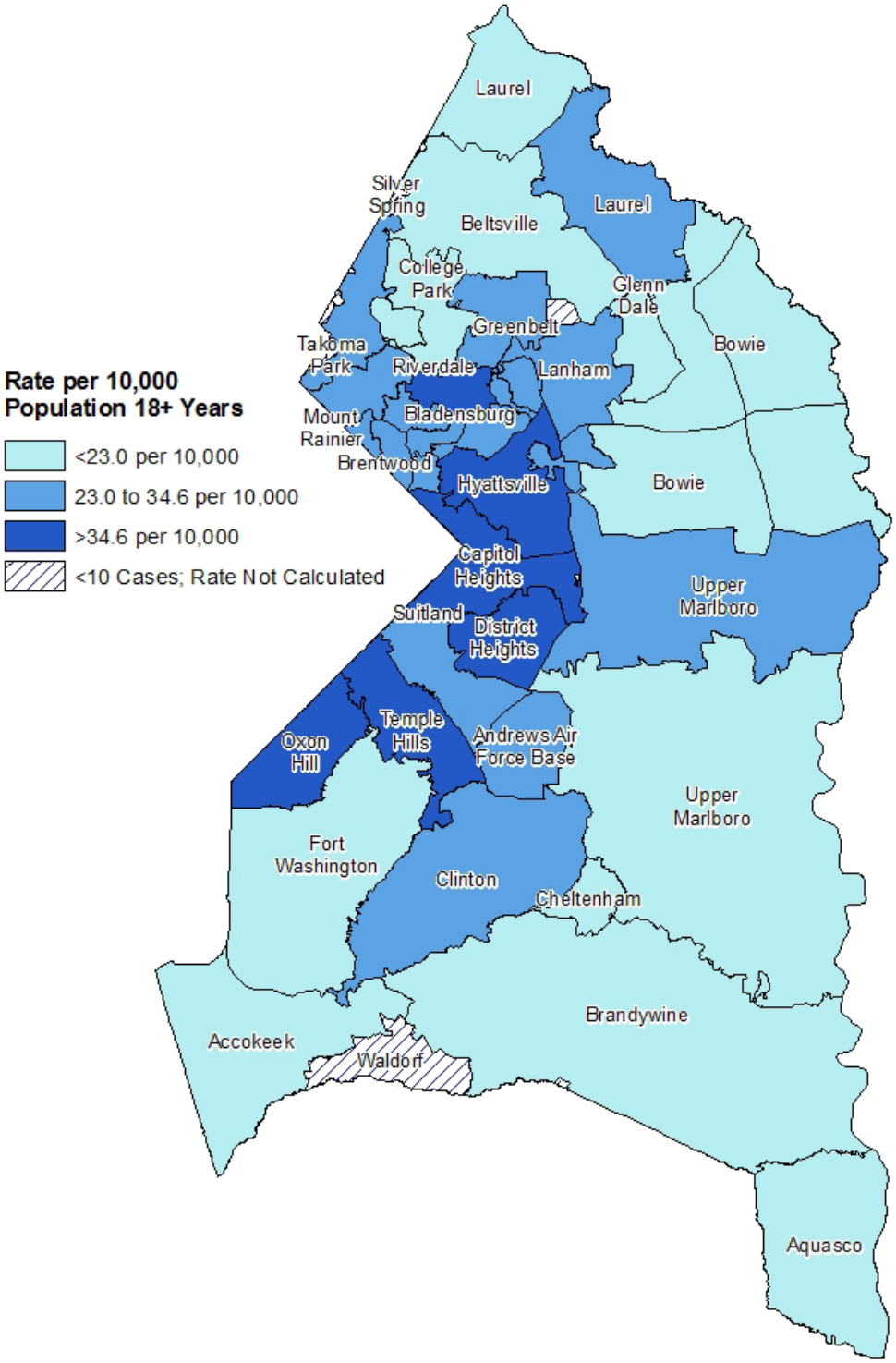
Age-Adjusted Hospital Inpatient Visit Rate due to Diabetes by Sex, Prince George's County, 2010-2012



* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient Visit Rate due to Diabetes, Prince George's County, 2010-2012



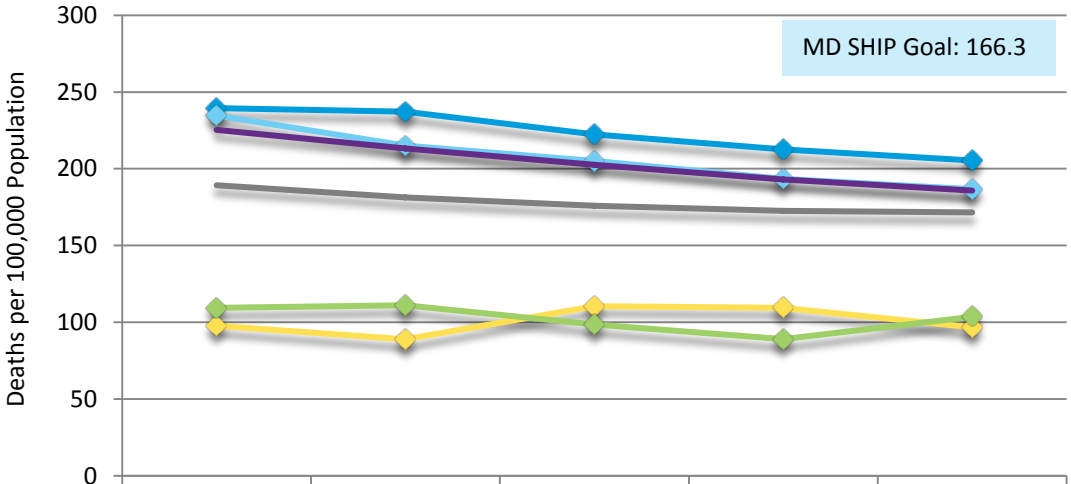
* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: The Maryland Health Services Cost Review Commission & Maryland Health Care Commission

□eart Disease

Overview	
What is it?	Heart Disease is a disorder of the blood vessels of the heart that can lead to a heart attack, which happens when an artery becomes blocked. Heart Disease is one of several cardiovascular diseases.
Who is affected?	Heart disease is a leading cause of death in the county with an age-adjusted death rate of 185.8 per 100,000 population in 2014. Heart disease accounted for 1,300 or 24% of deaths in the county in 2014.
Prevention and Treatment	• Eating a healthy diet, maintaining a healthy weight, getting enough physical activity, not smoking, and limiting alcohol use can lower the risk of heart disease. (Source: CDC). • The goals of heart disease treatment is to control high blood pressure and high cholesterol by focusing on: eating healthier, increasing physical activity, quitting smoking, medication, and surgical procedures. (Source: CDC).
What are the outcomes?	Complications of heart disease include: heart failure, heart attack, stroke, aneurysm, peripheral artery disease, and sudden cardiac arrest.
Disparity	Men have a higher rate of Emergency Department (ED) visits for Heart Disease than women, and more men die from heart disease. Black non-Hispanic residents have a higher rate of Emergency Department visits for Heart Disease, but White, non-Hispanic residents have a higher mortality rate (White non-Hispanic men have the highest mortality rate at 250.1 per 100,000 in 2012-2014). Residents 65 years of age and older account for 45% of Heart Disease ED visits.
How do we compare?	The age-adjusted death rate for Heart Disease for other Maryland counties range from 121.7 to 208.5 per 100,000 population; the state overall is 171.6 per 100,000 population, and the U.S. is at 169.1 per 100,000. While the county's age-adjusted death rate from Heart Disease has improved, it lags behind the state and nation at 185.8 per 100,000 population. From 2008-2010 to 2012-2014, there was a 17.5% decline in age-adjusted death rates for heart disease in the county.

Age-Adjusted Death Rate per 100,000 for Heart Disease by Race and Ethnicity, 2008-2014



	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PGC White NH	239.5	237.1	222.3	212.7	205.4
PGC Black NH	234.6	215.0	205.1	193.5	186.7
PGC Hispanic	97.8	89.0	110.6	109.5	96.7
PGC Asian NH	109.4	111.1	98.6	89.1	103.7
PGC	225.3	213.2	202.7	193.1	185.8
Maryland	189.3	181.3	175.9	172.7	171.6

Data Source: CDC, National Center for Health Statistics, CDC WONDER Online Database

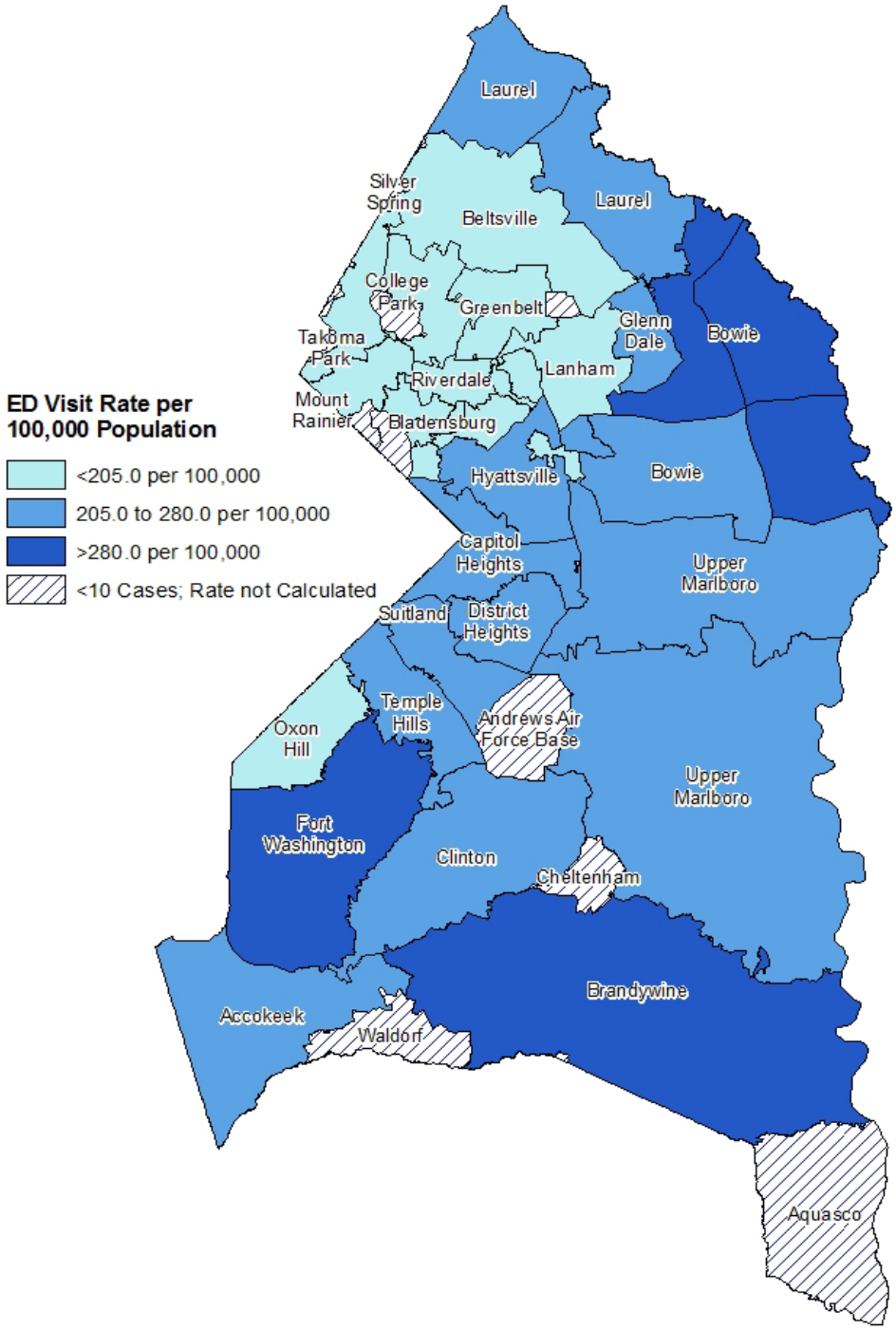
Emergency Department Visits for Heart Disease, 2014

Demographic	Number of ED Visits	Age-Adjusted Rate per 100,000 Population
Race and Ethnicity		
White, non-Hispanic	422	222.4
Black, non-Hispanic	1,433	257.4
Asian, non-Hispanic	18	48.2
Hispanic	55	62.6
Gender		
Male	1,056	273.2
Female	977	204.1
Age		
Under 18 Years	25	12.2
18 to 39 Years	226	96.9
40 to 64 Years	861	236.1
65 Years and Over	921	909.1
Total	2,033	234.6

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Outpatient Discharge Data File 2014, Maryland Health Services Cost Review Commission; Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

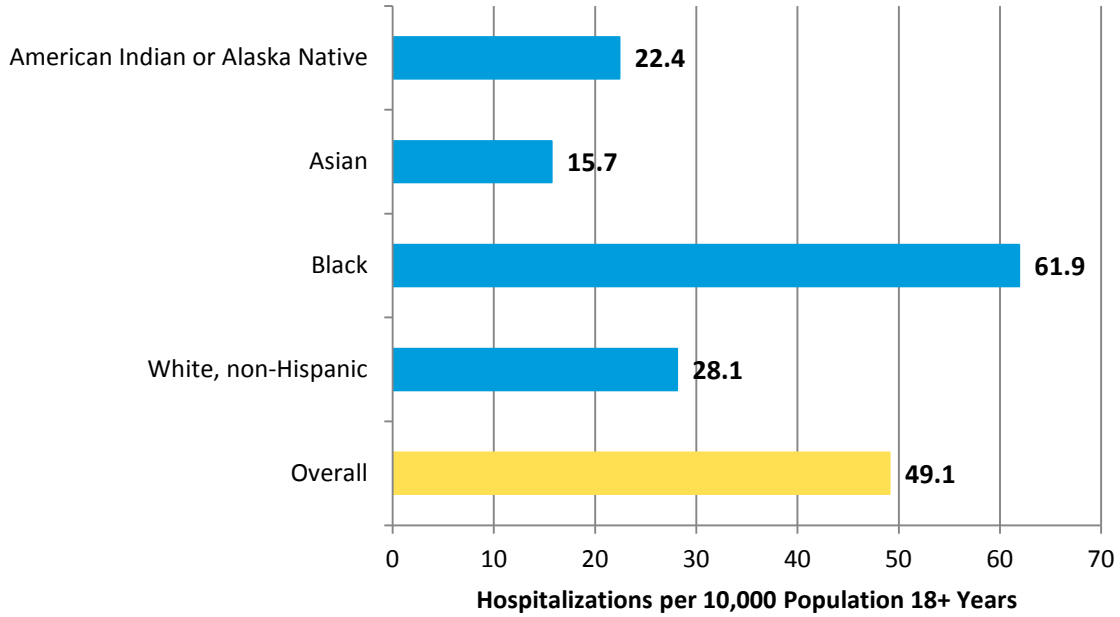
Emergency Department □isit□Crude Rate per 100,000 Population, □eart Disease as Primary Discharge Diagnosis, Prince □eorge□s County, 201□



* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

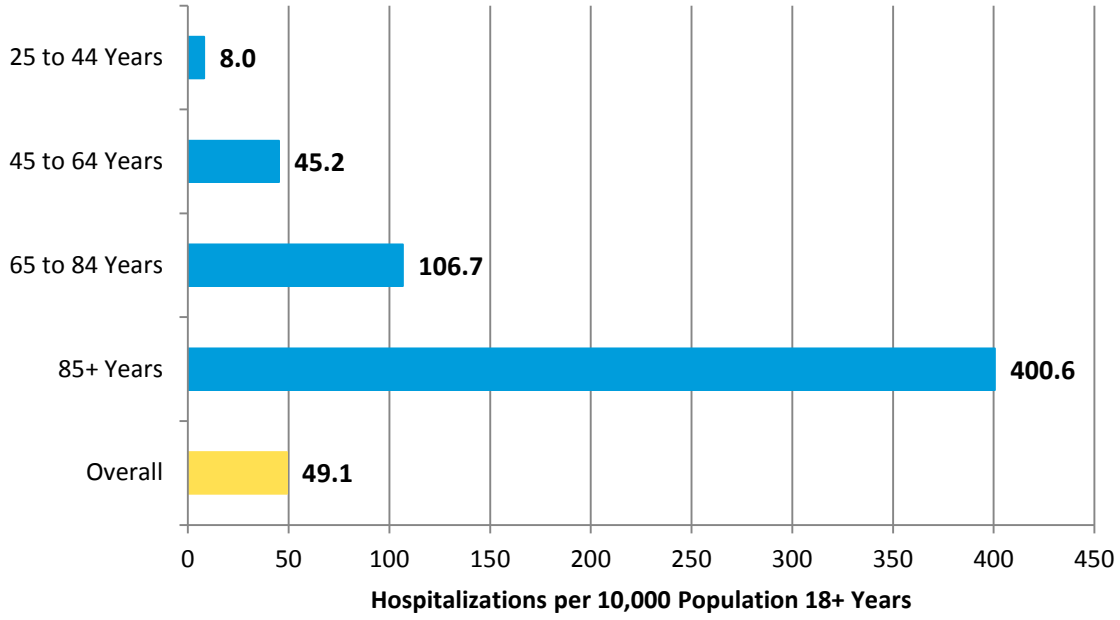
Data Source: Outpatient Discharge Data File 2014, Maryland Health Services Cost Review Commission

Age-Adjusted Hospital Inpatient Visit Rate due to Heart Failure by Race and Ethnicity, Prince George's County, 2010-2012



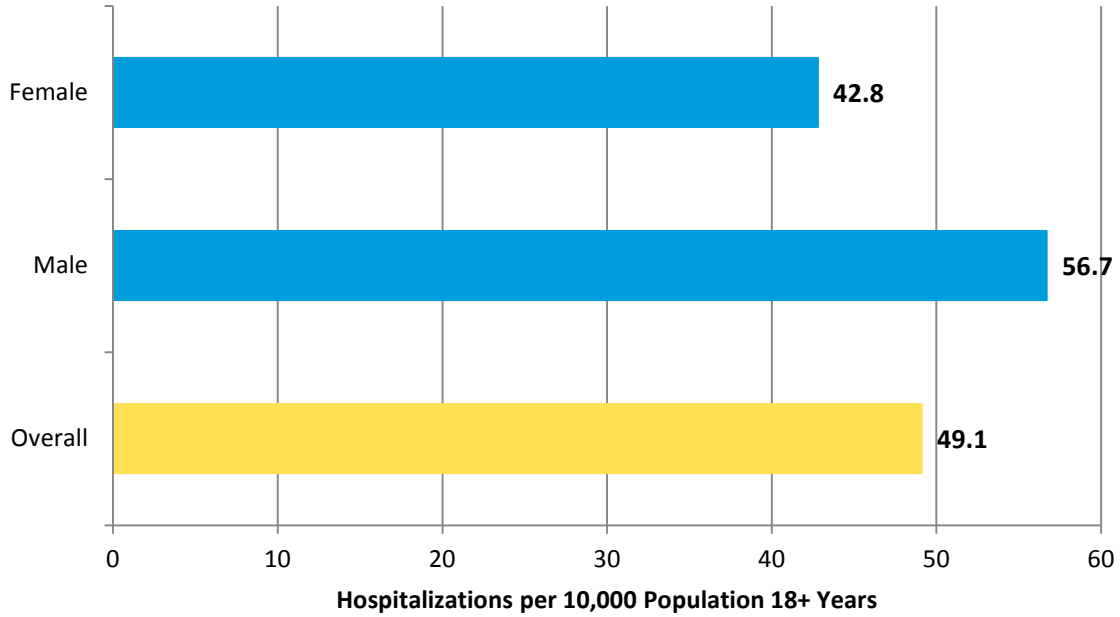
* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: www.pgchealthzone.org, Maryland Health Services Cost Review Commission; Maryland Health Care Commission;

Age-Adjusted Hospital Inpatient Visit Rate due to Heart Failure by Age, Prince George's County, 2010-2012



* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: www.pgchealthzone.org, Maryland Health Services Cost Review Commission; Maryland Health Care Commission

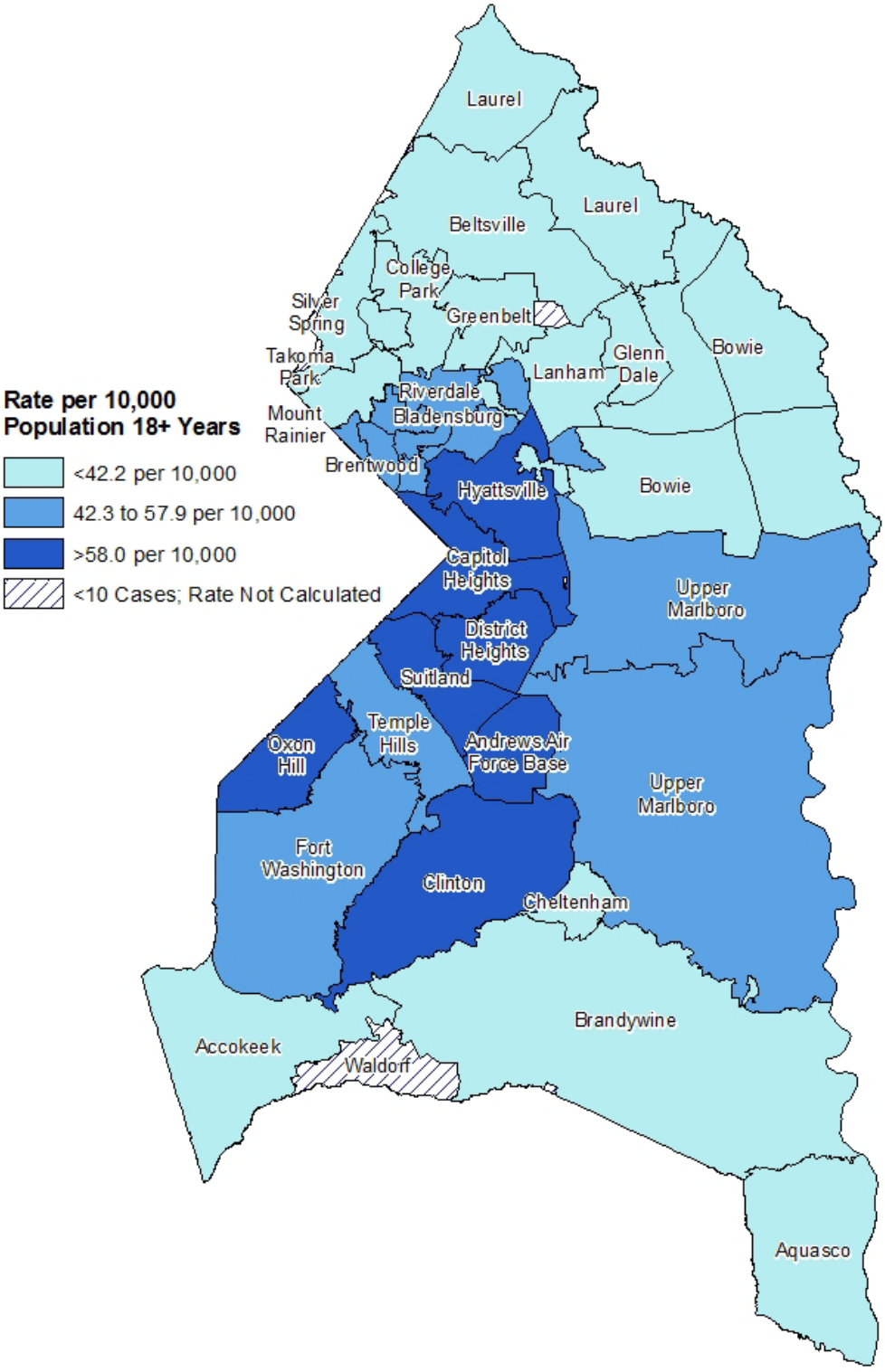
Age-Adjusted Hospital Inpatient Visit Rate due to Heart Failure by Sex, Prince George's County, 2010-2012



* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: www.pgchealthzone.org, Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient Visit Rate due to Heart Failure, Prince Georges County, 2010-2012



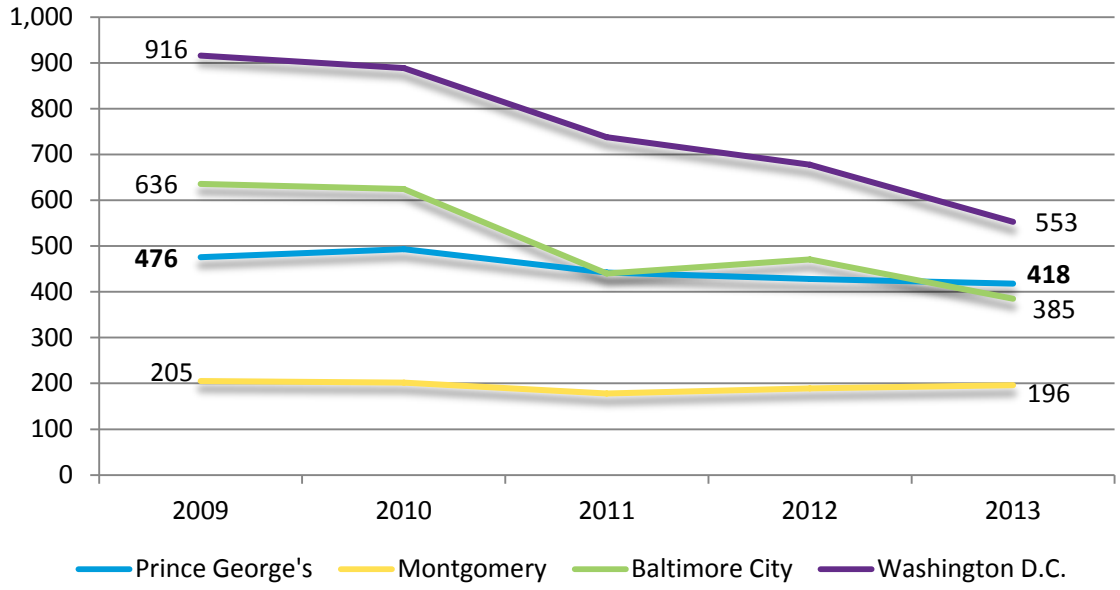
* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: www.pgchealthzone.org, Maryland Health Services Cost Review Commission; Maryland Health Care Commission

□uman Immunodeficiency □irus □□I□□

Overview	
What is it?	HIV is a virus that attacks the body's immune system and can, over time, destroy the cells that protect us from infections and disease.
Who is affected?	In 2013, 418 residents were diagnosed with HIV, a rate of 56.2 per 100,000 population. The total number of living HIV cases (with or without AIDS) was 6,479. In 2013, 31 residents died from HIV with an age-adjusted death rate of 4.3 per 100,000 population.
Prevention & Treatment	• HIV can be prevented by practicing abstinence, limiting the number of sexual partners, never sharing needles, and using condoms the right way during sex. Medications are also available to prevent HIV. (CDC) • There is no cure for HIV but antiretroviral therapy (ART) is available which helps to control the virus so you can live a longer, healthier life and reduce the risk of transmitting HIV to others. (AIDS.gov)
What are the outcomes?	HIV weakens the immune system leading to opportunistic infections (OIs). OIs are the most common cause of death for people with HIV/AIDS and can include *Cryptococcus*, *cytomegalovirus* disease, *histoplasmosis*, *tuberculosis,* and *pneumonia*. (AIDS.gov)
Disparity	In 2013, 73% of new HIV cases occurred among men; by race and ethnicity, 85% of new cases were Black non-Hispanic residents. One-third of new HIV cases were ages 20 to 29 years (34%), and 46% were ages 30-49. Nearly 60% of new HIV cases in 2013 occurred among men who have sex with men, compared to Heterosexual exposure for 38% of new cases.
How do we compare?	Prince George's County had the second highest rate of HIV diagnoses in the state in 2013 (56.2 per 100,000 population) after Baltimore City; however the county had the highest number of actual cases in the state (418, Baltimore City had 385). The rate of HIV diagnoses in other Maryland counties range from 0.0 to 73.6 per 100,000 population. The state overall had a rate of 28.1 per 100,000 population and the U.S. had a rate of 13.4 per 100,000. In 2013, Prince George's County had 28% of new HIV cases in Maryland, but is only 15% of the total population for the state. New HIV cases in the county have decreased by 12% between 2009 and 2013, while the nearly jurisdictions of Washington, D.C. and Baltimore City decreased by 40%.

□ew □I□ Cases by □urisdiction, 200□-201□



Data Source: County Annual HIV Epidemiological Profile, 2013, DHMH; 2014 HAHSTA Annual Epidemiology and Surveillance Report for Washington, D.C

Demographics of □ew □I□ Cases, 201□

	MD SHIP Goal: 26.7	Prince George's		Maryland	
		Number	Rate*	Number	Rate*
Sex at Birth					
Male		305	86.4	990	41.6
Female		112	28.8	405	15.7
Race/Ethnicity					
Asian non-Hispanic		4	11.9	16	5.3
Black, non-Hispanic		355	75.5	1,041	72.8
White, non-Hispanic		19	16.4	211	7.7
Hispanic		25	23.1	77	19.2
Age					
13 to 19 Years		21	25.3	59	10.9
20 to 29 Years		141	102.5	414	50.7
30 to 39 Years		92	73.1	324	42.0
40 to 49 Years		99	77.5	300	35.9
50 to 59 Years		43	34.7	199	23.1
60+ Years		21	14.5	100	8.8
Country of Birth					
United States		323	58.3	1,109	27.1
Foreign-born		57	33.3	139	17.8
TOTAL		417	56.2	1,395	28.1

*Rate per 100,000 Adult/Adolescents 13 years or older

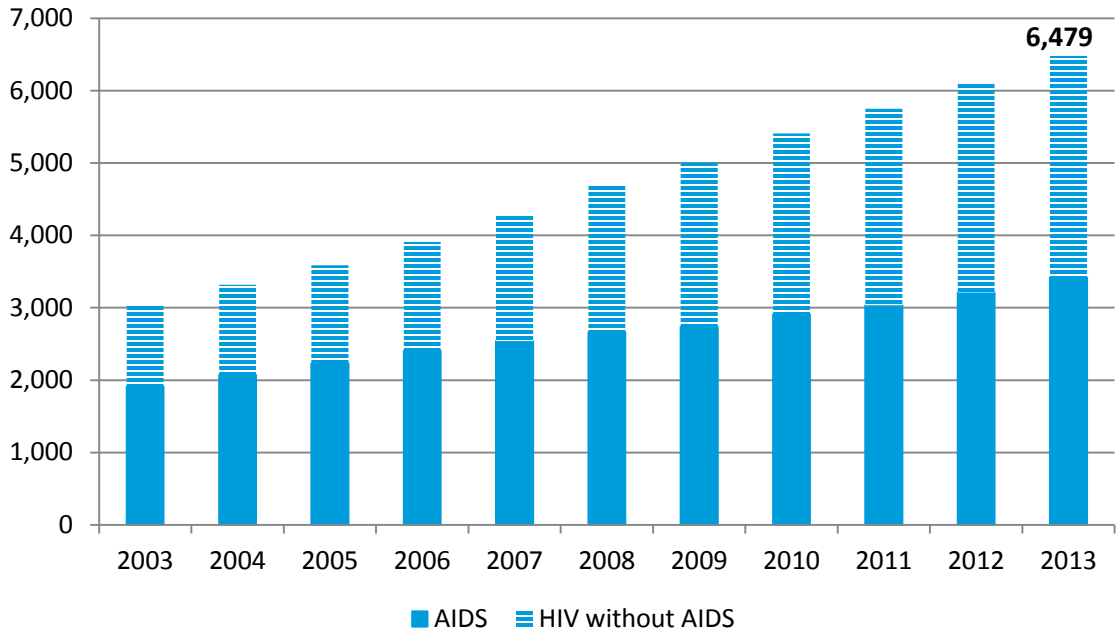
Data Source: County Annual HIV Epidemiological Profile, 2013, DHMH for Prince George's County, Maryland; Maryland State Health Improvement Process (SHIP) □ew □I□ Cases by Exposure, 201□

	Prince George's		Maryland	
	Number	**Rate***	**Number**	**Rate***
Exposure				
Men who have Sex with Men (MSM)	139	59.4%	506	53.0%
Injection Drug Users (IDU)	**	**	52	5.4%
MSM & IDU	0	0.0%	15	1.6%
Heterosexual	88	37.6%	377	39.5%
Other	**	**	5	0.5%
No Reported Exposure	183		440	
TOTAL	**417**	**56.2**	**1,395**	**28.1**

**Data withheld due to low population and/or case counts

Data Source: County Annual HIV Epidemiological Profile, 2013, DHMH for Prince George's County

Living □I□ Cases, Prince □eorge□s County, 200□ to 201□



Data Source: Prince George's County Annual HIV Epidemiological Profile, 2013, DHMH
http://phpa.dhmh.maryland.gov/OIDEOR/CHSE/SitePages/statistics.aspx

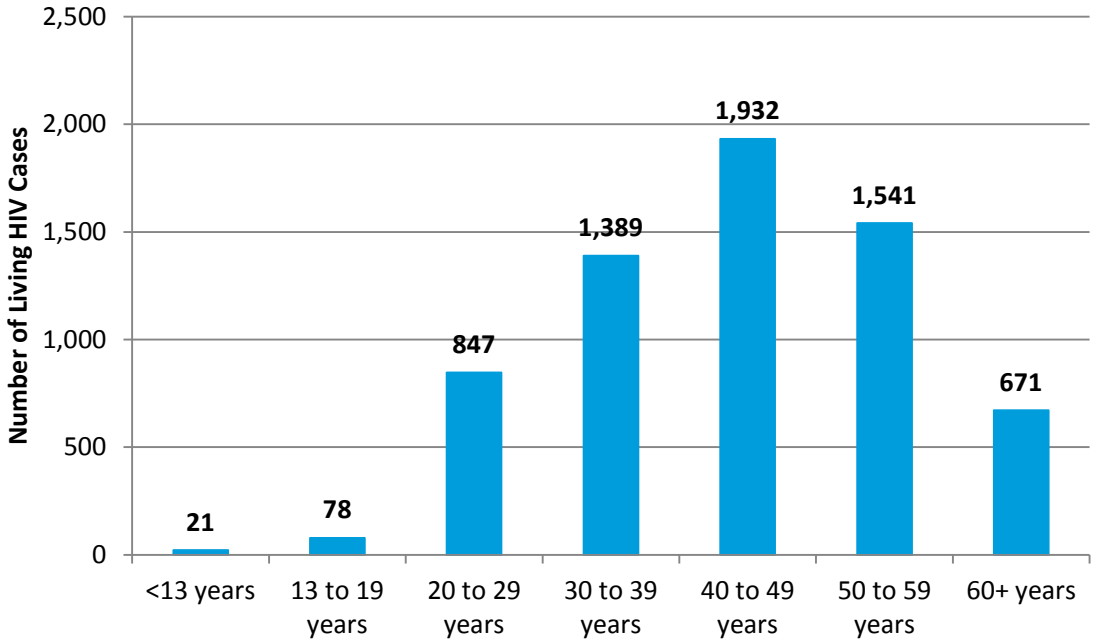
Demographics of □otal Living □I□ Cases, 201□

	Prince George's		Maryland	
	Number	Rate*	Number	Rate*
Sex at Birth				
Male	4,076	1,155.1	19,667	825.5
Female	2,305	591.7	10,639	412.2
Race/Ethnicity				
Asian non-Hispanic	26	77.2	163	54.3
Black, non-Hispanic	5,447	1,157.9	23,016	1,610.0
White, non-Hispanic	336	290.7	4,543	165.9
Hispanic	390	360.1	1,477	368.7
Current Age				
13 to 19 Years	78	94.1	260	48.2
20 to 29 Years	847	615.7	3,134	383.3
30 to 39 Years	1,389	1,104.2	5,107	662.5
40 to 49 Years	1,932	1,512.7	8,926	1,067.3
50 to 59 Years	1,541	1,245.3	9,364	1,083.9
60+ Years	671	463.6	3,896	343.3
Country of Birth				
United States	5,330	962.1	26,877	657.6
Foreign-born	738	431.5	2,368	303.4

*Rate per 100,000 Adult/Adolescents 13 years or older

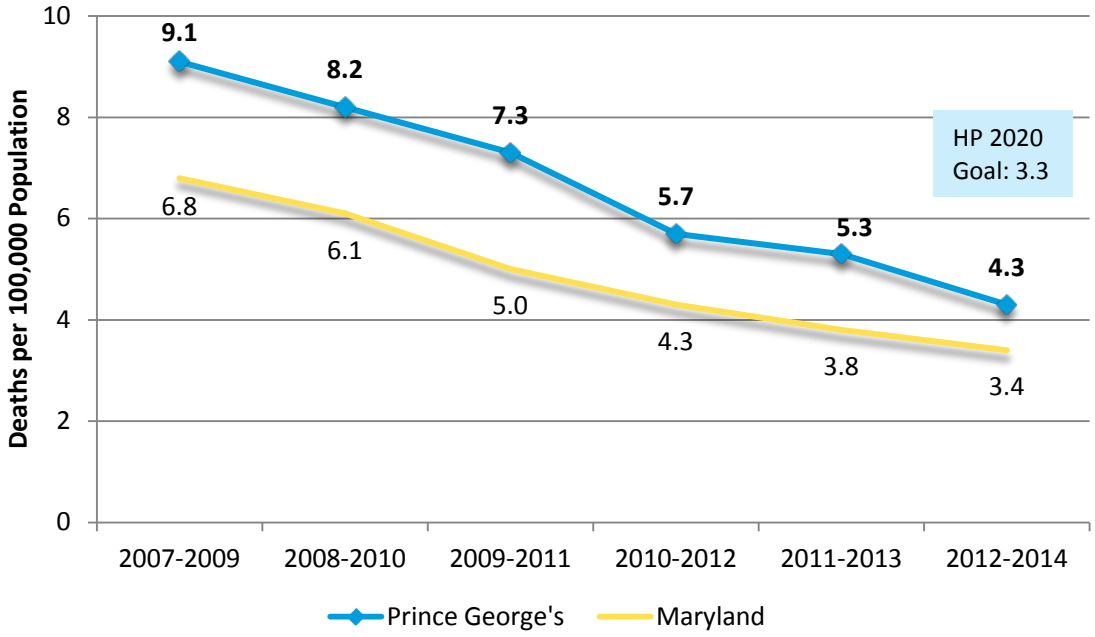
Data Source: County Annual HIV Epidemiological Profile, 2013, DHMH for Prince George's County, Maryland

□otal Living □I□ Cases by Current Age, Prince □eorge□s County, 201□



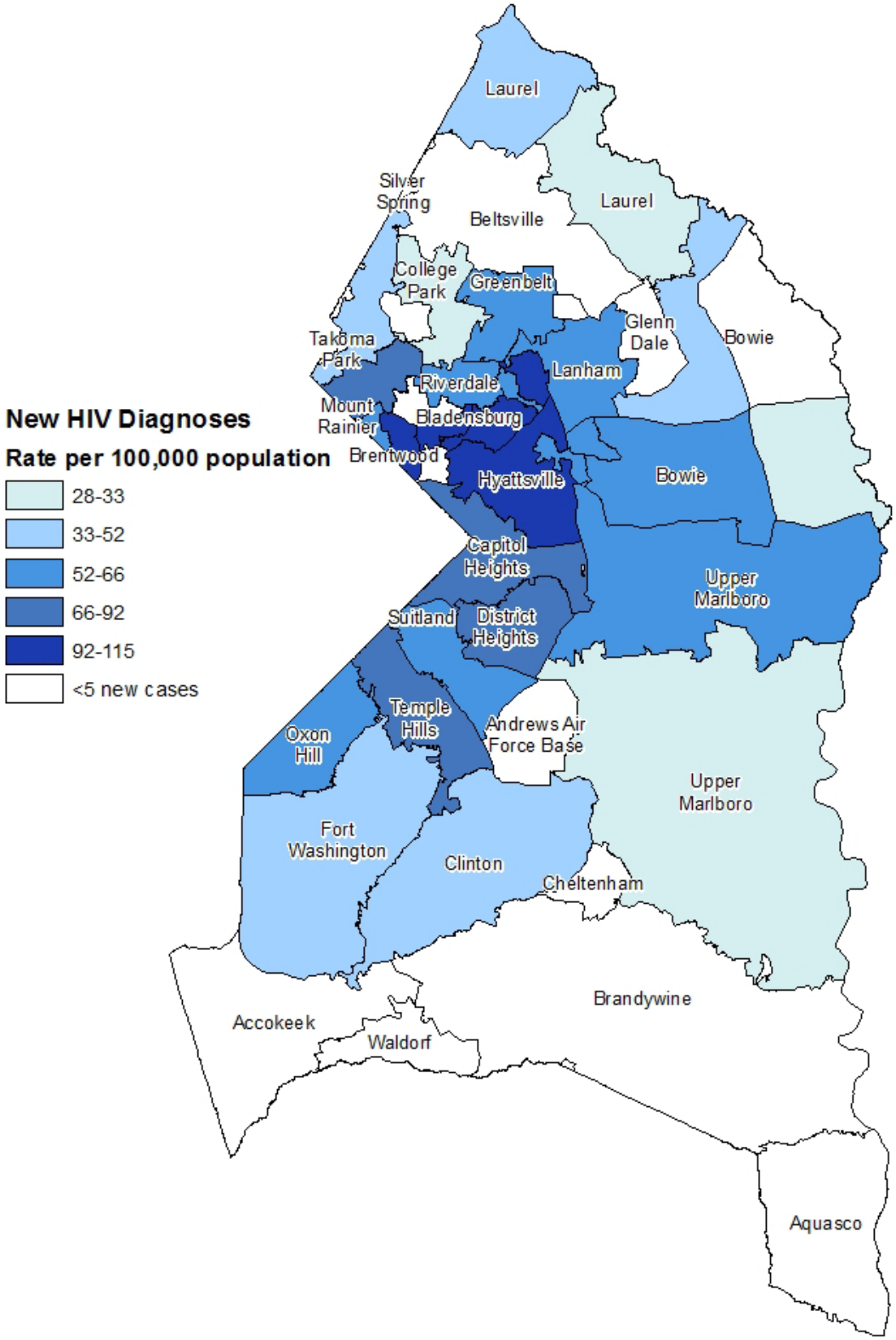
Data Source: Prince George's County Annual HIV Epidemiological Profile, 2013, DHMH

□I□ Age-Ad□usted □ortality Rate, Prince □eorge□s County Compared to □aryland, 200□-201□



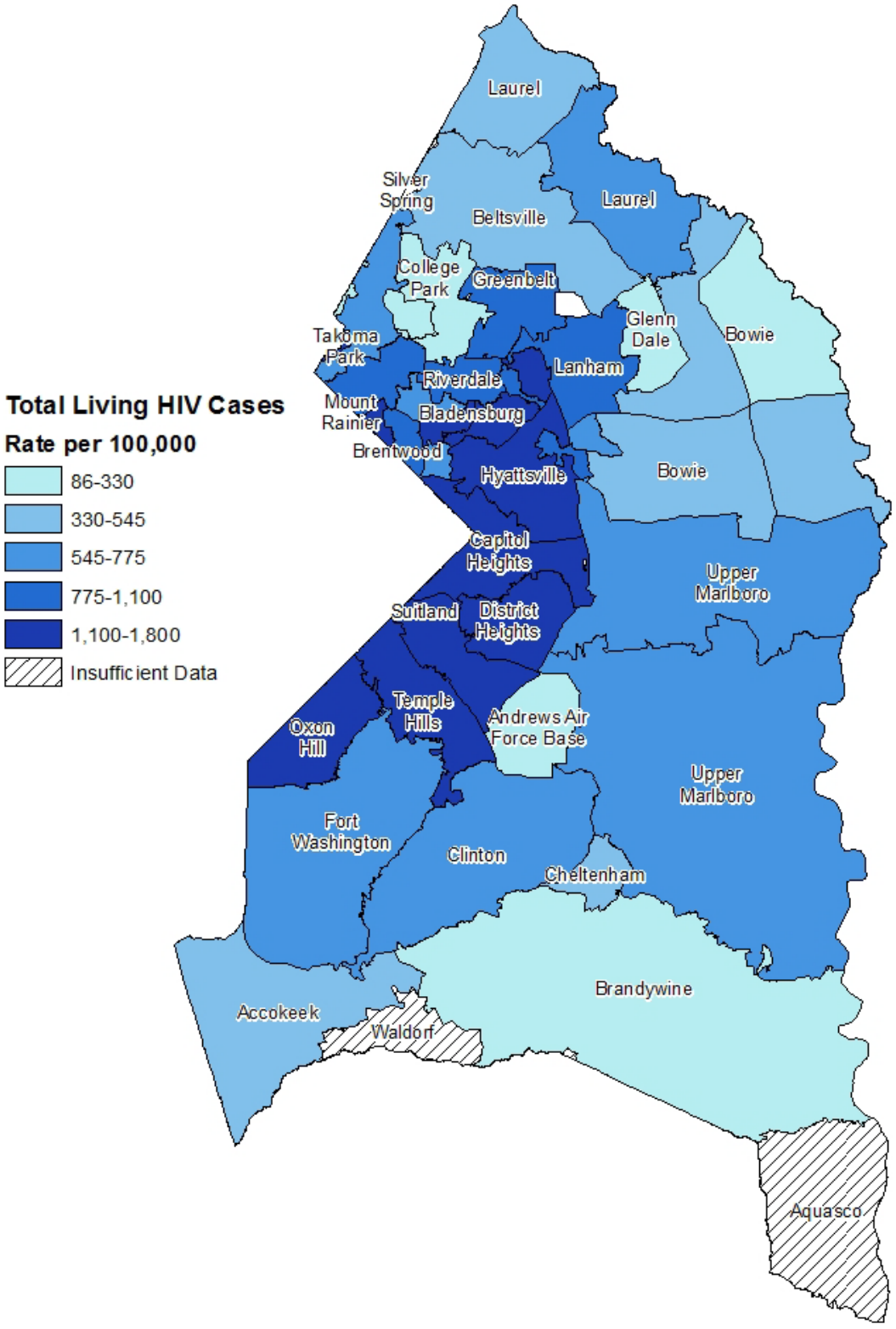
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database;

201□ □ew □I□ Cases per 100,000 Population, Age 1□ and Over



Data Source: Prince George's County Annual HIV Epidemiological Profile, 2013, DHMH

201□ □otal Living □I□ Cases per 100,000 Population, Age 1□ and Over



Data Source: Prince George's County Annual HIV Epidemiological Profile, 2013, DHMH

□ypertension and Stro□e

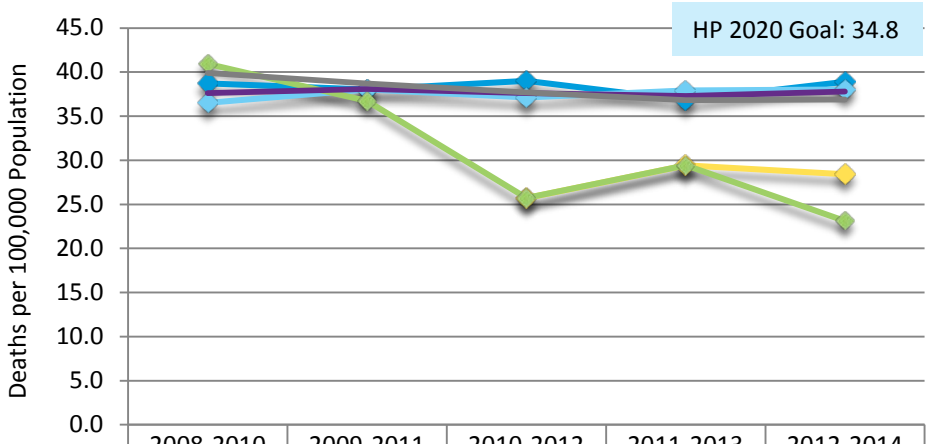
Overview	
What is it?	High blood pressure, or hypertension, is when the force of blood pumping through the arteries is too strong. Hypertension is a risk factor for stroke, which is when the flow of blood (and thus oxygen) to the brain is blocked.
Who is affected?	In the county, 37.9% (252,160) of adults are estimated to have hypertension (Maryland BRFSS 2013). Among Medicare beneficiaries, 4.6% were treated for stroke in 2014 (CMS). In 2014, 298 county residents died from stroke.
Prevention & Treatment	• Hypertension and stroke can be prevented by eating a healthy diet, maintaining a healthy weight, exercising regularly, avoiding stress, and limiting alcohol and tobacco use (source: CDC) • The goal of stroke treatment is to maintain healthy blood pressure through proper nutrition, exercise, and medication (source: American Heart Association).
What are the outcomes?	Complications from hypertension include damage to the heart and coronary arteries, stroke, kidney damage, vision loss, erectile dysfunction, angina, and death. (source: American Heart Association).
Disparity	In 2013, 29.9% of White, non-Hispanic (NH) and 42.6% of Black NH residents are estimated to have hypertension; Black NH residents have the highest age-adjusted Emergency Department visit rate. Slightly more men (38.7%) are estimated to have hypertension than women (37.1%), but women have a higher rate of Emergency Department visits due to hypertension. Both Black NH and White NH have a higher mortality rate due to stroke compared to Asian NH and Hispanic residents. Over 75% of residents aged 65+ and half of adults ages 50 to 64 are estimated to have hypertension (MD BRFSS 2013).
How do we compare?	Other Maryland counties range from 25.8% to 44.6% of residents with hypertension; the county (37.9% with hypertension) is higher than the state at 33.6% (Maryland BRFSS 2013) and the U.S. at 31.4% (BRFSS). The county has a slightly higher age-adjusted death rate due to stroke (37.8 per 100,000) compared to the state (36.9 per 100,000) and U.S (36.5 per 100,000).

Percent of Adults □ ho □ave Ever □een □old □y A □ealth Professional □hey □ave □igh □lood Pressure, 201□

	Prince George's	Maryland
Overall	37.9%	33.6%
Sex		
Male	38.7%	33.9%
Female	37.1%	33.2%
Race/Ethnicity		
White, non-Hispanic	29.9%	33.3%
Black, non-Hispanic	42.6%	39.2%
Hispanic	29.9%	22.6%
Age Group		
18 to 34 Years	13.6%	11.4%
35 to 49 Years	36.1%	23.6%
50 to 64 Years	49.5%	45.6%
Over 65 Years	76.1%	66.3%

Data Source: Maryland BRFSS 2013

Age-Ad□usted Death Rate per 100,000 for Sto□e by Race and Ethnicity, Prince □eorge□s County, 200□-201□

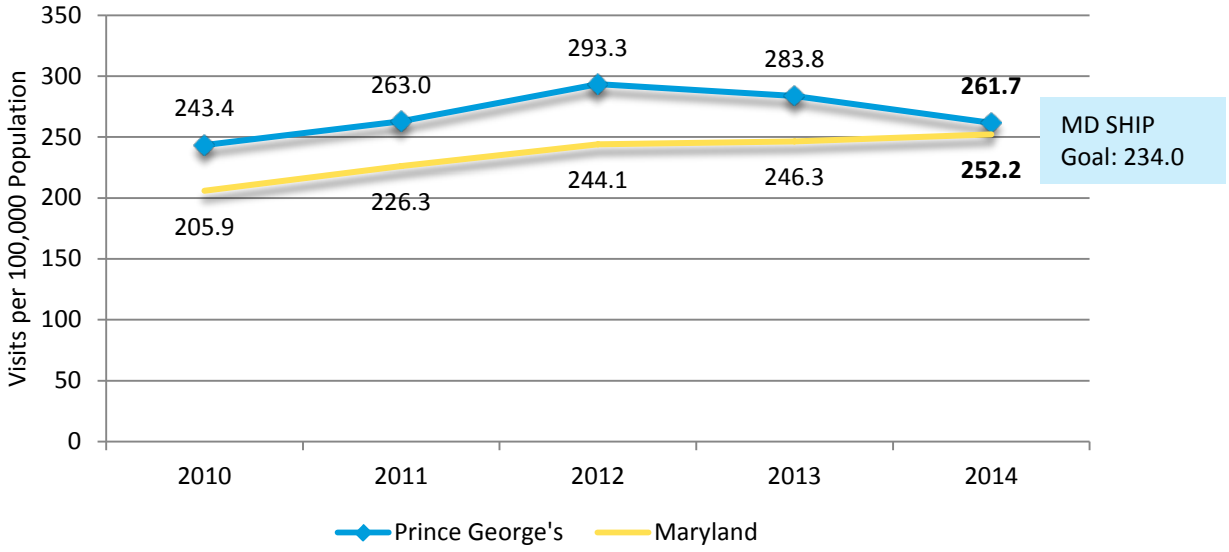


	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PGC White NH	38.7	38.0	39.0	36.8	38.9
PGC Black NH	36.5	38.0	37.1	37.9	38.0
Hispanic*, any race			25.7	29.4	28.4
PGC Asian NH	40.9	36.7	25.7	29.4	23.1
PGC	37.6	38.1	37.6	37.3	37.8
Maryland	39.9	38.7	37.7	36.8	36.9

*Rates are unavailable due to small numbers

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Age-Adjusted Emergency Department Visits per 100,000 Population Due to Hypertension, 2010-2014



* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Maryland Health Services Cost Review Commission, Maryland SHIP metrics http://dhmh.maryland.gov/ship

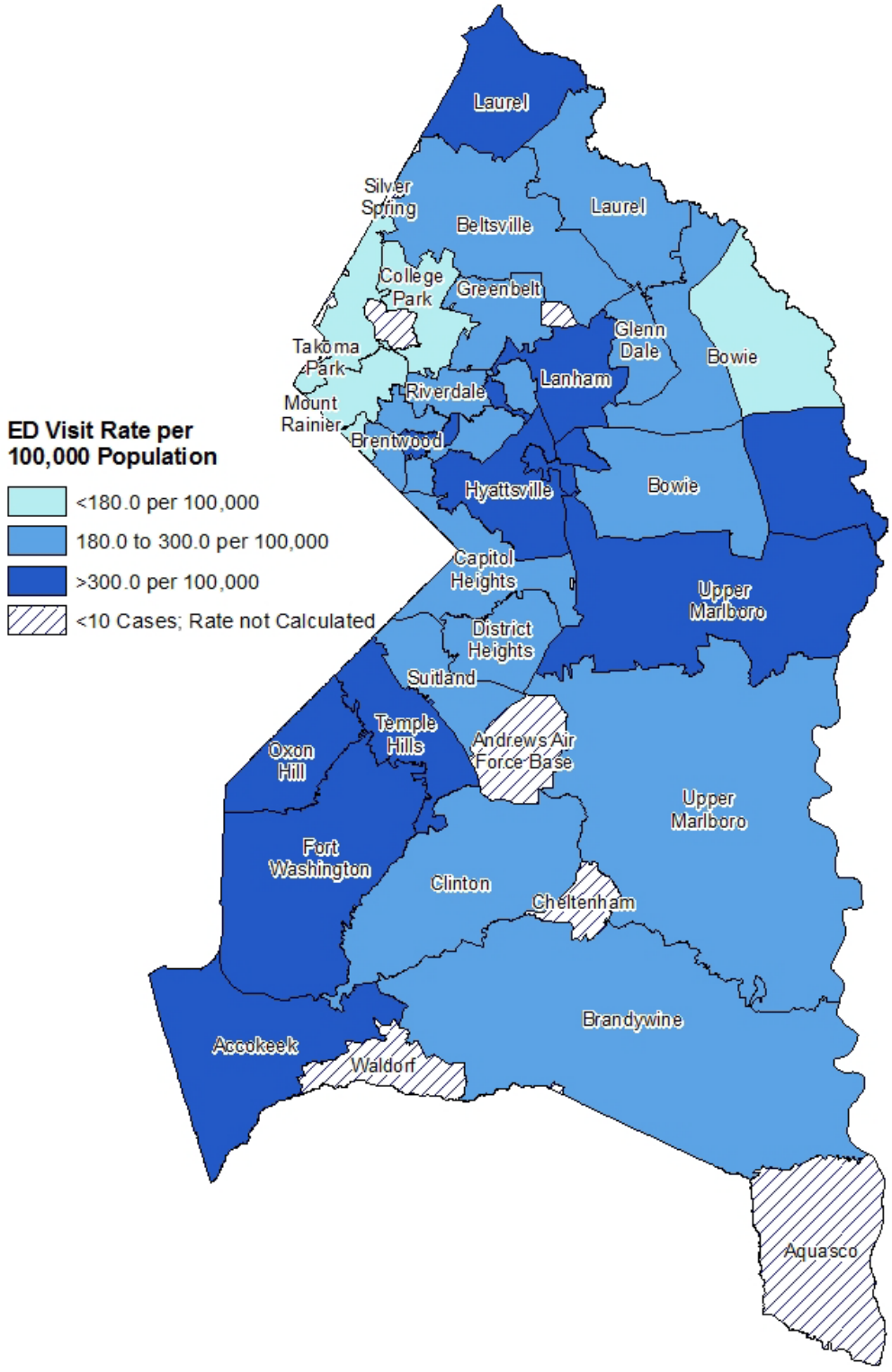
Emergency Department Visits for Hypertension, 2014

Demographics	Prince George's County Number of ED Visits	Age-Adjusted ED Visit Rate per 100,000 Population	
		Prince George's County	Maryland
Race and Ethnicity			
White, non-Hispanic	178	**113.6**	113.2
Black, non-Hispanic	1,772	**295.3**	415.1
Asian, non-Hispanic	32	**72.3**	54.6
Hispanic	96	**93.9**	125.0
Gender			
Male	899	**212.7**	---
Female	1,290	**259.0**	---
Age			
Under 18 Years	<10	--	---
18 to 39 Years	342	146.6	---
40 to 64 Years	1,376	377.3	---
65 Years and Over	679	670.2	---
TOTAL	**2,189**	**261.7**	**252.2**

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Outpatient Discharge Data File 2014, Maryland Health Services Cost Review Commission; DHMH Maryland SHIP; Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

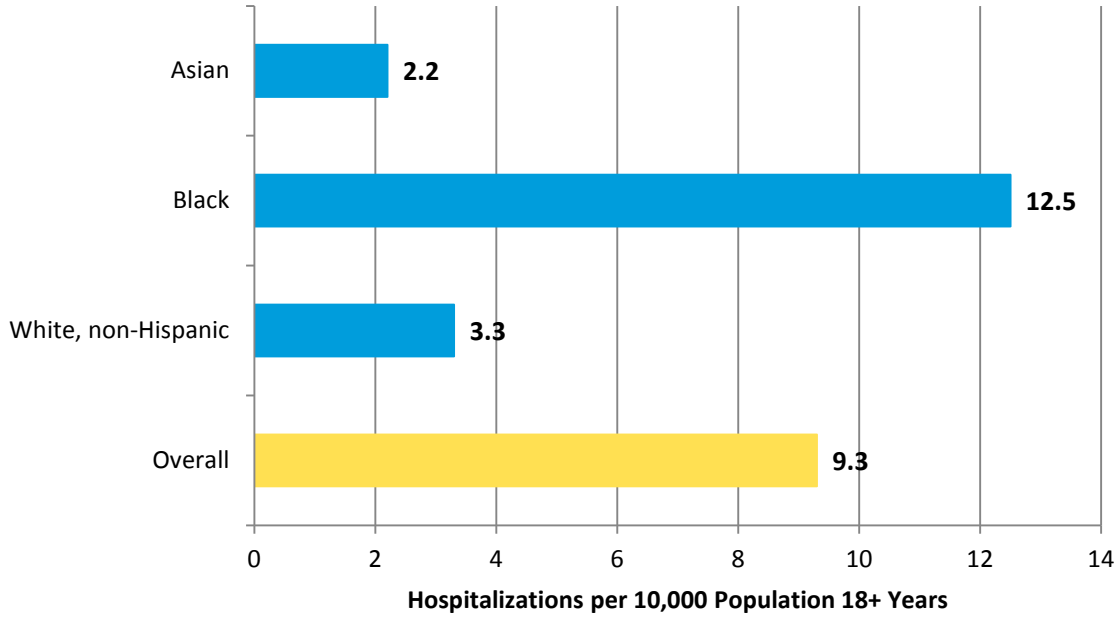
Emergency Department□□isit Crude Rate per 100,000 Population, □ypertension as Primary Diagnosis, Prince □eorge□s County, 201□



* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

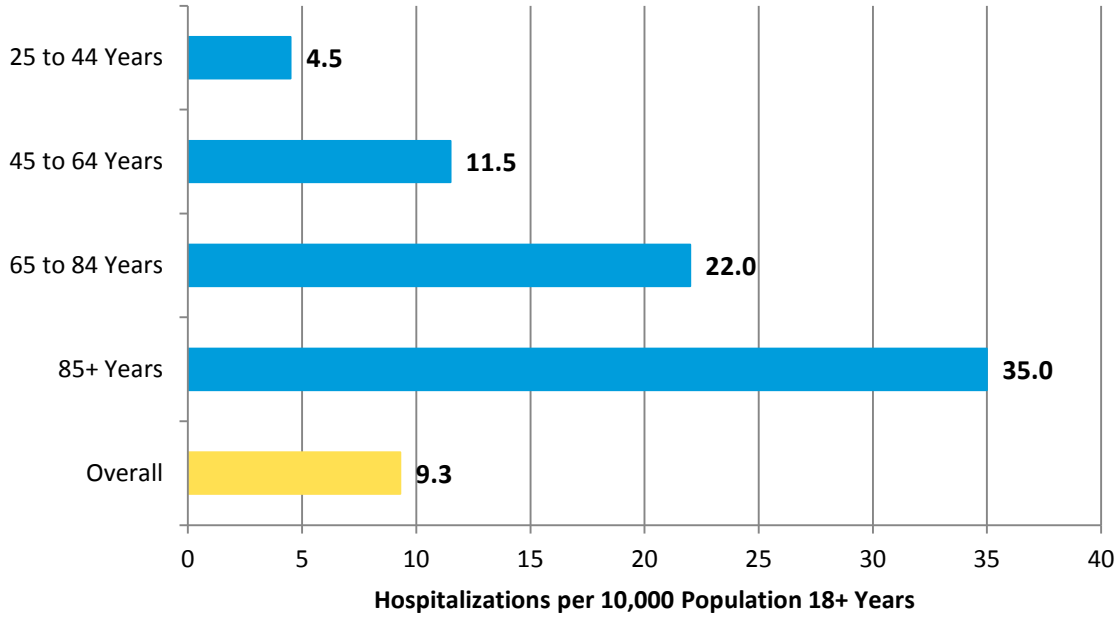
Data Source: Outpatient Discharge Data File 2014, Maryland Health Services Cost Review Commission

Age-Adjusted Hospital Inpatient Visit Rate due to Hypertension by Race and Ethnicity, Prince George's County, 2010-2012



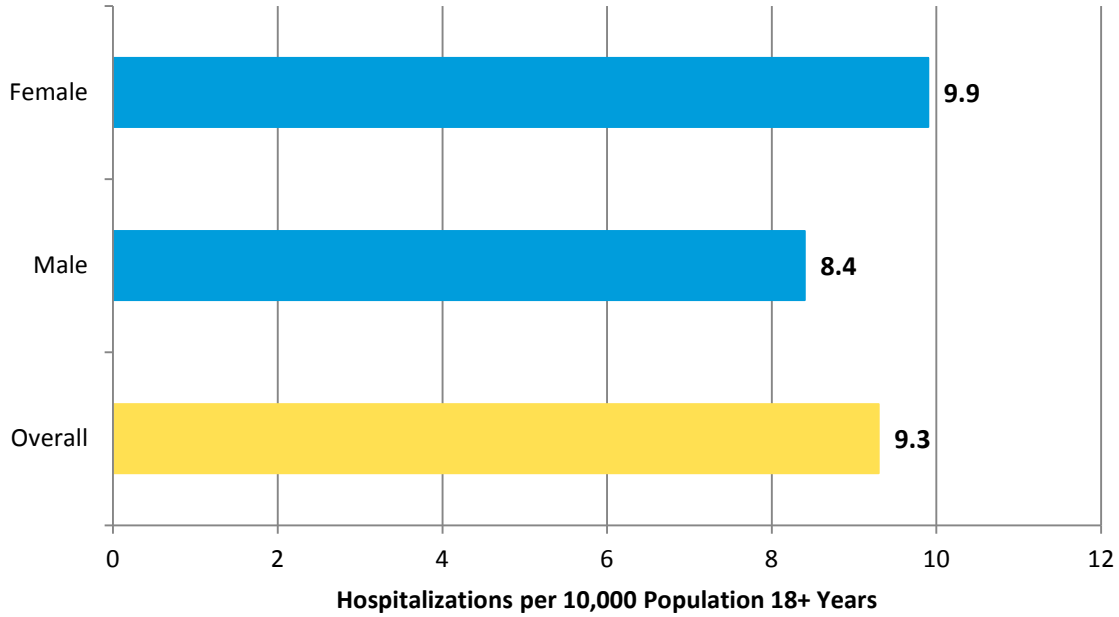
* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: The Maryland Health Services Cost Review Commission & Maryland Health Care Commission

Age-Adjusted Hospital Inpatient Visit Rate due to Hypertension by Age Group, Prince George's County, 2010-2012



* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: The Maryland Health Services Cost Review Commission & Maryland Health Care Commission

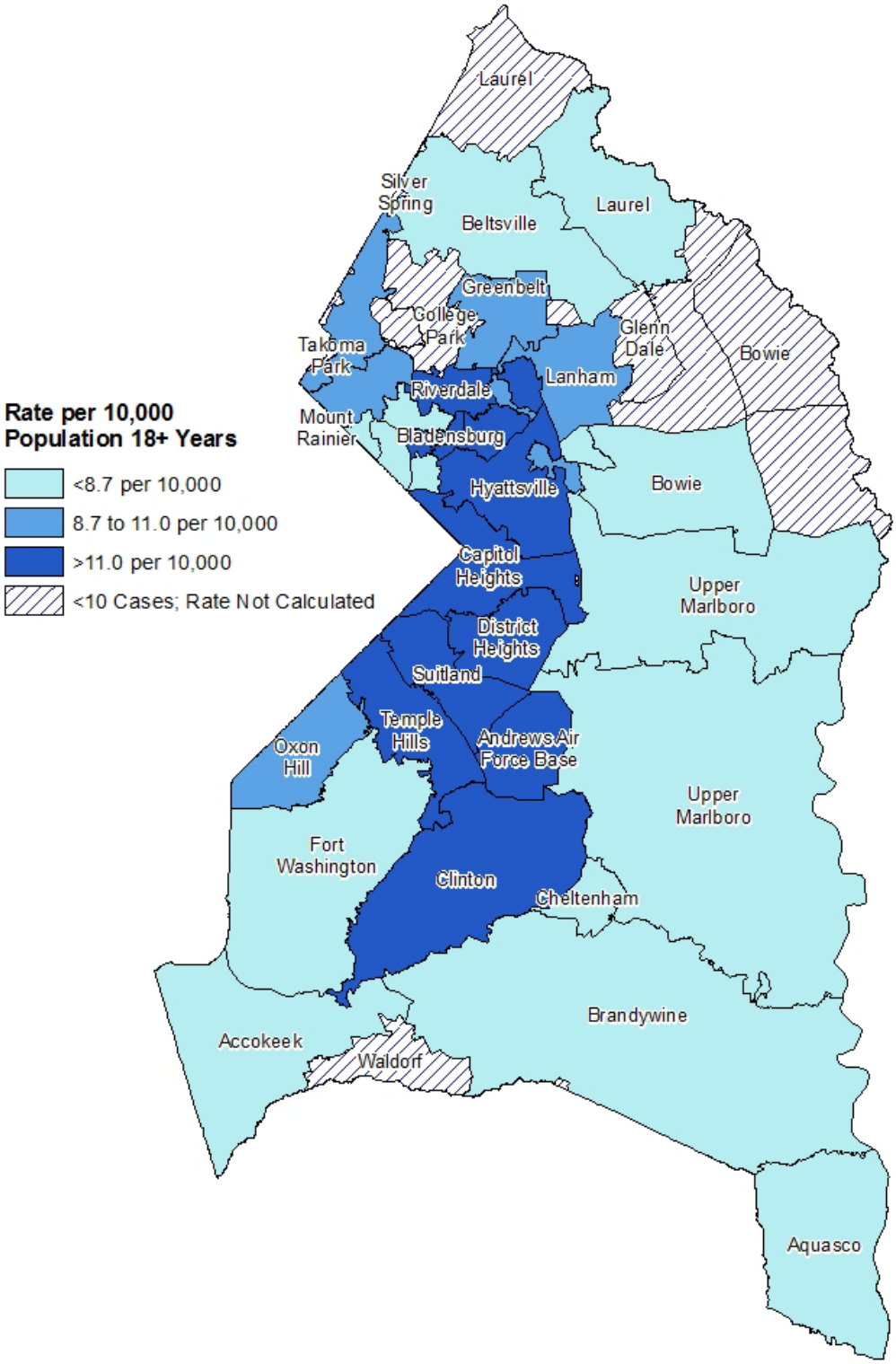
Age-Adjusted Hospital Inpatient Visit Rate due to Hypertension by Sex, Prince George's County, 2010-2012



* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: The Maryland Health Services Cost Review Commission & Maryland Health Care Commission

Age-Adjusted Hospital Inpatient Visit Rate due to Hypertension, Prince George's County, 2010-2012



* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: The Maryland Health Services Cost Review Commission & Maryland Health Care Commission

Infectious Disease

Selected Reportable Disease, Prince □eorge□s County, 2012-201□

Morbidity	2012	2013	2014	5-Year Mean
Campylobacteriosis	32	39	38	35
H. influenza, invasive	14	10	12	11
Hepatitis A, acute	7	3	3	5
Legionellosis	14	30	18	17
Measles	0	0	0	0
Meningitis, viral	43	28	78	60
Meningitis, meningococcal	0	0	0	1
Pertussis	34	18	9	16
Salmonellosis	86	70	82	88
Shiga-toxin producing E.coli	5	6	2	6
Shigellosis	36	22	59	32
Strep Group B	53	55	76	66
Strep pneumonia, invasive	44	36	47	45
Tuberculosis	50	43	50	47
Outbreaks				
Outbreaks: Gastrointestinal	17	7		
Outbreaks: Respiratory	2	1		
Animal-Related Illness				
Animal Bites	781	752	912	746
Animal Rabies	21	17	24	19

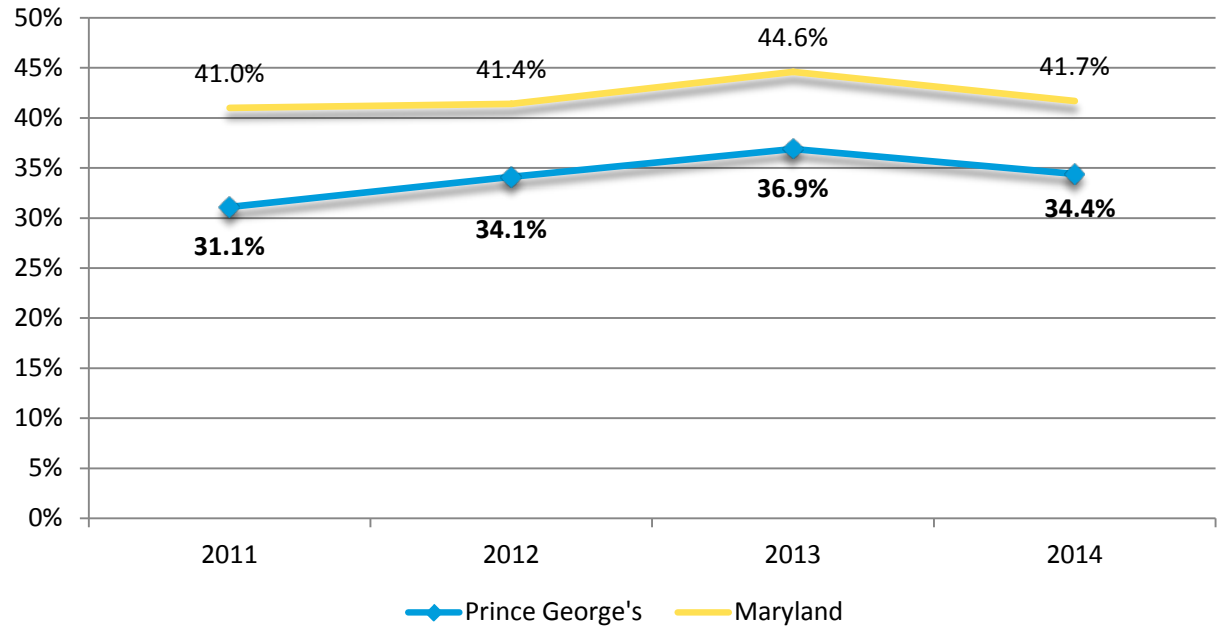
Data Source: Infectious Disease Bureau, Prevention and Health Promotion Administration, DHMH

Percent of Adults □ ho □ad a Seasonal Influen□a Shot or Influen□a □accine □asal Spray During the Past Year, 201□

	Prince George's	Maryland
Male	34.8%	38.0%
Female	34.1%	45.2%
Race/Ethnicity		
White, non-Hispanic	54.1%	45.4%
Black, non-Hispanic	35.7%	39.0%
Hispanic	12.1%	27.0%
Age Group		
18 to 34 Years	22.2%	30.1%
35 to 49 Years	24.1%	36.7%
50 to 64 Years	45.7%	44.9%
Over 65 Years	59.7%	62.1%
Overall	**34.4%**	**41.7%**

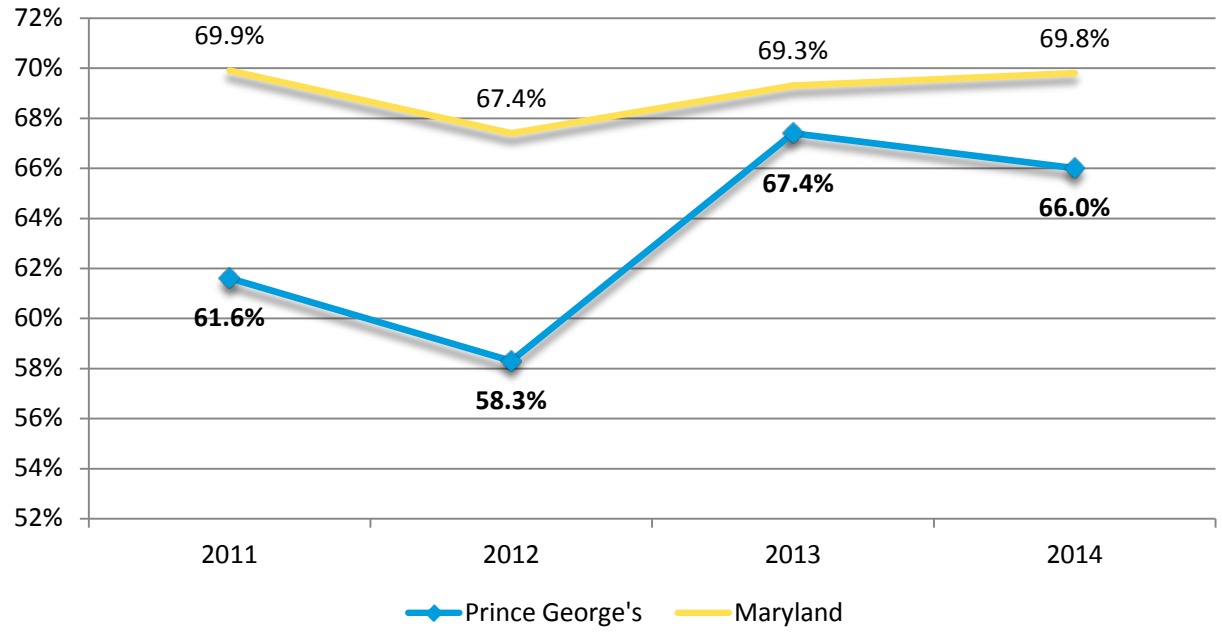
Data Source: Maryland BRFSS

Percent of Adults □ ho □ad a Seasonal Influen□a Shot or Influen□a □accine □asal Spray During the Past Year, 2011-201□



Data Source: Maryland BRFSS

Percent of Adults Age □□□ □ ho Ever □ad a Pneumonia □accine, 2011-201□

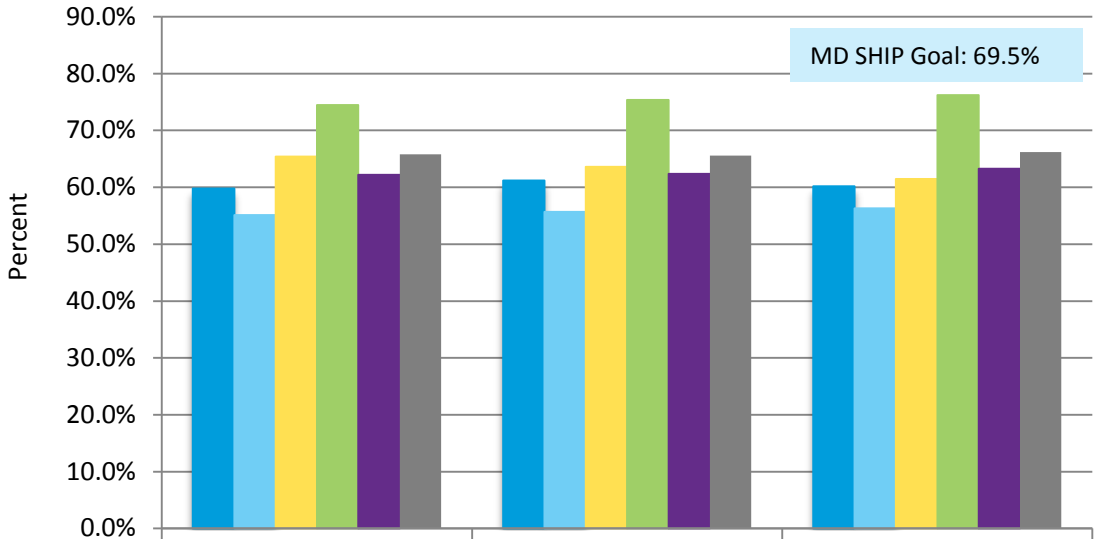


Data Source: Maryland BRFSS 2014

Lead Poisoning

Children can be exposed to lead through lead-based paint and dust with lead in it. Although lead paint was banned in 1978 it can be found in homes built before then, and the deterioration of the paint results in the contaminated dust. Lead exposure often occurs without symptoms and can go unrecognized; however, lead can affect nearly every system in the body. There is no safe blood lead level in children, and action is recommended with levels above 5 micrograms per deciliter. Lead poisoning can result in damage to the brain, slowed development and growth, learning and behavior problems, and hearing and speech problems (CDC).

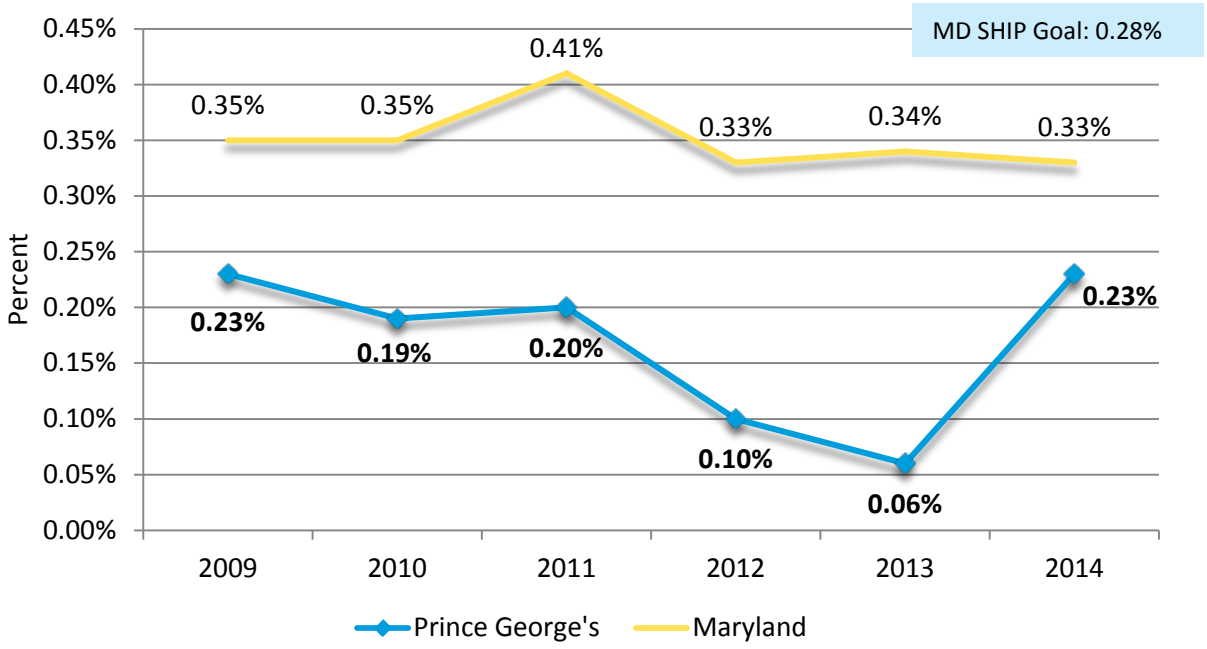
Percentage of Children Ages 12-□□ □onths Enrolled in □edicaid□□ ho Received a □lood Lead □est, 2011-201□



	2011	2012	2013
PGC White	59.8%	61.2%	60.2%
PGC Black	55.1%	55.7%	56.3%
PGC Asian	65.4%	63.6%	61.5%
PGC Hispanic	74.5%	75.4%	76.2%
Prince George's	62.2%	62.4%	63.3%
Maryland	65.8%	65.6%	66.2%

***** Includes children enrolled in Medicaid for at least 90 days
Data Source: Maryland Medicaid Service Utilization, Maryland SHIP website, http://dhmh.maryland.gov/ship

Percentage of Children Under Six Years of Age □ested for □lood Lead who have 10 or □ore □icrograms□Deciliter of Lead in □lood, 200□ to 201□



Data Source: Maryland Department of the Environment

Maternal and Infant Health

Live Birth Rate per 1,000 Population, 2014

	Prince George's	Maryland	United States
Live Births per 1,000 Population	13.6	12.3	12.5

Data Source: Maryland Department of Health and Mental Hygiene, Vital Statistics Administration, 2014; National Center for Health Statistics, National Vital Statistics Report, 2014

Number of Births by Race and Ethnicity of Mother, Prince George's County, 2014

Race/Ethnicity	Number of Live Births	Percent of Births	Rate per 1,000 population
White, NH	1,225	10.0%	9.3
Black, NH	7,211	58.7%	12.5
Hispanic, Any Race	3,241	26.4%	21.2
Asian	562	4.6%	12.3
American Indian/Alaska Native	33	0.3%	2.9
All Races	**12,288**	**100.0%**	**13.6**

Data Source: Maryland Department of Health and Mental Hygiene, Vital Statistics Administration, 2014

Number and Percent of Births by Age Group, 2014

	Prince George's		Maryland	United States
Age Group	**Number**	**Percent**	**Percent**	**Percent**
<15 years	5	0.04%	0.07%	0.1%
15 to 17 years	178	1.4%	1.3%	1.7%
18 to 19 years	455	3.7%	3.3%	4.6%
20 to 24 years	2,403	19.6%	17.4%	22.1%
25 to 29 years	3,329	27.1%	27.3%	28.7%
30 to 34 years	3,419	27.8%	30.8%	27.1%
35 to 39 years	1,962	16.0%	15.9%	12.8%
40 to 44 years	478	3.9%	3.5%	2.8%
45+ years	58	0.5%	0.3%	0.2%

Data Source: Maryland Department of Health and Mental Hygiene, Vital Statistics Administration, 2014; National Center for Health Statistics, National Vital Statistics Report, 2014

Infant Mortality Rate, 2014

HP 2020 Goal: 6.3 MD SHIP Goal: 6.0	Prince George's	Maryland	HP 2020 Goal	MD SHIP Goal
Infant Mortality Rate per 1,000 Births	**6.9**	6.5	6.0	6.3

*U.S. rate is unavailable for 2014.

Data Source: Maryland Department of Health and Mental Hygiene, Vital Statistics Administration, 2014

Infant Deaths, 2012-201

	2012	2013	2014
Prince George's County Infant Deaths			
White, non-Hispanic	4	6	3
Black, non-Hispanic	69	61	59
Hispanic (any race)	26	21	17
Total Deaths	103	92	85
Infant Mortality Rate: All Races per 1,000 Live Births			
Prince George's	**8.6**	**7.8**	**6.9**
Maryland	6.3	6.6	6.5
Infant Mortality Rate: White, non-Hispanic per 1,000 Live Births			
Prince George's	*	**5.4**	*
Maryland	3.8	4.6	4.4
Infant Mortality Rate: Black, non-Hispanic per 1,000 Live Births			
Prince George's	**9.6**	**8.7**	**8.2**
Maryland	10.4	10.6	10.7
Infant Mortality Rate: Hispanic (any race) per 1,000 Live Births			
Prince George's	**8.8**	**6.9**	**5.2**
Maryland	5.5	4.7	4.4

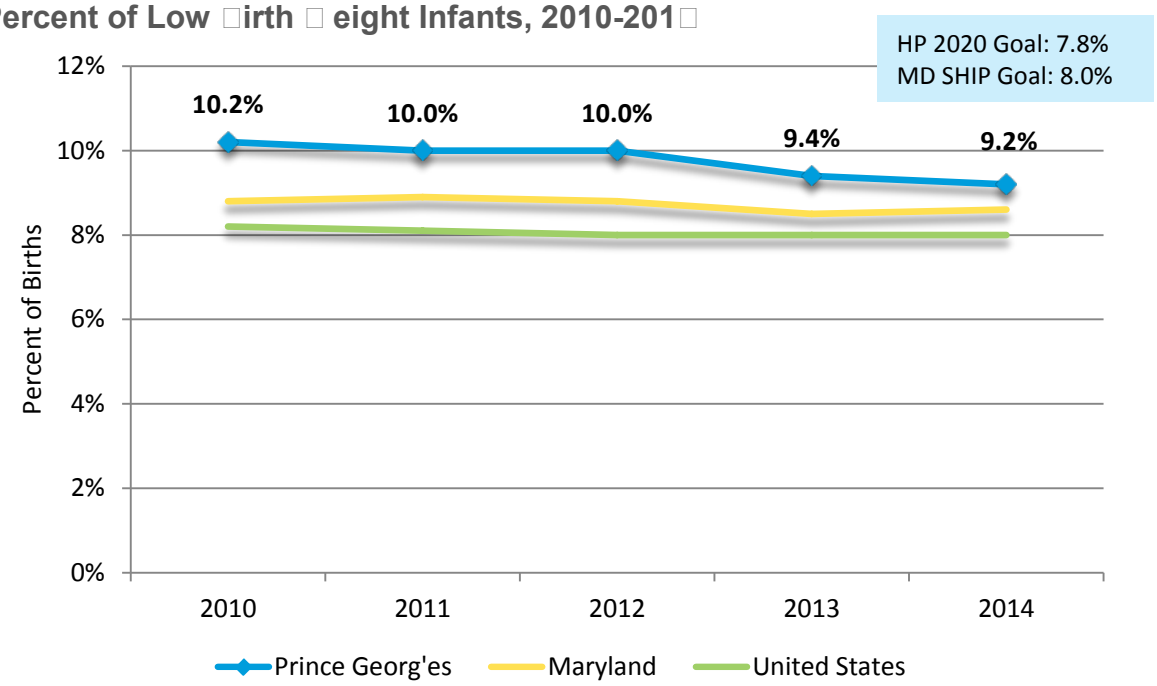
*Rates based on <5 deaths are not presented since they are subject to instability.
Data Source: Maryland Department of Health and Mental Hygiene, Vital Statistics Administration

Low irth eight 2 00g by Race Ethnicity and Age, 201

HP 2020 Goal: 7.8% MD SHIP Goal: 8.0%	Prince George's	Maryland	United States
Race/Ethnicity			
White, NH	5.3%	6.6%	7.0%
Black, NH	11.0%	12.1%	13.2%
Asian/PI	8.0%	8.1%	*
Hispanic, any race	7.1%	7.3%	7.1%
Age Group			
Under 18 years	9.3%	11.1%	9.7%
18 to 19 years	12.5%	10.9%	9.2%
20 to 24 years	9.0%	9.3%	8.2%
25 to 29 years	8.3%	7.8%	7.4%
30 to 34 years	9.3%	7.9%	7.5%
35 to 39 years	9.2%	9.2%	8.7%
40 + years	13.1%	11.6%	11.6%
Overall	**9.2%**	**8.6%**	**8.0%**

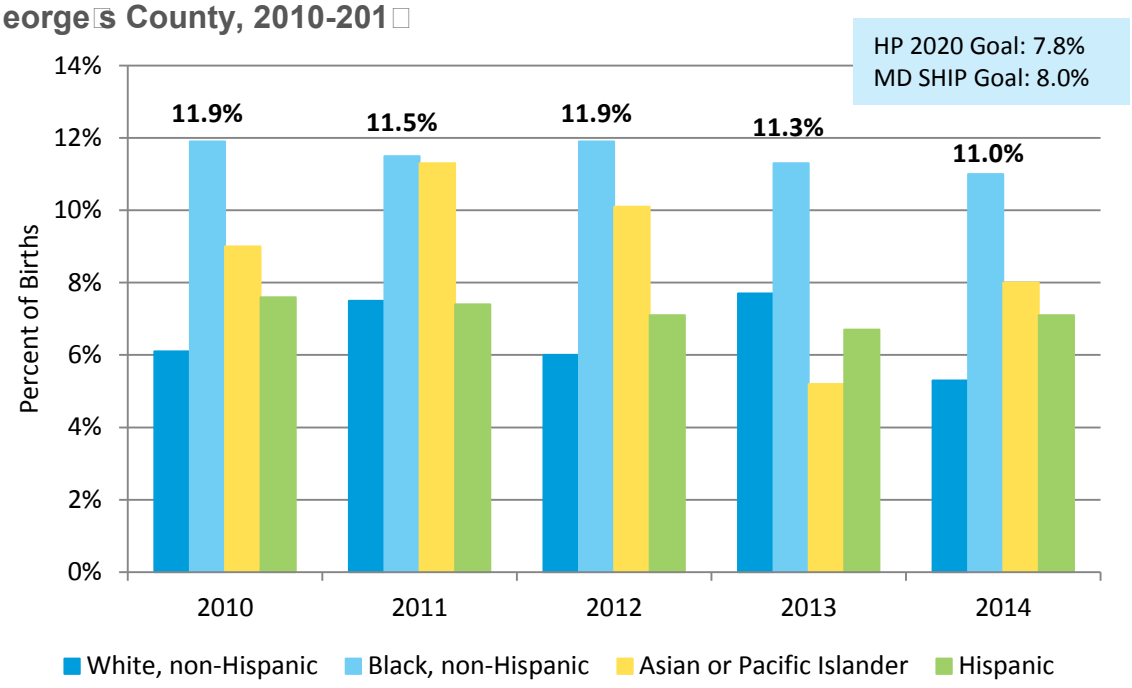
*Data not available for Asian/Pacific Islander
Data Source: Maryland Department of Health and Mental Hygiene, Vital Statistics Administration, 2014; National Center for Health Statistics, Births Final Data for 2014

Percent of Low □irth □ eight Infants, 2010-201□



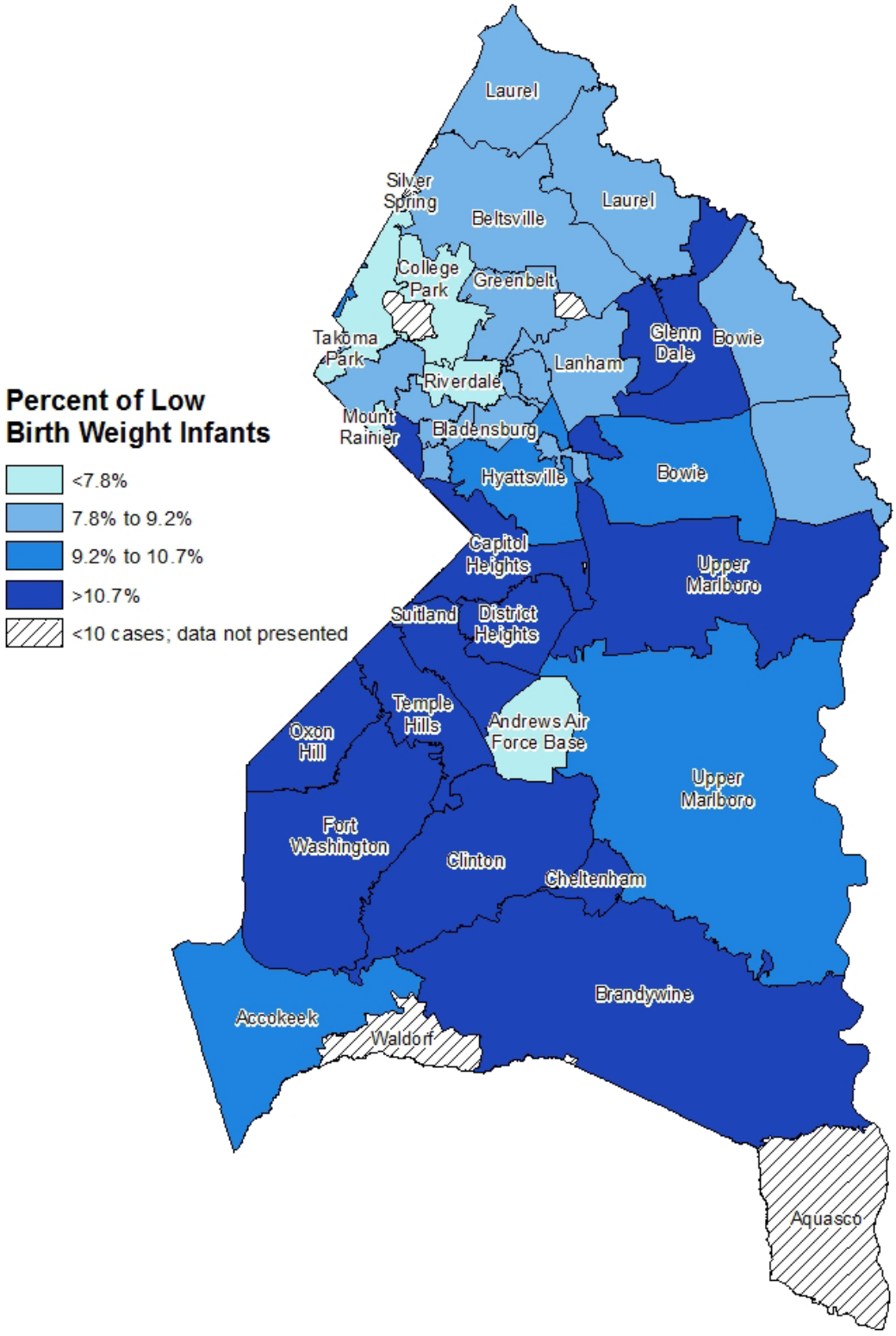
Data Source: Maryland Department of Health and Mental Hygiene, Vital Statistics Administration, 2014; National Center for Health Statistics, National Vital Statistics Report

Percent of Low □irth □ eight □2□00g□Infants by Race and Ethnicity, Prince □eorge□s County, 2010-201□



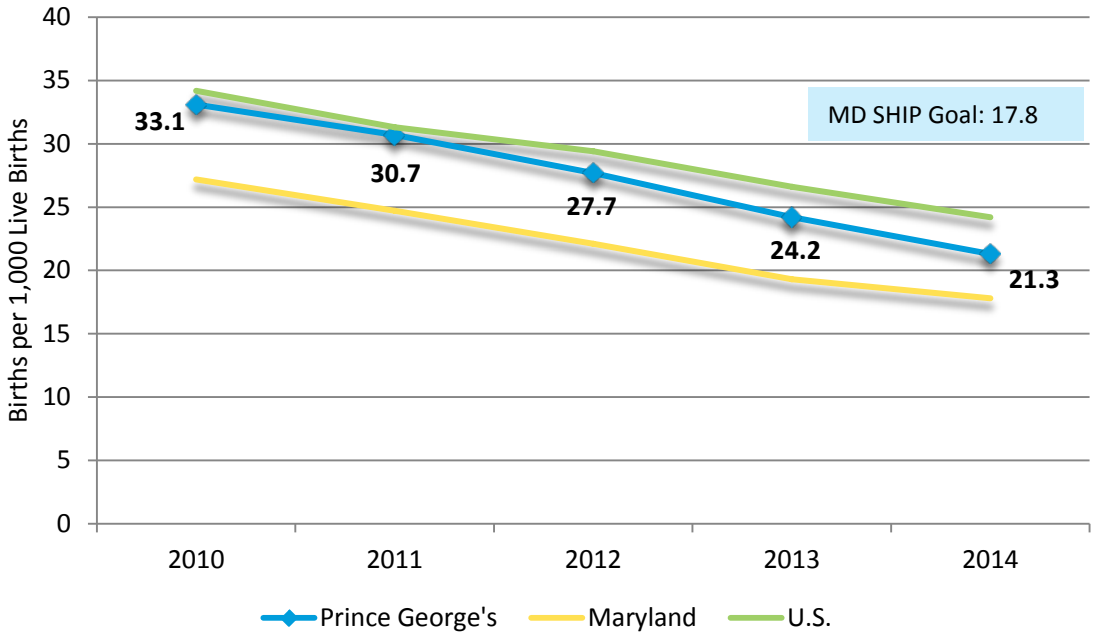
Data Source: Maryland Department of Health and Mental Hygiene, Vital Statistics Administration

Percentage of Low □irth □ eight Infants by □IP Code, Prince □eorge□s County, 2010-201□



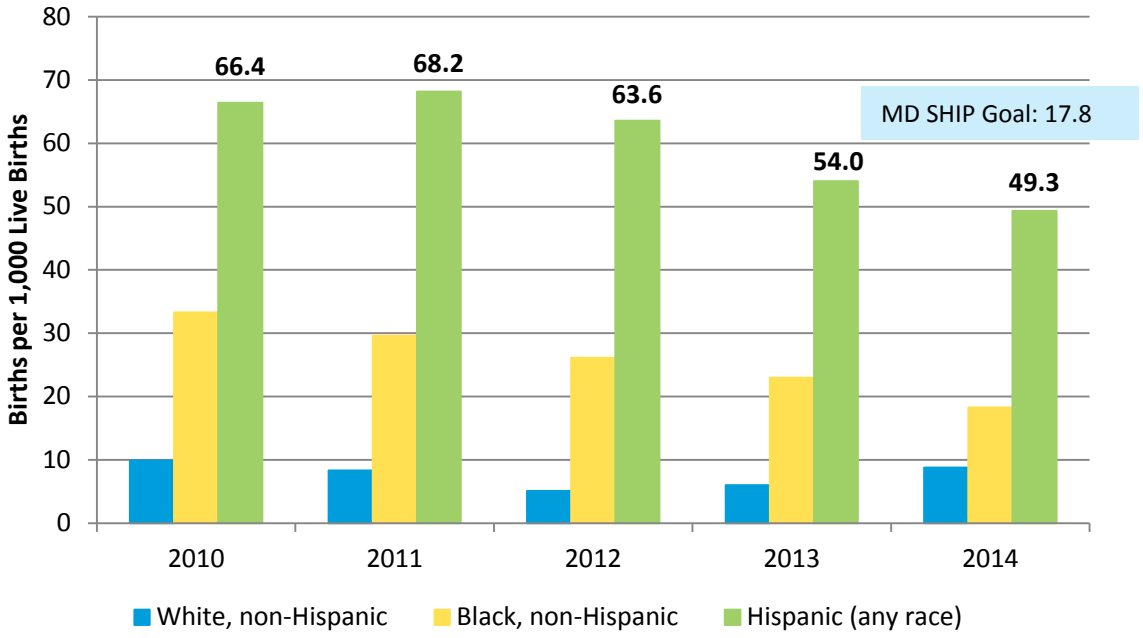
Data Source: Maryland Department of Health and Mental Hygiene, Vital Statistics Administration

□een □irth Rate □Ages 1□ to 1□ Years□, 2010-201□



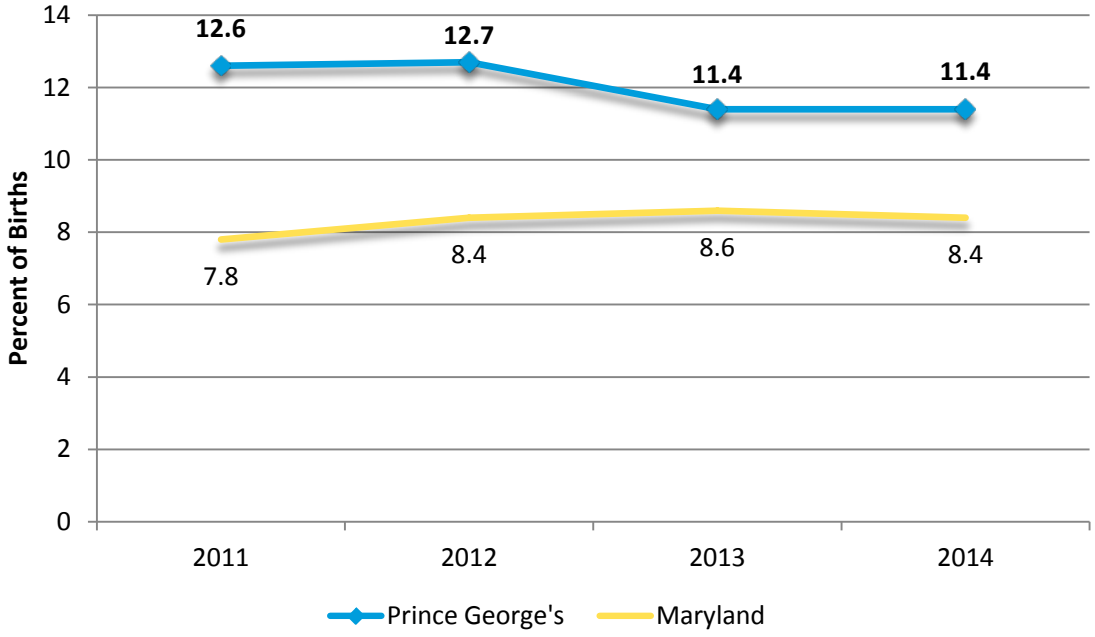
Data Source: Maryland Department of Health and Mental Hygiene, Vital Statistics Administration; National Center for Health Statistics, National Vital Statistics Report, 2014

□een □irth Rate □Ages 1□ to 1□□by Race and Ethnicity, Prince □eorge□s County, 2010-201□



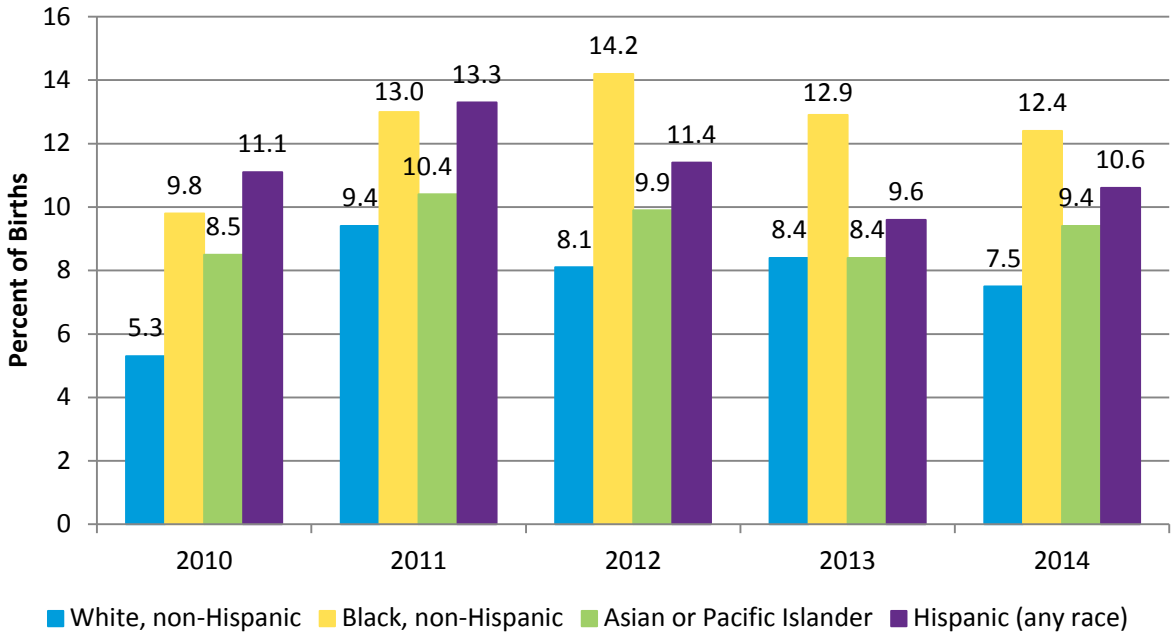
Data Source: Maryland Department of Health and Mental Hygiene, Vital Statistics Administration

Percent of □irths with Late or □o Prenatal Care□, 2011-201□



*Late care refers to care beginning in the third trimester.
Data Source: Maryland Department of Health and Mental Hygiene, Vital Statistics Administration, Annual Report

Percent of □irths with Late or □o Prenatal Care by Race and Ethnicity, Prince □eorge□s County, 2010-201□

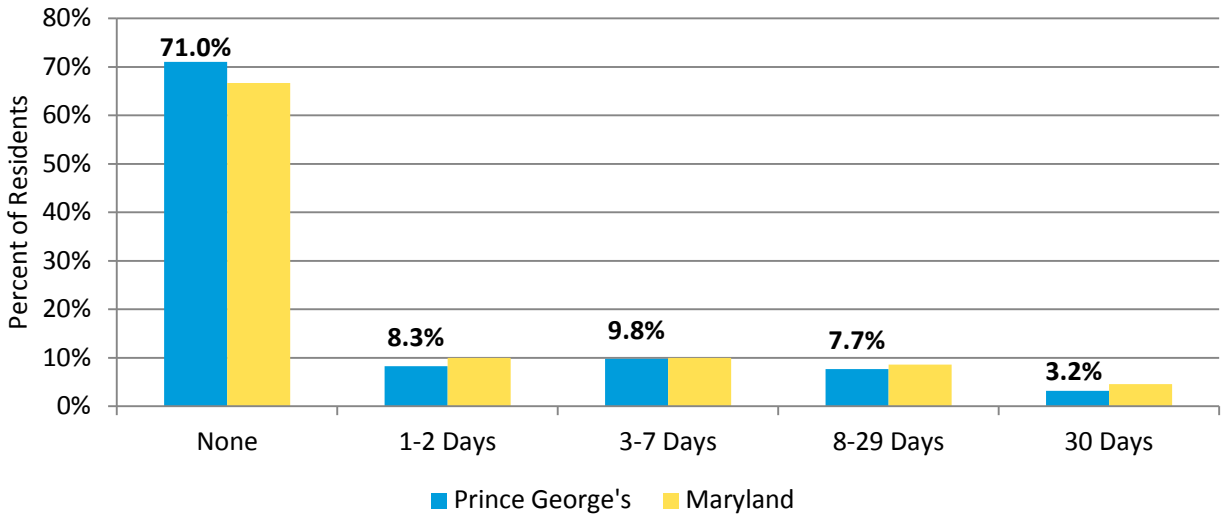


*Late care refers to care beginning in the third trimester.
Data Source: Maryland Department of Health and Mental Hygiene, Vital Statistics Administration, Annual Report

□ental □ealth

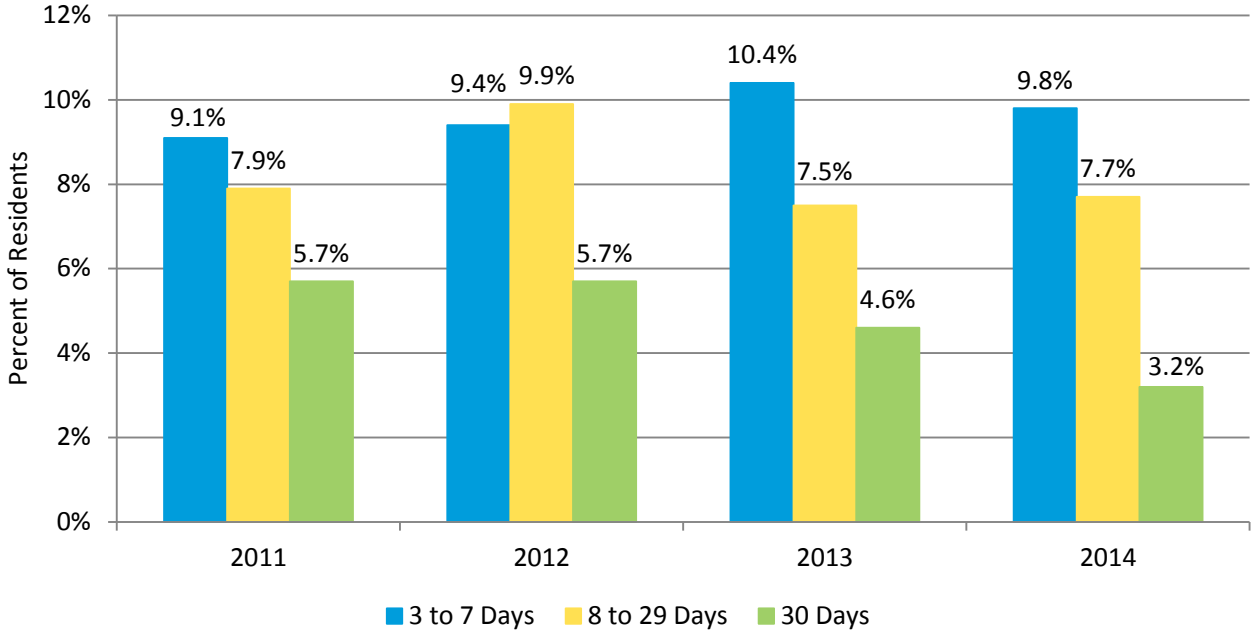
Overview	
What is it?	Mental health includes emotional, psychological, and social well-being. It affects how we think, feel and act. It also helps determine how we handle stress, relate to others, and make choices.
Who is affected?	10.9% (74,502) of residents reported experiencing at least 8 days of poor mental health during the last 30 days (2014 MD BRFSS). In 2014, there were 51 suicide deaths in the county.
Prevention & Treatment	• Poor mental health prevention includes helping individuals develop the knowledge, attitudes, and skills they need to make good choices or change harmful behaviors (SAMHSA.gov). • Mental health treatment includes psychotherapy, medication, case management, partial hospitalization programs, support groups, and peer support.
What are the outcomes?	Mental health covers a number of different conditions that can vary in outcomes. Early engagement and support are crucial to improving outcomes.
Disparity	White non-Hispanic residents had a higher Emergency Department (ED) visit rate related to mental health conditions compared to other county residents. The suicide rate was also higher among White non-Hispanics compared to other county residents.
How do we compare?	While 10.9% of county residents reported at least 8 poor mental health days, other Maryland counties range from 6.4% to 24.2%; the state overall is 13.2% (2014 MD BRFSS). The county has the lowest suicide age-adjusted death rate in the state.

Percent of Residents with Poor □ental □ealth Days within a □onth, 201□



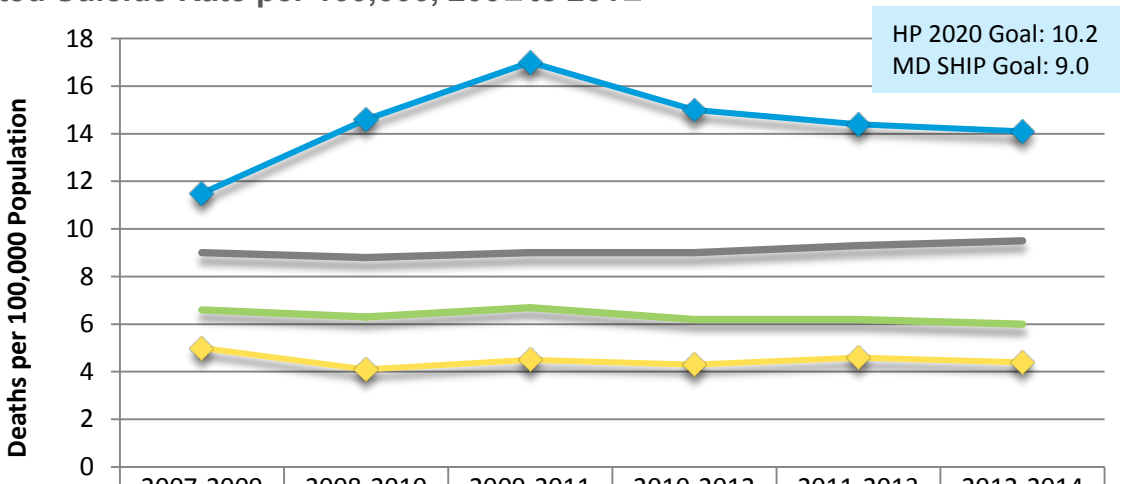
Data Source: 2014 Maryland BRFSS

Percent of Residents with Poor □ental □ealth Days within the Past □onth, Prince □eorge□s County, 2011 to 201□



Data Source: 2014 Maryland BRFSS

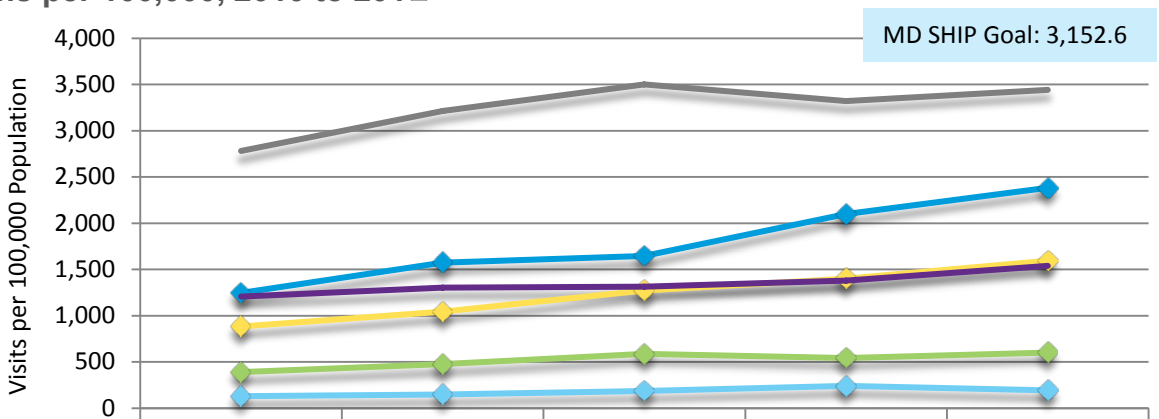
Age-Ad□usted Suicide Rate per 100,000, 200□ to 201□



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PGC White NH	11.5	14.6	17.0	15.0	14.4	14.1
PGC Black NH	5.0	4.1	4.5	4.3	4.6	4.4
PGC Total	6.6	6.3	6.7	6.2	6.2	6.0
Maryland	9.0	8.8	9.0	9.0	9.3	9.5

***** Residents of Hispanic Origin and Asian/Pacific Islanders were not included due to insufficient numbers
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Age-Adjusted Rate of Emergency Department Visits Related to Mental Health Conditions per 100,000, 2010 to 2014



	2010	2011	2012	2013	2014
PGC White NH	1,245.7	1,573.5	1,646.1	2,097.2	2,381.9
PGC Black NH	882.4	1,042.1	1,270.6	1,400.5	1,591.8
PGC Asian NH	129.2	147.3	185.6	239.0	191.2
PGC Hispanic	389.4	474.7	586.4	542.3	601.2
PGC Total	1,206.2	1,304.3	1,314.5	1,379.5	1,539.3
Maryland	2,780.8	3,211.2	3,500.6	3,318.5	3,442.6

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: MD Health Services Cost Review Commission (HSCRC), Research Level Statewide Outpatient Data Files

Emergency Department Visits for Behavioral Health Conditions, Prince George's County, 2014

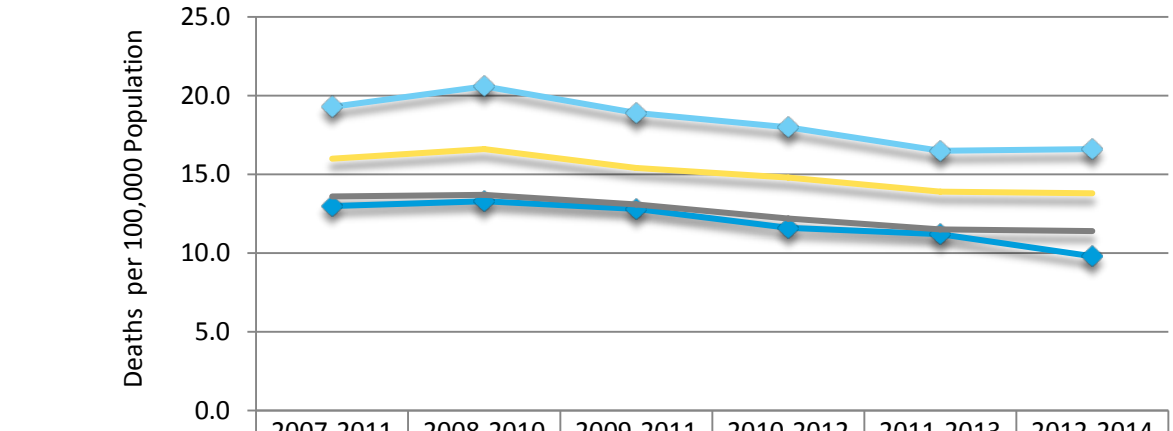
Behavioral Health Condition	Frequency	Percent
Alcohol-related disorders	1,795	26.2%
Mood disorders	1,497	21.9%
Anxiety disorders	1,225	17.9%
Schizophrenia and other psychotic disorders	829	12.1%
Drug-related disorders	652	9.5%
Miscellaneous disorders	298	4.4%
Suicide and intentional self-inflicted injury	252	3.7%
Adjustment disorders	165	2.4%
Disruptive behavior disorders	89	1.3%
Personality disorders	27	0.4%
Disorders usually diagnosed in infancy, childhood, or adolescence	13	0.2%
Total	**6,842**	

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County numbers and percent.

Data Source: Outpatient Discharge Data File 2014, Maryland Health Services Cost Review Commission

□ephritis □Chronic □idney Disease□

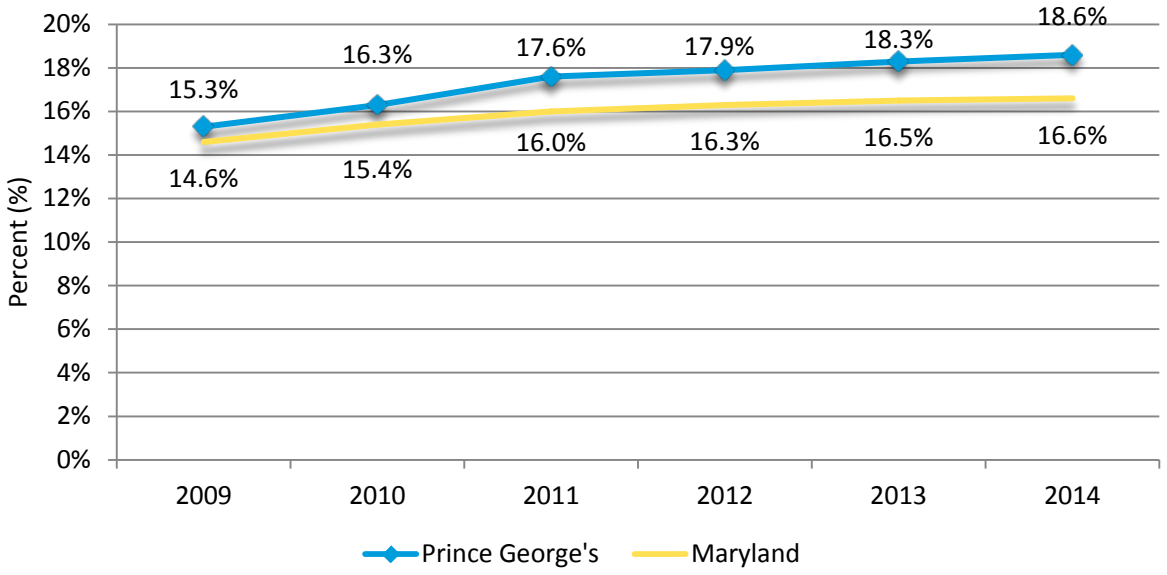
Age-Ad□usted Death Rate for □ephritis, 200□-201□



	2007-2011	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PGC White NH	13.0	13.3	12.8	11.6	11.2	9.8
PGC Black NH	19.3	20.6	18.9	18.0	16.5	16.6
Prince George's	16.0	16.6	15.4	14.8	13.9	13.8
Maryland	13.6	13.7	13.1	12.2	11.5	11.4

***** Residents of Hispanic Origin and Asian/Pacific Islanders were not included due to insufficient numbers
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Percentage of □edicare □eneficiaries □ ho □ ere □reated for Chronic □idney Disease, 200□ to 201□



Data Source: Centers for Medicare and Medicaid Services

Obesity

Overview	
What is it?	Weight that is higher than what is considered a healthy weight for a given height is described as overweight or obese. Body Mass Index (BMI) is used as a screening tool for overweight or obesity that takes into consideration height and weight. Children and adolescents are measured differently based on their age and sex.
Who is affected?	34.2% (218,270) of adults in the county are estimated to be obese, and an additional 34.1% are considered to be overweight. (2014 MD BRFSS). In 2013, 52.6% (310,107) of adults did not meet physical activity recommendations of participating in at least 150 minutes of aerobic physical activity per week. In 2013, 13.7% of high school students were estimated as obese.
Prevention and Treatment	• The key to achieving and maintaining a healthy weight is not short-term dietary changes; it's about a lifestyle that includes healthy eating and regular physical activity. (CDC.gov). • Follow a healthy eating plan, focus on portion size, be active, reduce screen time and a sedentary lifestyle, and keep track of your weight (NHLBI.NIH.gov).
What are the outcomes?	Obesity causes an increased risk for hypertension, type 2 diabetes, heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea and breathing problems, some cancers, low quality of life, and mental illness. (CDC.gov)
Disparity	In the county, more adult females (40.4%) than males (27.5%) are estimated to be obese. By age, more residents age 45 and are obese compared to those under 45 (2014 MD BRFSS). For adolescents, more Hispanic youth were obese compared to other students. More males (50.5%) than females (44.6%) participate in regular physical activity (2013 MD BRFSS).
How do we compare?	While 34.2% of county residents are obese, other Maryland counties range from 20.3% to 49.5%; the state overall is at 29.6% (2014 MD BRFSS) and the U.S. is at 29.5% (BRFSS). 47.4% of county residents met aerobic recommendations, other Maryland counties range from 32% to 55.3%; the state overall is 48% (2014 MD BRFSS) and the U.S. is at 50.6% (BRFSS). More county high school students are estimated to be obese (13.7%) compared to the state (11.0%) (YRBS).

□ow Obesity Is Classified

Body Mass Index (BMI)	Weight Status
Below 18.5	Underweight
18.5 – 24.9	Normal or Healthy Weight
25.0 – 29.9	Overweight
30.0 and Above	Obese

Data Source: Centers for Disease Control and Prevention

Percent of Adults □ ho Are Obese, 201□

HP2020 Goal: 30.5%	Prince George's	Maryland
Sex		
Male	27.5%	27.8%
Female	40.4%	31.3%
Race/Ethnicity		
White, non-Hispanic	34.6%	27.9%
Black, non-Hispanic	38.9%	39.1%
Hispanic	20.9%	22.6%
Age		
18 to 44 Years	25.9%	25.8%
45 to 64 Years	42.8%	34.8%
Over 65 Years	42.9%	29.0%
Total	**34.2%**	**29.6%**

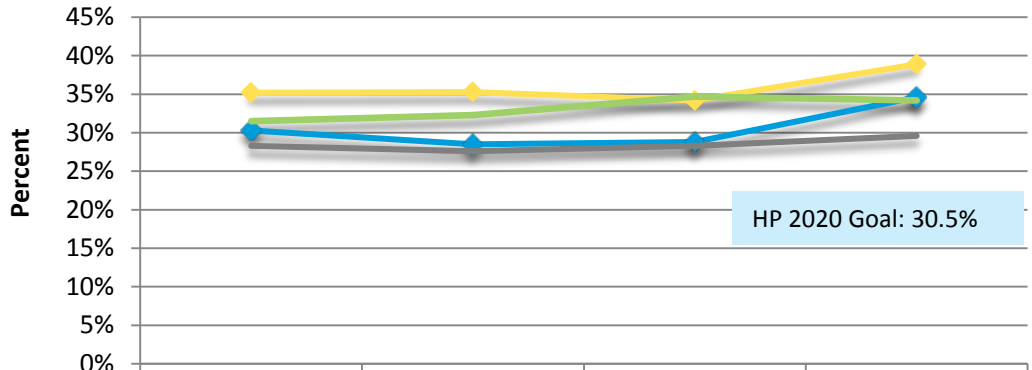
Data Source: Maryland Behavioral Risk Factor Surveillance System, DHMH

Percent of Adults □ ho Are Overweight, 201□

	Prince George's	Maryland
Sex		
Male	37.4%	40.7%
Female	31.1%	30.1%
Race/Ethnicity		
White, non-Hispanic	32.0%	34.8%
Black, non-Hispanic	35.9%	34.7%
Hispanic	34.6%	46.2%
Age		
18 to 44 Years	33.2%	32.0%
45 to 64 Years	35.7%	37.1%
Over 65 Years	33.9%	40.3%
Total	**34.1%**	**35.4%**

Data Source: Maryland Behavioral Risk Factor Surveillance System, DHMH

Percent of Adults □ ho Are Obese, 2011 to 201□

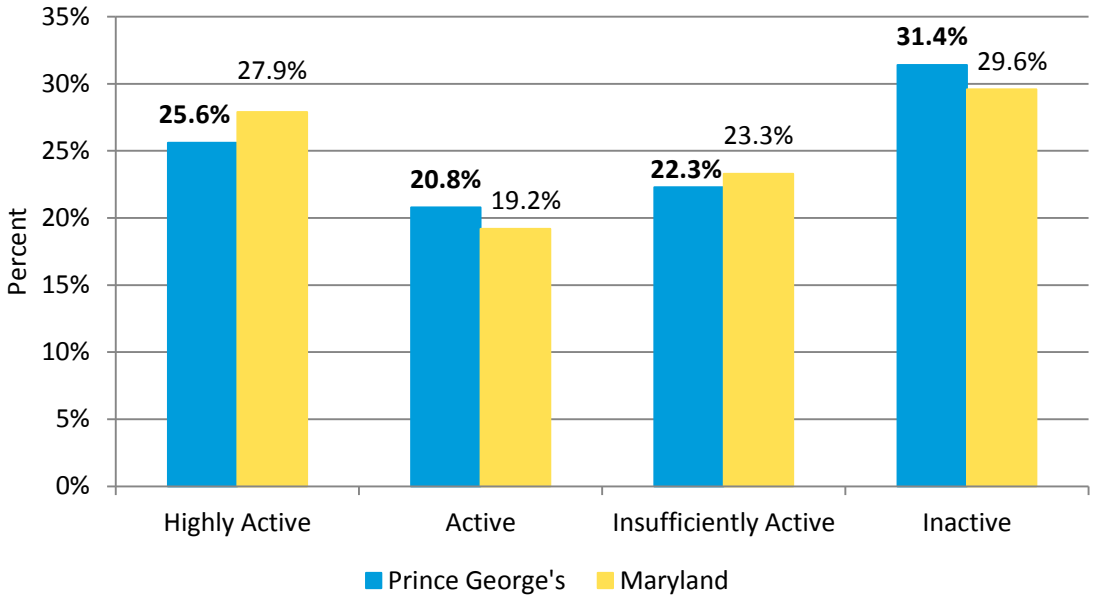


	2011	2012	2013	2014
PGC White NH	30.3%	28.5%	28.8%	34.6%
PGC Black NH	35.2%	35.3%	34.2%	38.9%
Prince Geroge's	31.5%	32.3%	34.7%	34.2%
Maryland	28.3%	27.6%	28.3%	29.6%

PGC White NH PGC Black NH Prince Geroge's Maryland

Data Source: Maryland Behavioral Risk Factor Surveillance System, DHMH

Percent of Adults by Physical Activity Level, 201□



Data Source: Maryland Behavioral Risk Factor Surveillance System, DHMH

Percent of Adults □hat Participated in at least 1□0 □inutes of □oderate Physical Activity or □□ □inutes of □igorous Activity per □ ee□, 201□

MD SHIP Goal: 50.4%	Prince George's	Maryland
Sex		
Male	50.5%	50.0%
Female	44.6%	46.0%
Race/Ethnicity		
White, non-Hispanic	49.3%	51.5%
Black, non-Hispanic	49.6%	45.4%
Hispanic	33.6%	30.0%
Age Group		
18 to 44 Years	50.0%	49.1%
45 to 64 Years	45.6%	48.1%
Over 65 Years	43.5%	45.4%
Total	**47.4%**	**48.0%**

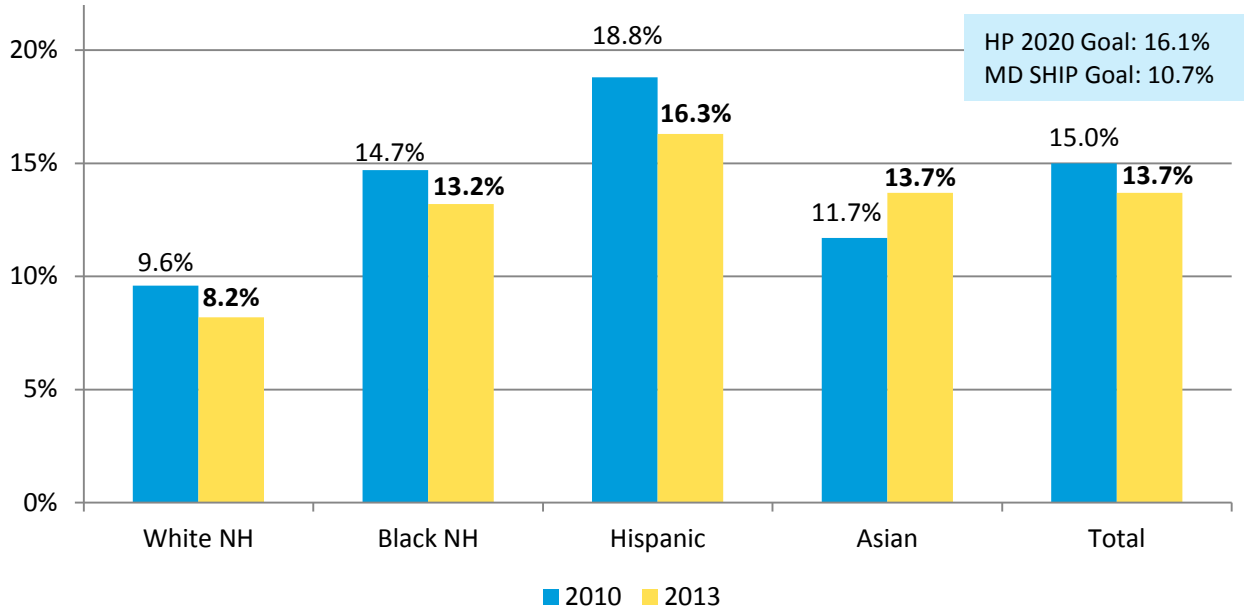
Data Source: Maryland Behavioral Risk Factor Surveillance System

Percentage of □igh School Students who are Obese, 201□

HP 2020 Goal: 10.7% MD SHIP Goal: 16.1%	Prince George's	Maryland
Sex		
Male	15.9%	13.8%
Female	11.3%	8.1%
Race/Ethnicity		
White, non-Hispanic	8.2%	9.1%
Black, non-Hispanic	13.2%	13.5%
Hispanic	16.3%	12.7%
Age Group		
15 or Younger	14.4%	11.1%
16 or 17 Years	12.6%	10.8%
18 or Older	15.1%	11.5%
Total	**13.7%**	**11.0%**

Data Source: 2013 Youth Risk Behavior Survey Report for Prince George's County and Maryland, Maryland DHMH

Percent of □igh School Students who are Obese, Prince □eorge□s County, 2010 and 201□



Data Source: Youth Risk Behavior Survey Report for Prince George's County and Maryland, Maryland DHMH

Percentage of □igh School Students □ ho Ate Fruits and □egetables Five or □ore □imes per day During the Past □ ee□, 201□

	Prince George's	Maryland
Sex		
Male	21.4%	21.1%
Female	15.4%	19.0%
Race/Ethnicity		
White, non-Hispanic	16.7%	19.0%
Black, non-Hispanic	17.8%	19.6%
Hispanic	19.6%	22.1%
Age Group		
15 or Younger	17.8%	19.4%
16 or 17 Years	19.3%	20.3%
18 or Older	18.7%	22.4%
Total	**18.6%**	**20.1%**

Data Source: 2013 Youth Risk Behavior Survey Report for Prince George's County and Maryland, Maryland DHMH

Percentage of □igh School Students who were Physically Active for a □otal of at Least □0 □inutes per day on Five or □ore of the Past □ ee□, 201□

	Prince George's	Maryland
Sex		
Male	34.7%	46.8%
Female	25.0%	33.8%
Race/Ethnicity		
White, non-Hispanic	39.4%	47.4%
Black, non-Hispanic	29.2%	33.3%
Hispanic	29.7%	34.1%
Age Group		
15 or Younger	28.8%	42.4%
16 or 17 Years	31.3%	39.1%
18 or Older	25.1%	34.8%
Overall	**29.6%**	**40.1%**

Data Source: Youth Risk Behavior Survey Report for Prince George's County and Maryland, Maryland DHMH

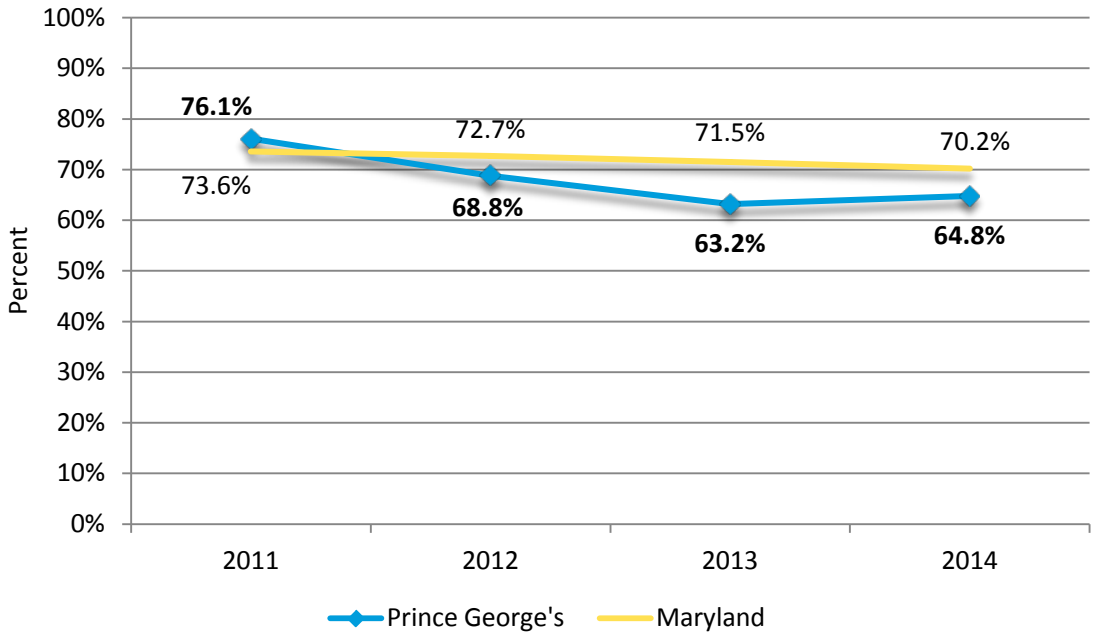
Oral □ealth

Percent of Adult □ ho □isited a Dentist in the Past Year, 201□

	Prince George's	Maryland
Sex		
Male	59.6%	66.2%
Female	69.5%	73.9%
Race/Ethnicity		
White, non-Hispanic	68.5%	74.7%
Black, non-Hispanic	64.7%	64.7%
Hispanic	58.1%	59.1%
Age Group		
18 to 34 Years	55.4%	67.2%
35 to 49 Years	64.2%	68.3%
50 to 64 Years	76.9%	74.8%
Over 65 Years	65.2%	69.9%
Total	**64.8%**	**70.2%**

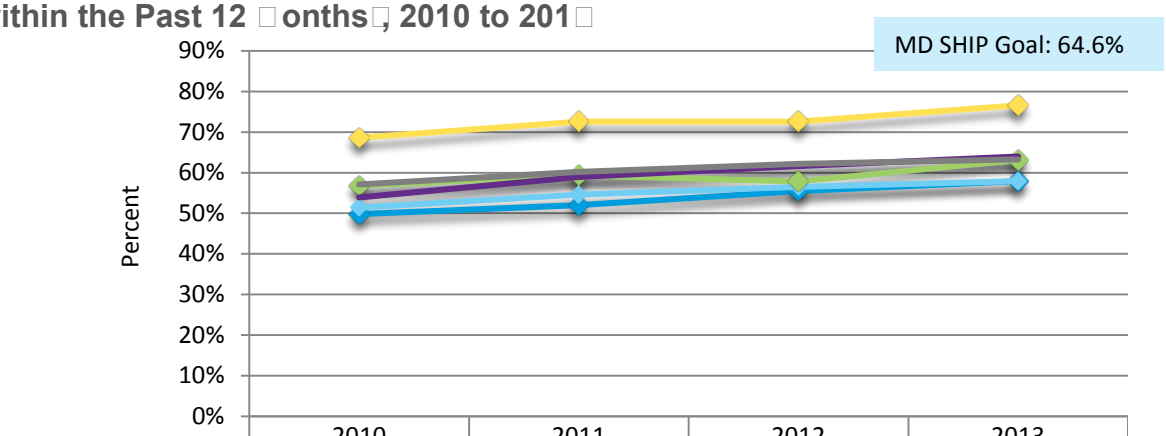
Data Source: Maryland Behavioral Risk Factor Surveillance System, DHMH

Percent of Adults who □isited a Dentist in the Past Year, 2011-201□



Data Source: Maryland Behavioral Risk Factor Surveillance System, DHMH

Percent of Children □0 to 20 years□Enrolled in □edicaid who had a Dental □isit within the Past 12 □onths□, 2010 to 201□

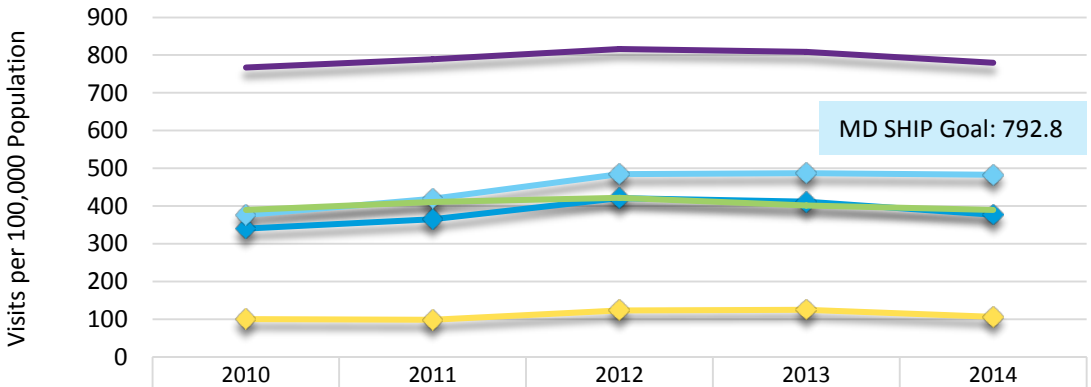


	2010	2011	2012	2013
PGC White	49.8%	52.0%	55.5%	57.9%
PGC Black	51.4%	54.6%	56.5%	57.9%
PGC Hispanic	68.6%	72.6%	72.6%	76.6%
PGC Asian	56.8%	59.3%	57.8%	63.1%
Prince George's	53.9%	58.9%	61.6%	64.0%
Maryland	57.1%	60.2%	62.2%	63.3%

*Only children enrolled in Medicaid for at least 320 days were included in the measure

Data Source: Maryland Department of Health and Mental Hygiene, Maryland State Health Improvement Process

Age-Ad□usted Emergency Department □isit□Rate for Dental Care, 2010 to 201□

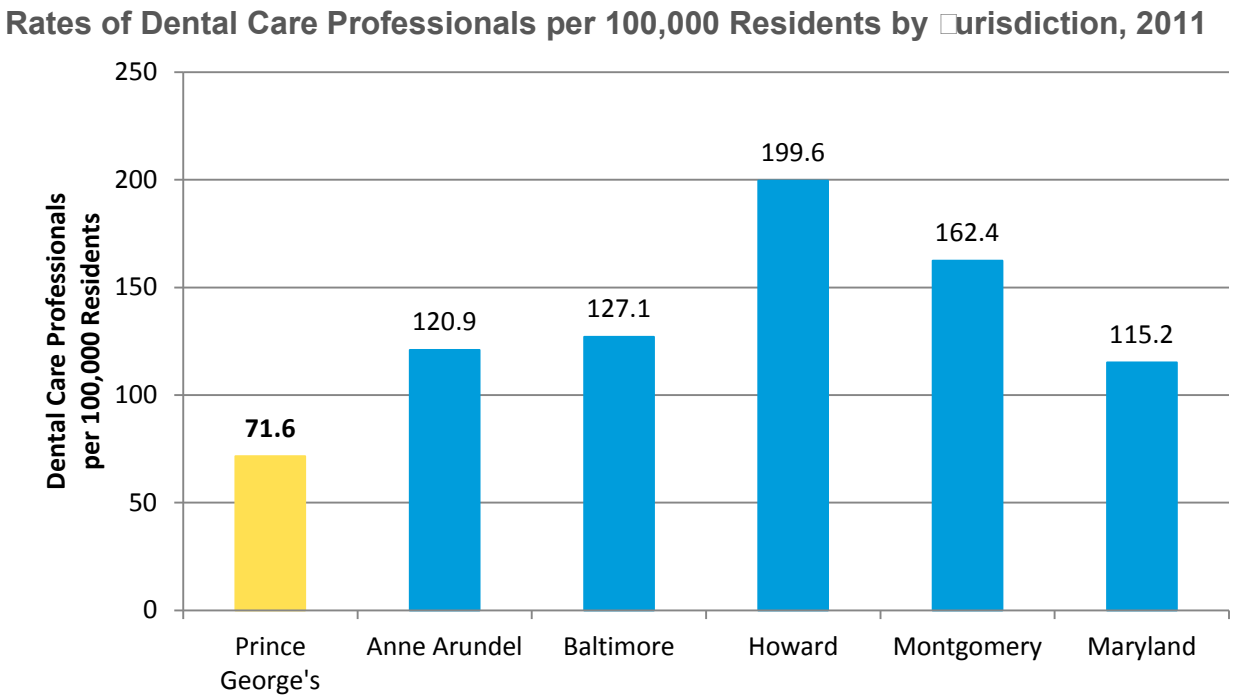


	2010	2011	2012	2013	2014
PGC White NH	340.7	365.5	421.4	411.7	377.7
PGC Black NH	376.8	419.9	484.6	487.2	483.2
PGC Hispanic	100.6	99.1	123.9	125.6	106.8
PGC	391.7	411.4	422.3	401.8	390.1
Maryland	767.5	789.6	816.7	809.0	779.7

PGC White NH PGC Black NH PGC Hispanic PGC Maryland

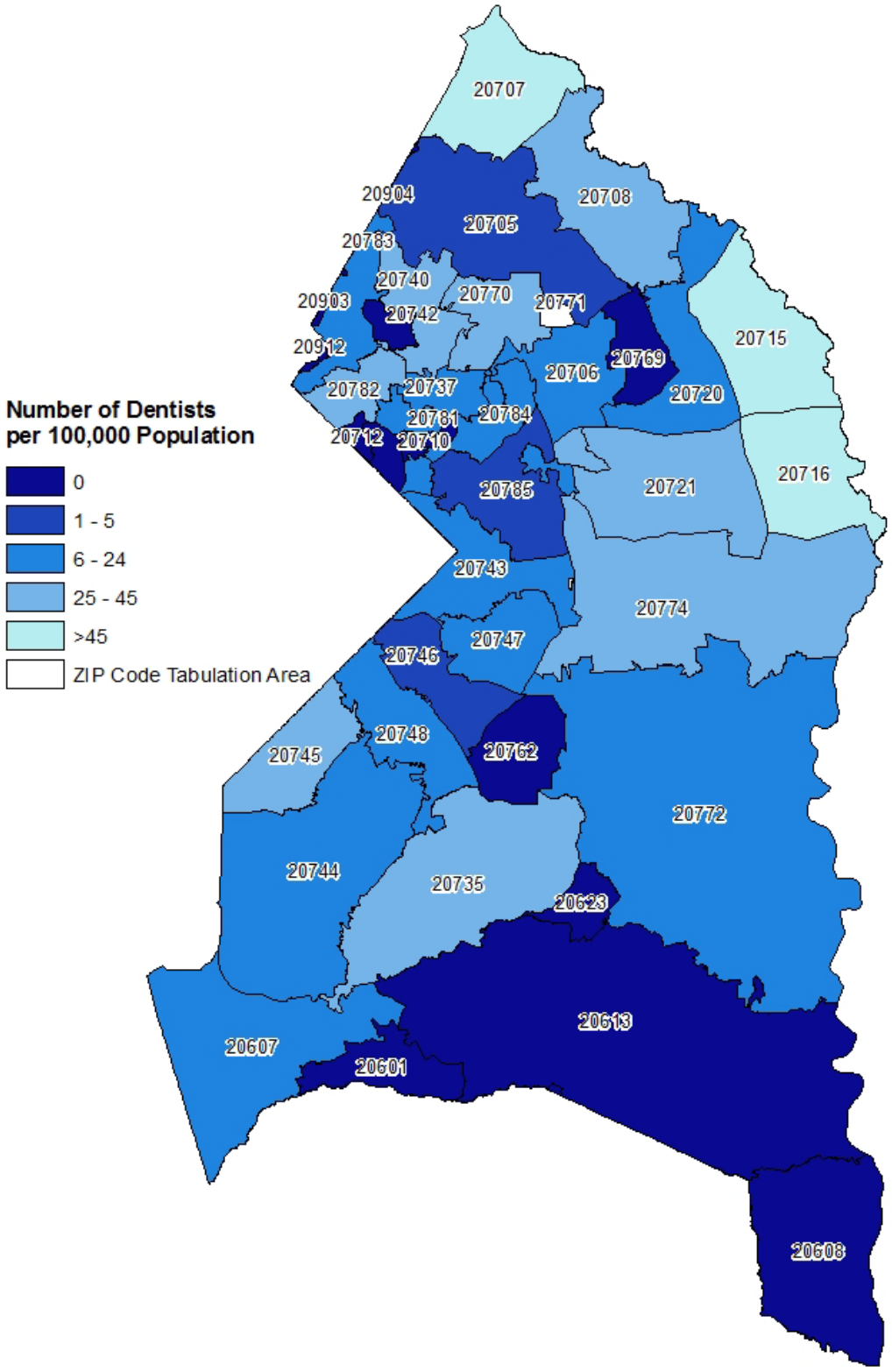
* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Maryland Health Services Cost Review Commission (HSCRC) Research Level Statewide Outpatient Data Files



Data Source: Transforming Health Public Impact Study, UMD SPH, page 120

Rate of Dentists per 100,000 Residents, Prince □eorge□s County, 2011



Data Source: Transforming Health Public Impact Study, UMD SPH, page 122

Sexually □ransmitted Infections

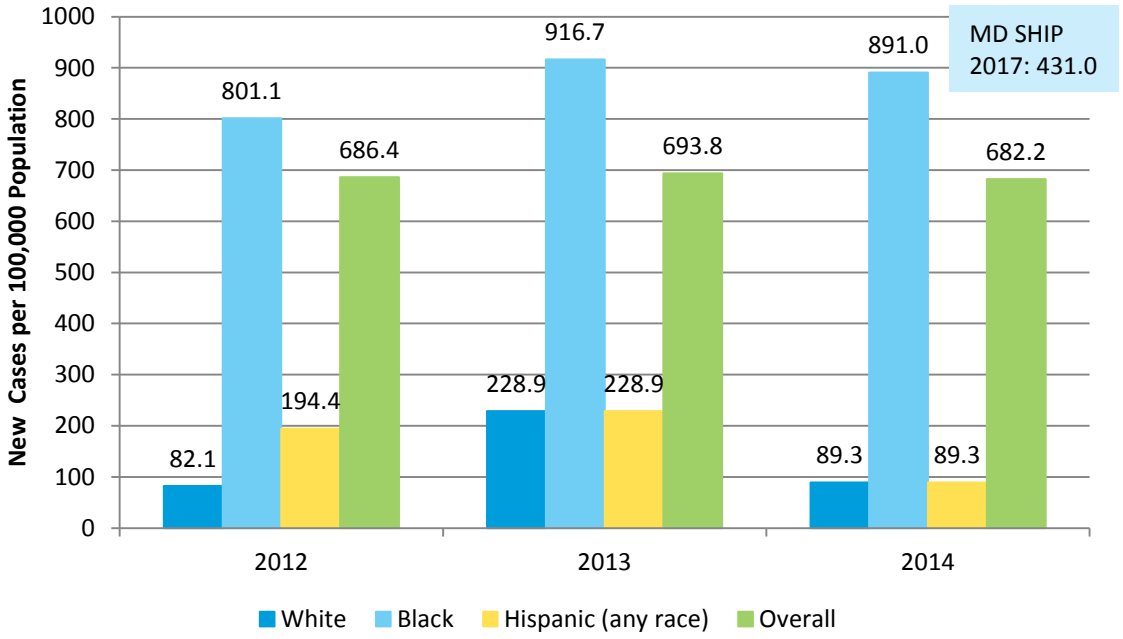
□umber of Sexually □ransmitted Infections, Prince □eorge□s County

STI	2012	2013	2014	5-Year Mean
Chlamydia	6,037	6,163	6,130	6,060
Gonorrhea	1,465	1,482	1,276	1,511
Syphilis*	83	122	111	99

*Includes both Primary and Secondary Syphilis

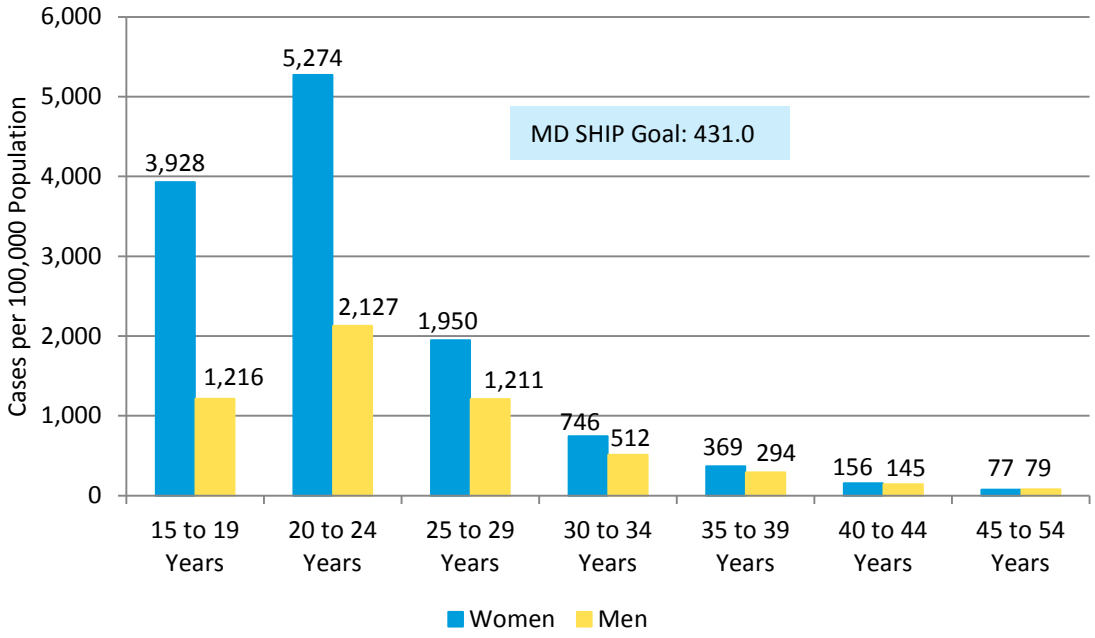
Data Source: Infectious Disease Bureau, Prevention and Health Promotion Administration, DHMH

Chlamydia Rates by Race and Ethnicity, Prince □eorge□s County, 2012-201□



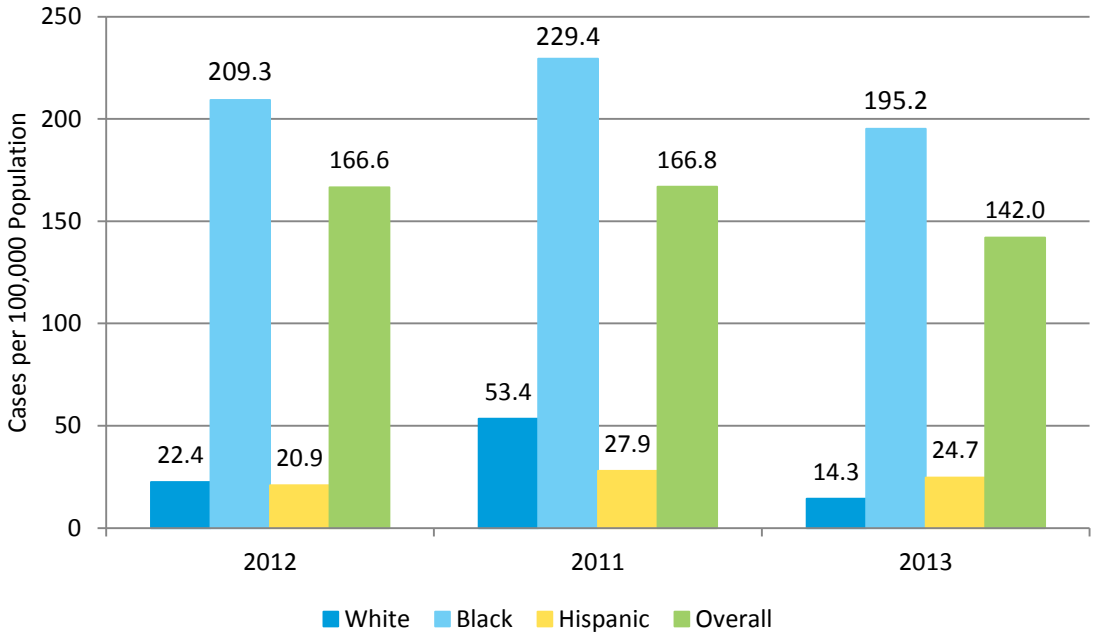
Data Source: Infectious Disease Bureau, Prevention and Health Promotion Administration, DHMH

Chlamydia Rates by Age □roup and Sex, Prince □eorge□s County, 201□



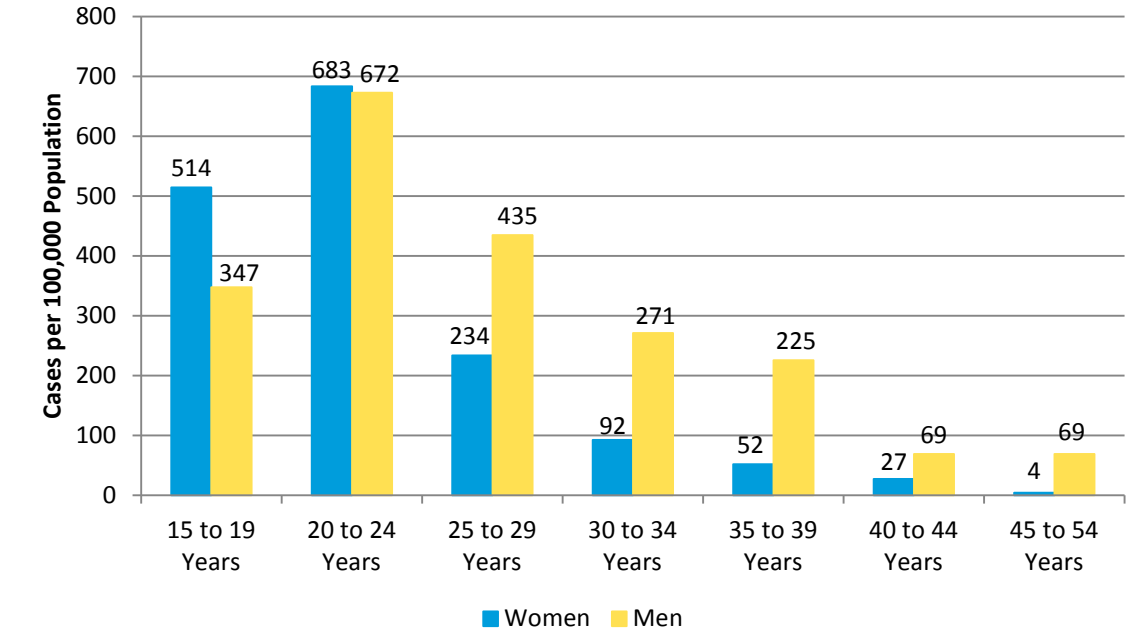
Data Source: Infectious Disease Bureau, Prevention and Health Promotion Administration, DHMH

□onorrhea Rates by Race and Ethnicity, Prince □eorge□s County, 2012-201□



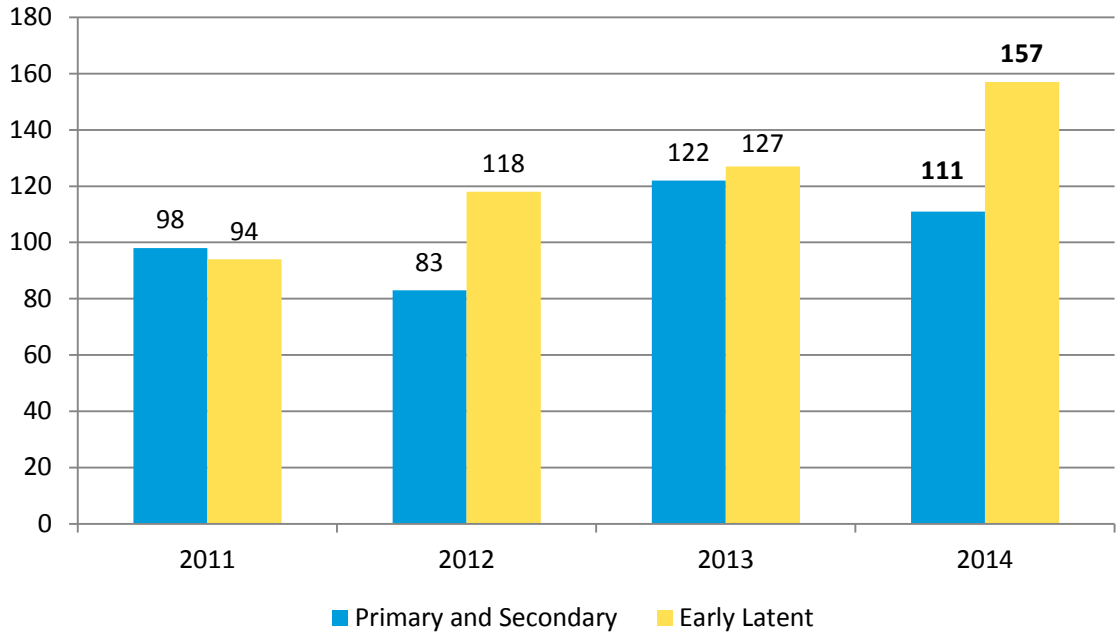
Data Source: Infectious Disease Bureau, Prevention and Health Promotion Administration, DHMH

□onorrhea Rates by Age □roup and Sex, Prince □eorge□s County 201□



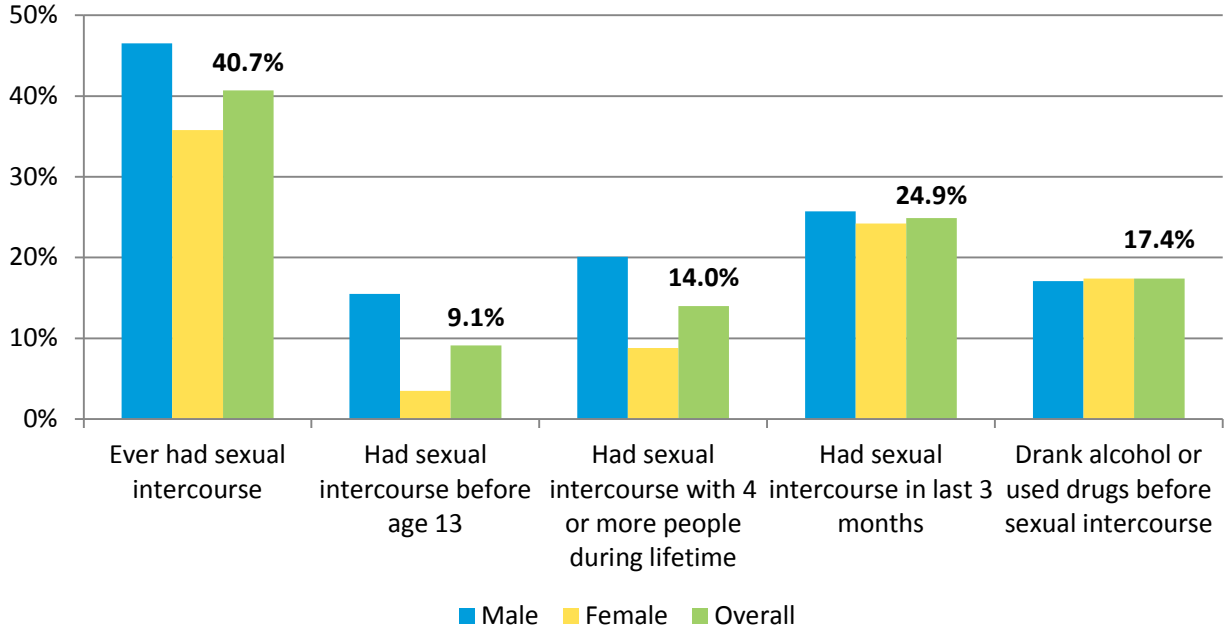
Data Source: Infectious Disease Bureau, Prevention and Health Promotion Administration, DHMH

□umber of Early Syphilis Cases, Prince □eorge□s County, 2011-201□



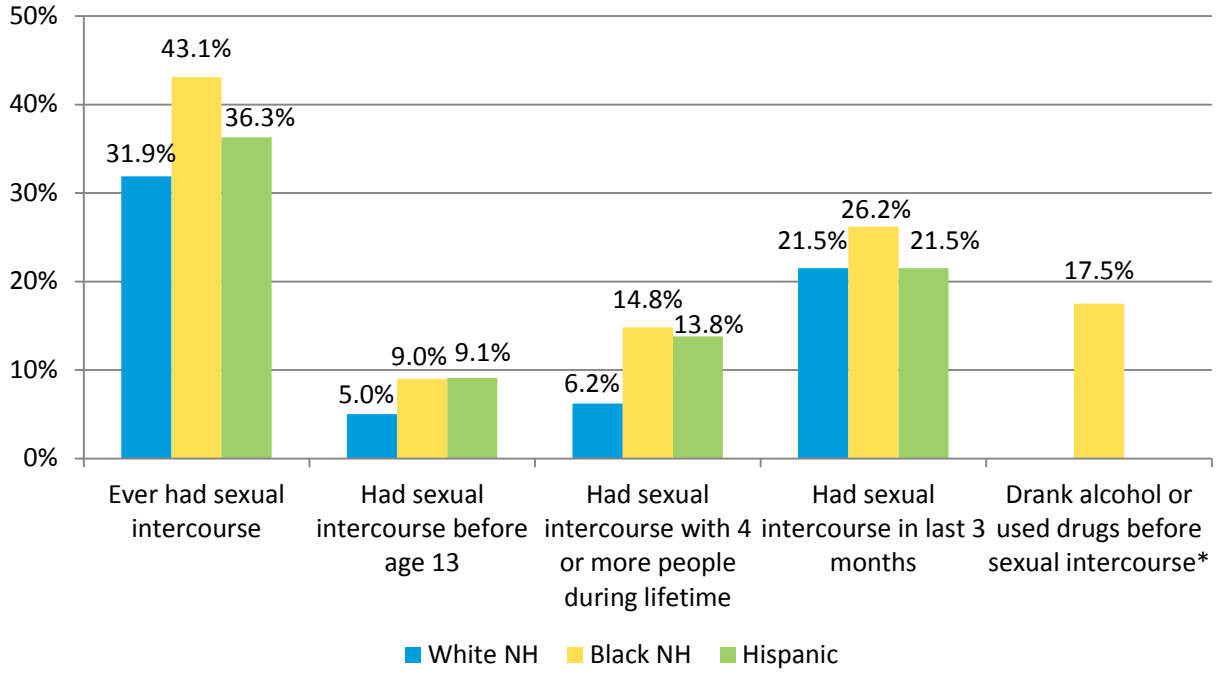
Data Source: Infectious Disease Bureau, Prevention and Health Promotion Administration, DHMH

Sexual □ehavior of □igh School Students by Sex, Prince □eorge□s County, 201□



Data Source: 2013 Youth Risk Behavior Survey, Maryland Department of Health and Mental Hygiene

Sexual □ehavior of □igh School Students by Race□Ethnicity, Prince □eorge□s County, 201□



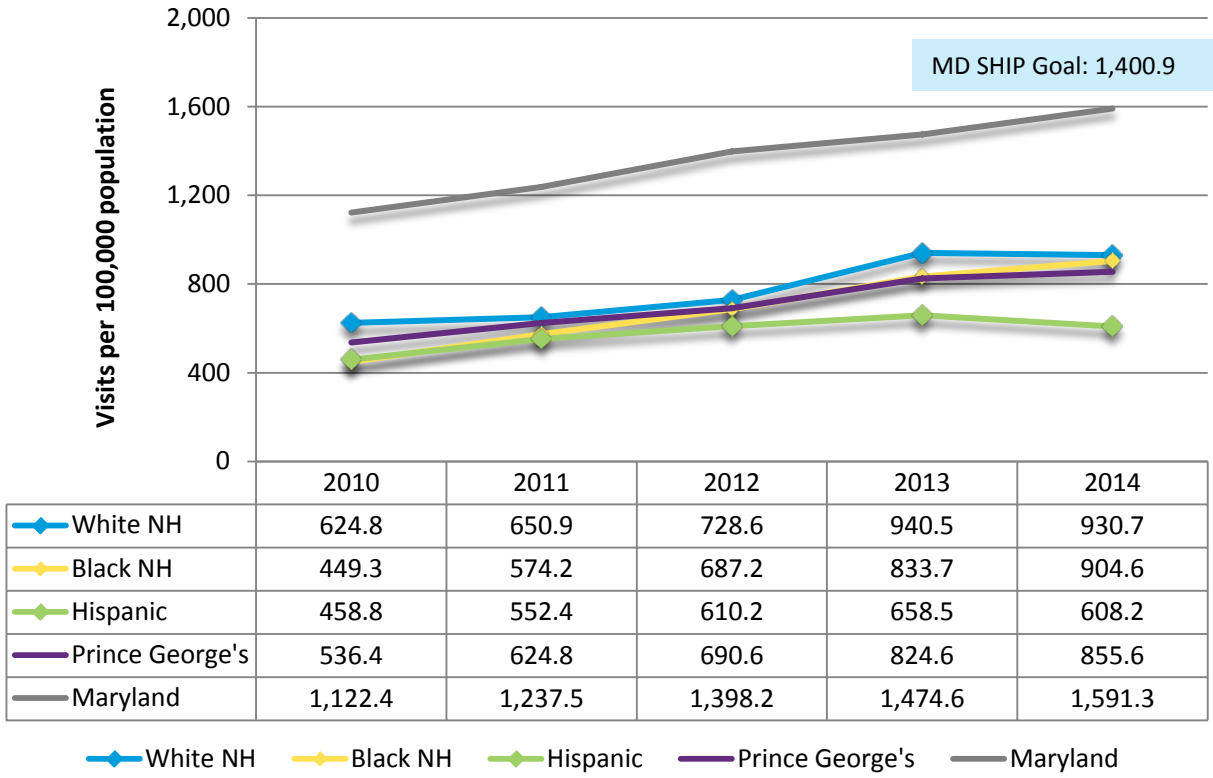
*Hispanic and White NH not displayed due to insufficient data

Data Source: 2013 Youth Risk Behavior, Maryland Department of Health and Mental Hygiene

Substance Use Disorder

Overview	
What is it?	Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability and failure to meet major responsibilities at work, school, or home. (SAMHSA.gov)
Who is affected?	In 2014, 14% of county residents reported binge drinking, and 4.5% indicated they chronically drink. There were 855.6 Emergency Room visits per every 100,000 county residents in 2014. In 2013, 13.3% of adolescents reported using tobacco. Between 2012 and 2014, there were 184 drug-induced deaths in the county of which 123 (67%) were White males.
Prevention & Treatment	• Substance use prevention includes helping individuals develop the knowledge, attitudes, and skills they need to make good choices or change harmful behaviors (SAMHSA.gov). • Substance use treatment includes counseling, inpatient and residential treatment, case management, medication, and peer support.
What are the outcomes?	Substance use disorders result in human suffering for the individual consuming alcohol or drugs as well as their family members and friends. Substance use disorders are associated with lost productivity, child abuse and neglect, crime, motor vehicle accidents and premature death (SAMHSA).
Disparity	White non-Hispanic (NH) residents had a higher Emergency Department (ED) visit rate and a much higher drug-induced death rate compared to other county residents. A higher percentage of White NH residents also binge drink compared to other residents. For Adolescents, White NH residents also had a higher percent of tobacco use.
How do we compare?	The county has a lower drug-induced death rate compared to the state. The percent of residents reporting binge drinking for the county is lower than the state.

Age-Adjusted Emergency Department Visit Rate per 100,000 Population due to Addictions-Related Conditions, 2011-2014



	2010	2011	2012	2013	2014
White NH	624.8	650.9	728.6	940.5	930.7
Black NH	449.3	574.2	687.2	833.7	904.6
Hispanic	458.8	552.4	610.2	658.5	608.2
Prince George's	536.4	624.8	690.6	824.6	855.6
Maryland	1,122.4	1,237.5	1,398.2	1,474.6	1,591.3

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County numbers and percent.

Data Source: Maryland Health Services Cost Review Commission Outpatient File, Maryland SHIP

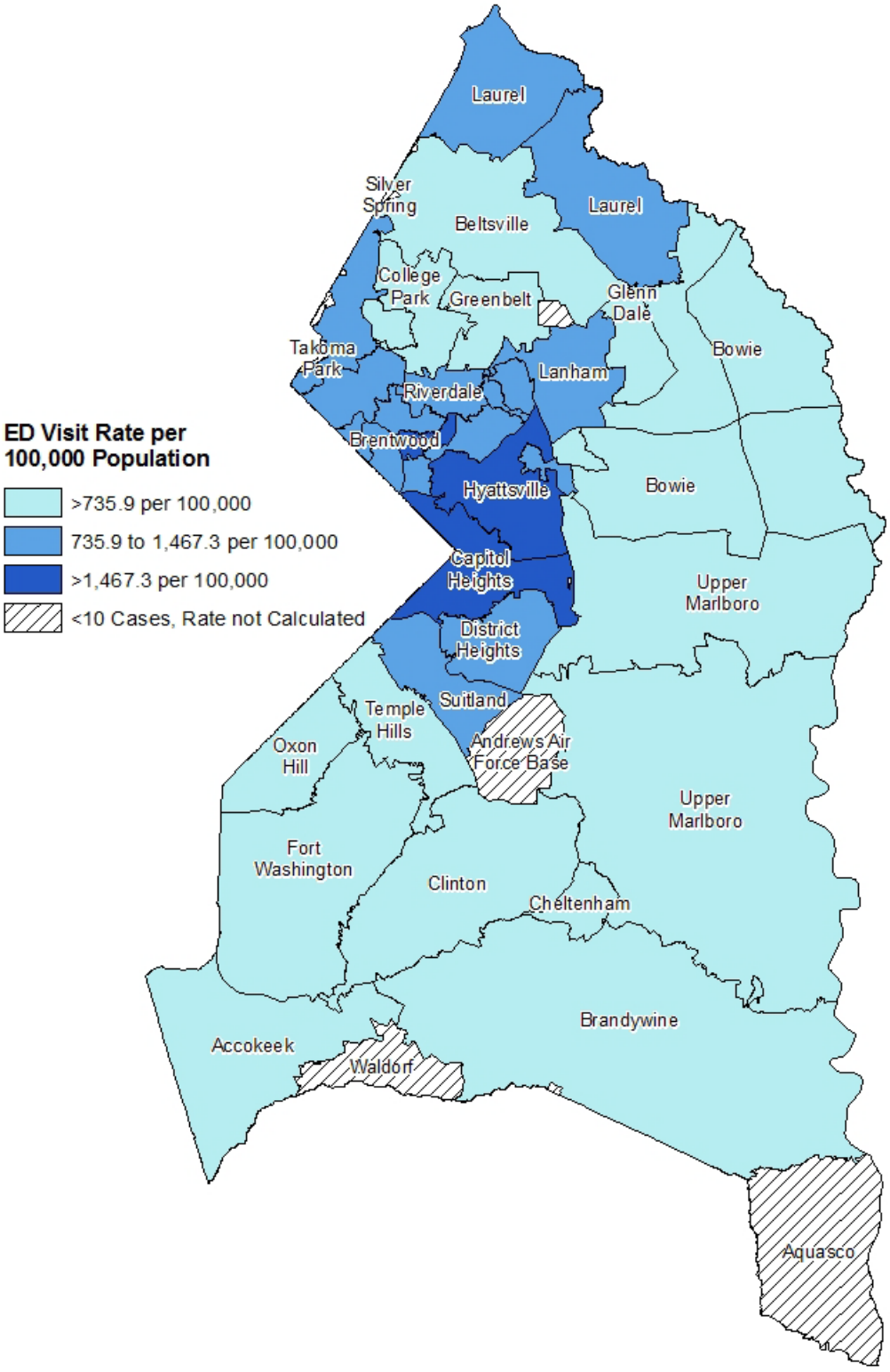
Emergency Department Visits for Addictions-Related Conditions, Prince George's County, 2014

	Number of ED Visits	Age-Adjusted ED Visit Rate per 100,000 Population
Sex		
Male	5,551	1,204.1
Female	2,553	526.0
Age		
Under 18 Years	184	89.7
18 to 39 Years	4,424	1,896.6
40 to 64 Years	3,237	887.6
65 Years and Over	259	255.7
Total	**8,104**	**855.6**

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County numbers and rate.

Data Source: Outpatient Discharge Data File 2014, Maryland Health Services Cost Review Commission; Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

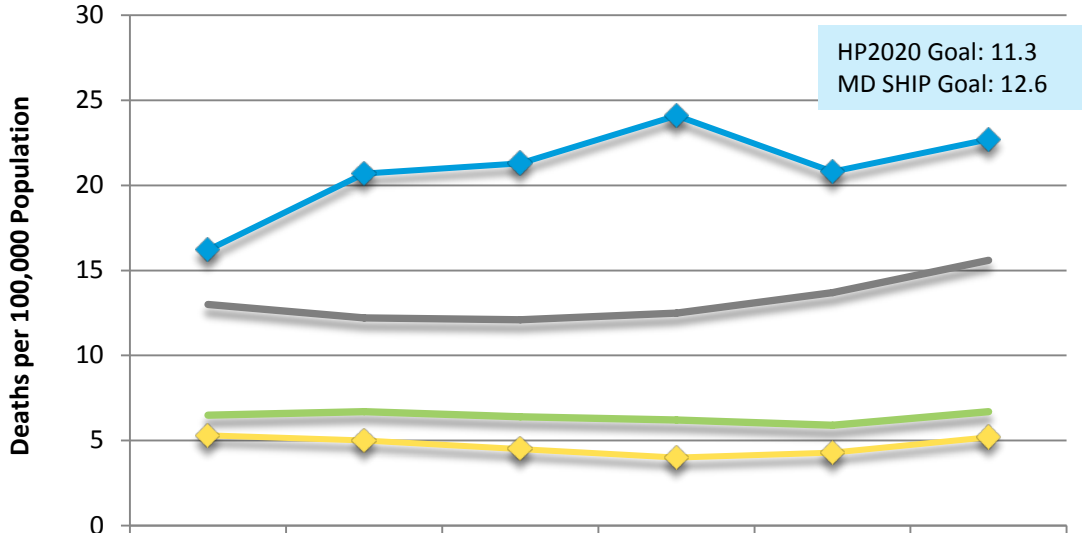
Emergency Department □isit□Crude Rate per 100,000 Population, Addictions-Related Conditions as any Discharge Diagnosis, Prince □eorge□s County, 201□



* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Outpatient Discharge Data File 2014, Maryland Health Services Cost Review Commission

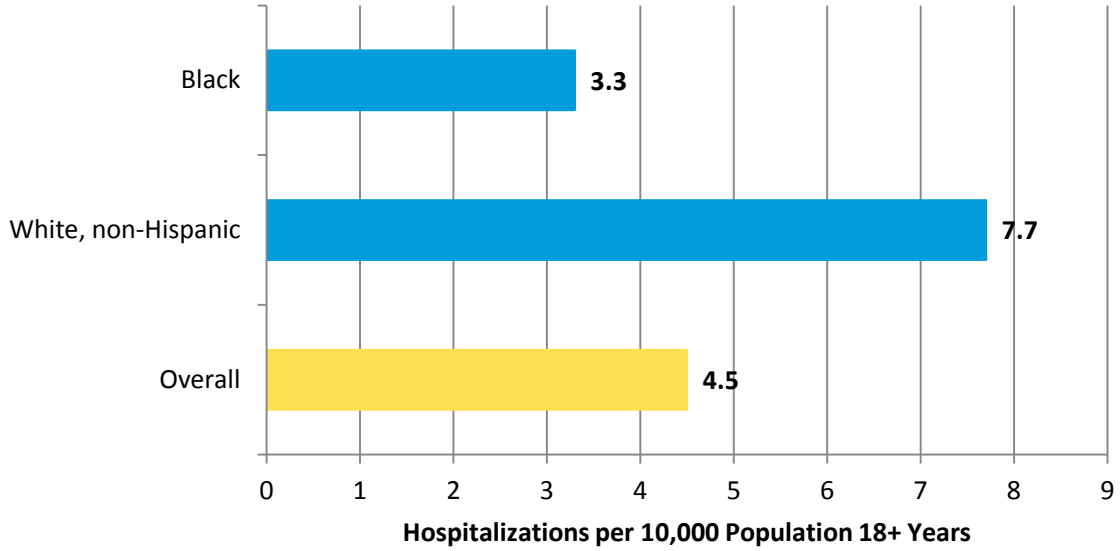
Drug-Induced Death Rate per 100,000 Population, 200□ to 201□



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PGC White NH	16.2	20.7	21.3	24.1	20.8	22.7
PGC Black NH	5.3	5.0	4.5	4.0	4.3	5.2
PGC Total	6.5	6.7	6.4	6.2	5.9	6.7
Maryland	13.0	12.2	12.1	12.5	13.7	15.6

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

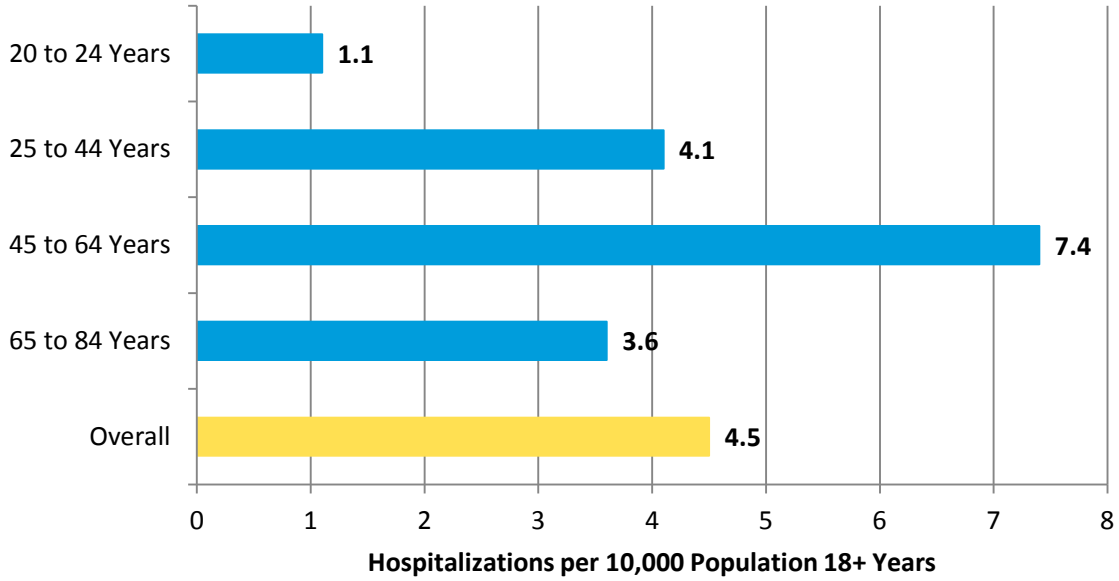
Age-Ad□usted □ospital Inpatient□□isit Rate due to Alcohol Abuse by Race and Ethnicity, Prince □eorge□s County, 2010-2012



* Includes visits to Maryland and Washington, D.C. hospitals

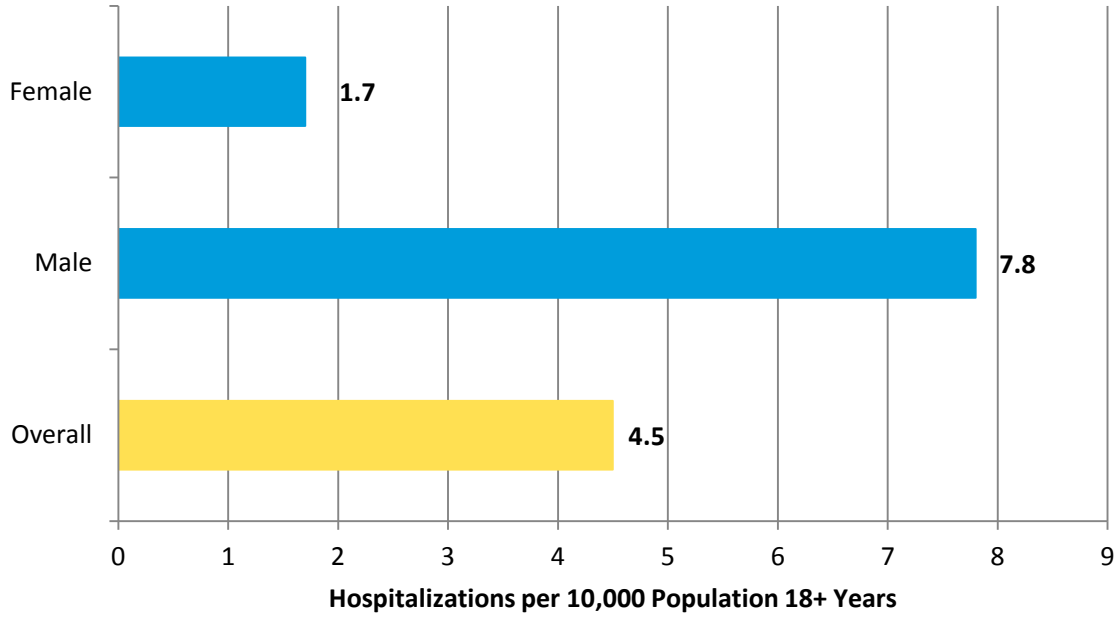
Data Source: The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient Visit Rate due to Alcohol Abuse by Age Group, Prince George's County, 2010-2012



* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient Visit Rate due to Alcohol Abuse by Sex, Prince George's County, 2010-2012



* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

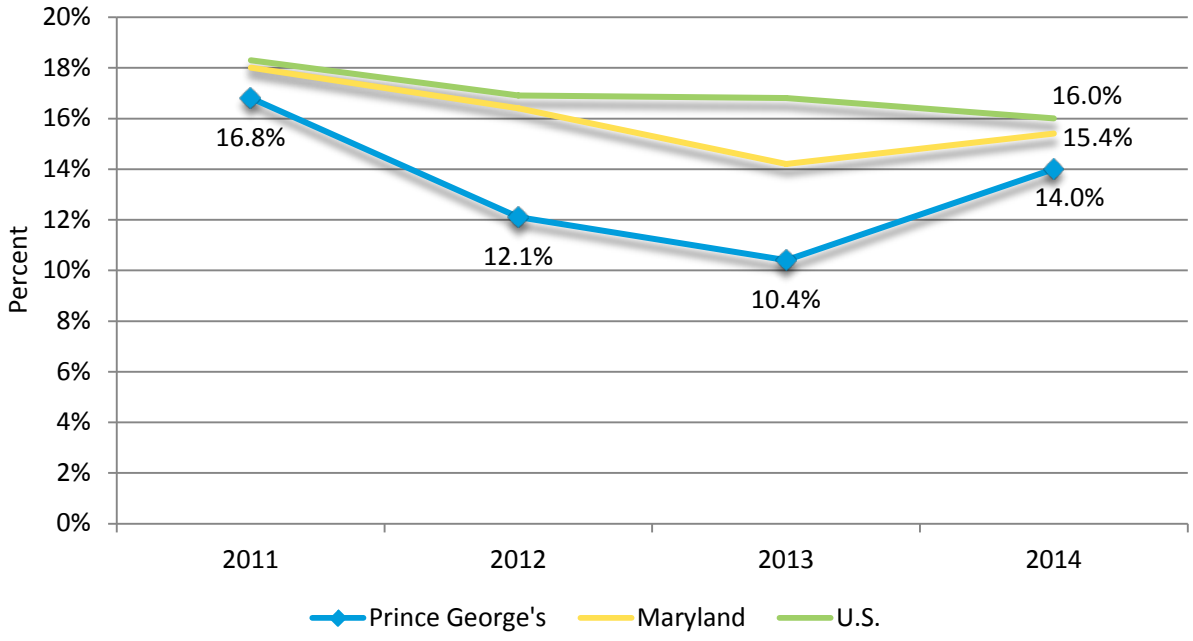
Percent of Adult □inge Drin□ers□in the Past □onth, 201□

	Prince George's	Maryland
Overall	14.0%	15.4%
Sex		
Male	18.4%	19.8%
Female	10.0%	11.5%
Race/Ethnicity		
White, non-Hispanic	21.3%	17.8%
Black, non-Hispanic	11.4%	12.8%
Hispanic	17.6%	13.8%
Age Group		
18 to 34 Years	21.4%	26.4%
35 to 49 Years	12.2%	15.0%
50 to 64 Years	11.9%	11.8%
Over 65 Years	5.3%	4.2%

*Binge drinking is defined as males having five or more drinks on one occasion, females having four or more drinks on one occasion

Data Source: Maryland Behavioral Risk Factor Surveillance System, DHMH

Percent of Adult □inge Drin□ers□in the Past □onth, 2011 to 201□



*Binge drinking is defined as males having five or more drinks on one occasion, females having four or more drinks on one occasion

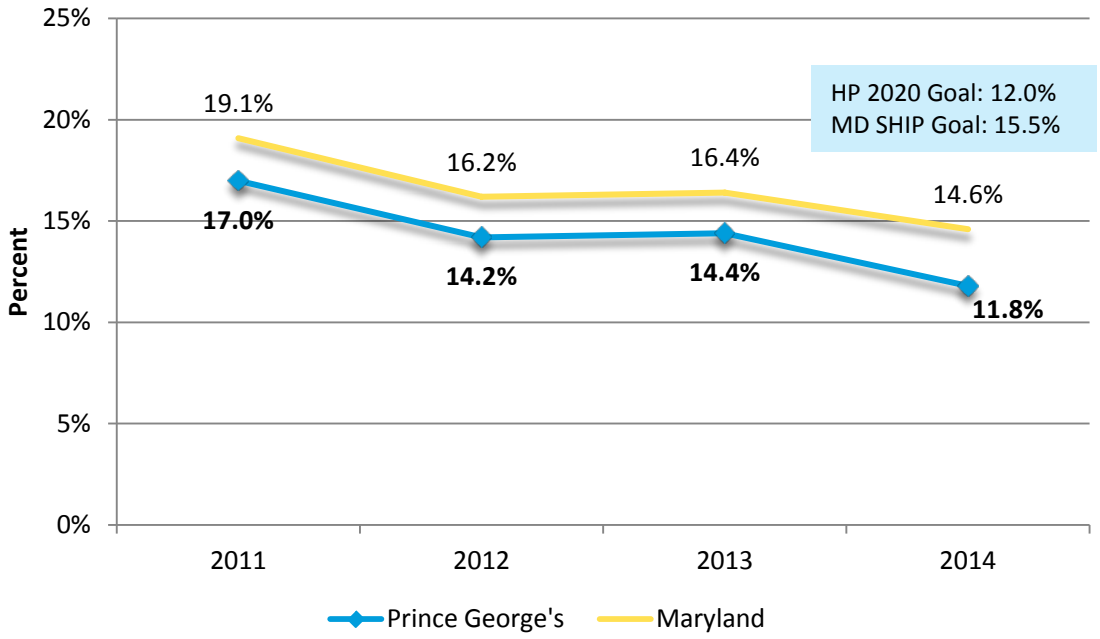
Data Source: Maryland Behavioral Risk Factor Surveillance System, DHMH

Percent of Residents □ ho Currently Smo□e 1□ Years and Older, 201□

	Prince George's	Maryland
Sex		
Male	14.7%	16.8%
Female	9.2%	12.7%
Race/Ethnicity		
White, non-Hispanic	15.3%	15.5%
Black, non-Hispanic	11.9%	16.8%
Hispanic	8.3%	8.1%
Age Group		
18 to 34 Years	7.4%	14.0%
35 to 49 Years	16.2%	17.1%
50 to 64 Years	16.1%	17.5%
Over 65 Years	7.2%	8.6%
Overall	**11.8%**	**14.6%**

Data Source: Maryland Behavioral Risk Factor Surveillance System, DHMH

Percent of Current Adult Smo□ers, 2011 to 201□



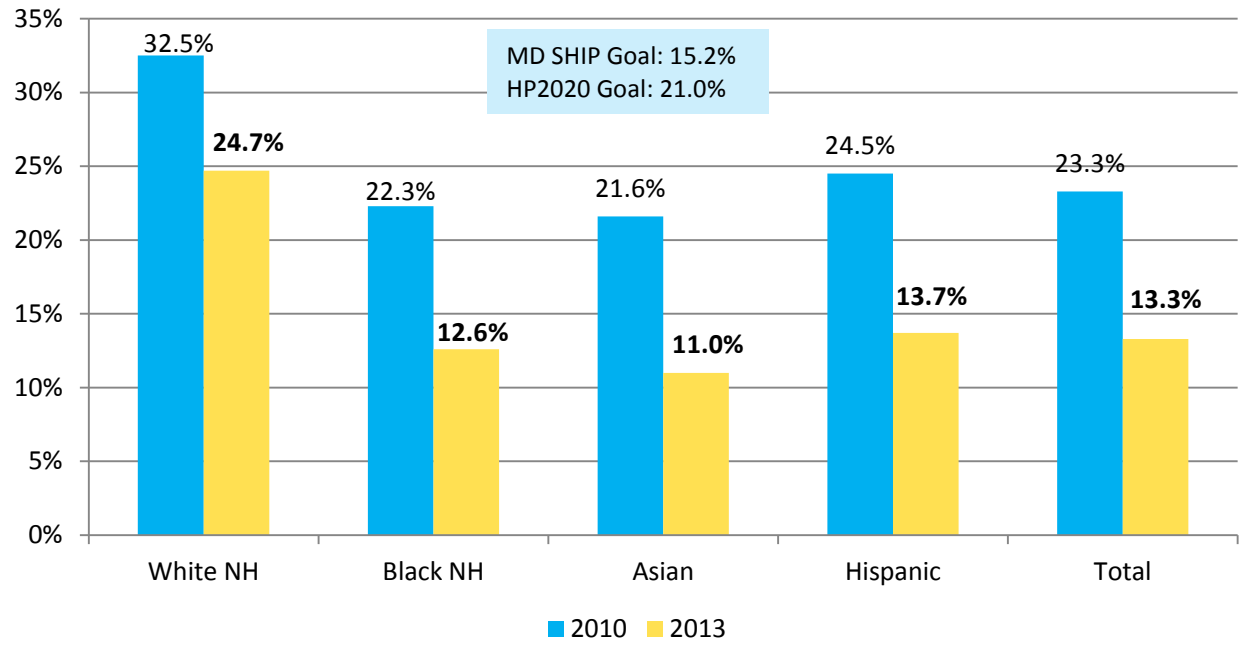
Data Source: Maryland Behavioral Risk Factor Surveillance System, DHMH

Percentage of Students who Dran□ Alcohol During the Past □onth, 201□

	Prince George's	Maryland
Sex		
Male	19.3%	29.3%
Female	26.5%	33.0%
Race/Ethnicity		
White, non-Hispanic	28.2%	37.4%
Black, non-Hispanic	22.9%	25.2%
Hispanic	23.1%	30.4%
Age Group		
15 or Younger	19.8%	23.5%
16 or 17 Years	24.6%	35.8%
18 or Older	32.7%	42.9%
Total	**23.2%**	**31.2%**

Data Source: 2013 Youth Risk Behavior Survey Report for Prince George's County and Maryland, Maryland Department of Health and Mental Hygiene

Adolescents □ ho Used □obacco Products During the Past □onth, Prince □eorge□s County, 2010 and 201□

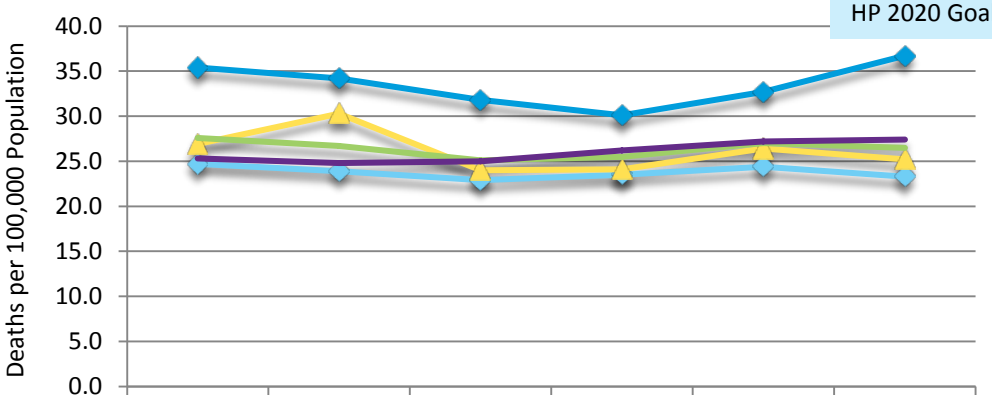


Data Source: 2013 Youth Risk Behavior Survey Report for Prince George's County and Maryland, Maryland Department of Health and Mental Hygiene

Unintentional In□uries □Accidents□

Age-Ad□usted Death Rate per 100,000 for Unintentional In□uries, 200□-201□

HP 2020 Goal: 36.4

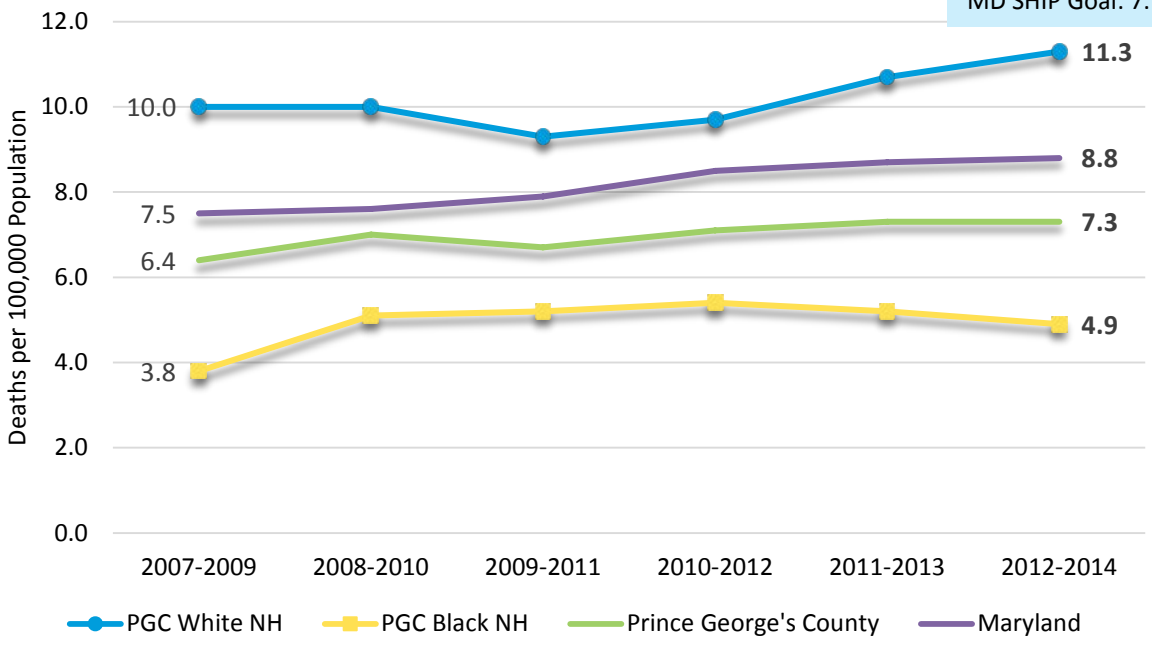


	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PGC White NH	35.4	34.2	31.8	30.1	32.7	36.7
PGC Black NH	24.7	23.9	22.9	23.5	24.4	23.3
PGC Hispanic	26.9	30.3	24.0	24.1	26.4	25.2
PGC	27.6	26.7	25.1	25.5	27.0	26.5
Maryland	25.3	24.8	25.0	26.2	27.2	27.4

***** Asian/Pacific Islanders were not included due to insufficient numbers
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

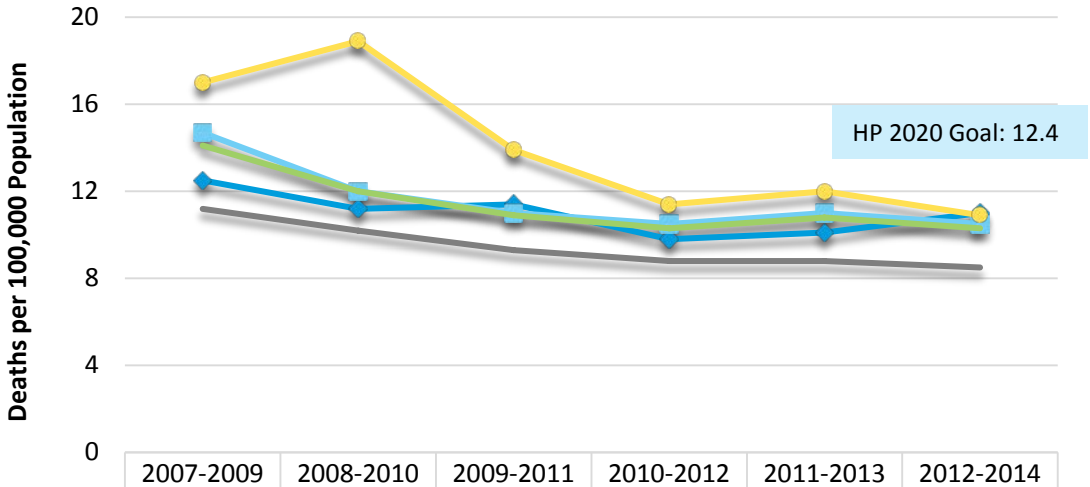
Age-Ad□usted Fall-Related Death Rate, 200□ to 201□

HP 2020 Goal: 7.0
MD SHIP Goal: 7.7



***** Residents of Hispanic Origin and Asian/Pacific Islanders were not included due to insufficient numbers
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database;

Age-Adjusted Death Rate due to Motor Vehicle Accidents, 2007 to 2014

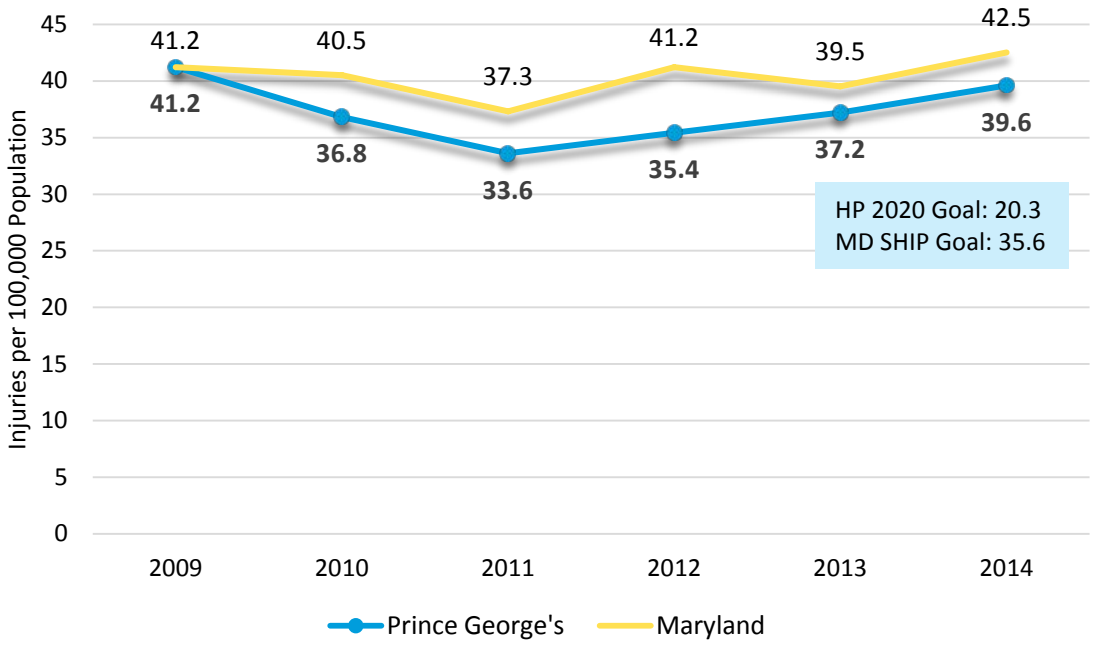


	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
PGC White NH	12.5	11.2	11.4	9.8	10.1	11.0
PGC Black NH	14.7	12.0	11.0	10.5	11.0	10.5
PGC Hispanic	17.0	18.9	13.9	11.4	12.0	10.9
PGC	14.1	12.0	10.9	10.3	10.8	10.3
Maryland	11.2	10.2	9.3	8.8	8.8	8.5

***** Asian/Pacific Island Residents were not included due to insufficient numbers

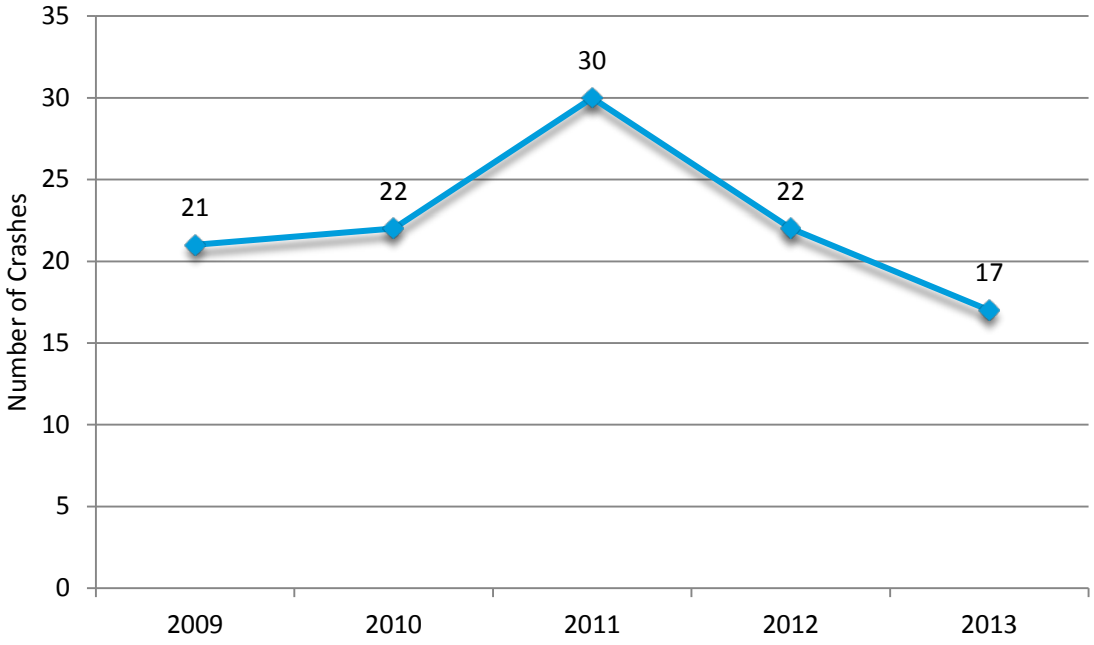
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database; Healthy People 2020 https://www.healthypeople.gov/

Pedestrian Injury Rate on Public Roads, 2007 to 2014



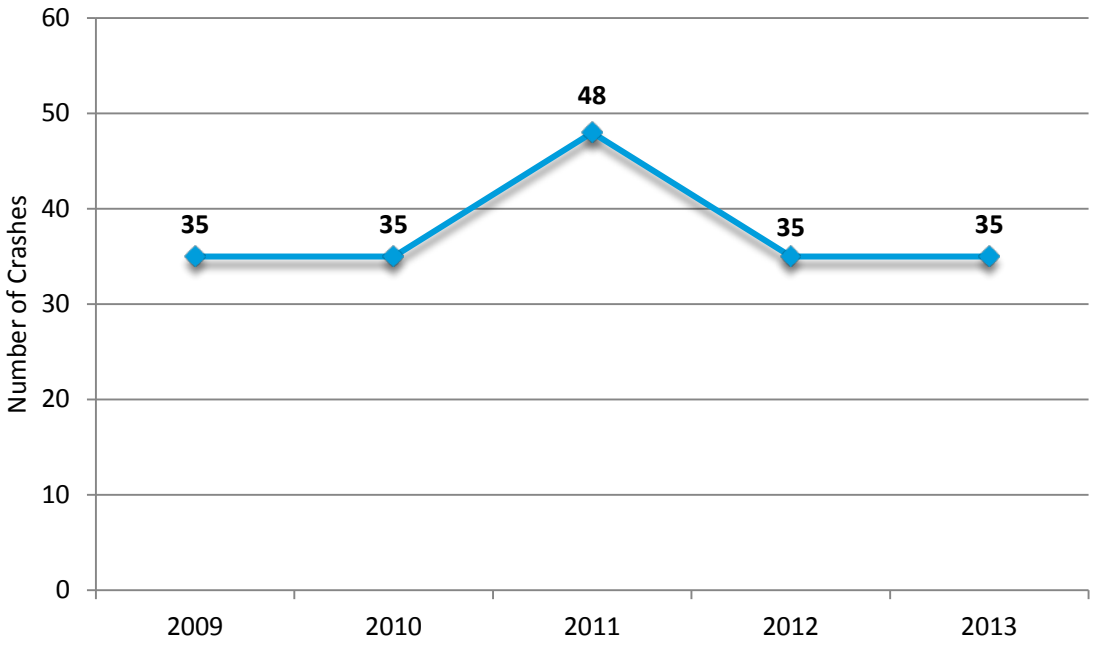
Data Source: Maryland State Highway Administration (SHA)

Fatal □otor □ehicle Crashes Involving Pedestrians on Foot, Prince □eorge□s County, 200□ to 201□



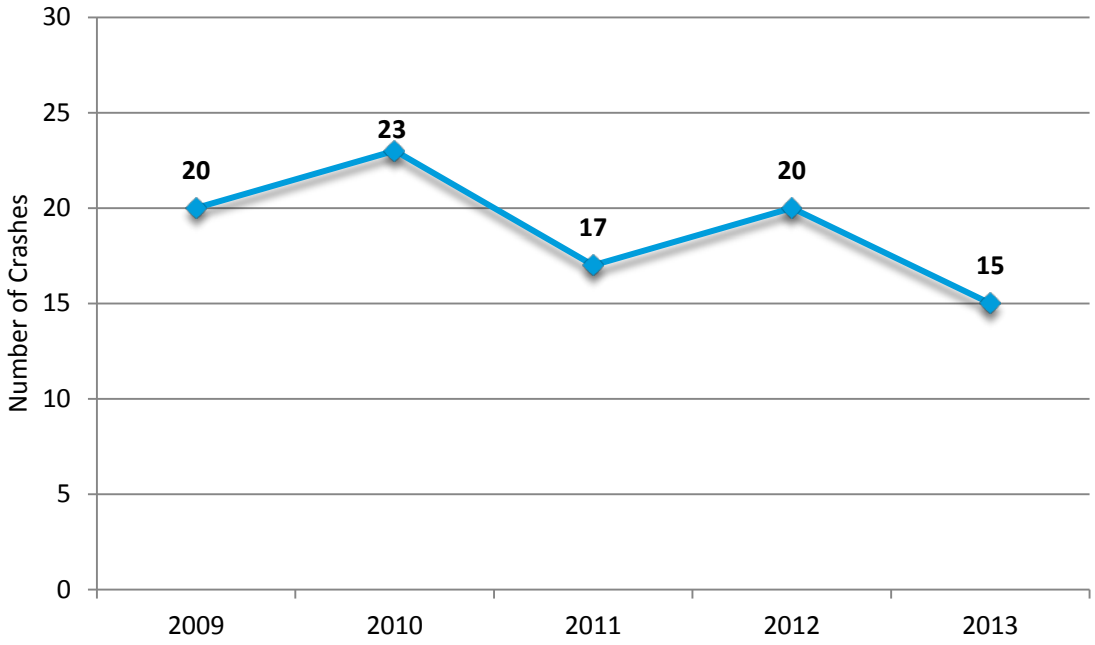
Data Source: Motor Vehicle Administration, Maryland Department of Transportation

Fatal □otor □ehicle Crashes Involving Distracted Driving, Prince □eorge□s County, 200□ to 201□



Data Source: Motor Vehicle Administration, Maryland Department of Transportation

Fatal □otor □ehicle Crashes Involving Driver Speed, Prince □eorge□s County, 200□-201□



Data Source: Motor Vehicle Administration, Maryland Department of Transportation

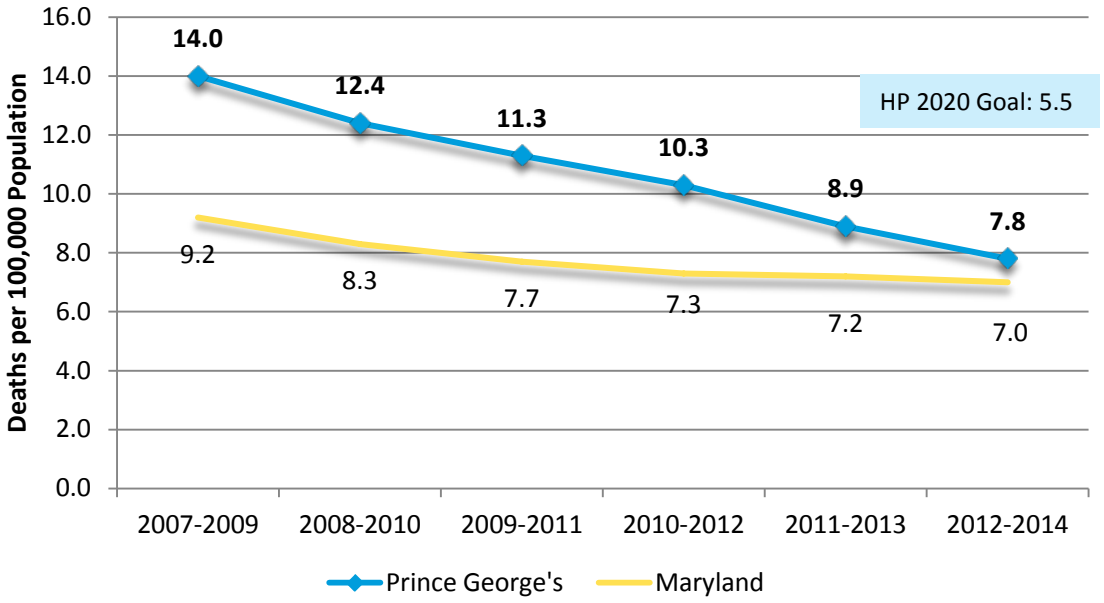
□iolence and Domestic □iolence

Overview	
What is it?	Violence affects all stages of life and includes child abuse, elder abuse, sexual violence, homicides, and domestic violence. Domestic violence is a pattern of abusive behavior including willful intimidation, physical assault, battery, and sexual assault used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can happen to anyone regardless of age, economic status, race, religion, sexual orientation, nationality, sex, or educational background (National Coalition Against Domestic Violence).
Who is affected?	There were 4,490 violent crimes (includes homicide, rape, robbery, and aggravated assault) in 2014, and 66 residents in the county died by homicide. (MD Vital Statistics). In 2014, there were 2,083 reports of domestic violence in the county and from July 2014 to June 2015 there were 14 domestic violence-related deaths. (Maryland Network Against Domestic Violence).

Prevention and Treatment	• Domestic violence prevention efforts depend on the population and include:
	  • Prevent domestic violence before is exists (primary prevention)
	  • Decrease the start of a problem by targeting services to at-risk individuals and addressing risk factors (secondary prevention)
	  • Minimize a problem that is clear evidence and causing harm (tertiary prevention) (Maryland Network Against Domestic Violence).

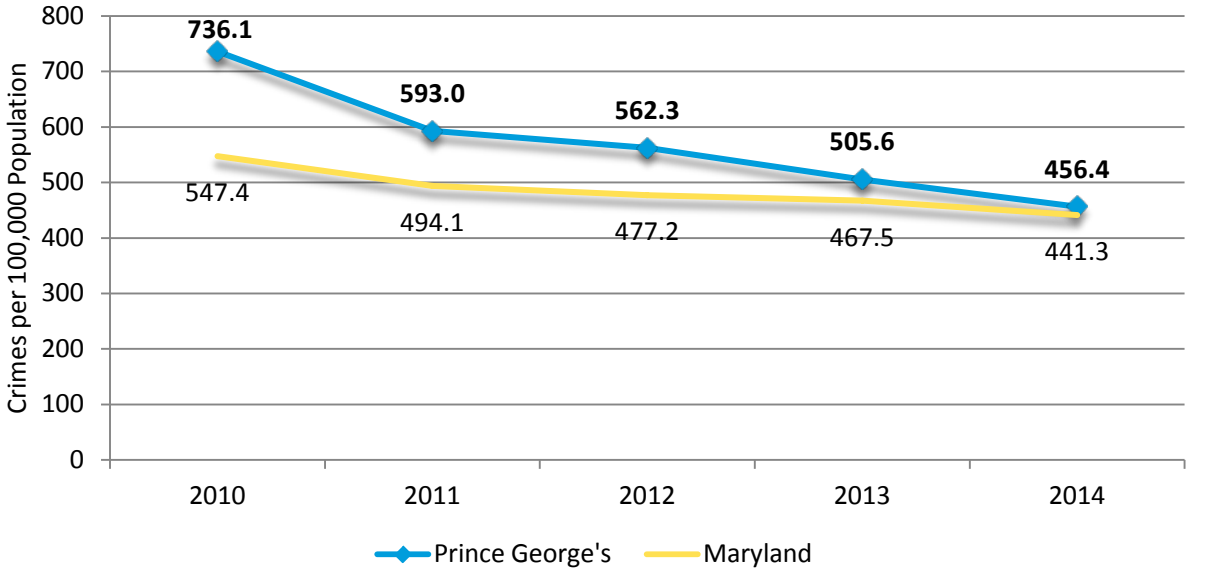
What are the outcomes?	Apart from deaths and injuries, domestic violence is associated with adverse physical, reproductive, psychological, social, and health behaviors. (CDC.gov).
Disparity	No data is currently available about disparities for violence and domestic violence. However, anyone can experience domestic violence. Women generally experience the highest rates of partner violence compared to males. Teenaged, pregnant, and disabled women are especially at risk. (MD Network Against Domestic Violence).
How do we compare?	The county's homicide rate in 2014 was 7.5; other Maryland counties ranged from 2.2 to 30.6; the state overall is 7.0 and the U.S. is at 5.8 per 100,000 population. The county's violent crime rate in 2013 was 505.6, the third highest in the state with a range from 118.8 to 1,406.4 among other Maryland counties, and the state rate was 467.5 per 100,000. The county ranked as the fifth lowest for the rate of domestic violence in 2014. (MD Governor's Office of Crime Control and Prevention)

Age-Adjusted Death Rate for Homicide, 2007 to 2014



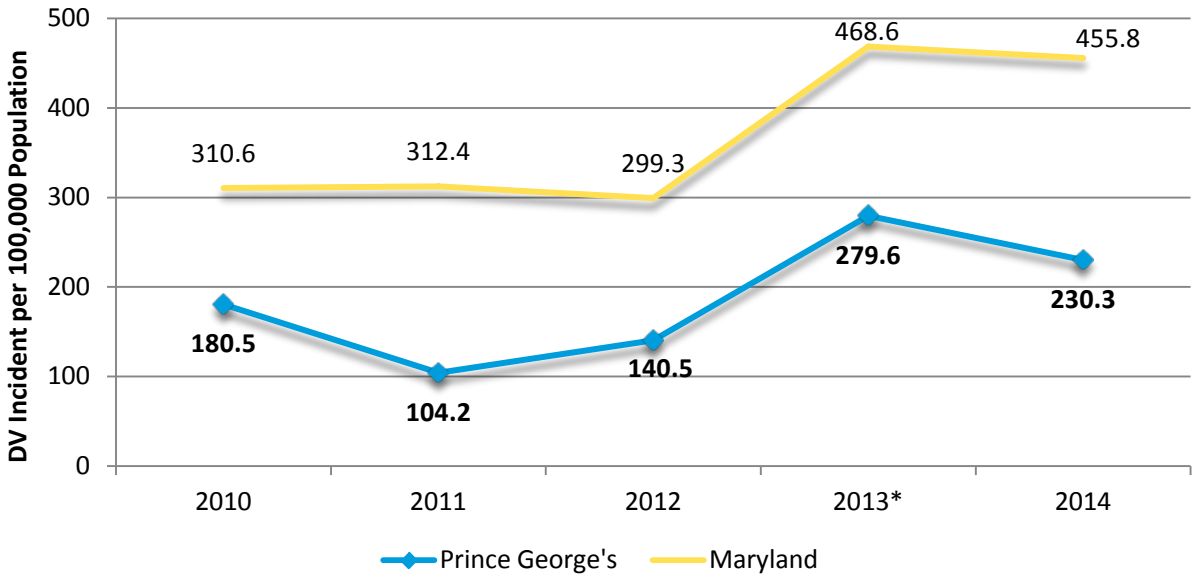
* Data unavailable by race and ethnicity.
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Violent Crime Rate, Prince George's County Compared to Maryland, 2010 to 2014

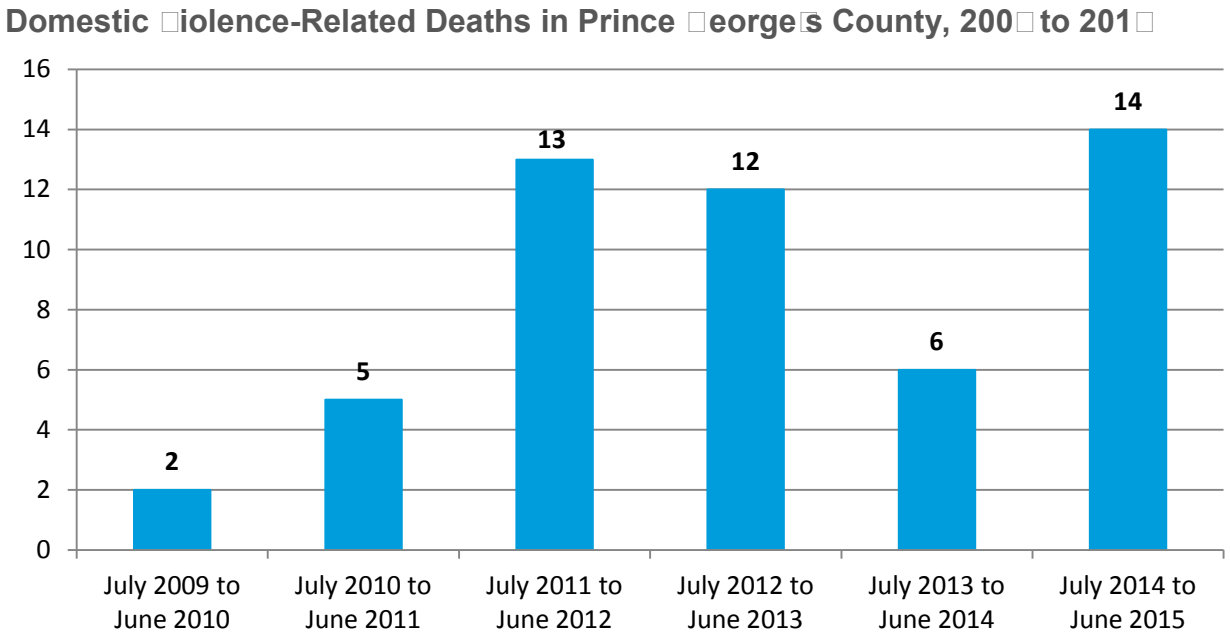


*Violent crimes include homicide, rape, robbery, and aggravated assault.
Data Source: Maryland Uniform Crime Report

Rate of Domestic Violence, 2010 to 2014



*In 2013, domestic violence data reporting was expanded to include additional relationships and reflect changes in Maryland law. This change explains the increase in the total number of Domestically Related Crimes reported.
Data Source: Maryland Uniform Crime Report



Data Source: Maryland Network Against Domestic Violence

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KEY INFORMANT INTERVIEWS

Introduction

As part of the 2016 Community Health Needs Assessment conducted in partnership with the county's five hospitals, the Prince George's County Health Department (PGCHD) conducted key informant interviews with 24 County residents drawn from diverse backgrounds with varying perspectives on health in the County. The present report summarizes the approach to the interviews and the findings.

Key Findings

- The three most important health issues facing the County are improving access to primary care, improving access to healthy food, and increasing prevention efforts around chronic disease.
- The most important social determinants of health in the County are (1) lack of transportation; (2) immigration status that renders some residents uninsurable; (3) low health literacy and (4) poverty.
- The three most important barriers relative to the health and well being of residents are (1) limited access to healthcare due to lack of insurance, poverty, provider shortages, lack of transportation, and low health literacy; (2) limited access to healthy foods; and (3) poor adoption of behaviors and activities that promote healthy eating and active living.
- The leading physical health concerns are the incidence and prevalence of chronic disease- cardiovascular disease, hypertension, Type 2 diabetes in adults and Type 2 diabetes and asthma in children.
- The rising incidence of behavioral health problems among adults and children, the stigma around seeking help for mental conditions, and limited access to behavioral health services due to a lack of providers, are three pressing problems in the County.
- Environmental health challenges mainly affect children and are poor air quality that is associated with high rates of asthma and exposure to lead in older housing stock.
- Current health challenges are being addressed through direct services; community health education and outreach; and partnerships and collaborations

but the County needs to develop permanent solutions by allocating funding to expand and strengthen the health safety net and build the capacity of local non-profits to address the health needs of residents.

- Partnerships and collaborations that promote systems of care; the integration of primary and public health services ; and community care coordination hold promise of being effective approaches to tackling serious systemic problems in the County.
- More needs to be done to ensure the cultural and linguistic competency of providers and available services, particularly as they relate to vulnerable sub-populations such as the uninsured, the Piscataway Indians, and recent immigrants and refugees.

ethodology

Sample: PGCHD provided a consultant with the names of 38 individuals who were proposed by the five hospitals and PGCHD. These individuals represented Local government; patient advocates; faith-based organizations; the public school health service; local politicians; safety net providers; state government; physician providers; academia; private industry; local philanthropy and special populations – seniors, Hispanics, the Piscataway Indian tribe; veterans, and the disabled. The representatives live and work in all areas of the County. Of the 38 potential respondents 24 completed the interviews by the deadline set by PGCHD. Notably absent were respondents representing physician providers and academia. Despite repeated contacts representative of these groups did not respond to the request for an interview. **Appendix A** presents the list of persons who completed the interviews.

Interview Protocol: PGCHD approved the interview guide (see **Appendix**) which consisted of 17 open ended questions with related probes. The guide addressed the following main topics- assets and barriers relative to health promotion in the County; opinions on the leading health threats currently facing the County; specific priorities in the areas of physical, behavioral and environmental health; and emerging threats to residents health.

Implementation: The consultant conducted 20 of the 24 interviews by telephone. Interviews ranged from 30 to 45 minutes in duration and respondents were emailed the questions in advance of the interview. PGCHD extended the option of completing the interview questions in writing to four respondents who were unavailable by telephone

due to scheduling difficulties. All of the interview data were collected between March 10 and 31, 2016.

Analysis: Preliminary content analysis of the interview data occurred at the conclusion of each data collection activity. The consultant identified and recorded first impressions and highlights. The second stage of content analysis identified common categories and overarching themes that emerged as patterns in the data. In the presentation of the interview findings, key patterns are reported along with supportive quotes.

Question-by-Question Analysis

1. What is your organization/ program's role relative to the health and well being of County residents?

See **Appendix A** for a list of participants.

2. How long has your organization/ program played this role?

As stated earlier the interviewee sample was drawn to reflect various disciplines including local government; patient advocates; faith-based organizations; the public school health service; local politicians; safety net providers; state government; physician providers; academia; private industry; local philanthropy and special populations. Local government agencies represented included the County's health department; social services; family services; public housing; transportation; emergency response; division of aging; planning; and domestic violence and human trafficking prevention services, respectively. Three faith leaders representing the health ministries in their respective organizations also participated as did a representative from the County's Chamber of Commerce. Other respondents included a school health administrator; three safety net providers; five providers serving different special populations; one representative of a local philanthropy; and two local elected officials. These respondents averaged 15.5 years of active service in some aspect of healthcare in the County.

3. In your opinion has the health of County residents improved, stayed the same or declined over the past few years? What makes you say that?

Roughly half (54%, 13) of the respondents believed that over the past few years, residents' health has improved. However, ten of the 13 emphasized that the improvement has been 'slight' or 'limited'. Evidence cited for improvement included: the trend in the health status indicators presented in the County's 2015 Health Report[1]; residents' increasing awareness of and demands for prevention information and programming; and increases in the number of residents able to access healthcare due to the provisions of the Affordable Care Act and the County's Health Enterprise Zone. Nevertheless, the observed improvements were restricted, as one respondent voiced **'to persons who are in a position to take advantage of the resources in the County. For various reasons not everyone can do so'.** Respondents who felt that residents' health has declined concur with that observation. They noted that a significant proportion[2] of the population continues to be uninsured, and several were concerned

[1] PGCHD, Office of Assessment and Planning, Health Report 2015

that the health status of the uninsured may not be adequately measured since they tend not to be included in routine surveillance and monitoring efforts. Others pointed to rising incidence of chronic disease (diabetes, hypertension, and cardiovascular disease) in adults and diabetes and asthma among children, as well as the aging of the population as signs of overall health decline. The increasing incidence of untreated behavioral health problems was another indicator cited by some as evidence of declining health.

4□□ hat are the County's three □ost i□portant assets/strengths relative to the health an□ □ell □eing o□resi□ents□

Perhaps due to the highly diverse nature of the sample, this question elicited a very wide range of answers. The most common responses were in descending order of frequency: the County□s parks and recreation centers that promote active living; the proposed regional health center that holds promise of increasing residents□access to health care; and the Health Department that has assumed a proactive and collaborative approach to promoting the public□s health.

5□□ hat are the County's three □ost i□portant □arriers relative to the health an□ □ell □eing o□resi□ents□

In contrast to the variation observed in the responses to the question about the County□s assets relative to health, there was a virtual consensus that the three most important barriers are in descending order of frequency cited: limited access to healthcare due to lack of insurance, poverty, provider shortages, lack of transportation, and low health literacy; limited access to healthy foods as evidenced by food desserts in some communities and the ubiquity of fast food restaurants; and poor adoption of behaviors and activities that promote healthy eating and active living.

Access to Care: With respect to access to healthcare, several respondents noted that although the ACA provided many previously uninsured or underinsured residents with insurance, some of these persons cannot afford the monthly premiums and/or co-payments for service. The provider shortage, particularly for primary care and pediatric, behavioral health and oral health services, also creates long waiting lists and effectively means that some residents will not receive needed care in a timely and efficient manner, if ever. While respondents believe that this problem may be redressed somewhat when the proposed regional health center opens, a few individuals pointed to the elimination of maternal and child health services as well as inpatient care at Laurel Regional Hospital and the cessation of PGCHD prenatal services as moves that have further curtailed access to care. In addition, several respondents observed that it is unreasonable to expect the proposed regional center alone to close the gaps in the

County's current frayed safety net. Safety net representatives who were interviewed noted that while their organizations deliver sliding scale services to uninsured residents, ultimately the service model is not viable because in some cases over 30% of all persons seeking care are uninsured. Also symptomatic of the lack of access is the fact that, according to EMS personnel who were interviewed, the fourth most common reason for medical emergency calls in the County is for generic sick patients, i.e. persons with a non-acute problem who lack a medical home and therefore seek care from an emergency department.

Transportation was mentioned so frequently and in relation to so many barriers to health that comments were sought from a manager at the County's Department of Public Works and Transportation, Office of Transportation. According to this individual the County currently provides transportation services to dialysis patients; seniors who eat the County's four senior centers; and the Call-a-Bus service that takes any County resident who is not served by or cannot use existing bus or rail services. However, priority is given to senior and persons with disabilities. The respondent noted that demand for all of these services far outstrips capacity and that would-be riders need to reserve a ride a minimum of two weeks in advance. The manager expressed that augmenting the current fleet of 41 vehicles and 45 drivers with ten (10) additional buses and ten (10) additional drivers would allow meet the present demand during business hours. However, demand is predicted to rise as the population ages. Furthermore, transportation services are not offered after business hours, or on weekends or holidays, and Call-a-Bus is only available between the hours of 8:30 and 3:30.

The lack of culturally and linguistically competent health services is also a barrier to access according to some respondents. This is particularly the case for persons with behavioral health conditions, where provider sensitivity and communication style may greatly influence the treatment intervention. Treatment approaches and/or providers that do not take into consideration patients' health beliefs discourage care seeking and hinder access.

Access to Healthy Food: According to respondents limited access to healthy food caused by food desserts, and the presence of numerous fast food establishments do not support healthy eating. Several respondents cited the closure of major supermarkets; the community's lack of awareness of the produce offered by and the location of local farmers markets; and limited transportation options that prevent residents from traveling to farmers markets or full service supermarkets as ongoing challenges to health. Others noted that the permitting process and other regulations surrounding the opening and operation of farmers markets are much more complicated

than those relative to fast food establishments. Perhaps as a result the fast food restaurant density in the County is .83/1000 residents as opposed to .58 for counties of comparable population and geographic size elsewhere in the country.[3] Yet, even when healthy food is accessible some residents do not necessarily access it. According to one respondent **some family traditions around diet, they ust are not healthy hen culture plays a role In all of the diverse cultures within the County there are foods that are tasty but bad for you Unfortunately they are also often the most affordable foods**

Personal/Behavioral Factors: Low health literacy and poverty were given as the main reasons for residents not engaging in healthy eating and active living (HEAL) behaviors. Nearly all (92%, 22) of the respondents mentioned residents lack of understanding of the importance of HEAL as a major barrier. One respondent observed that the needs of residents with limited or no proficiency in English are not addressed by current community health education efforts. Specifically, the Health Department s website does not provide information in Spanish, the second most commonly spoken language after English in the County, or any other language for that matter. As a result non-English speaking residents often lack accurate information about available resources and how to access them. Even in cases where there is no linguistic barrier, patient advocates report that the lack of coordination among the various health and social services and providers in the County makes navigating the system a challenge for many residents. While the Health Department s efforts to deploy community health workers (CHWs)are welcomed the consensus is that more are needed, with some respondents calling for **a networ of C s across the County** that can raise community awareness of available services and how to access them.

The high cost of living in the County results in a significant number of working poor. These are often residents who work two or more jobs and commute long distances from home. Many struggle to achieve an optimal work–life balance that favors health. The average commute to work for County residents is 41 minutes versus 35 for the rest of the State. Roughly half (57%) of County residents who commute drive alone to work and commute for more than 30 minutes versus 47.2% for the rest of the State.[4] Roughly one in five (20.5%) of County residents suffer from severe housing problems that include overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities.[5] According to several patient advocates, the homeless population (particularly

[3] PGCHD PGC Health Zone. Accessed on April 5, 2016 at www.pgchealthzone.org
[4] Ibid
[5] Ibid

unaccompanied youth) suffers disproportionately because of their unstable living situation and often present for services in advanced stages of disease.

The parks and recreation centers touted as some of the County's most important health assets may not be readily accessible to some communities. Respondents observed that in fact, some residents in poorer neighborhoods may lack safe outdoor or even indoor space to engage in physical activity. Furthermore due to changes in the school curricula, children in these neighborhoods may not engage in physical education at school.

6. What do you think are the three most important social determinants of health in the County? Social determinants of health are factors related to the social environment, physical environment, health services and structural and societal characteristics.

In descending order of frequency the social determinants that were mentioned were: Lack of transportation (see discussion under Question 5 above), immigration status that renders some residents uninsurable, and low health literacy and poverty tied in third place. A closer analysis of the responses indicate that in fact poverty could be singled out as the key determinant because poverty limits the transportation options such as owning and operating a personal vehicle, affording housing close to public transportation and/or affording the cost of public transportation. Undocumented status is typically a proxy for poverty. However, several interviewees noted that low health literacy has been observed even among the County's significant population of highly educated individuals. In this connection, one respondent observed that the County's low birthweight rate of 9.2%[6] is high even after controlling for maternal socioeconomic status and urged further study to explore the reasons behind this finding.

7. What do you think are the three most important physical health needs or concerns of County residents?

The incidence and prevalence of chronic disease- cardiovascular disease, hypertension, and Type 2 diabetes in adults and Type 2 diabetes and asthma in children are seen as the leading physical health concerns. The overwhelming majority (88%, 21) of respondents believe that low income residents, uninsured residents, and linguistic minorities are disproportionately affected by these conditions as these tend to be the persons who experience the most difficulty accessing healthcare, for reasons discussed earlier under Question 5. Oral and vision health particularly for the homeless

[6] Ibid

and for adults is also key concerns as they are typically not covered by basic insurance policies or included in safety net services.

8□□ hat □o you thin□ are the three □ ost i□ portant □ehavioral/□ ental health nee□s □acing the County□

□irtually all (96%, 23) of the respondents expressed that the rising incidence of behavioral health problems among adults and children, the stigma around seeking help for mental conditions, and limited access to behavioral health services due to a lack of providers, are three pressing problems in the County. Respondents noted that substance abuse, depression, anxiety, and suicide provoked by the stresses of long commutes, high cost of living, limited social support, and for some immigrants, feelings of isolation from the greater community are prevalent concerns. Several observed that the County is home to the highest number of veterans in the state and yet veterans remain unaware of or are unwilling to seek mental health services despite the increasing prevalence of post traumatic stress disorder (PTSD) in this sub-population. Family dysfunction including the exposure of children and youth to violence within or outside the home is another contributor to the incidence of mental health conditions. A provider who serves the Hispanic population expressed the view that 60 to 70 percent of all physical problems actually have a root cause in mental health.

Seeking mental health treatment has traditionally been stigmatized in the African American community. A similar pattern is observed in the Hispanic population, whereas the Native American culture has its own approaches to the management of mental health, approaches that mainstream providers may not understand and/or respect. One respondent noted that few of the local faith organizations actively promote care seeking for mental disorders, yet faith organizations are a trusted if not the trusted source of health information, counseling and social support for many residents, particularly those who lack ready access to healthcare. Thus according to one respondent, perhaps a lack of awareness of and/or confidence in the available behavioral health resources may explain why only 7% of all Medicaid beneficiaries in the County access the available services.

When residents do attempt to seek behavioral health care however, they are often confronted by a lack of providers. PGCHD reports that it would like to cease offering direct services in behavioral health but cannot do so until private and safety net provider capacity in this area is significantly enhanced. The majority of behavioral health providers in the County do not accept insurance, necessitating efforts by the PGCHD to make the business case to providers as to why they should do so. EMS staff report that because of the provider shortage only the most acute cases are referred to behavioral

health providers. The rest are taken to the local hospitals that lack inpatient capacity and so end up returning to the community, experiencing another crisis, and entering an endless cycle between the community and under-resourced hospitals. Seniors lack providers trained to address their specific behavioral problems as do children and youth. Housing officials report that seniors with behavioral problems are often incapable of living independently in the community and are therefore at high risk of becoming homeless. As one official stated **"deinstitutionalization means there is nowhere for them to go"** Another respondent lamented that an entire generation of minority youth is at risk for mental health misdiagnoses because of the lack of pediatric behavioral health providers who are culturally competent. Similar concerns were expressed by respondents who serve recent immigrants and refugees, many of whom have suffered or continue to suffer trauma and different forms of abuse. Immigrant and refugee children in particular are in need of early intervention to detect and address problems proactively. Some attribute the County's rising incidence of domestic violence to untreated mental health issues.

"What do you think are the three most important health-related environmental concerns facing the County"

The most commonly mentioned concern (75%, 18) was residential air quality which respondents felt might be responsible for the rising incidence of childhood asthma. Respondents noted that the County has made great strides in reducing exposure to secondhand smoke including the ban on smoking in all public housing which goes into effect on May 1, 2016. However, overcrowded, substandard, poorly maintained housing is said to be responsible for compromised air quality.

Additional concerns relate to lead exposure – a problem in parts of the County with older housing stock. Several respondents reflected that the community, particularly parents of young children, does not seem sufficiently aware of the dangers of lead. Others note that, given the recent, widely publicized problems with water quality in Flint, Michigan, water quality assessments should be conducted, particularly in poor neighborhoods in close proximity to the Anacostia River. Interestingly, none of these respondents was aware that childhood lead levels and water quality measures are both reported on the PGCHD health statistics website – www.pgchealthzone.org

10. "If you had to prioritize and select the three most important health issues facing the County from among those you just mentioned what would they be"

The three issues that were most commonly (75%, n=18) mentioned were: improving access to primary care, improving access to healthy food, and increasing prevention

efforts around chronic disease. These issues are seen as intertwined and fueled in large part by poverty, low health literacy and a provider shortage, as discussed earlier. Several respondents expressed the view that the success of the proposed regional health center will be in jeopardy if the County does not address the problem of care for the uninsured. One respondent wondered **"why won't the regional health center face the same problems as Prince George's Health Center if it has to treat the same if not a larger volume of uninsured patients? What's the plan for addressing that before the new center opens?"** Several responses mentioned the need to address super-users: persons who utilize hospital inpatient and emergency services because they either lack a medical home and/or do not practice effective self-management. One respondent estimated that effective management of super-users could save the County upwards of $6,000,000 annually in reduced healthcare costs. Efforts to expand access also need to be tailored to the specific cultural and linguistic needs of specials populations. For example, provider recruitment and professional development should include considerations of cultural and linguistic competency.

Respondents were equally adamant that the County must curtail the proliferation of fast food restaurants and work actively to end food deserts and make farmers markets and full service supermarkets readily accessible to all residents. To this end, several respondents believe that more needs to be done to promote farmers markets including the fact that many accept Supplemental Nutrition Assistance Program (SNAP) and Women Infants and Children (WIC) benefits. Respondents proposed that increased public and private collaboration to raise awareness of available services and resources through social marketing campaigns and enhancing the capacity of faith based and community based organizations would further this goal.

Many respondents appeared to agree with the view that the County **"should make health the center of all its planning- economic development, education, housing, transportation – all should revolve around the health of residents."** The consensus was that policies that support living wages, expansion of the safety net, and creation of more jobs within the County will reduce poverty and thereby reduce stress and allow residents to focus more on prevention and have the financial and other resources to practice effective preventive behaviors.

11. In what way does your organization/ program address each of the three issues you just mentioned?

Efforts to address the myriad of health problems and concerns raised by the respondents fell into three main categories –direct services; community health education and outreach; and partnerships and collaborations.

Direct Service: All of the direct service providers reported working at capacity and still being unable to meet the demand. Many predict that the demand for services will continue to rise and given the significant proportion of highly educated residents in the County, savvy consumers will increasingly demand high quality services. A few providers mentioned making a concerted effort to hire culturally and linguistically competent staff. All noted that in addition to the provider shortage the non-profit sector particularly in the area of supportive services is very underdeveloped often leaving providers with no referral options. To illustrate the paucity of options, one respondent stated that the County with a population of almost one million has just one domestic violence shelter with approximately 50 beds and a maximum stay of 89 days.

Education and Outreach: FBOs and CBOs were most likely to mention health education and outreach as their response to health issues facing the community. However, several respondents expressed that their organizations need capacity building so that they are better equipped to disseminate the latest information to their constituents. PGCHD has undertaken various countywide health education efforts including one around HEAL and is proposing additional efforts in the area of behavioral health. The Health Department is also using the HE as the incubator for its health literacy interventions with the goal of scaling them up countywide over time. EMS continues a practice of providing health education, e.g. the importance of daily blood glucose measurements for diabetics or the need for working smoke detectors in the home, during each resident encounter.

Partnerships and Collaborations: Several respondents praised PGCHD s efforts to form partnerships and collaborations such as the local health action coalition; the Community Care Coordination Team of the HE to address various public health issues in the County; the involvement of Maryland-National Capital Park and Planning Commission (MNCPPC) in the County s Primary Healthcare Strategic Plan; and prevention partnerships formed with local hospitals and advocacy groups such as the American Diabetes Association and the American Cancer Society. However, several providers observed that at times the Health Department, safety net providers, and private practices seemed to be in competition for limited resources. Some stated that more needs to be done to ensure that all stakeholders participate fully in various planning functions and that decisions are data-driven. Several respondents noted that the more needs to be done to integrate school health, public health and primary care. The existing four school-based health clinics are considered a step in the right direction but some respondents would like to see the clinics expanded to serve the entire school community including students families, perhaps through extending current school health resources through the addition of federally qualified health center staff.

Some respondents complained that it is not clear that the results of various needs assessments, such as the present effort, are used to inform policy and programmatic decisions. At times assessment results appear to be deliberately ignored undermining efforts at collaboration. Additionally, several advocated for specialized studies to be conducted on the needs of special populations including but not limited to the Piscataway Indian tribe, the uninsured, the homeless, and recent immigrants as a way of engaging these groups.

12□ Ho□ □ell is the County as a □hole respon□ing to these issues□

The County, particularly PGCHD, is lauded for its increasing efforts to partner with other public and private agencies, as discussed under □uestion 11. PGCHD is also seen as leading the effort to design interventions, solutions, and programs that are data-driven and evidence based. Respondents would like to see other County agencies adopt a similar approach as they work in the health arena.

However, overall the County received mixed marks on its efforts to address the various public health challenges raised by the respondents. Some respondents felt that the County faces an uphill battle to counter the negative image of Prince George□s that tends to be presented in the media and that discourages economic growth including provider recruitment. Others believe that the battle involves dispelling deeply held personal, cultural beliefs that impact health behaviors and outcomes at the individual level. Another viewpoint is that County leaders do not recognize the interrelationship between economic development and health and as result proposed policies and programs in both areas are not synergistic. County bureaucracy is also seen as a hindrance to innovation and rapid response to identified problems.

Frustrations were voiced that very little has been done to address the following longstanding and well documented problems: access to care for the uninsured; improved transportation services to improve access to care; the proliferation of fast food establishments; adult oral health; and the needs of sub-populations particularly non-English speaking residents and the Piscataway Indians. Some respondents suggested that there may be efforts underway to address the above mentioned problems, but if they are not widely known in the community the resulting impression is that nothing is being done. Others voiced concerns that the Health Department is eliminating some direct service programs and Laurel Regional Hospital is transitioning to become an ambulatory care center in an environment where access to care continues to be limited for significant portions of the population. Again, many expressed doubts that the proposed regional center could completely or even partially correct the problems associated with caring for the uninsured in the absence of dedicated funds to reimburse

these costs. Thus Montgomery Cares is cited as model worthy of emulation in Prince George□s County.

13□□ hat □ore nee□s to □e □one an□ □y □hich organi□ations/ progra□ s□

As far as the County is concerned promoting service integration across public and private providers and developing systems of care for physical and behavioral health were noted as high priorities by most (75%, n□18) respondents. In this connection, respondents commended PGCHD□s efforts around behavioral health. In general, respondents hoped that these efforts will lead to a strengthening of the safety net and address key barriers to care. PGCHD also needs to explore the use of telehealth to stretch the limited provider resources and do a better job of raising community awareness of available resources and how to access them. Additional recommendations for PGCHD include spearheading a more comprehensive but streamlined countywide, health planning process that engages a wide array of stakeholders; increased care coordination efforts; and leveraging the expertise of local academic institutions to ensure that proposed interventions are state of the art and evidence based.

The role of non profits was less clear, however. Respondents expressed the view that more non profits need to be involved in addressing the County□s health needs but acknowledged that many lack the capacity to do so. Therefore, a pressing priority is capacity building for non-profits so that more may participate meaningfully in promoting and protecting the health of residents. Capacity building may include technical assistance in board development, grant writing, and program planning, monitoring and evaluation in addition to professional development to ensure that staff is linguistically and culturally competent□It is noteworthy, that respondents did not identify who should deliver the proposed capacity building or how it would be funded.

14□□ hat resources are nee□e□ □ut not availa□le to a□□ress each o□the three issues□

All except one respondent stated that funding is the missing ingredient and the key resource needed. Respondents commented on the disparity in the funding accorded to health in the County when compared to the funding made available to the health departments of neighboring counties and the District. One respondent stated flatly **□Public health is not a top priority for the leadership of this County□Loo□ at what we spend on health□Loo□ at what □ontgomery, □oward even the District spends on health□Loo□ at what we spend on schools, libraries and public safety compared to health□It doesn□t compare□□** Several respondents observed that a significant proportion of the costs of many essential public health services such as the

safety net, medical transportation, basic primary care, and community behavioral health are covered by grant funding that may be eliminated at any time. In addition, safety net providers are currently unable to be reimbursed by insurers for much of the primary prevention services they offer. Given that the non-profit sector is currently unable to meet the demand for these and other services, this creates a highly unstable environment in which to attempt to promote public health. Another noted that new spirit of partnership and collaboration fostered by the Health Department is leading to innovative ideas but funding is needed to implement them. In the same vein, one respondent affirmed, **"You can't do great things without good staff and you have to pay good staff"**

15. What are the 3 most important emerging threats to health and well being in the County?

Only half of the respondents were able to cite any emerging threats. The three most commonly mentioned threats were- effective management of a mass disaster due to natural or terrorist forces; Zika; and the increasing demand for behavioral health services across the population. Several respondents felt that the County has no disaster relief plans or at least has not publicized any plans and residents do not appear cognizant of the threat of a mass disaster and how to respond. Related to this concern is the high probability that an infectious disease like Zika or Ebola could become epidemic in the County. Respondents note that the County is very diverse with residents coming from and traveling to all corners of the globe. One respondent queried **"what's to prevent an infectious disease from coming to the County and what do we do when it does"**

One respondent predicted a silver tsunami as the population ages that will result in a growing demand for services related to dementia and Alzheimer's in addition to those needed by the growing population of veterans returning from stressful combat theaters. PCP addiction, synthetic marijuana use, and electronic cigarettes use, particularly among youth are other behavioral health problems that respondents expect to increase.

16. How is your organization/program addressing these emerging threats?

Respondents uniformly agreed that although they identified threats their organizations are hardly addressing them because they are too occupied with responding to current needs. In addition, some respondents believe that the three threats outlined above require a uniform, comprehensive approach by a County agency and not siloed actions undertaken by individual organizations. The proposed behavioral health system of care is considered to be such a comprehensive approach. Nevertheless, the District Heights

Police Force is poised to unveil a plan for mass evacuation in the event of a disaster. One F□HC has retained an infectious disease specialist to retrain its staff on the latest prevention protocols as they are released by the Department of Health and Mental Hygiene (DHMH). Another provider is offering online mental health screening as well as other mental health services and supports and has joined a workgroup that will be studying dementia in the County. These examples are illustrative of the individual actions taken by local entities to address threats that they have identified.

1□□□o you have any other co□ □ents to a□□ relative to health an□ the County□

The bulk of respondents□closing remarks centered on four key recommendations. The County needs to improve access to care by strengthening the safety net; improve health literacy; improve the cultural and linguistic competence of providers and services offered; and ensure stable levels of funding that are commensurate to the size and scope of identified and emerging health needs in the County.

Appendix A: List of Key Informants

NAME	ORGANIZATION	TYPE
Rev. Esther Gordon	First Baptist Church of Glenarden	Faith-based
Karen Bates, RN, MS	PGC Public Schools	School Health
David Harrington	PGC Chamber of Commerce	Business
Cathy Stasny, RD, L.D.	PGC Area Agency on Aging	Seniors
Maria Gomez	Mary's Center	FQHC, Hispanic Population
Melony Griffith	Greater Baden Medical Services.	FQHC
Kathleen Knolhoff	Community Clinic, Inc.	FQHC
Pamela Creekmur	PGC County Health Department	Local Government
Elizabeth M. Hewlett	Maryland-National Capital Park and Planning Commission	State Government
Gus Suarez	First Baptist Church of Laurel	Latino Population; Faith-based
Craig Moe	City of Laurel	Elected Official
Natalie Standing on the Rock Proctor	Wild Turkey Clan, Cedarville Band of Piscataway Indians	Tribal Leader
Reverend Robert Screen	River Jordan Project, Inc	Faith-based
Rosa Goyes	Mary's Center	FQHC, Hispanic Population
Marcus Daniels	United Way	Local Philanthropy
Christal Batey	City of Greenbelt Assistance in Living Program	Local Government; Seniors
Cynthia Miller	City of District Heights	Elected Official
Eric Brown	PGC Department of Housing and Community Development	Local Government; Housing
Renee Ensor-Pope	PGC Department of Social Services, Community Services Division	Local Government
Dennis Wood	PGC Fire/EMS Department	Local Government
Jackie Rhone	PGC Department of Family Services	Local Government; Domestic Violence and Human Trafficking
Carol-Lynn Snowden	PGC Department of Family Services	Local Government; Veterans
Michelle Howell	The ARC	Non profit, Disabled persons
Geralyn Bruce	PGC Department of Public Works and Transportation	Local Government

Appendix □: Community □ealth □eeds Assessment

□ey Informant Interview Protocol

1□□ hat is your/your organi□ation □progra□'s□role relative to the health an□ □ell □eing o□County resi□ents□

2□Ho□ long have you/ your organi□ation/ progra□ playe□ this role□

3□□n your opinion has the health o□County resi□ents i□prove□□staye□ the sa□e□or □ecline□over the past □e□ years□ □ hat □a□es you say that□

4□□ hat are the County's three □ost i□portant assets/strengths relative to the health an□ □ell □eing o□resi□ents□

5. What are the County□s three most important barriers relative to the health and well being of residents□

6□□ hat □o you thin□are the three □ost i□portant social □eter□inants o□health in the County□ □□ocial □eter□inants o□health are □actors relate□ to the social environ□ent□ physical environ□ent□health services□an□ structural an□ societal characteristics□□

□□□ hat □o you thin□are the three □ost i□portant physical health nee□s or concerns o□ County resi□ents□

8□□ hat □o you thin□are the three □ost i□portant □ehavioral/□ental health nee□s □acing the County□

□□□ hat □o you thin□are the three □ost i□portant health□relate□ environ□ental concerns □acing the County□

10□ □o□ i□you ha□ to prioriti□e an□ select the three □ost i□portant health issues □acing the County □ro□ a□ong those you □ust □entione□ □hat □oul□ they □e□

11□□n □hat □ay □oes your organi□ation/ progra□ a□□ress each o□the three issues you □ust □entione□□

12□ Ho□ □ell is the County as a □hole respon□ing to these issues□

13□□ hat □ore nee□s to □e □one an□ □y □hich organi□ations/ progra□s□

14□□ hat resources are nee□e□ □ut not availa□le to a□□ress each o□the three issues□

15□ □ hat are the 3 □ost i□portant e□erging threats to health an□ □ell □eing in the County□

16□Ho□ is you/ your organi□ation/progra□ a□□ressing these e□erging threats□

1□□□o you have any other co□ □ents to a□□ relative to health an□ the County□

COMMUNITY-BASED ORGANIZATION SURVEY

Introduction

Prince George□s County is diverse; our growing population has a wide range of health needs and disparities. The Community-Based Organization Survey was developed as a strategy that complements the overall Community Health Assessment (CHA) goal of identifying the health needs and issues among the county□s different populations, through establishments that work closely with them.

□ethodology

The core CHA team provided lists of community-based partners and providers to be included in the survey; this included the membership of the Prince George□s County Health Action Coalition, as well as hospital board members, partners, and community leaders. The survey was developed based on existing community surveys, with some modifications specific to the county. Efforts were made to ensure the survey questions corresponded with the Community-At-Large Survey which was also part of CHA data collection efforts. An email request was sent to approximately 250 participants by the Prince George□s County Health Officer with an electronic link for the survey on March 4, 2016, with efforts made to resolve missing or incorrect emails. Two reminder requests were sent to those who had not yet participated during the collection period, and the survey closed on March 23, 2016.

The survey questions included multiple choice, ranking, and open-ended responses. Each multiple choice question is presented as a simple descriptive statistic. □uestions 4 and 6 both required ranking; each ranked score was weighted in reverse order, with the participants first choice having the largest weight, and their last choice with a weight of one. For □uestion 4 there were three ranked slots, so a first choice was given a weight of 3; for □uestion 6 with five ranked slot the first choice was given a weight of 5. An example of how each response was weighted is provided in the table below, with 86 participants total responding to the question:

Ran□	**□umber of Responses**	**□ eight**	**Response□□ eight**	**Sum of □ eighted Responses□□otal □**
1	4	3	12	$\frac{12□6□2}{86}$ □0.23
2	3	2	6	
3	2	1	2	

Open-ended response questions were initially reviewed for content analysis, which was used to identify common categories and overarching themes that emerged as patterns in the data.

Each response was then reviewed and analyzed according to the categories and themes, with summary responses presented to capture the participants information.

Participation

Surveys were submitted by 92 participants, with a return rate of 36.8%. All areas of the county were represented by the participants (uestion 19), and most IP codes had at least one expert participant (uestion 20). Participants represented a variety of organizations (uestion 18): not-for-profits (32.6%), Healthcare Providers (21.7%), Community Members (17.4%), Government Organizations (16.3%), Faith-Based Organizations (12.0%), and Social Service Organizations (8.7%); participants also worked with a variety of populations in the county (uestion 21). Not all participants responded to every question; each question includes the number (N) of participants that did respond.

ey Findings

- ***Overall health***: Two-third of respondents indicated Prince George s County to be unhealthy or very unhealthy.
- ***Leading health issues***: Chronic disease and related issues including diabetes, obesity/overweight, and heart disease led as the most pressing health issues for the overall county. However, every health issue that was rated had over half of participants indicate it was at least a major or moderate problem in the county.
- ***Access to healthcare***: While nearly 60% of participants agreed or somewhat agreed that most residents could access a primary care provider, three-fourths disagreed or somewhat disagreed that county residents are able to access bilingual providers and mental health providers, closely followed by providers accepting Medicaid or other forms of medical assistance. More than half of participants also indicated issues with access to dentists and medical specialists. In addition, open-ended comments noted a lack of quality healthcare and providers in the county and that the available services need improvement.
- ***Leading barriers****:* The leading barriers to care varied by number of responses through the related questions, though the same list of issues was consistently included:
    - Inability to pay for care; those with co-pays could not afford them, and those without insurance could not afford overall care for those without insurance (also cited as a specific issue)
    - Transportation needs outstrip the available services and lack flexibility
    - nowledge of available services and ability to utilize

- Basic unmet needs, including food insecurity and access to healthy foods (food deserts), transitional and permanent housing, employment, and overall adequate financial resources
- Access to healthcare providers included lack of primary care, but also included lack of specialists, lack of providers accepting a variety of insurance, and lack of enough hospitals in the county. The open-ended responses also included an overall lack of □quality□and □culturally appropriate□healthcare as a barrier. Lack of dental and behavioral health was also included as a barrier.
- Lack of insurance, both for those than have not yet applied and for those that do not qualify
- Cultural/language barriers were noted as an issue especially for immigrants, and affected their ability to access medical care, including basic tasks such as completing forms and enrolling in services.
- Trust and fear included issues with poor quality care as well as fear for residents who are not U.S. citizens

- □***ey resources to access healthcare***: One-third of participants noted a need for health navigation, education, and provision of information to residents as a key resource needed to improve access to care; some participants specified this should be tailored to communities with cultural sensitivity. This was followed by the need for transportation, affordable healthcare, and an increase in primary care and specialists, specifically increasing culturally competent providers located within communities who accept Medicaid and Medicare.

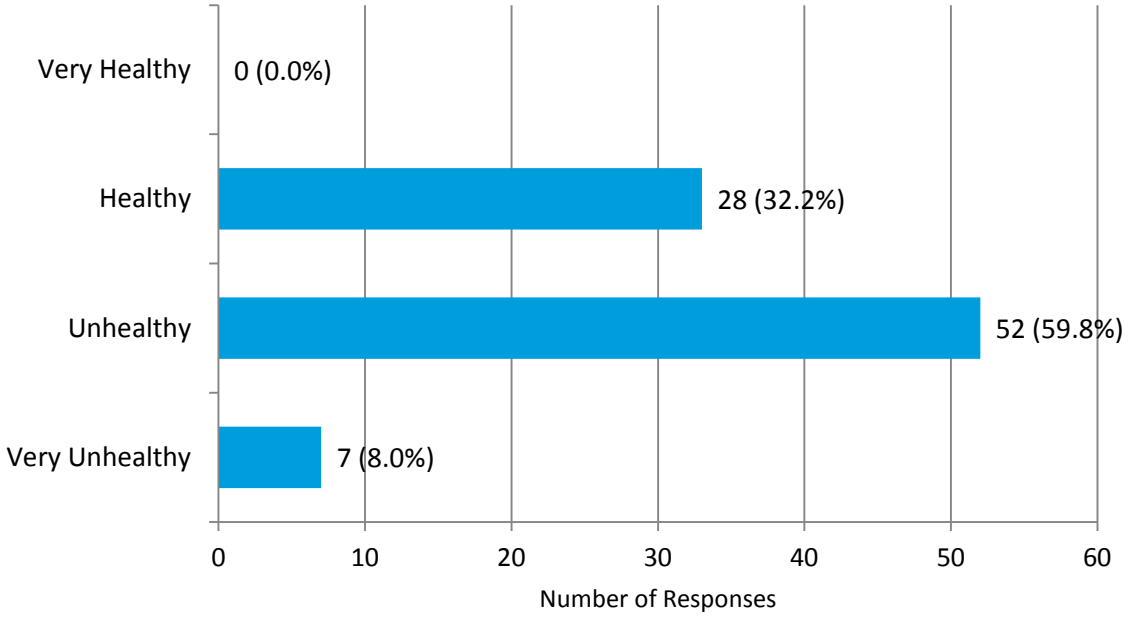
- □***nderserved populations***: The populations that were selected as most underserved included the homeless, the uninsurable, those with low incomes, immigrants, and non-English speaking.

- ***Recommendations to improve health***□Participants echoed the □ey Resources needed in this response, with 40% of participants identifying Health Education and Outreach as the leading recommendation, followed by increasing providers and improving access, affordable healthcare, and focusing on building partnerships and increasing funding to organizations that work to improve health.

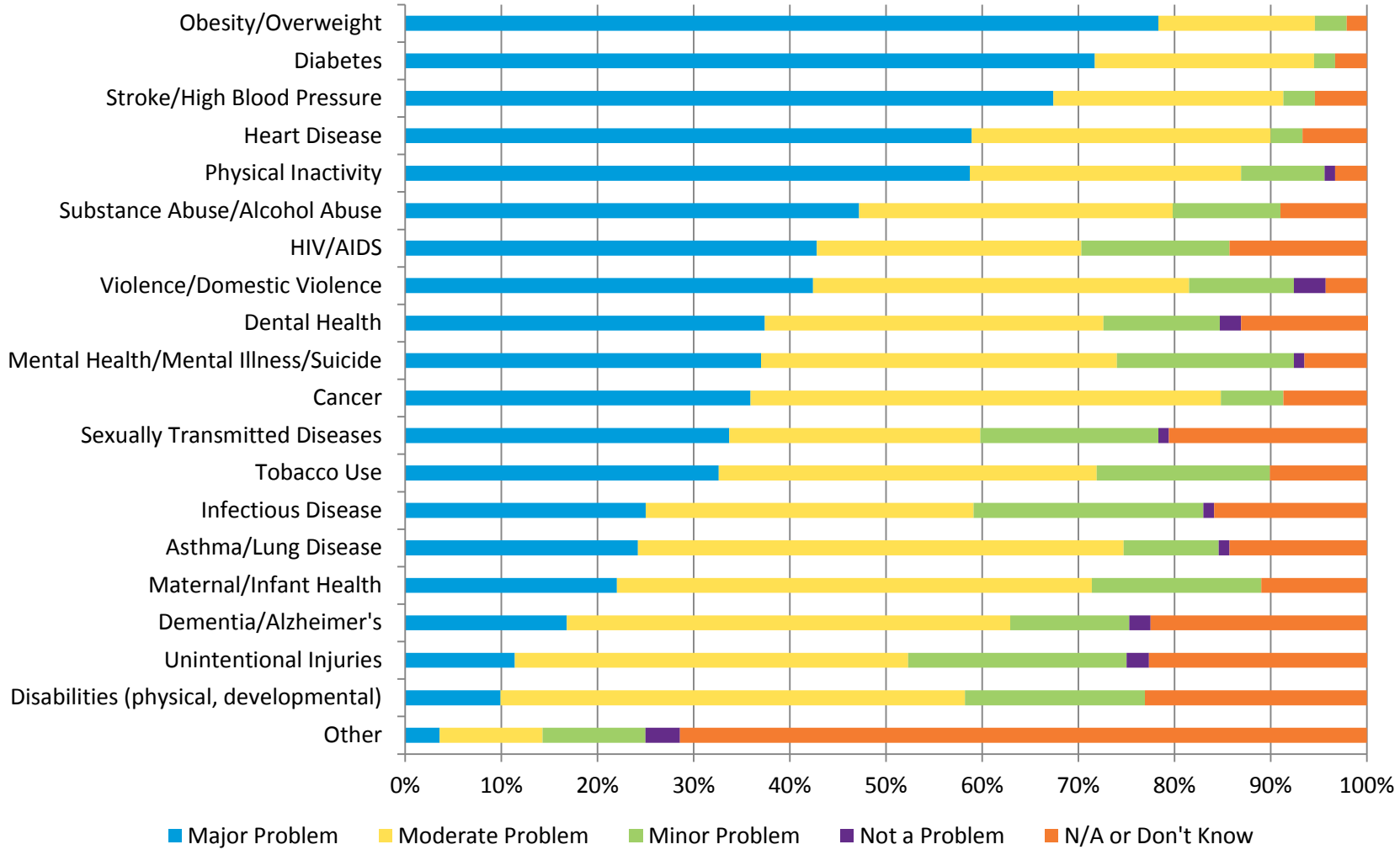
- □ ***hat is wor□ing well***□Participants noted improvement in collaboration and partnerships among healthcare providers, hospitals, health department, and community-based organizations. Programs focused on specific communities and community outreach and education were also viewed positively. Some participants noted that what is working well is often limited by available funding and resources.

Results

uestion 1: How would you rate the overall health of Prince George s County (N 87 responses)

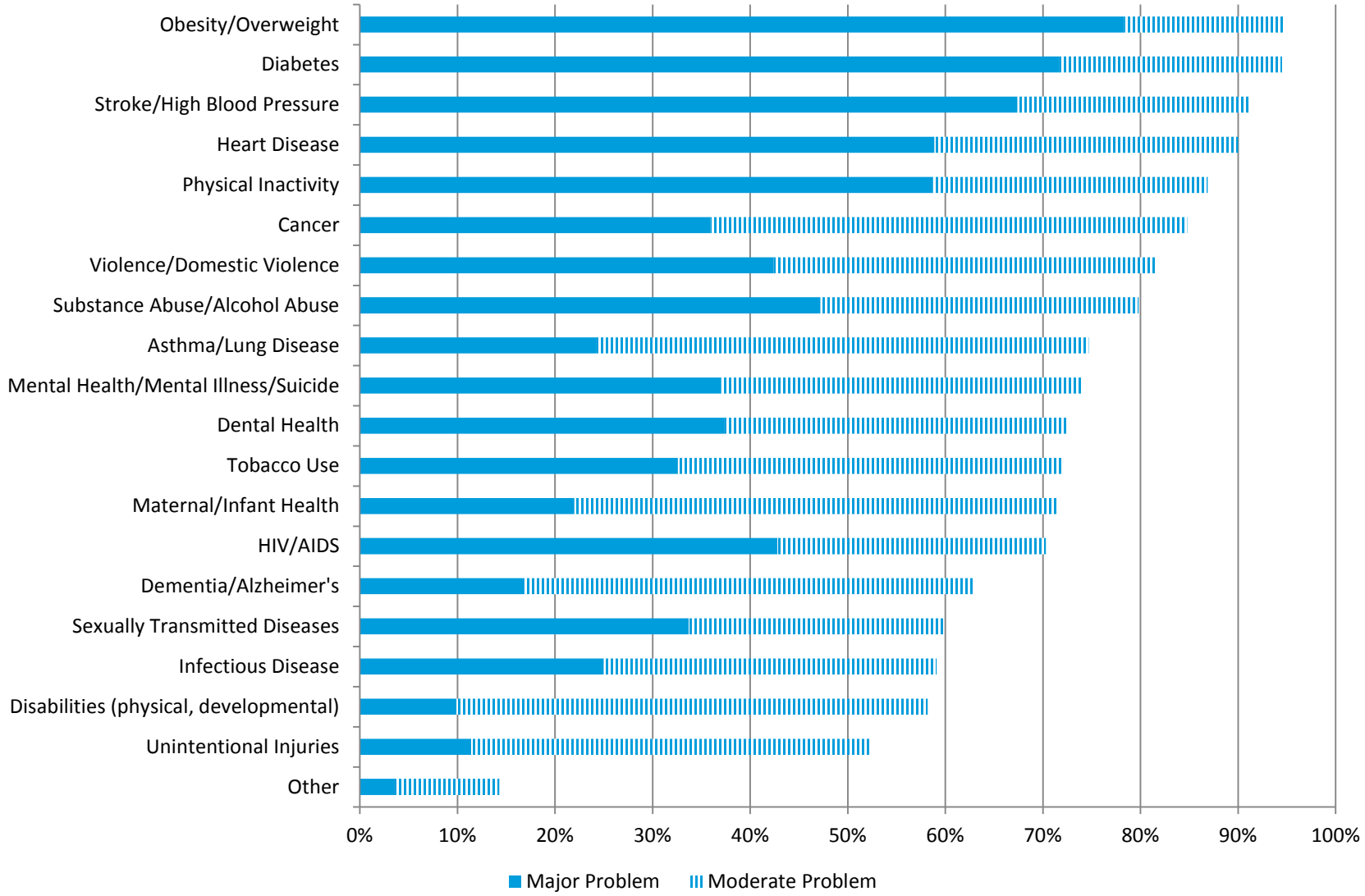


uestion 2: Please rate the following health issues for Prince George s County. (N 92 responses)



"Other" Included: lead poisoning; kidney disease; health education disparity; hunger/lack of healthy food/lack of knowledge about healthy foods; residents with comorbidities; young adults lacking employment; pedestrian injury and death

uestion 2: Please rate the following health issues for Prince George s County. Major and Moderate Responses

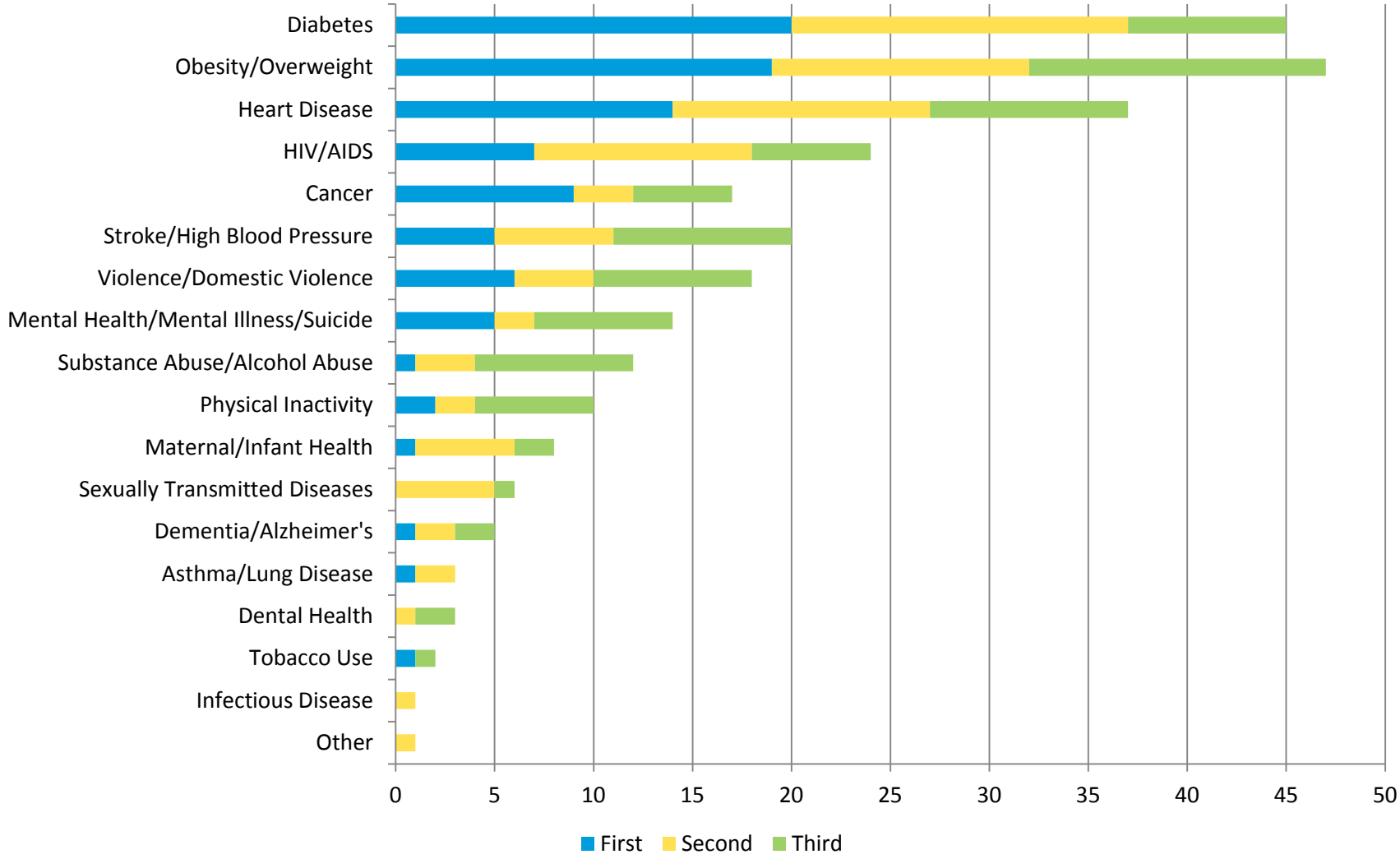


□uestion □: Respondents were asked to share any additional information about health issues in the county in an open-ended response (N□21 responses). The responses are summarized in the table below; many responses included statements about multiple issues.

Issues mentioned	Number of Responses	Summary of Responses
Prevention/Addressing Issues	6	Need for prevention and focus on a variety of issues, including: cancer; breast cancer (mortality); crisis pregnancy & abortion; violence (gun); need more HIV prevention (condoms, needle exchange, PREP) and retention in care; dementia/Alzheimer's; heart disease/stroke; hepatitis treatment
Healthy Lifestyle	5	Need to focus on promoting healthy lifestyles; built environment (walkable/bike trails); encourage physical activity; opportunities for exercise are underutilized; county needs to focus more on prevention overall
Healthy Food/Food Desert/Food Security	5	Communities need more healthy food options available to them; too many fast food restaurants; areas of food insecurity impact ability to eat healthy (mentioned south county)
Health Disparities	3	The lower income population with chronic disease issues do not have the resources to address them and lacks access to care; disparity between different health issues needs to have a tailored response to the affected population; immigrant population is difficult to care for; stigma for those with HIV
Health Insurance/ Affordable Care	3	Concern for population that are un-and under-insured; inability for many to pay
Providers/Clinics	3	Not enough primary care and specialty providers; need for better access to primary care
Social Determinants of Health/Basic Needs	3	Overall lack of public health infrastructure, education, housing, poverty, crime, disengagement of residents, lack of resources and political will have to be addressed to improve health
Health Education and Campaigns	2	Focus on developing good habits at an early age; hospitals need to be involved in providing education
Hospitals/Acute Care	2	Hospitals need to help address local issues, and need to have services throughout the county within the communities; need for more and better quality healthcare facilities

"Other" Included: multiple tobacco stores opening recently in south county; need for improve the quality and number of mental health programs/providers

**uestion **: From the list for uestion 2, please select the three overall most important health issues in Prince George s County. (Shown in order of ranked score) (N 92 responses)



uestion : Please rate the following statements about health care access in Prince George s County. (N 86 responses)

	Disagree	Somewhat Disagree	Somewhat Agree	Agree
Most residents in are able to access a primary care provider. (N=84)	14 (16.7%)	20 (23.8%)	37 (44.0%)	13 (15.5%)
Most residents are able to access a medical specialist. (N=82)	21 (25.6%)	23 (28.0%)	27 (32.9%)	11 (13.4%)
Most residents can access a mental health provider. (N=84)	32 (38.1%)	31 (36.9%)	17 (20.2%)	4 (4.8%)
Most residents are able to access a dentist. (N=79)	25 (31.6%)	20 (25.3%)	24 (30.4%)	10 (12.7%)
Transportation for medical appointments is available to the majority of residents. (N=81)	13 (16.0%)	38 (46.9%)	22 (27.2%)	8 (9.9%)
There are a sufficient number of providers accepting Medicaid or other forms of medical assistance. (N=68)	19 (27.9%)	31 (45.6%)	12 (17.6%)	6 (8.8%)
There are a sufficient number of bilingual providers. (N=72)	30 (41.7%)	24 (33.3%)	12 (16.7%)	6 (8.3%)

uestion : Please rate the following statements about health care access in Prince George s County

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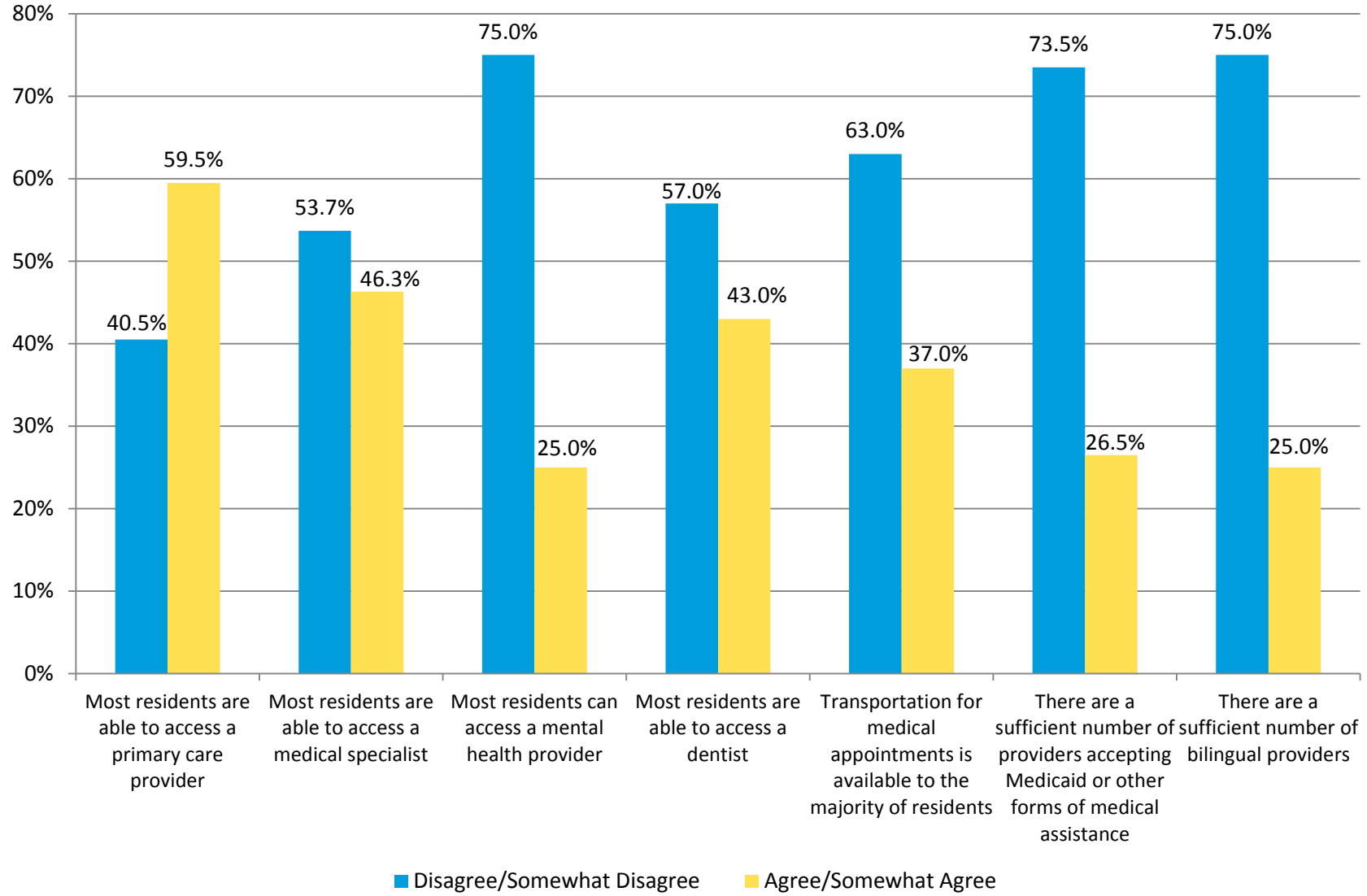
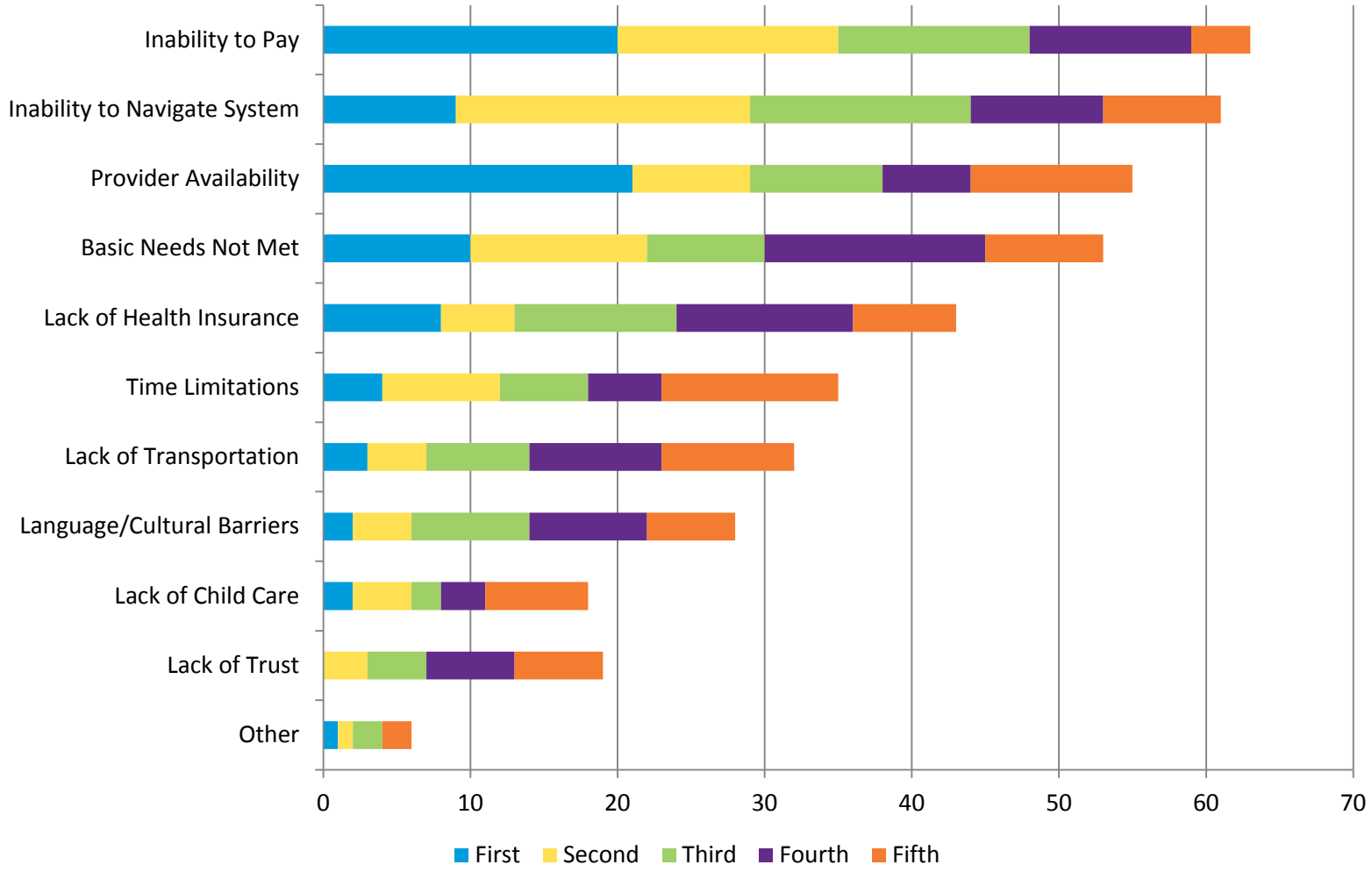


**uestion : Please rank the top five most significant barriers that keep people in Prince George s County from accessing health care. (Shown in order of ranked score) (N 86 responses)



"Other" Included: lack of investment in own health; lack of quality providers; fear by undocumented residents, social determinants of health; pattern of using hospital emergency department for regular care

uestion : Respondents were asked to name two key resources that are needed to improve access to health care for County residents in an open-ended response (N 85 responses). The responses are grouped and summarized in the table below; some responses included statements about multiple issues.

Key Resources	Number of Responses	Summary of Responses
Health navigation, education, and information	28 (32.9%)	Need for: culturally sensitive help in navigating the health care system; health literacy education for consumers; help with using Medicaid and Medicare; community-level engagement
Transportation	18 (21.2%)	Need for: both more and more reliable transportation options; more timely transportation options for handicap population; more options for south county; increased call-a-bus services
Affordable Healthcare	16 (18.8%)	Need for: assistance with co-pays; services that people (even with health insurance) can afford
More Primary Care Providers	14 (16.5%)	Need for: providers who are culturally competent; providers who are physically located in the community; providers who accept Medicaid/Medicare
More Medical Specialists	13 (15.3%)	Need for: providers who accept Medicaid/Medicare; providers who are culturally competent; providers who are physically located in the community; providers who are academically-affiliated; providers specializing in HIV
Health Insurance	11 (12.9%)	Need to: locate and enroll those eligible for insurance; have coverage for those who do not quality for Obamacare (like Montgomery Cares)
Improved Healthcare Quality	10 (11.8%)	Need for: providers who are diverse, culturally competent, and trained in mental health issues; better quality labor and delivery services; better quality inpatient services
More Behavioral Health Providers	7 (8.2%)	Need for: providers who are culturally competent; providers and support services for behavioral health issues
Location of Medical Providers	6 (7.0%)	Need for: health care centers and services to be located in communities throughout the county; ensure clinic-oriented offices are available for physicians
Better Integration of Services	6 (7.0%)	Need for: culturally competent services; integrated prevention services; need for more one-stop-shops
Basic Needs (Housing, Food, Employment)	5 (5.9%)	Need for: more supportive housing
Dental Care Coverage	4 (4.7%)	Need for: dental coverage for Medicaid; Dental care that covers prevention, extractions, and dentures
More and improved support for FQHCs and community centers	3 (35%)	Need for: better support/funding for existing FQHCs and community healthcare centers; increase in the number of FQHC and community healthcare centers in the county
More provider hours	3 (3.5%)	Need for: weekend and evening appointments

Additional Resources mentioned by one respondent: nursing aides, emergency department services, resources for domestic violence, telemedicine, county policies more supportive of health care coverage

uestion : Respondents were asked to share any additional information about barriers to health care in the county and their selection for uestion 7 in an open-ended response (N25 responses). The responses are summarized in the table below; some responses included statements about multiple barriers.

Barriers	Number of Responses	Summary of Responses
Lack of services tailored to different populations	5	Latinos are second largest group in county but there is a lack bilingual staff; there are difference in access to care by region and ethnicity; services are not tailored to the populations with the most need
Affordable Healthcare	4	Inadequate supply of affordable healthcare and insurance
Service Coordination	4	Lack of coordination to get residents connected with behavioral health services; need for more social/health service coordination; need for consistency across services; more challenging for non-English speaking residents
Providers	4	Lack of quality providers; lack of specialists accepting Medicaid; need to attract health care professionals to the county
Transportation	3	Need for more transportation options; need transportation for seniors;
Housing/Social Determinants	3	Lack of stable housing for low income; lack of transitional housing; lack of resources to improve the social determinants of health

Additional Barriers mentioned by one respondent: lack of resident motivation; lack of knowledge about health priorities in the county by providers/organizations; lack of routine health care access; lack of public health approach to addressing violence; residents with chronic health issues lack education and understanding of their issues

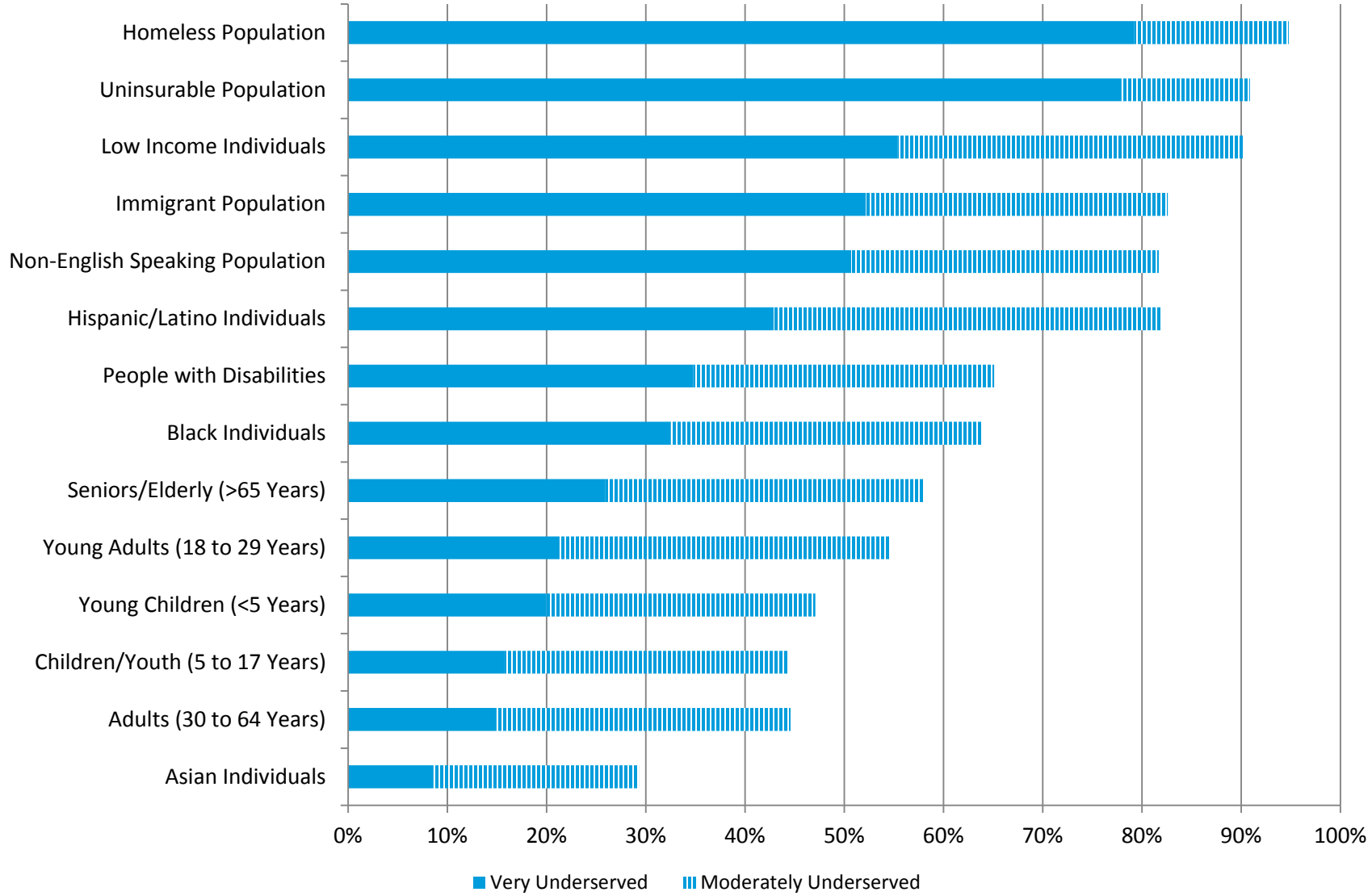
uestion : Please indicate if you believe the following populations are underserved for health-related services and issues in Prince George s County. (N listed for each population)

	Very Underserved	Moderately Underserved	Somewhat Underserved	Not Underserved
Homeless Population (N=77)	61 (79.2%)	12 (15.6%)	3 (3.9%)	1 (1.3%)
Uninsurable Population (N=77)	60 (77.9%)	10 (13.0%)	5 (6.5%)	2 (2.6%)
Low Income Individuals (N=83)	46 (55.4%)	29 (34.9%)	5 (6.0%)	3 (3.6)
Immigrant Population (N=69)	36 (52.2%)	21 (30.4%)	10 (14.5%)	2 (2.9%)
Non-English Speaking Population (N=71)	36 (50.7%)	22 (31.0%)	10 (14.1%)	3 (4.2%)

Hispanic/Latino Individuals (N=77)	33 (42.9%)	30 (39.0%)	10 (13.0%)	4 (5.2%)
People with Disabilities (N=66)	23 (34.8%)	20 (30.3%)	16 (24.2%)	7 (10.6%)
Black Individuals (N=80)	26 (32.5%)	25 (31.3%)	25 (31.3%)	4 (5.0%)
Seniors/Elderly (>65 years) (N=81)	21 (25.9%)	26 (32.1%)	24 (29.6%)	10 (12.3%)
Young Adults (18 to 29 years) (N=75)	16 (21.3%)	25 (33.3%)	27 (36.0%)	7 (9.3%)
Young Children (Under 5 years) (N=70)	14 (20.0%)	19 (27.1%)	24 (34.3%)	13 (18.6%)
Children/Youth (5 to 17 years) (N=70)	11 (15.7%)	20 (28.6%)	28 (40.0%)	11 (15.7%)
Adults (30 to 64 years) (N=74)	11 (14.9%)	22 (29.7%)	36 (48.6%)	5 (6.8%)
Asian Individuals (N=58)	5 (8.6%)	12 (20.7%)	24 (41.4%)	17 (29.3%)
Other (N=3)	0	2	0	1

"Other" Included: young children who are part of the immigrant population are very underserved; veterans; the population that lacks health education

uestion : Please indicate if you believe the following populations are underserved for health-related services and issues in Prince George's County. ery and Moderately Underserved Responses only.



uestion 10: Respondents were asked what the primary barriers are for the populations listed in uestion 9 in an open-ended response (N 80 responses). The responses are grouped and summarized in the table below; many responses included statements about multiple issues.

Primary Barriers	Number of Responses	Summary of Responses
Lack of Financial and Basic Resources	36 (45.0%)	For those with insurance, co-pays are too high; For those without insurance, health care is unaffordable; overall basic needs take priority over paying for medical care; lack of computer access
Access to Providers/Healthcare	30 (37.5%)	Providers need to be located within the community and have extended hours, need to provide quality care, and need to be culturally competent; need for more providers overall; need for more providers (including specialists) who see low income patients; need health care that is timely; long wait times on phone or in offices is not feasible due to jobs, limits to time on pre-paid cell phones
Cultural/Language Barriers	21 (26.3%)	Immigrant population are not treated with respect; lack of culturally competent healthcare; lack of diversity in languages spoken
Knowledge About Health and Services	20 (25.0%)	Lack of knowledge about available services increases use of emergency services; education needed about health and screenings
Navigation of Services/ Care Coordination	19 (23.8%)	Vulnerable populations need help connecting to available services; population released from jail/prison; need for healthcare advocates
Transportation	17 (21.3%)	Need for more transportation options
Lack of Insurance	15 (18.8%)	Uninsurable population will continue to have unmet health needs; Insurance is still not affordable for those who do qualify
Community Resources and Outreach	5 (6.25%)	Need for more public-private partnership; need for referral resources; lack of culturally competent community interventions; outreach and focus is not on more vulnerable populations; too much focus on African American population
Lack of Trust	4 (5%)	Fear and trust are a barrier to care
Inadequate Government Funding	2 (2.5%)	Need to serve more non-reimbursable residents

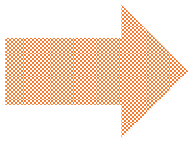
Additional Barriers mentioned by one respondent: immigration status, lack of access to medication

uestion 11: Respondents were asked is being done well in Prince George s County in terms of health and well-being and by whom in an open-ended response (n 77 responses). The responses are grouped and summarized in the table below; many responses included statements about multiple health and wellness activities and contributing organizations.

What is being done well	Number of Responses	Summary of Responses
Collaboration/Partnerships	17 (22.1%)	Seeing more collaboration between health department, healthcare providers, hospitals, and community groups; better care coordination; need to align priorities and strategies and for more sharing of resources for collaborative efforts.
Community-Based Services/Programs	13 (16.9%)	Community-focused programs that provided services within the community were cited as working well, including: mobile units, services being provided at community events, focus on specific communities (Health Enterprise Zone in 20743), programs at nontraditional locations (such as Langley Park MSC, the Salvation Army).
Community Outreach/Education	12 (15.6%)	Increased visibility through community outreach and education efforts; getting information to the public through the media;
Nothing	3 (3.9%)	Respondents did not believe anything is being done well or has improved in the county.

What organizations are doing well for health	Number of Responses	Summary of Responses
Health Department	26 (33.8%)	Planning and bringing community groups and hospitals together for collaboration (Health Action Coalition, care coordination); community-focused programs and strategies; outreach.
Community-based Organizations	16 (20.8%)	Coordination of efforts; outreach; addressing social determinants of health; providing a safety net; taking services to the residents.
Hospitals	15 (19.5%)	Hospitals have increased their efforts, are doing more community programs (outreach, cancer screenings for women, diabetes); new planned hospital; working to get patients into primary care through partnerships.
Clinics/Providers Hospitals	9 (11.7%)	Overall there is better access to care and more providers available; quality of care is improvement; shift to patient centered medical homes; health care at FQHCs and community clinics are viewed as necessary services.
Other	8 (10.4%)	Department of Social Services was noted for health insurance enrollment activities; MNCPP was noted as an active partner for improving county health; efforts by overall County government to improve health and access to care; providing immunizations at schools.

Sixteen responses also included information about needed improvements. The most frequently mentioned was the need for more funding and resources, which was often cited as limiting what could be done well in the county. Also included were: need for better use of funds by the county (decisions driven by politics and "legacy building"); need for more and better funded Community-based organizations; better funding for FQHCs that could also help improve quality of care; addressing policies and laws that negatively affect public health and service provision; residents not knowing about available services, need for better coordination of priorities and of services and resources; wanting more visibility and effort from the health department, community-based organizations, providers, and hospitals, better oversight of funding meant to increase access of affordable care (end result is not always affordable).



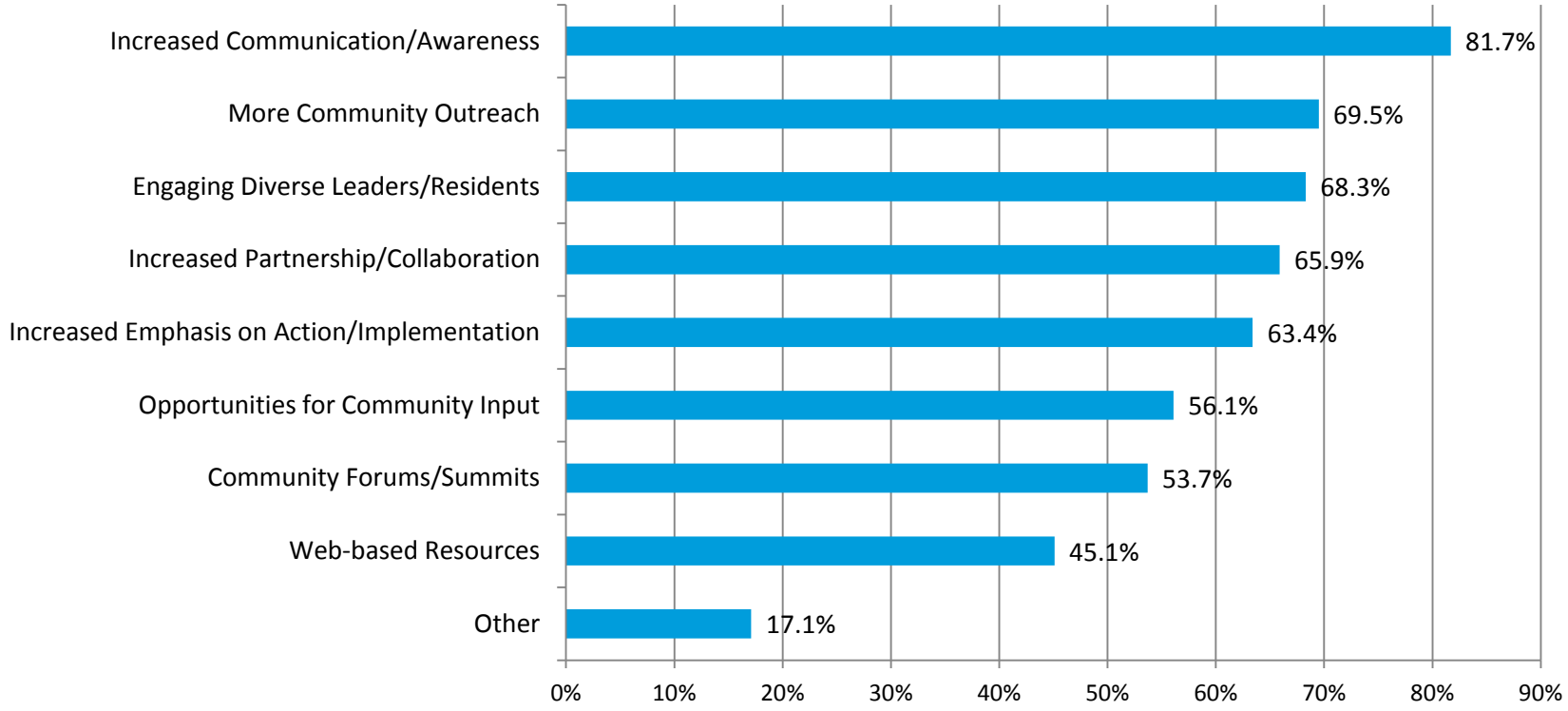
Question 12: Respondents were asked what recommendations or suggestions they have to improve health and quality of life in Prince George's County in an open-ended response (N=78 responses). The responses are grouped and summarized in the table below; many responses included multiple recommendations.

Recommendations	Number of Responses	Summary of Responses
Health Education and Outreach	31 (39.7%)	Tailor campaigns to diverse populations through the county; use a variety of media platforms; focus efforts on vulnerable and low income populations; provide information in a variety of languages
Increase and Improve Access to Providers & Clinics	19 (24.4%)	Improve provider/clinic proximity and hours; ensure providers/clinics are located throughout the county; increase specialists; more school-based healthcare; more specialty clinics (including one for seniors)
Affordable Healthcare	9 (11.5%)	Need assistance with co-pays; need options for uninsurable
Partnerships	9 (11.53%)	Hospitals, Community-based organizations (CBO), Health Department need to work together and share resources; need more care coordination among providers and services; continue to use the Health Action Coalition to address issues; County agencies need to work to strengthen and partner with CBOs
Increase Health Funding	8 (10.3%)	Need funding for resources; invest in citizens' health; better fund community-based organizations
Basic Needs	8 (10.3%)	Focus on job creation and education; ensure residents have basic needs met such as food and housing; focus on social determinants of health; access to healthy foods
Prevention and Screening	7 (9.0%)	Focus on HIV testing and prevention; work with adolescents (vaccination, work through schools for prevention); encourage exercise; work with employers to improve health of their workers

Recommendations	Number of Responses	Summary of Responses
Hospital Improvement	7 (9.0%)	Need to ensure hospitals are accessible throughout the county; existing hospitals need improved facilities and services to attract residents and physicians; affiliation with academic institutes is a positive; funding needs to be provided for new/improved facilities
Community Engagement	7 (9.0%)	Better engagement of diverse communities and vulnerable populations; better engagement beyond current areas of focus (TNI); work more with community leaders
Support CBOs	6 (7.7%)	Increase and expand CBOs in the county; train and utilize existing CBOs; more funds for CBOs that is not managed through County agencies
Quality Services and Providers	5 (7.7%)	Attract high quality providers; improve service quality; improve mental health services; provide better customer service
Transportation	4 (5.1%)	Increase transportation options; ensure transportation is available on weekends
Policy Changes	3 (3.8%)	Works towards policies for: nutrition labels in restaurants, less fast food restaurants and more access to healthy food, no smoking in public areas, require HPV vaccination, incentives to support quality providers and programs
Behavioral Health Providers	3 (3.8%)	Mental health services and substance use treatment need to be accessible; need more behavioral health services in the county
Community Health Workers (CHW)	2 (2.6%)	Increase CHWs in the communities; focus CHW efforts on residents with high hospital utilization
Data	2 (2.6%)	Collect and use data to inform program and interventions

Additional Key Resources mentioned by one respondent: better built environment; dental care; streamline enrollment process for programs/services (less paperwork); better government management of resources;

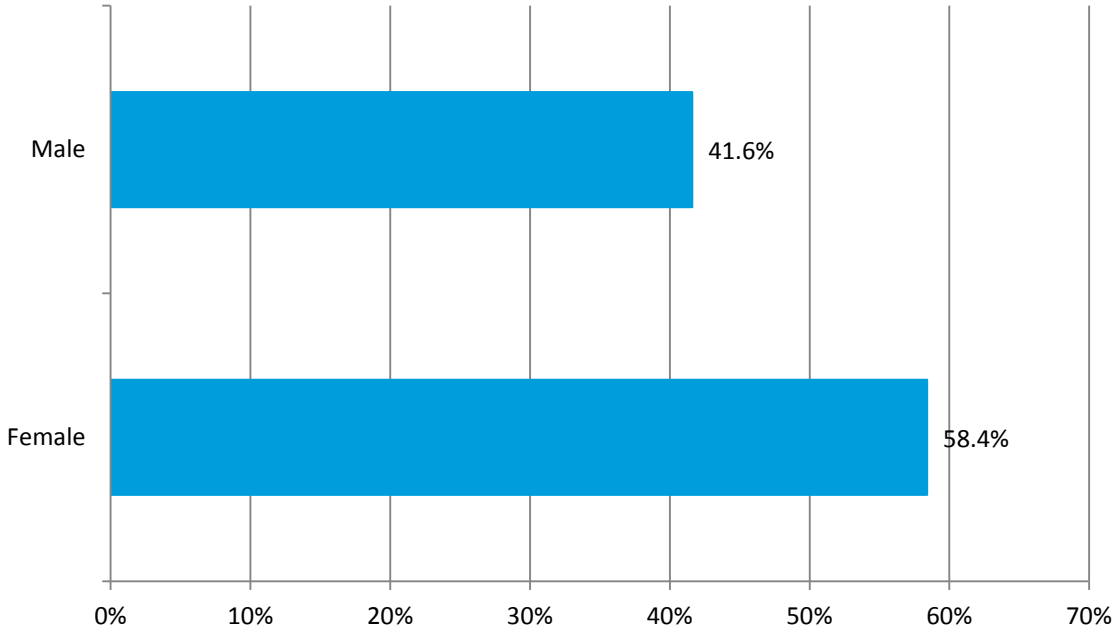
uestion 1 : What do you think could encourage and support more community involvement around health issues in Prince George s County (select all that apply) (N 82 responses)



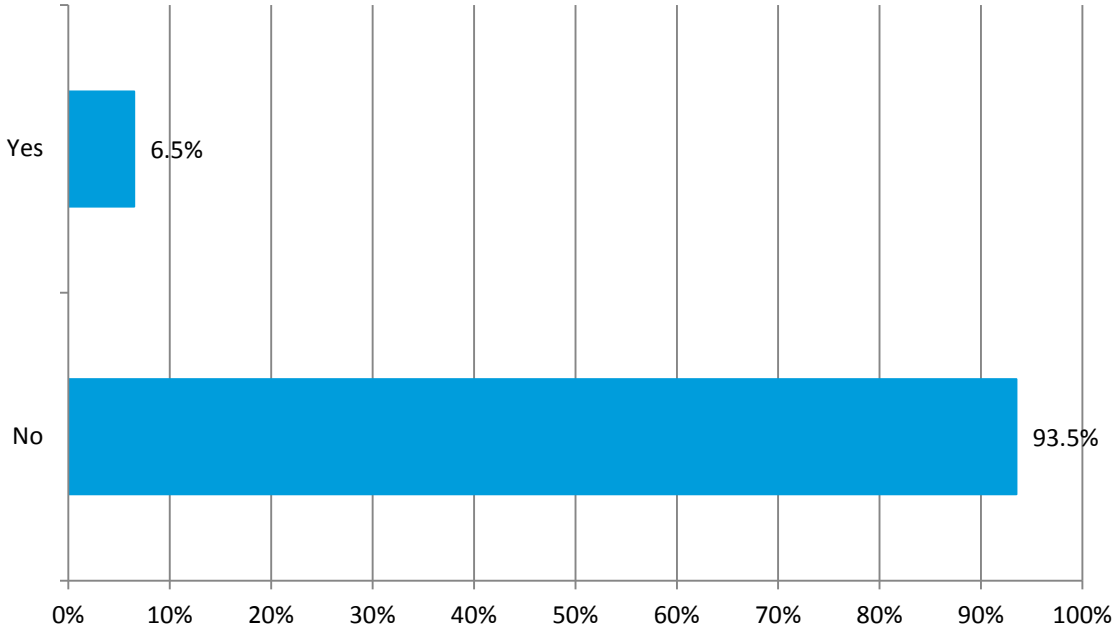
"Other" Included: More involvement of churches and school system; Use of media campaigns in coordination with community and faith-based organizations; incentives to attract mental health and medical specialists to the county; more engagement from providers regarding copayments; county policy around healthcare for contractors; better leadership; more community engagement and more effective outreach; provision of information about available services

Participant Profile

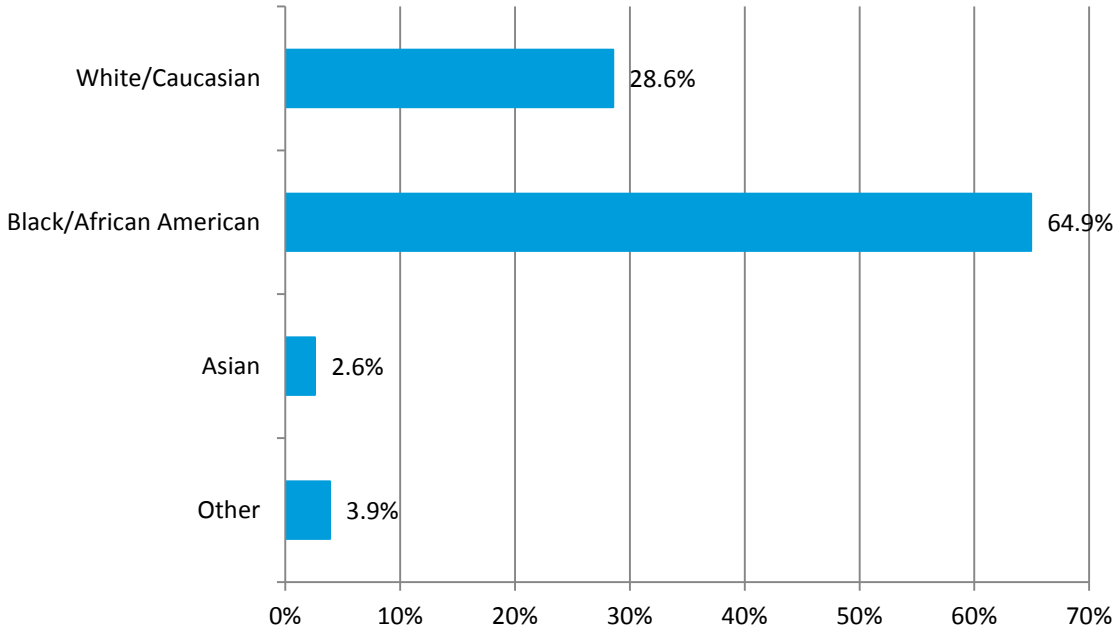
Question 1: What is your gender (N=77 responses)



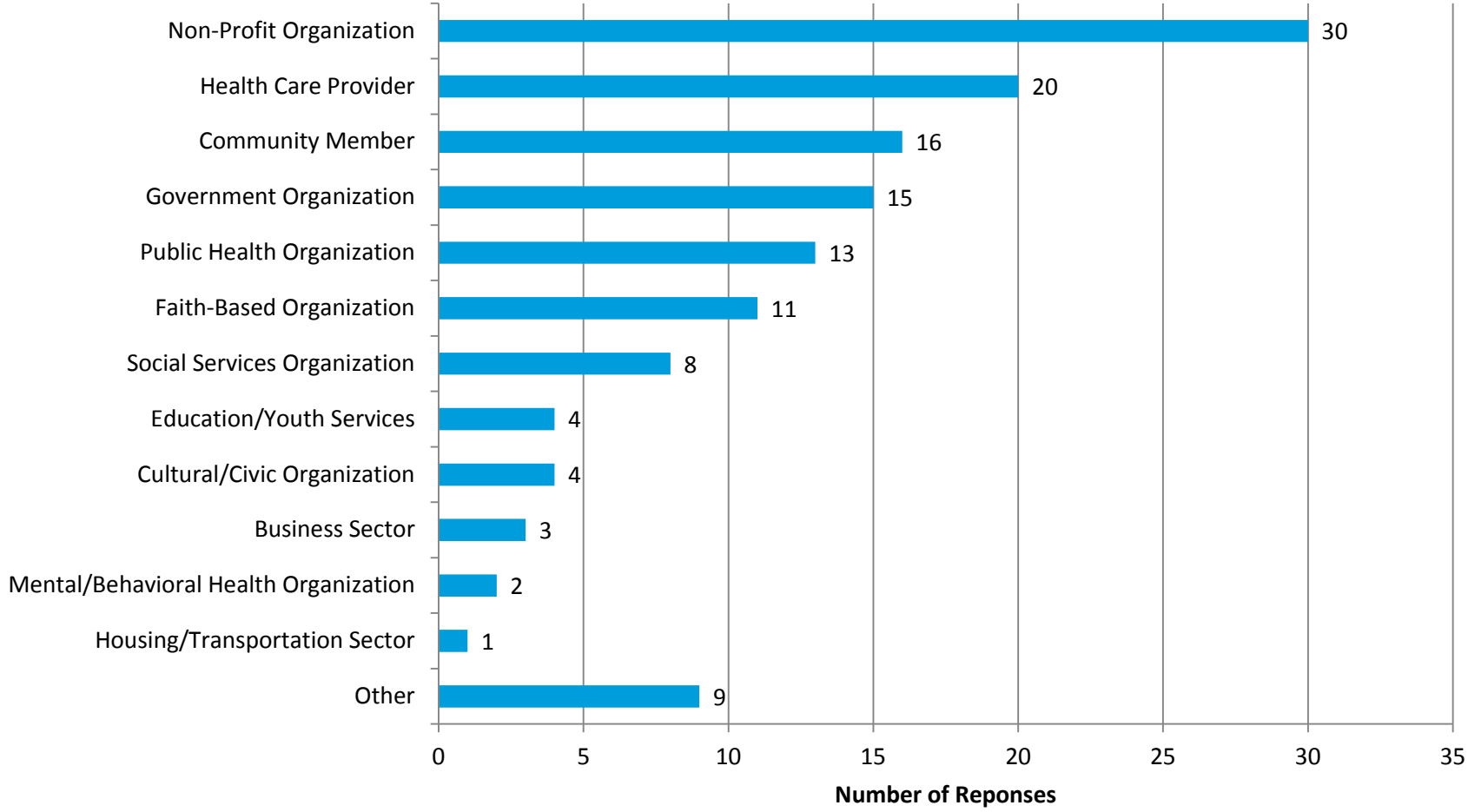
Question 1: Are you Hispanic or Latino (N=77 responses)



uestion 1 : Which one of these groups would you say best represents your race (N 77 responses)

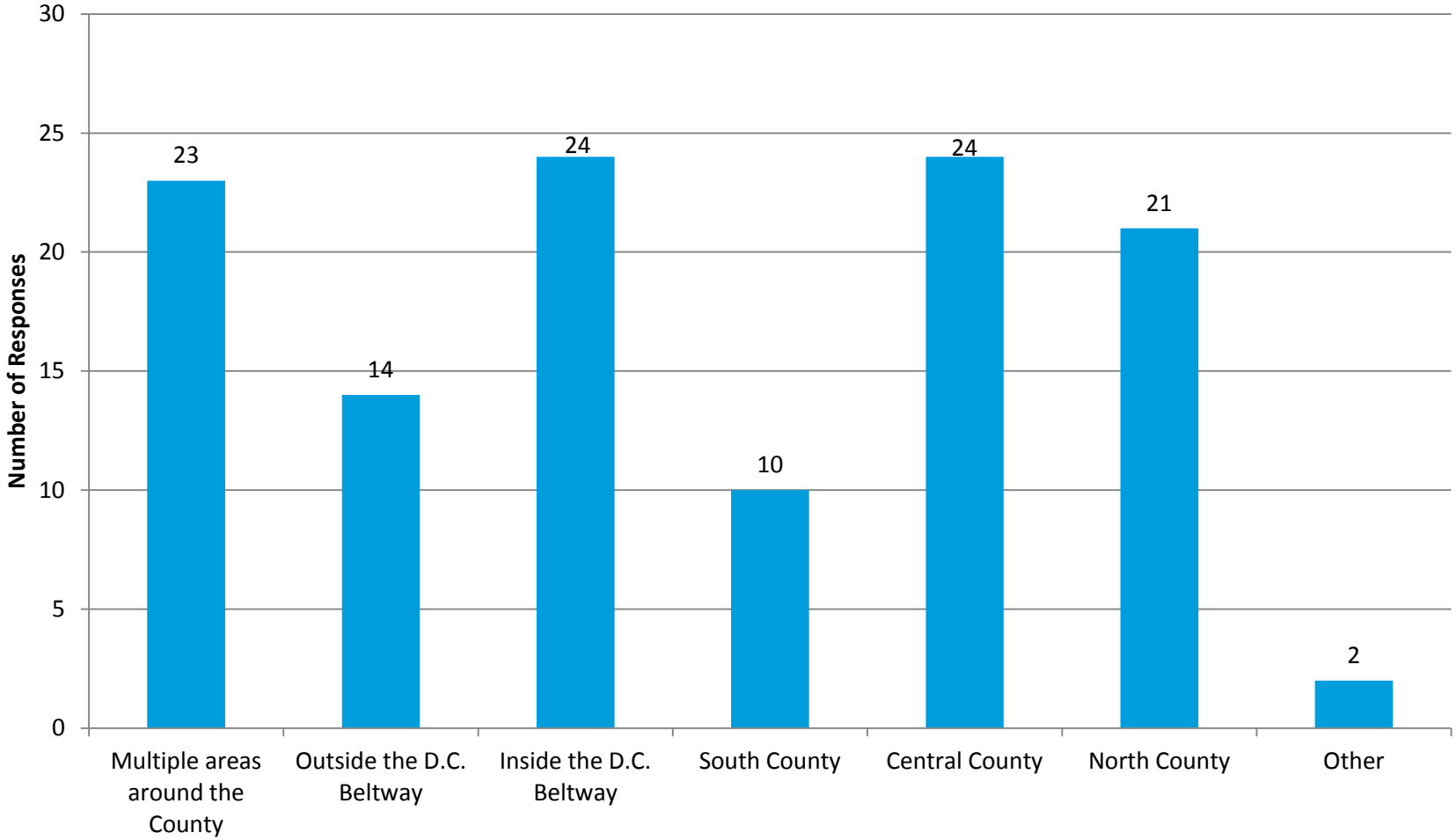


uestion 1 : Which of these categories would you say best represents your community affiliation Participants were asked to select all that apply. (N 77 responses)



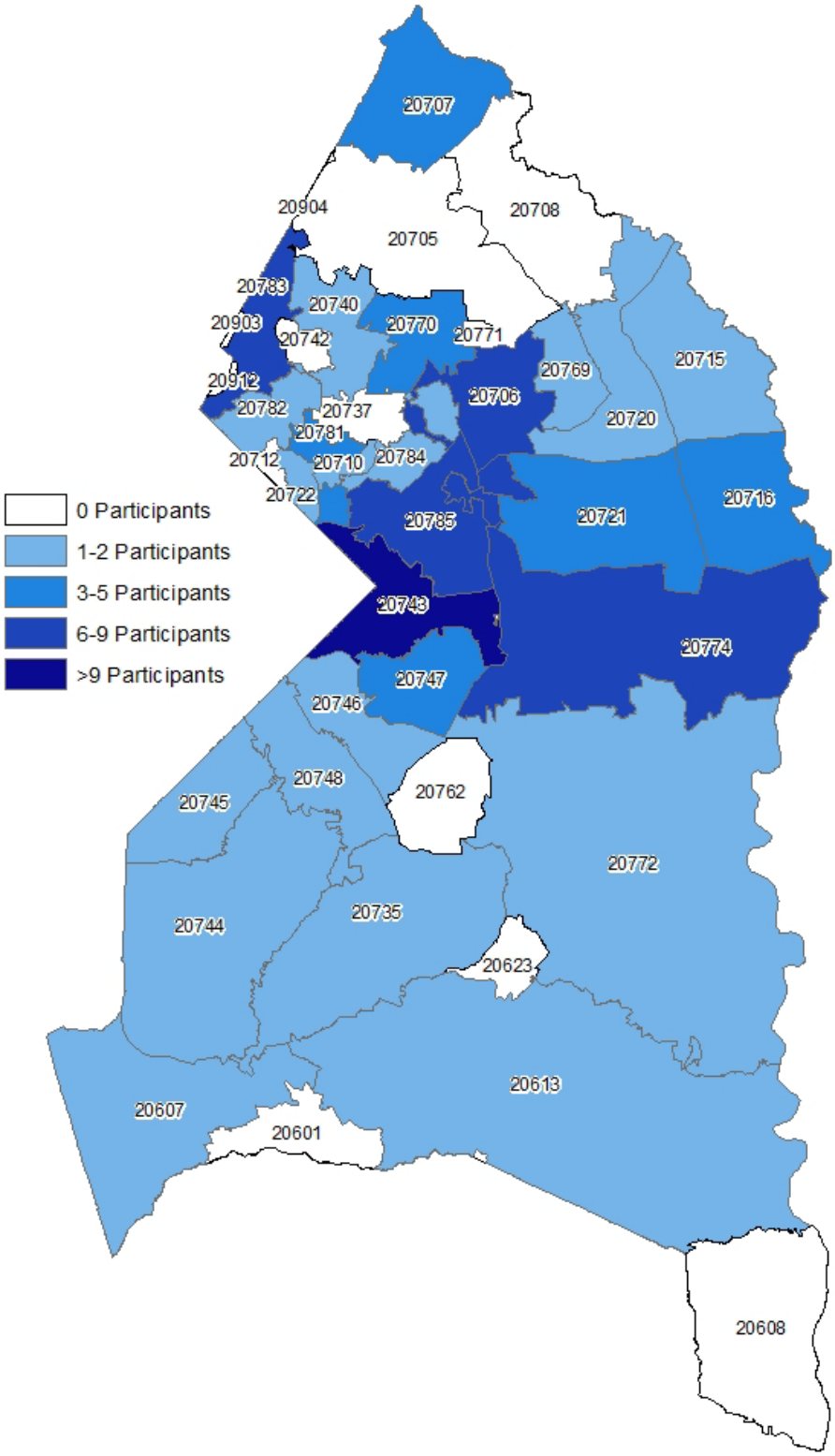
"Other" Included: FQHC; public housing; law enforcement; trade union; grant-funded program; resident of the county in addition to their position; mental health provider; academic; non-profit working with health care providers

uestion 1 : In what geographic part of Prince George s County are you most knowledgeable about the population Participants were asked to select all that apply. (N 77 responses)

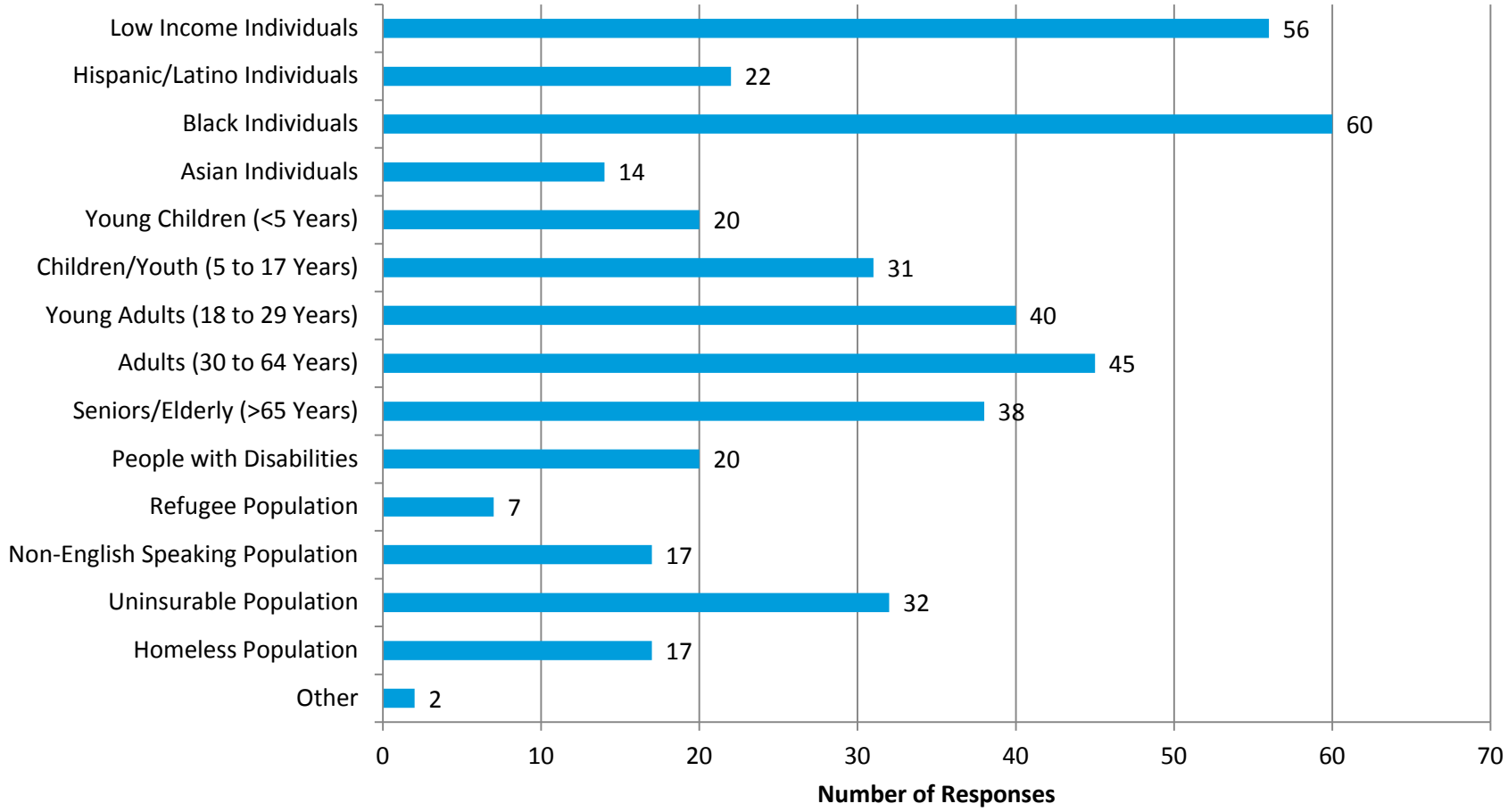


"Other" included: public housing throughout the county; county areas with a high Latino population

uestion 20: What one IP Code in the county are you most knowledgeable about for the population (N74 responses). Eight respondents listed multiple IP codes instead.



uestion 21: Please select the types of populations you can represent in Prince George s County through either professional or volunteer roles. Participants were asked to select all that apply. (N 77 responses)



"Other" included: women; victims of domestic violence, undocumented families, and people with mental health and substance abuse issues

uestion 22: Respondents were asked what are the most pressing needs of the population they serve based on their experience (N 73 responses). The responses are grouped and summarized in the table below; many responses included multiple needs.

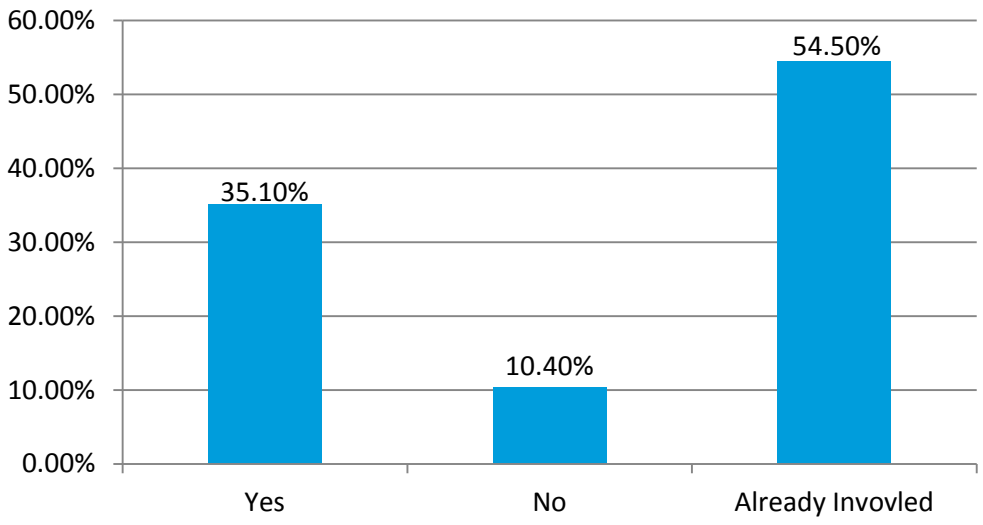
Needs for Service Population	Number of Responses	Summary of Responses
Access to Healthcare	36 (49.0%)	Improve provider/clinic proximity and hours; ensure providers and clinics are located throughout the county; increase specialists; better quality, more affordable, and more timely healthcare; culturally competent (mention of immigrants and LGTB)
Health Education and Outreach	22 (30.1%)	Tailor campaigns to diverse populations through the county (mentioned young black men, elderly, HIV, chronic diseases); promote knowledge about health and about available services; education about nutrition and healthy food; promote exercise
Basic Needs	19 (26.0%)	Focus on job creation and training; housing and transitional housing; ensure residents have basic needs met; financial assistance for basic needs; food security and access to healthy food
Insurance/Co-pay Assistance	12 (16.4%)	Need assistance with co-pays; need options for uninsurable
Navigation/Coordination	11 (15.1%)	Need help navigating healthcare system; help navigating public services; help understanding health insurance and care options
Transportation	7 (9.6%)	Increase transportation options; transportation for disabled and elderly
Behavioral Health Services	5 (6.8%)	Better access to mental health services and substance use treatment; more providers needed
Prevention and Screening	5 (6.8%)	Need more domestic violence prevention efforts; cancer screening; HIV prevention and testing; better overall access to prevention programs/services
General Resources	5 (6.8%)	Need for overall resources
Schools	3 (4.1%)	Need for better (higher quality) public schools
Child Care	2 (2.4%)	Need for child care, especially for single mothers
Language Services	2 (2.4%)	Need for translation services; need for English classes
Medication Assistance	2 (2.4%)	Need help in securing medications

Additional Needs mentioned by one respondent: trust of healthcare system; obesity and related chronic diseases (did not specify what the specific need was); dental care; and senior care.

uestion 22: Respondents were asked to share any additional information about the health of Prince George s County (N 8 responses). The responses are grouped and summarized in the table below; the majority of these responses reiterated information that had already been provided in previous questions.

Additional Information	Number of Responses	Summary of Responses
Collaboration	3	Need for more collaboration among hospitals, physician organizations, government, schools and employers; more collaboration between hospitals and faith-based organizations
Increase in providers/hospitals	2	Need for more providers; need for more hospitals
Better healthcare quality	2	Need for better quality providers; providers receiving public funds need to be held accountable in use of funds, better practice management, and better patient outcomes
Obesity	1	Need to focus on obesity as a cause of many other health issues
Not-for-profits	1	Need a strategy to build capacity of health and social service not-for-profits
Care coordination and information	1	Need for residents to know about and be able to access services
Overall County services	1	Need for better infrastructure ,and better schools
County funding	1	Need for funding to be used for the public instead of politically-motived projects

uestion 2 : Would you be interested in becoming more involved in local health initiatives



COMMUNITY RESIDENT SURVEY

Introduction

Prince George□s County is home to over 900,000 residents and growing, with a wide range of health needs and disparities. The Community Resident Survey was a strategy developed to complement the overall Community Health Assessment (CHA) goal of identifying the health needs and issues for the county□s diverse population by hearing directly from our residents.

□ethodology

The Community Resident Survey was developed based on existing community surveys provided by the CHA core team and examples from successful CHAs with some modifications specific to the county. Efforts were made to ensure the survey questions corresponded with the Community-Based Organization Survey which was also part of CHA data collection efforts. The survey questions included mostly multiple choice and rating scales with a few open-ended responses for demographics and an option for writing in a response if the participant answered with □other□.

The survey was translated into Spanish (the most common language spoken in the county after English), and was made available online and through printed copies. Due to time limitations, the survey was distributed as a convenience sample, with each participating hospital requested to help distribute the survey in their service area; two hospitals (Fort Washington Medical Center and Doctors Community Hospital) collected and entered surveys from their service area. The Health Department made the survey available by website, social media, and through provided services. Survey distribution began on March 14, 2016 and ended on April 8, 2016.

For analysis, each multiple choice and rating scale question is presented as a simple descriptive statistic. Because the surveys were collected as a convenience sample, the results were intended as an additional method of gaining community input in support of the overall process, while acknowledging the lack of an adequate sample size to statistically represent the county. Surveys were excluded if the majority of the survey was incomplete or if the participant did not indicate they were a county resident. The English and Spanish surveys were initially analyzed separately with the intent to combine the responses; however, due to notable differences in responses the survey results are presented separately. Each question includes the number (N) of responses.

Participation

Surveys were completed by 201 participants in English and 115 in Spanish for a total of 316 county residents. Nearly all areas of the county were represented by the participants with the exception of the most southern part of the county (a map of representation is available with

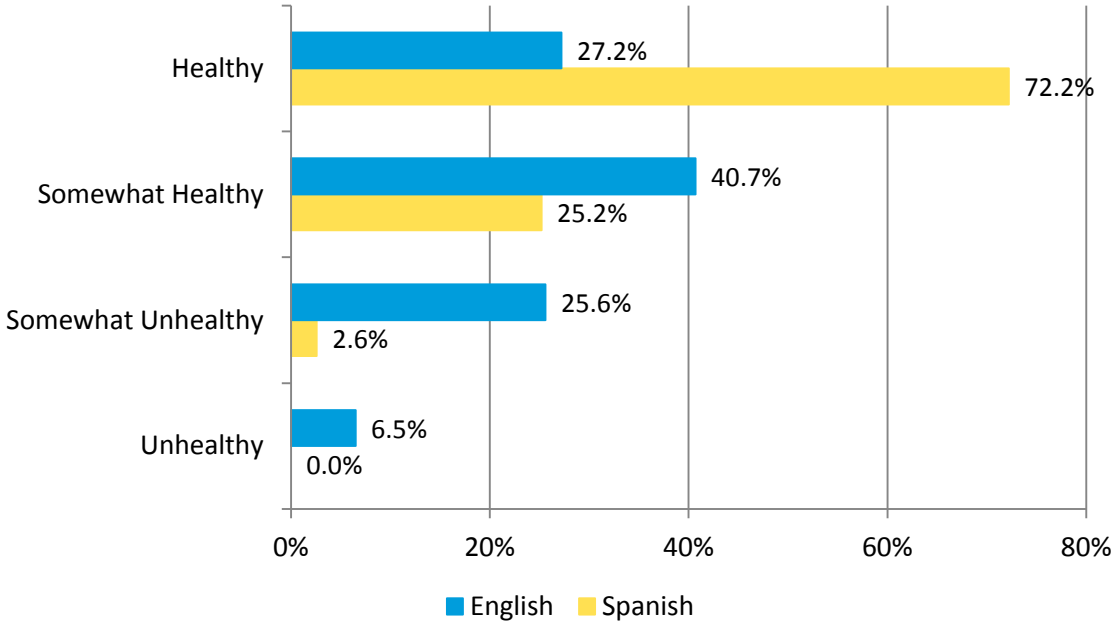
uestion 13). The demographics of those responding to the survey differ from the overall county: only 46% of the participants were born in the U.S. which is lower than the county, while approximately 75% of the participants were women which is higher than the county. Spanish survey participants were mostly between the ages of 25-44 years, while English survey participants were more evenly distributed by age. Participants indicated a wide range of income and education; over half of the English participants indicated they had a college degree or more, compared to 2% of Spanish survey participants. The majority of Spanish survey participants had an annual income of less than $50,000.

ey Findings

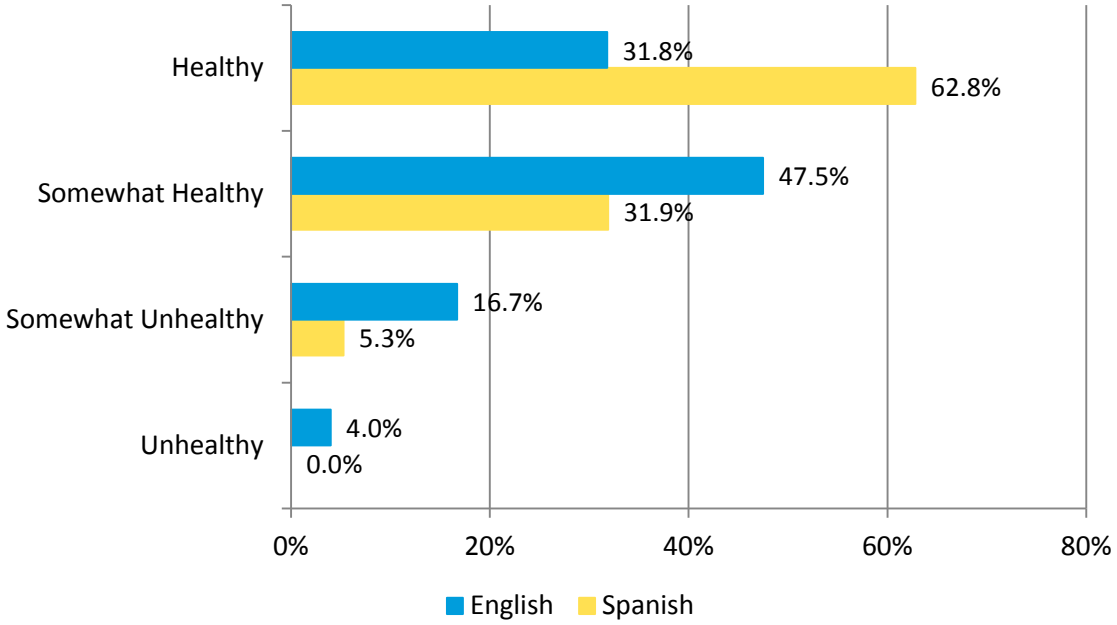
- ***Overall health***: Two-thirds of English survey participants indicated Prince George s County to be healthy or somewhat healthy, as did nearly all Spanish survey participants. Overall most survey participants also indicated their own community to be healthy or somewhat healthy.
- ***Leading health issues***: Chronic disease and related issues including diabetes, obesity/overweight, and heart disease led major health problems for the English survey participants, while HI , diabetes, and cancer led for Spanish survey participants. However, nearly every health issue had over half of the overall participants indicate it was at least a major or moderate problem in the county.
- ***Access to healthcare***: Over 60% of English survey participants agreed or somewhat agreed that residents in their community could access a primary care provider and dentist; while 37% indicated that medication cost was a barrier. For the Spanish survey participants, over 30% of participants disagreed or somewhat disagreed that community members could access a primary care provider and dentist, and over half indicated medication costs was a barrier.
- ***Leading barriers****:* 35% of English survey participants indicated the inability to pay as a major barrier to care in their neighborhood, followed by time limitations (29%) and lack of health insurance (27%). For Spanish survey participants, 66% indicated lack of health insurance was a major barrier to care, followed by inability to pay (44%) and language and cultural barriers (39%).
- ***Health Care*** Most of the English survey participants reported having health insurance (84%), and 80% reported seeing a primary care doctor within the last year. However, most of the Spanish survey participants did not have insurance (94%) and only 16% saw a primary care doctor in the past year. Nearly 20% of English survey participants and 27% of Spanish survey participants reported being unable to access needed medical care in the past year due to 1) lack of health insurance, 2) inability to pay, and 3) wait times to get an appointment that were too long.
- ***Recommendations to improve health*** Overall, participants recommended increased communication and awareness followed by community-level outreach to encourage and support more community involvement around health issues in Prince George s County.
- ***Community eterminants of Health*** For English survey participants, affordable housing was reported as a leading community issue followed by access to good schools and crime. For Spanish survey participants, crime was a leading community issue followed by affordable housing and a good economy.

Results

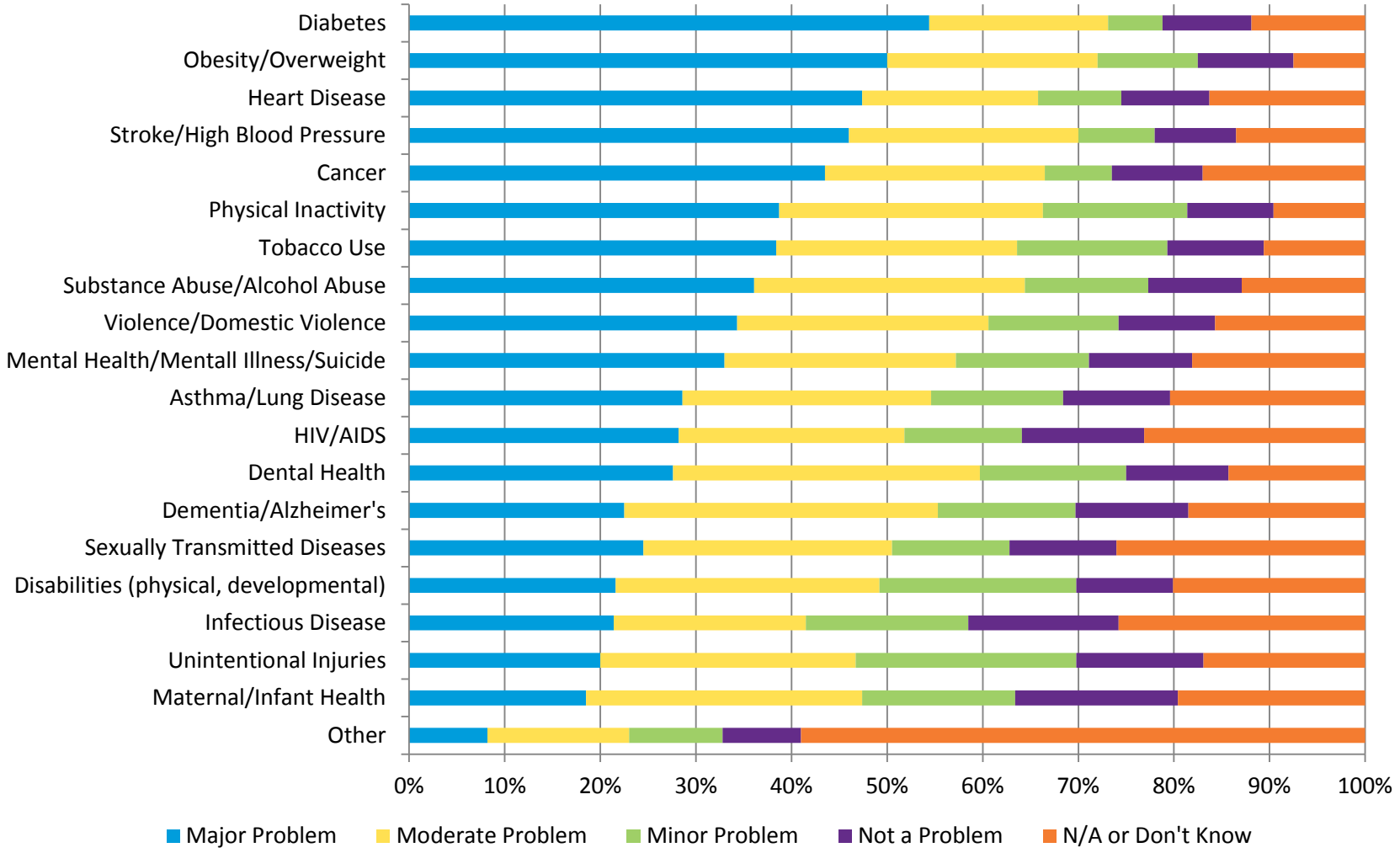
uestion 1: How would you rate the overall health of Prince George's County (N199 English responses; N115 Spanish responses)



uestion 2: How would you rate the overall health of your community (N198 English responses; N113 Spanish responses)

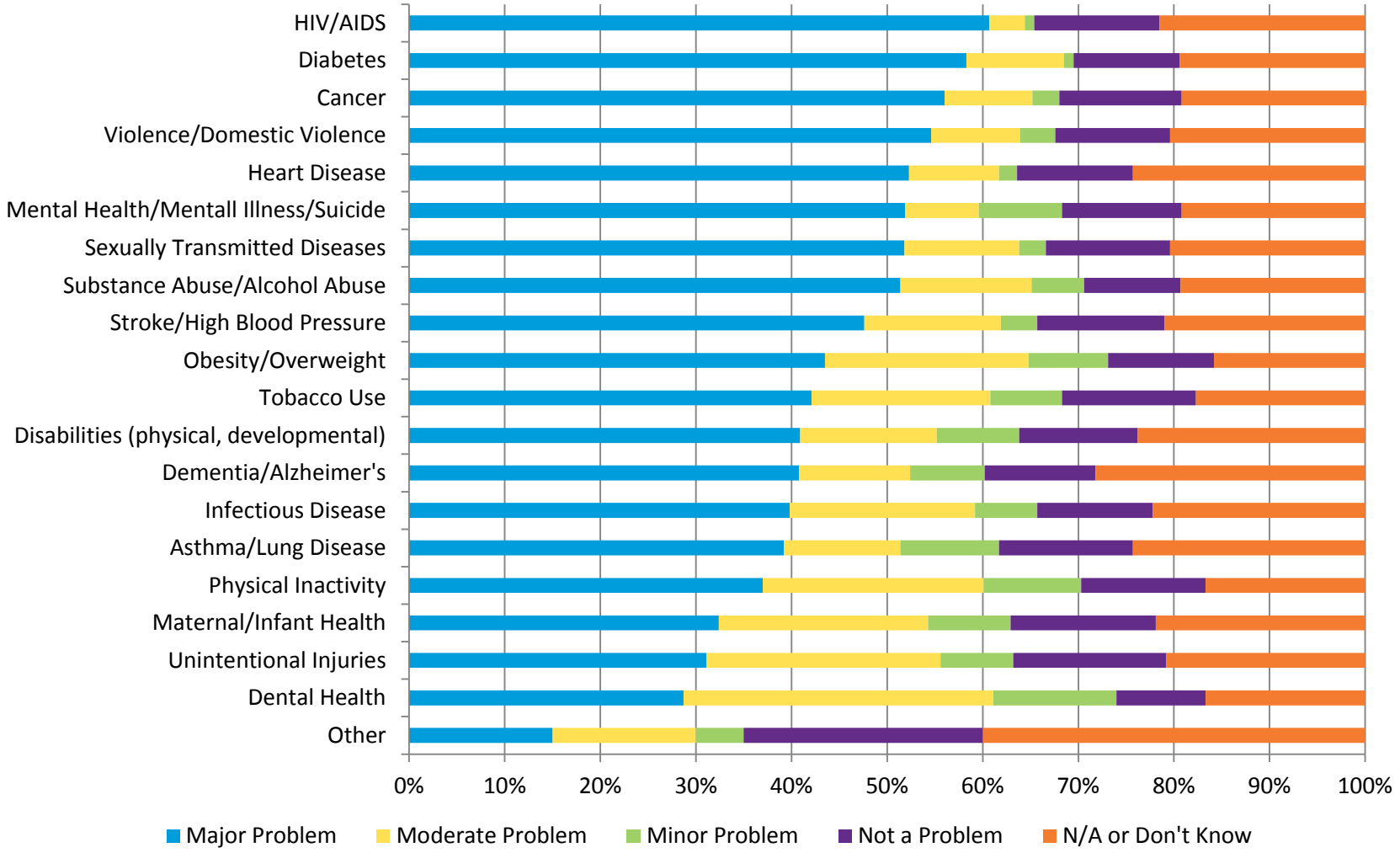


uestion : Please rate the following health issues for your neighborhood or community. (N 200 English responses)



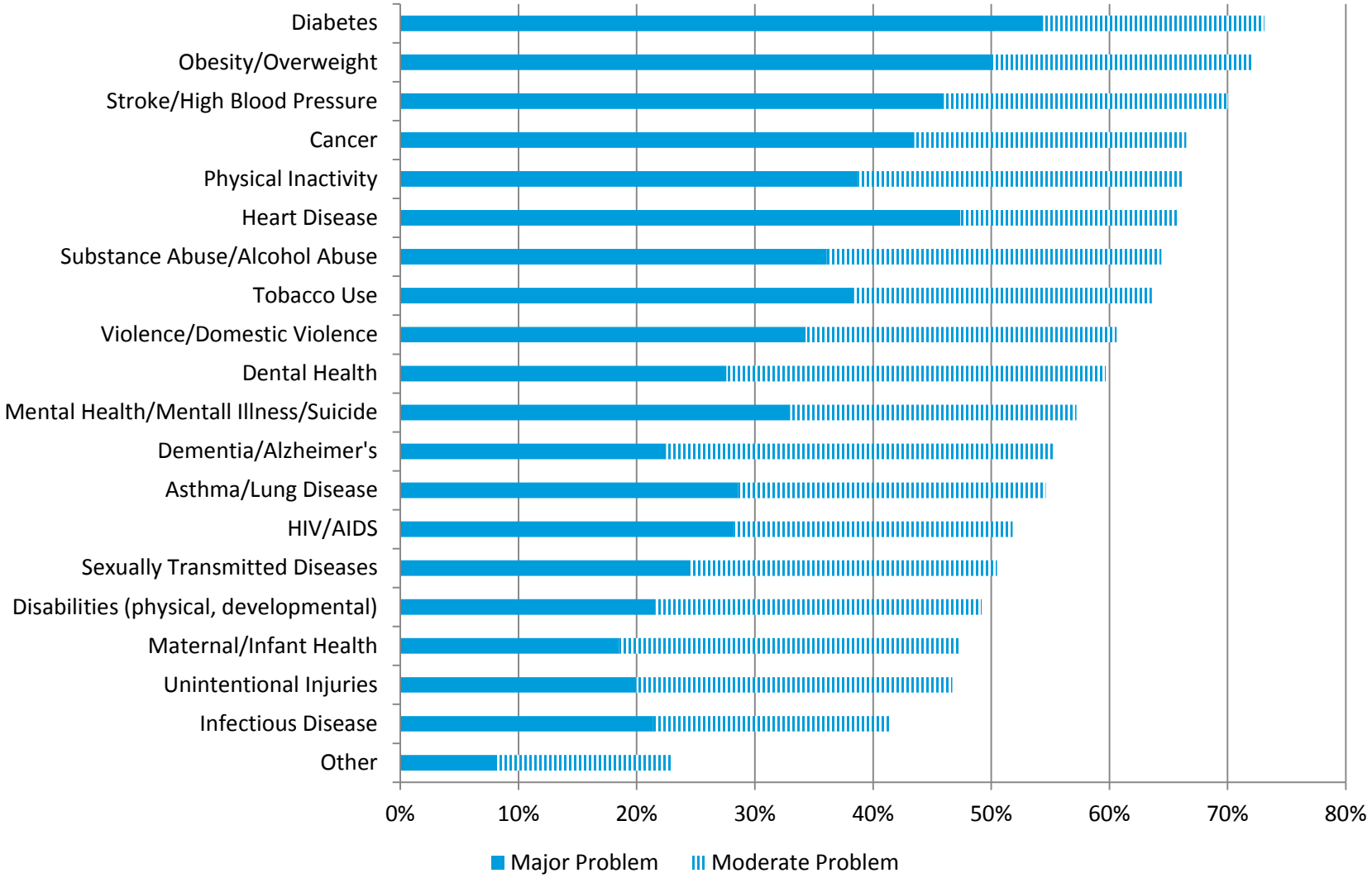
"Other" Included: teen violence; hearing; podiatry; vascular; lack of maternity clinic services

□uestion □: Please rate the following health issues for your neighborhood or community. (N□109 Spanish responses)

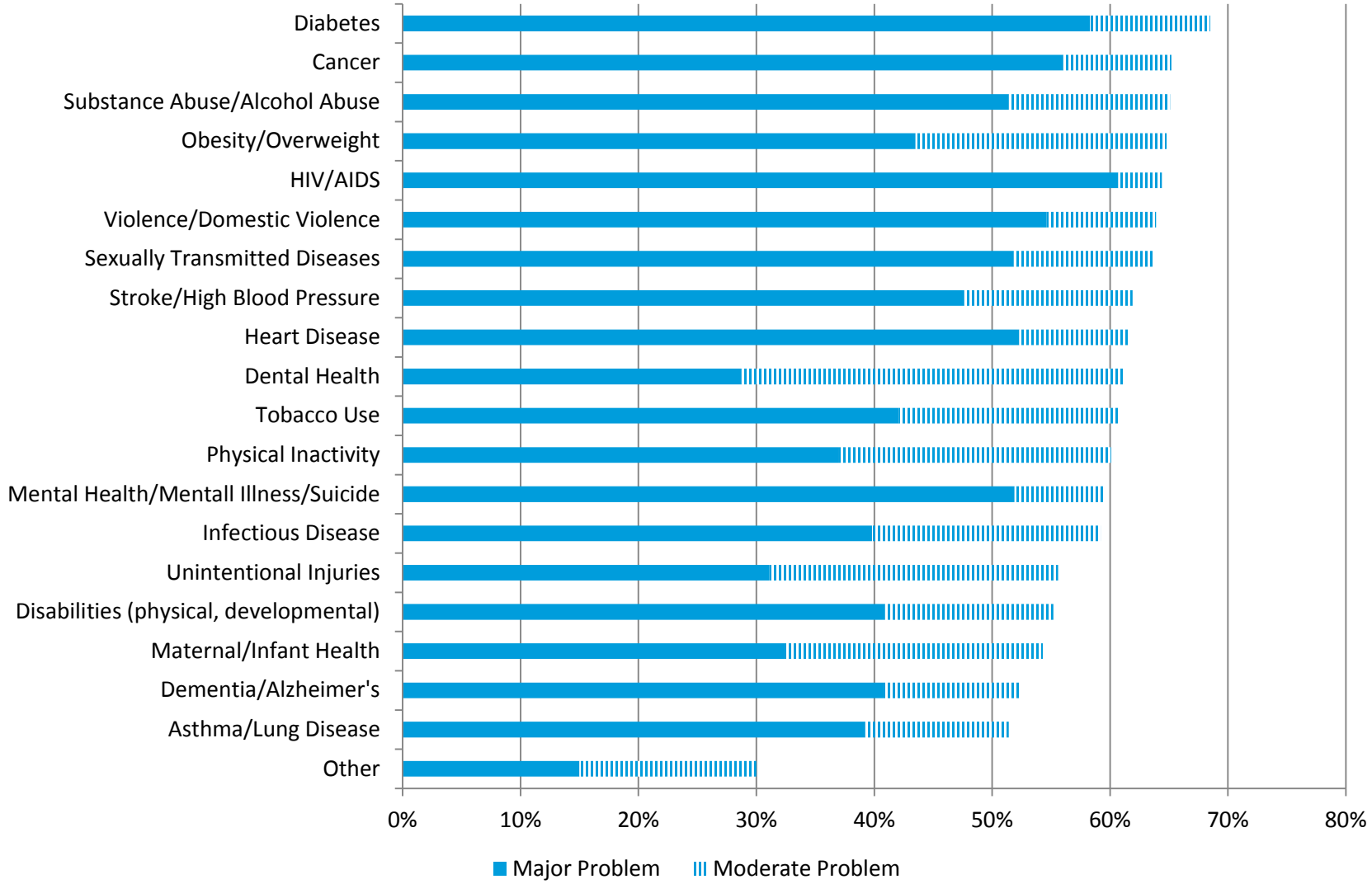


"Other" Included: drug abuse; the overall community's health

uestion : Please rate the following health issues for your neighborhood or community. Major and Moderate Responses (N200 English responses)



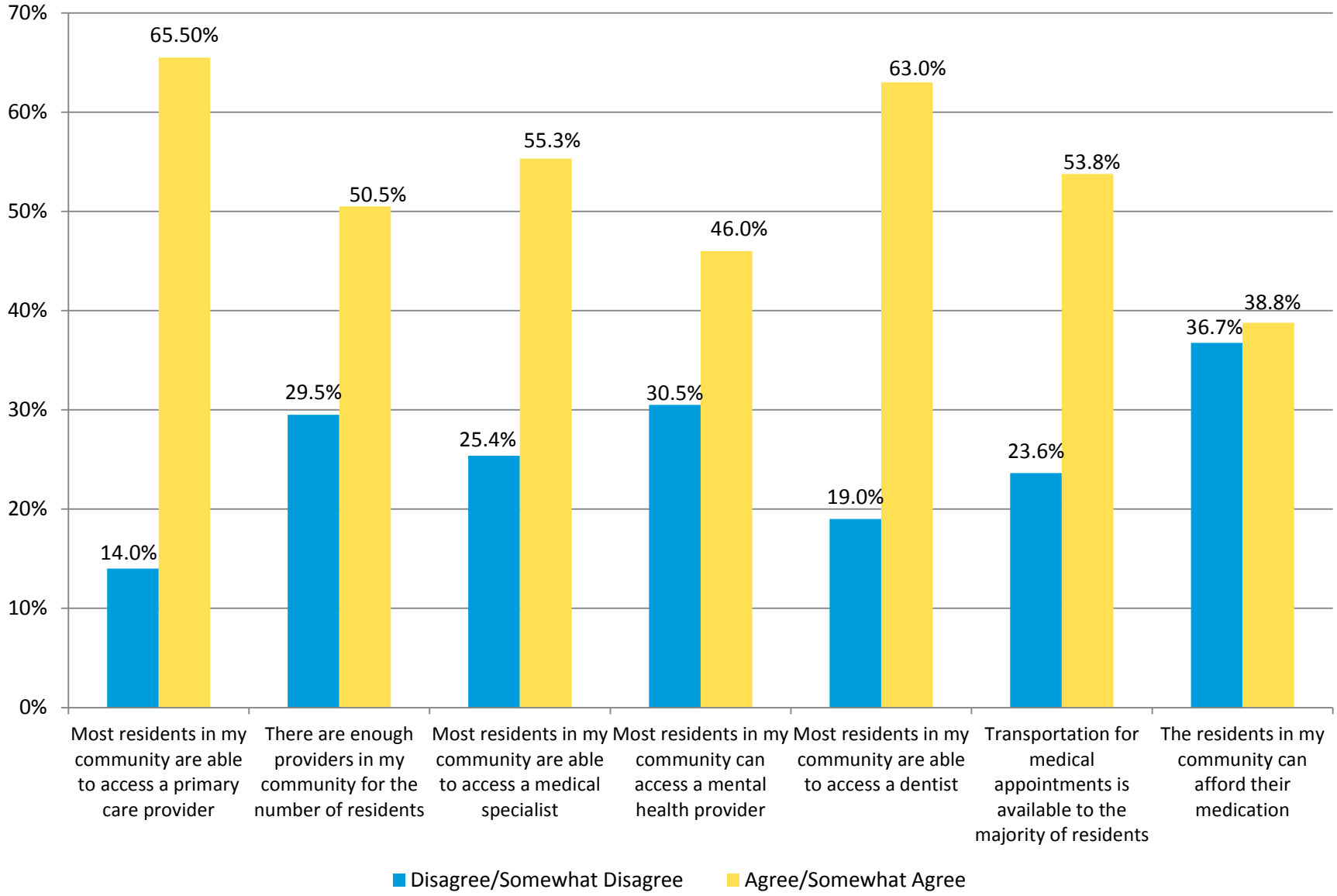
uestion : Please rate the following health issues for your neighborhood or community. Major and Moderate Responses (N109 Spanish responses)



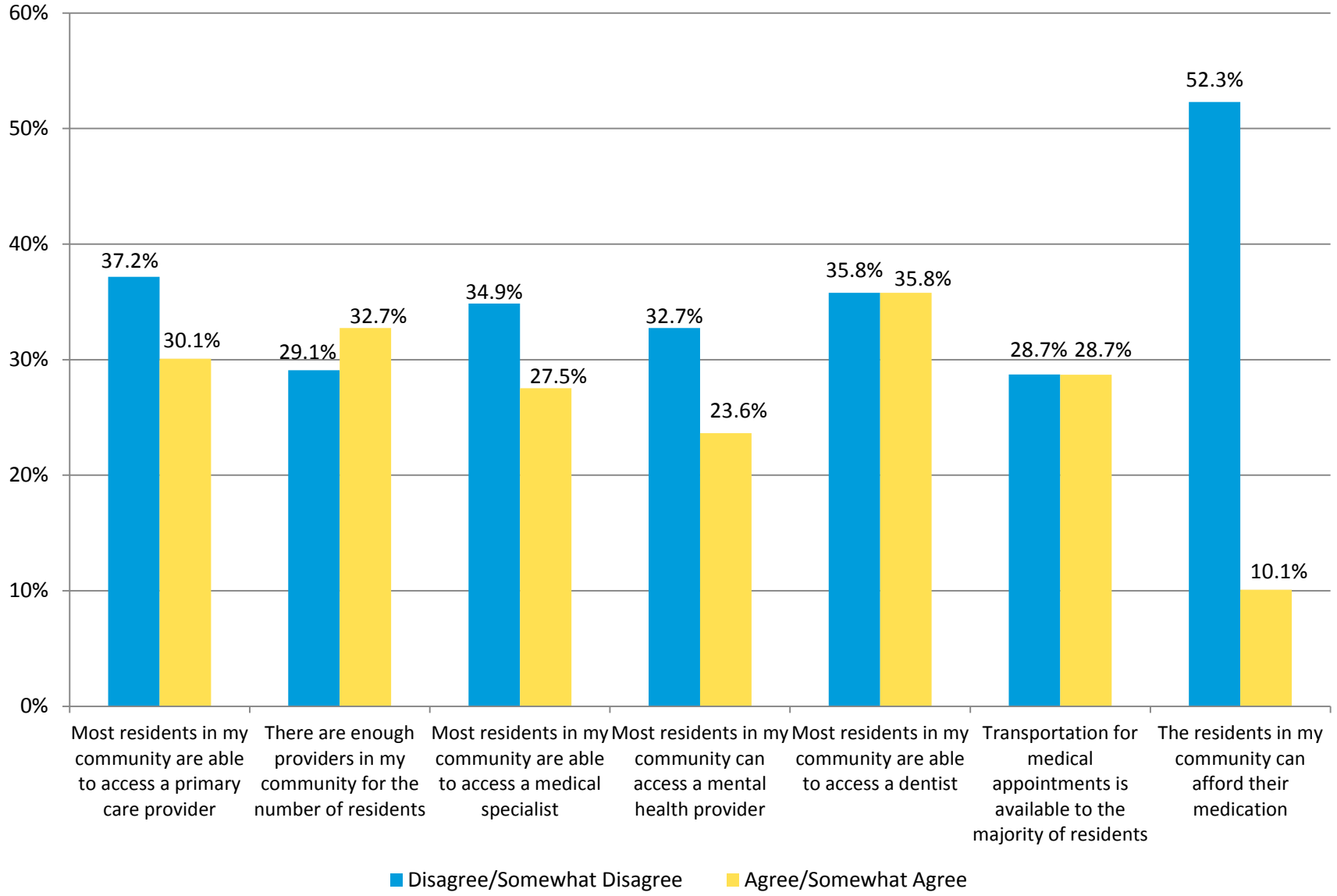
Question 3: Please rate the following statements about health care access in your community.

	Disagree		Somewhat Disagree		Somewhat Agree		Agree		NA/Don't Know	
	English	Spanish	English	Spanish	English	Spanish	English	Spanish	English	Spanish
Most residents in my community are able to access a primary care provider. (N=200; 113)	11 (5.5%)	29 (25.7%)	17 (8.5%)	13 (11.5%)	55 (27.5%)	15 (13.3%)	76 (38.0%)	19 (16.8%)	41 (20.5%)	37 (32.7%)
There are enough providers in my community for the number of residents. (N=200; 110)	28 (14.0%)	19 (17.3%)	31 (15.5%)	13 (11.8%)	44 (22.0%)	16 (14.6%)	57 (28.5%)	20 (18.2%)	40 (20.0%)	42 (38.2%)
Most residents in my community are able to access a medical specialist such as a dermatologist or neurologist. (N=197; 109)	26 (13.2%)	23 (21.1%)	24 (12.2%)	15 (13.8%)	58 (29.4%)	11 (10.1%)	51 (25.9%)	19 (17.4%)	38 (19.3%)	41 (37.6%)
Most residents in my community can access a mental health provider. (N=200; 110)	25 (12.5%)	20 (18.2%)	36 (18.0%)	16 (14.6%)	43 (21.5%)	10 (9.1%)	49 (24.5%)	16 (14.6%)	47 (23.5%)	48 (43.6%)
Most residents in my community are able to access a dentist. (N=200; 109)	15 (7.5%)	28 (25.7%)	23 (11.5%)	11 (10.1%)	55 (27.5%)	12 (11.0%)	71 (35.5%)	27 (24.8%)	36 (18.0%)	31 (28.4%)
Transportation for medical appointments is available to the majority of residents in my community. (N=199; 108)	17 (8.5%)	20 (18.5%)	30 (15.1%)	11 (10.2%)	54 (27.1%)	16 (14.8%)	53 (26.6%)	15 (13.9%)	45 (22.6%)	46 (42.6%)
The residents in my community can afford their medication. (N=196; 109)	32 (16.3%)	41 (37.6%)	40 (20.4%)	16 (14.7%)	44 (22.5%)	3 (2.8%)	32 (16.3%)	8 (7.3%)	48 (24.5%)	41 (37.6%)

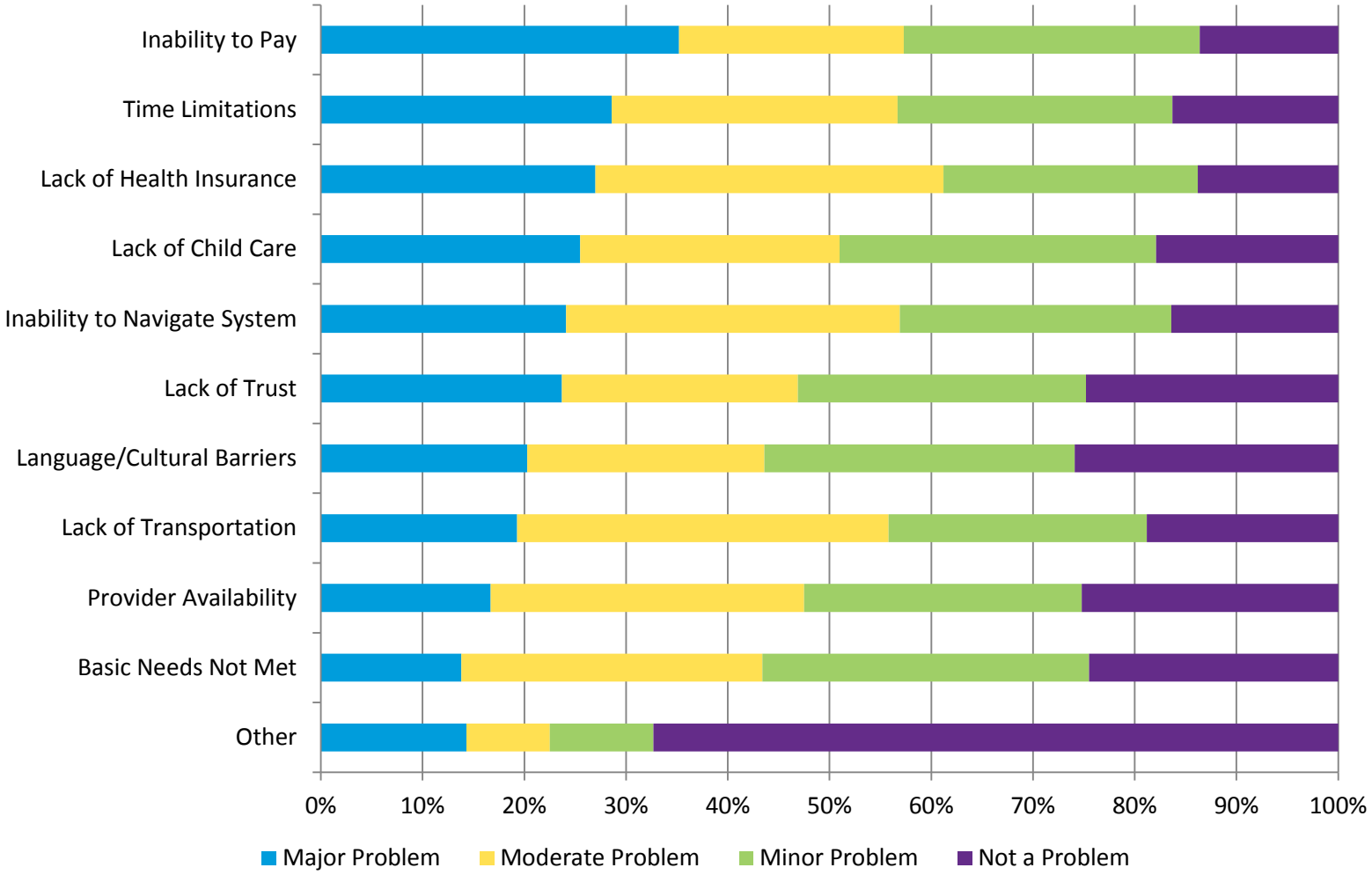
**uestion : Please rate the following statements about health care access in your community. (N 200 English responses).



□uestion □: Please rate the following statements about health care access in your community. (N□113 Spanish responses)

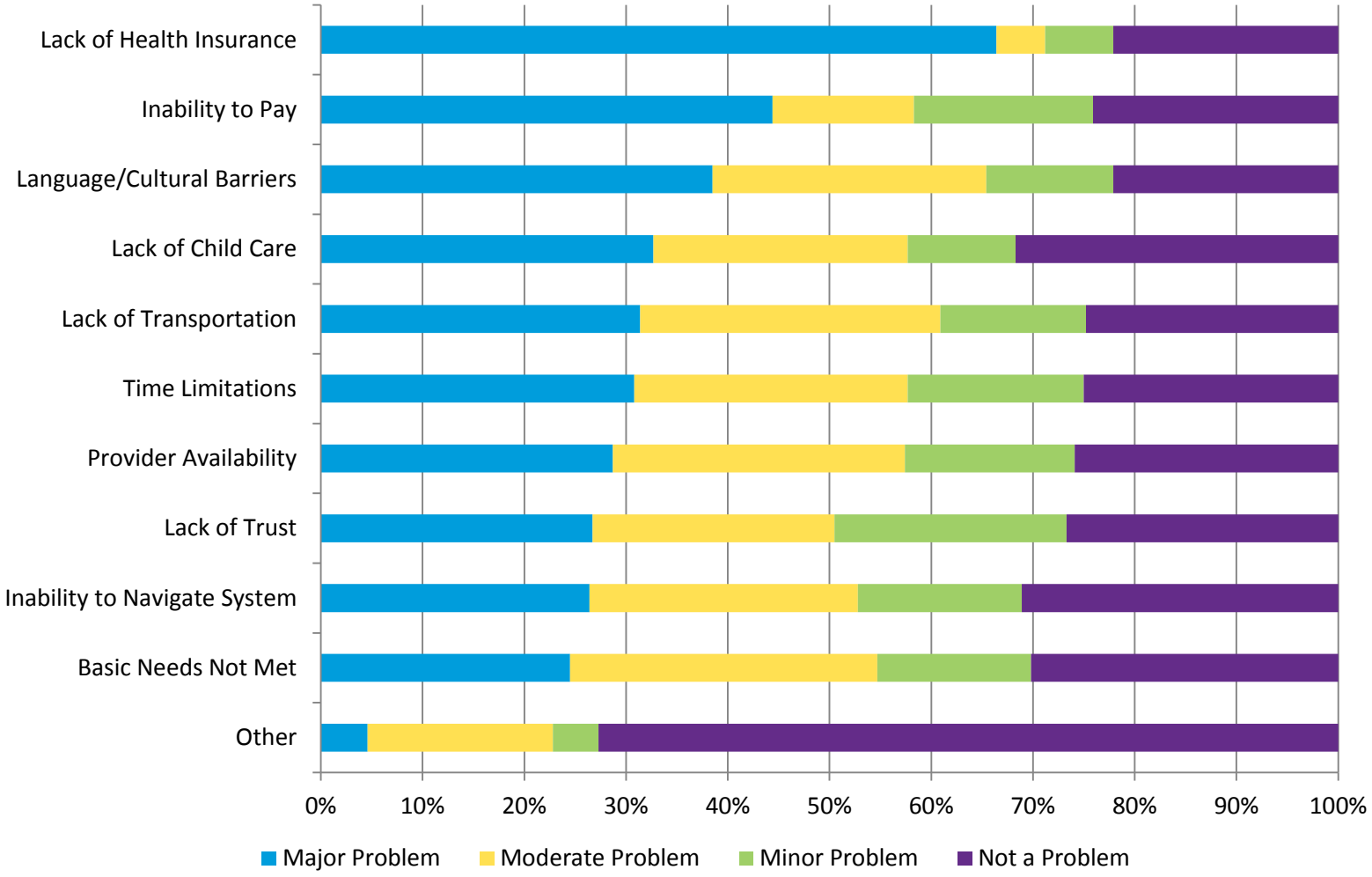


uestion : Please rate if the following barriers keep people in your community from accessing healthcare. (N198 English responses)



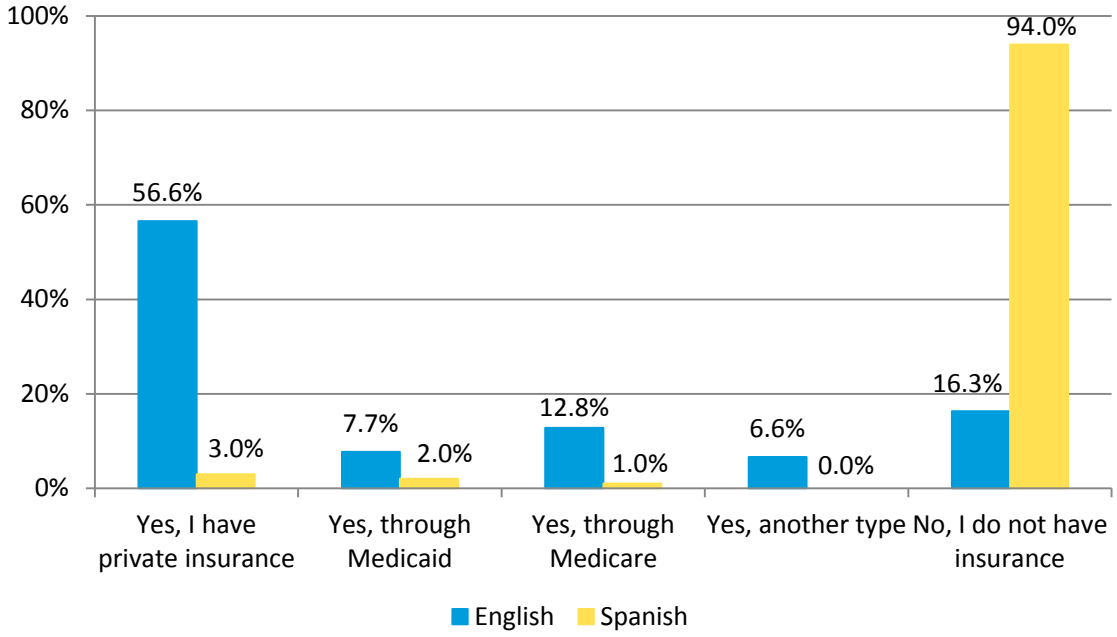
"Other" Included: lack of quality providers, hospitals, specialists, and dentists in the county; lack of appropriate transportation tailored to meet special health needs; urgent care clinics not accepting Medicare; lack of providers accepting insurance; residents whose insurance coverage lapses; lack of home care to support elderly; lack of personal responsibility for health

□uestion □: Please rate if the following barriers keep people in your community from accessing healthcare. (N□112 Spanish responses)

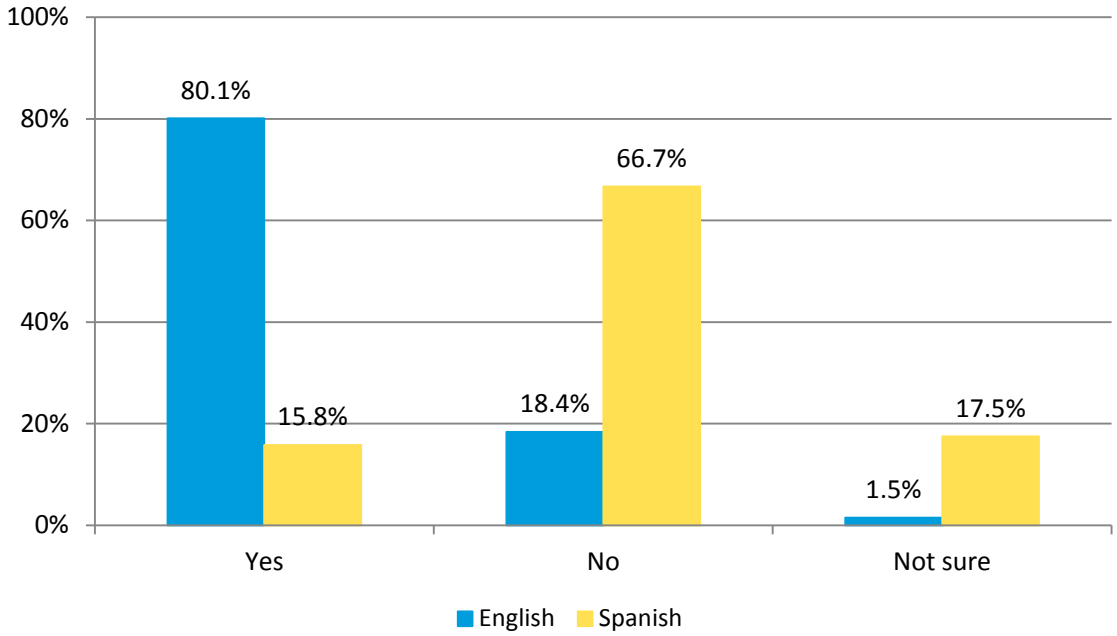


"Other" Included: "the family"

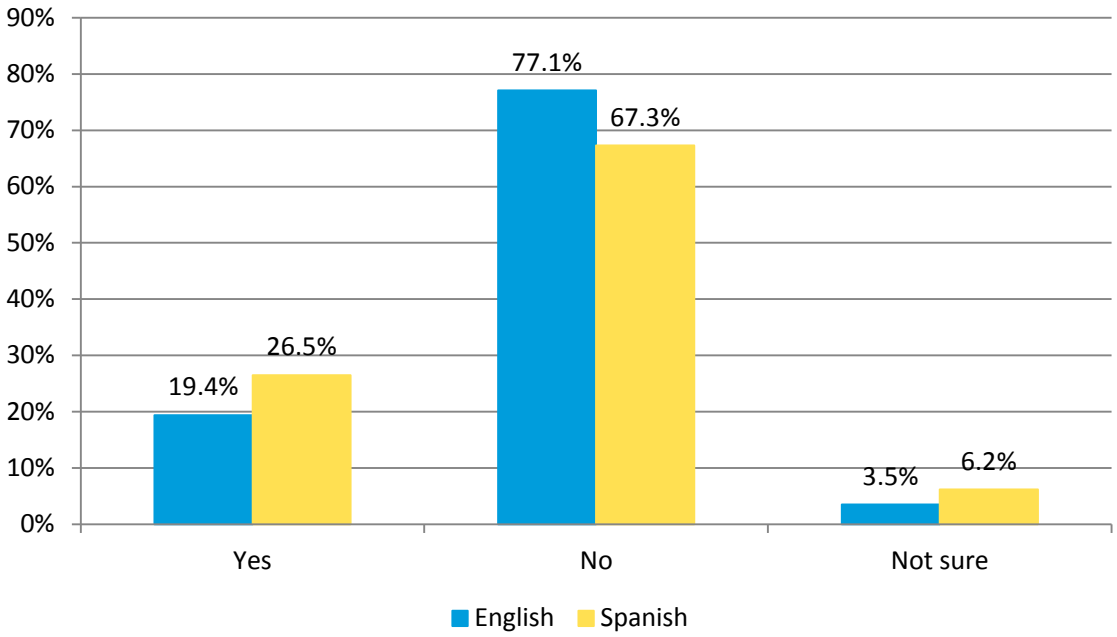
Question 3: Do you have health insurance? (N=196 English responses, N=100 Spanish responses)



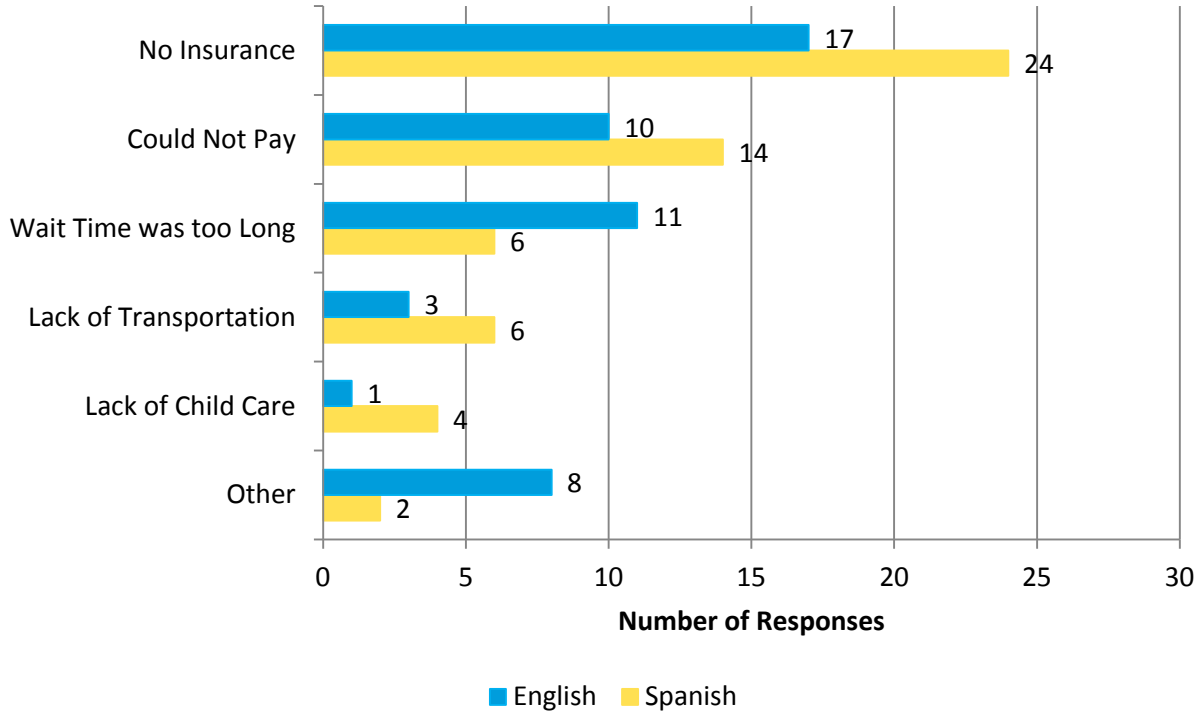
Question 4: Did you see a primary care doctor in the last year? (N=201 responses, N=114 Spanish responses)



**uestion : Has there been a time in the past year when you needed medical care but were not able to get it (N201 English responses; N113 Spanish responses)



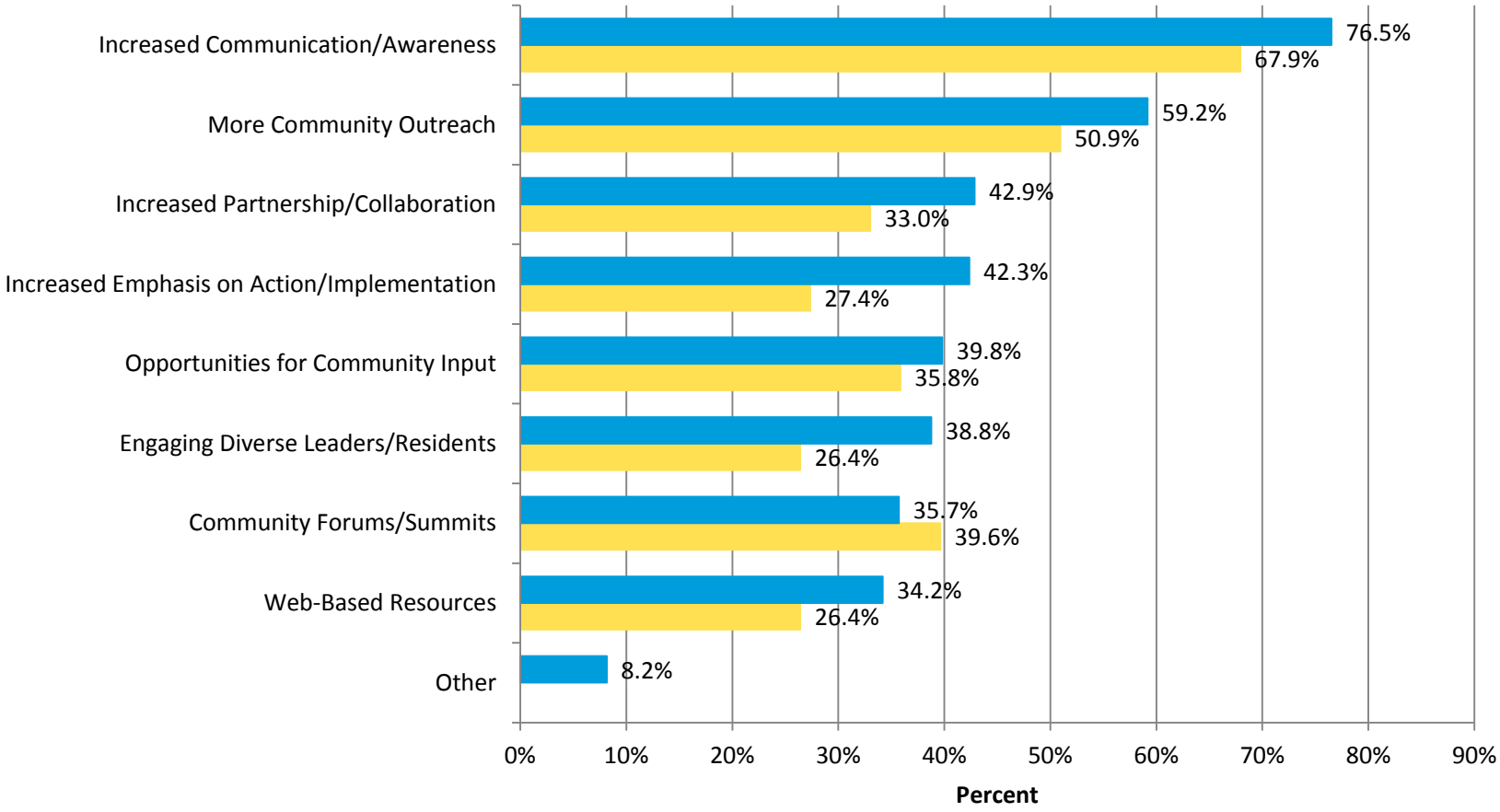
uestion : If you answered that you were unable to get medical care, what prevented you from getting the medical care you needed (select all that apply) (N 38 English responses; N 27 Spanish responses)



F**or English participants, "Other" included**: green card issues; doctor being fully booked for weeks; lack of quality healthcare in the county; Urgent Care not accepting Medicare; inadequate insurance, not having options close in proximity, and not being able to take time off work. Some participants did not select the items listed, but did include them as barriers in "other": transportation; co-payment; child care.

For Spanish participants, "Other" included: not having a Social Security Number, no place to go for a health consultation; no insurance and no money to pay for medical care; wait for Cobra enrollment after a job loss.

uestion 10: What do you think could encourage and support more community involvement around health issues in Prince George s County (select all that apply) (N 196 English responses; N 106 Spanish responses)



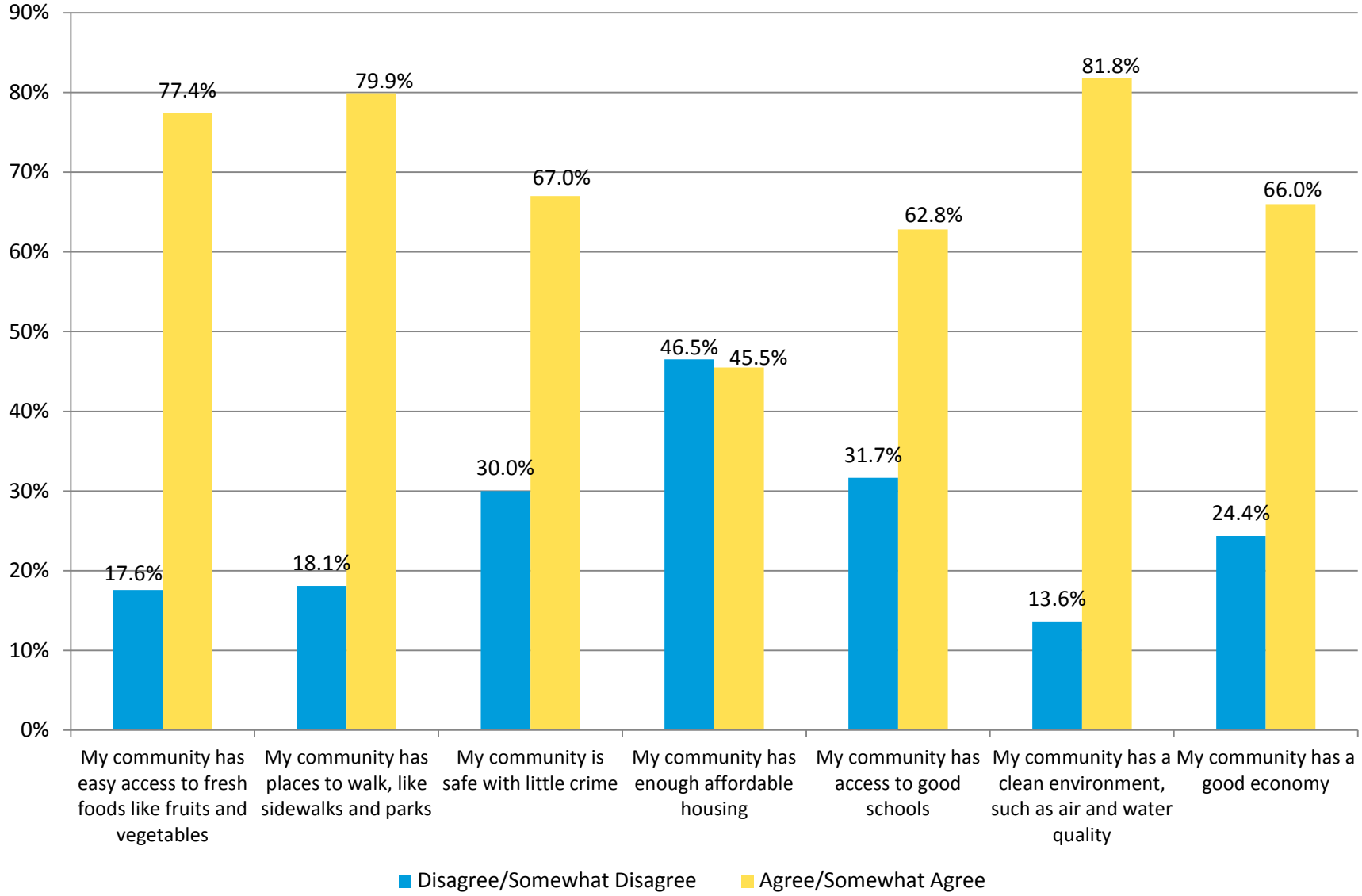
F**or English participants, "Other" included**: education on health risks, nutrition, prevention, health lifestyles; starting health education at an early age and tailoring education for culture and age groups; more funding for public health; using a variety of platforms for outreach (TV, radio, local store, schools); increase high quality healthcare providers; community-oriented events and partners; urgent cares that serve all insurance types; providing health-supporting services through schools, such as emergency mental health, immunizations, and access to bilingual providers; providing more education through the hospitals; adequate low income housing; more emphasis on prevention.

F**or Spanish participants, "Other" included**: community-level support; not needing to see a doctor; having insurance.

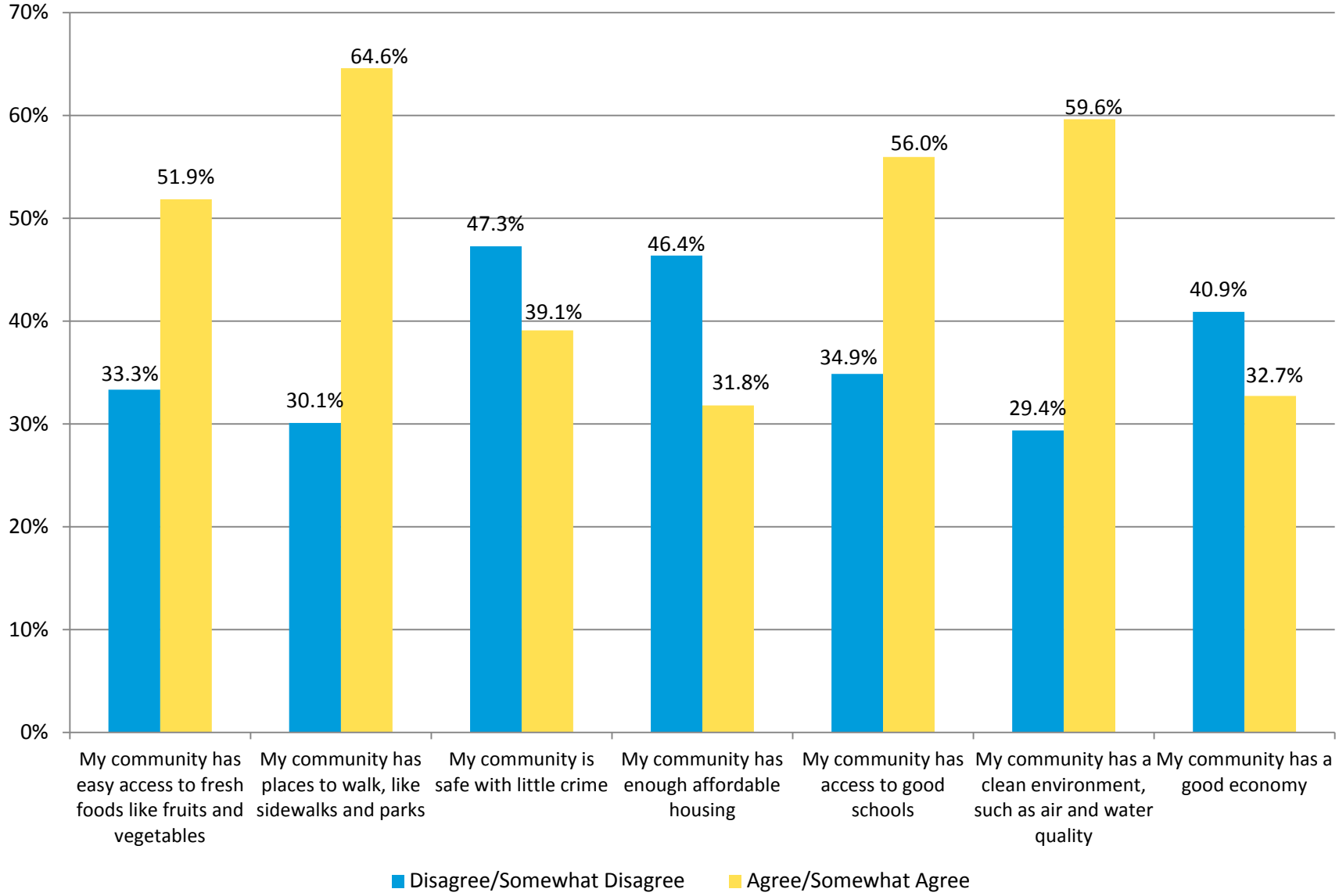
uestion 11: Please rate the following statements about your community.

	Disagree		Somewhat Disagree		Somewhat Agree		Agree		NA/Don't Know	
	English	Spanish	English	Spanish	English	Spanish	English	Spanish	English	Spanish
My community has easy access to fresh foods like fruits and vegetables. (N=199; 108)	16 (8.0%)	18 (16.7%)	19 (9.6%)	18 (16.7%)	51 (25.6%)	22 (20.4%)	103 (51.8%)	34 (31.5%)	10 (5.0%)	16 (14.8%)
My community has places to walk, like sidewalks and parks. (N=199; 113)	15 (7.5%)	24 (21.2%)	21 (10.6%)	10 (8.8%)	39 (19.6%)	19 (16.8%)	120 (60.3%)	54 (47.8%)	4 (2.0%)	6 (5.3%)
My community is safe with little crime. (N=200; 110)	25 (12.5%)	28 (25.4%)	35 (17.5%)	24 (21.8%)	72 (36.0%)	15 (13.6%)	62 (31.0%)	28 (25.4%)	6 (3.0%)	15 (13.6%)
My community has enough affordable housing. (N=200; 110)	46 (23.0%)	24 (27.3%)	47 (23.5%)	21 (19.1%)	50 (25.0%)	17 (15.4%)	41 (20.5%)	18 (16.4%)	16 (8.0%)	30 (21.8%)
My community has access to good schools. (N=199; 109)	35 (17.5%)	21 (19.3%)	28 (14.1%)	17 (15.6%)	65 (32.7%)	23 (21.1%)	60 (30.2%)	38 (34.9%)	11 (5.5%)	10 (9.2%)
My community has a clean environment, such as air and water quality. (N=198; 109)	9 (4.6%)	17 (15.6%)	18 (9.1%)	15 (13.8%)	68 (34.3%)	20 (18.3%)	94 (47.5%)	45 (41.3%)	9 (4.5%)	12 (11.0%)
My community has a good economy. (N=197; 110)	20 (10.2%)	22 (20.0%)	28 (14.2%)	23 (20.9%)	68 (34.5%)	16 (14.5%)	62 (31.5%)	20 (18.2%)	19 (9.6%)	29 (26.4%)

uestion 11: Please rate the following statements about your community. (N 200 English responses)

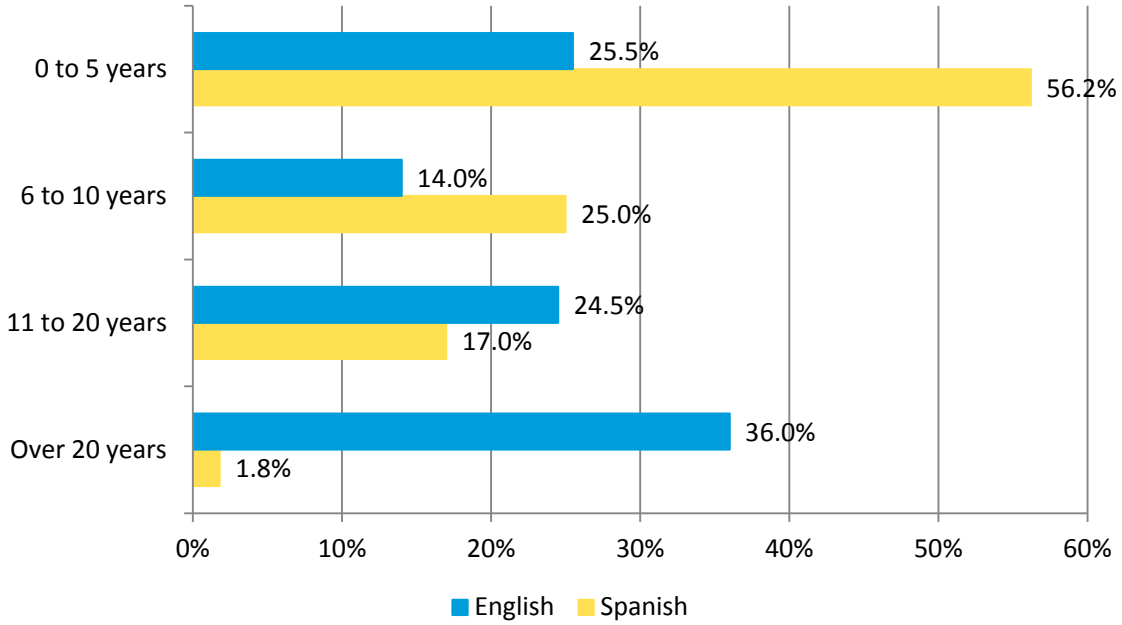


uestion 11: Please rate the following statements about your community. (N114 Spanish responses)

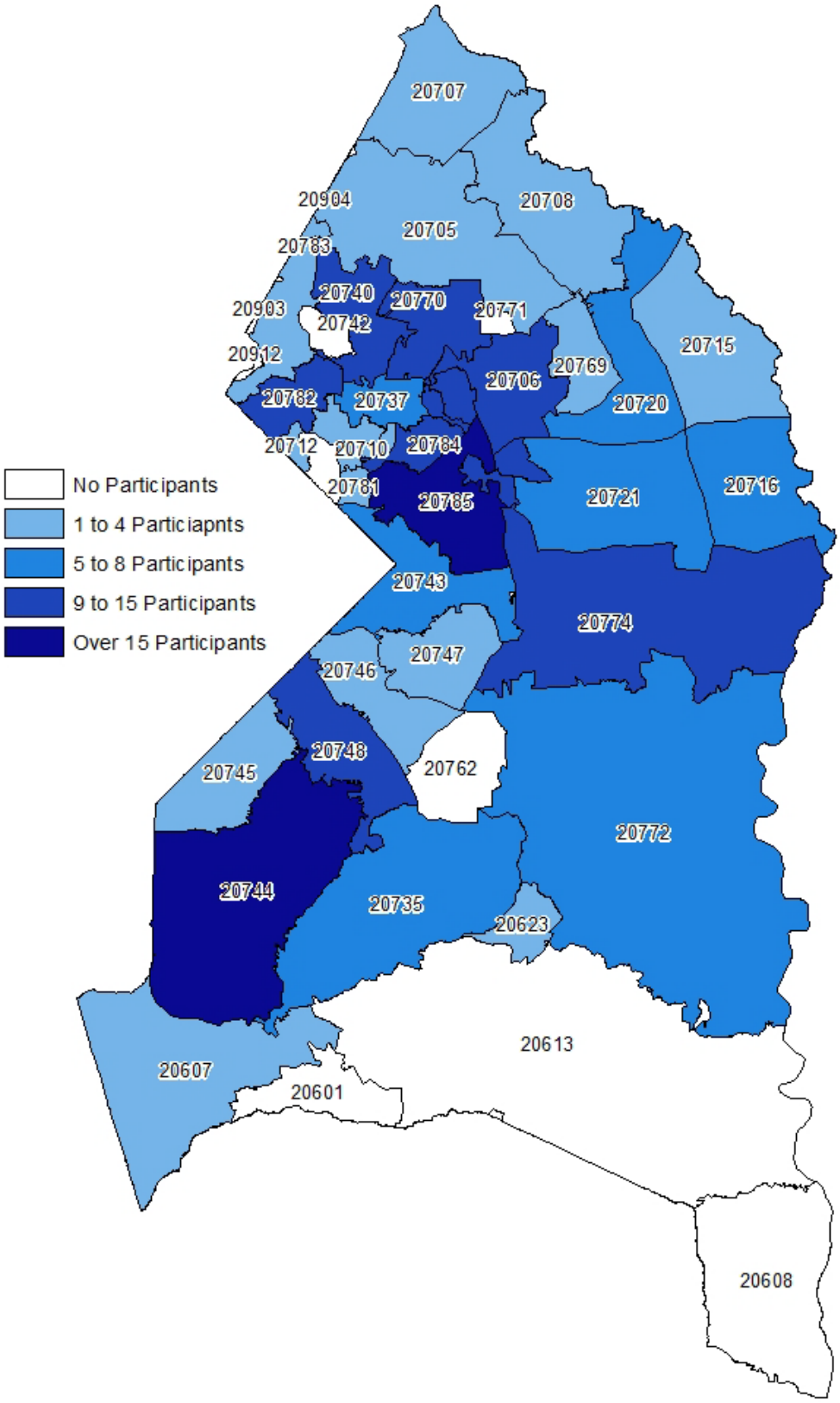


Participant Profile

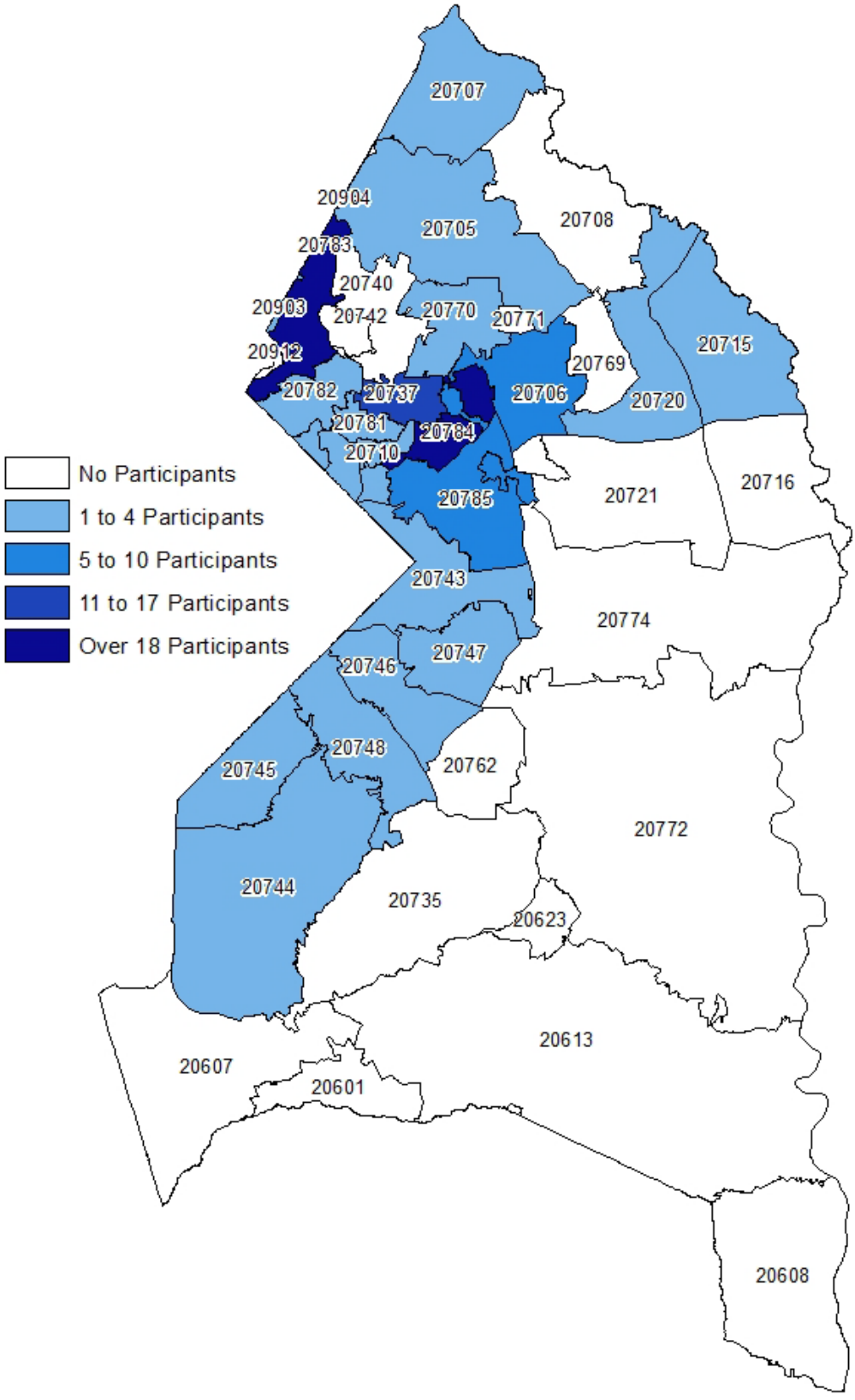
uestion 12: How long have you lived in Prince George's County (N 200 English responses; N 112 Spanish responses)



□uestion 1□: What □IP code do you live in□ (N□199 English responses)



uestion 1 : What IP code do you live in (N 90 Spanish responses)

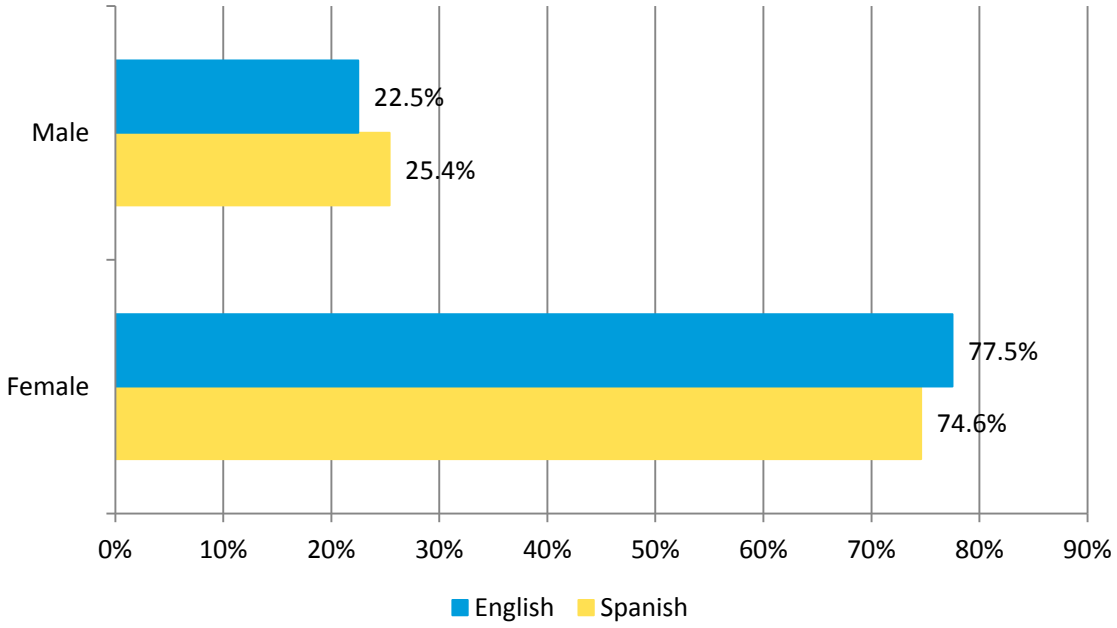


□**uestion 1**□**:** What community do you live in□ (N□175 English responses; 90 Spanish responses)

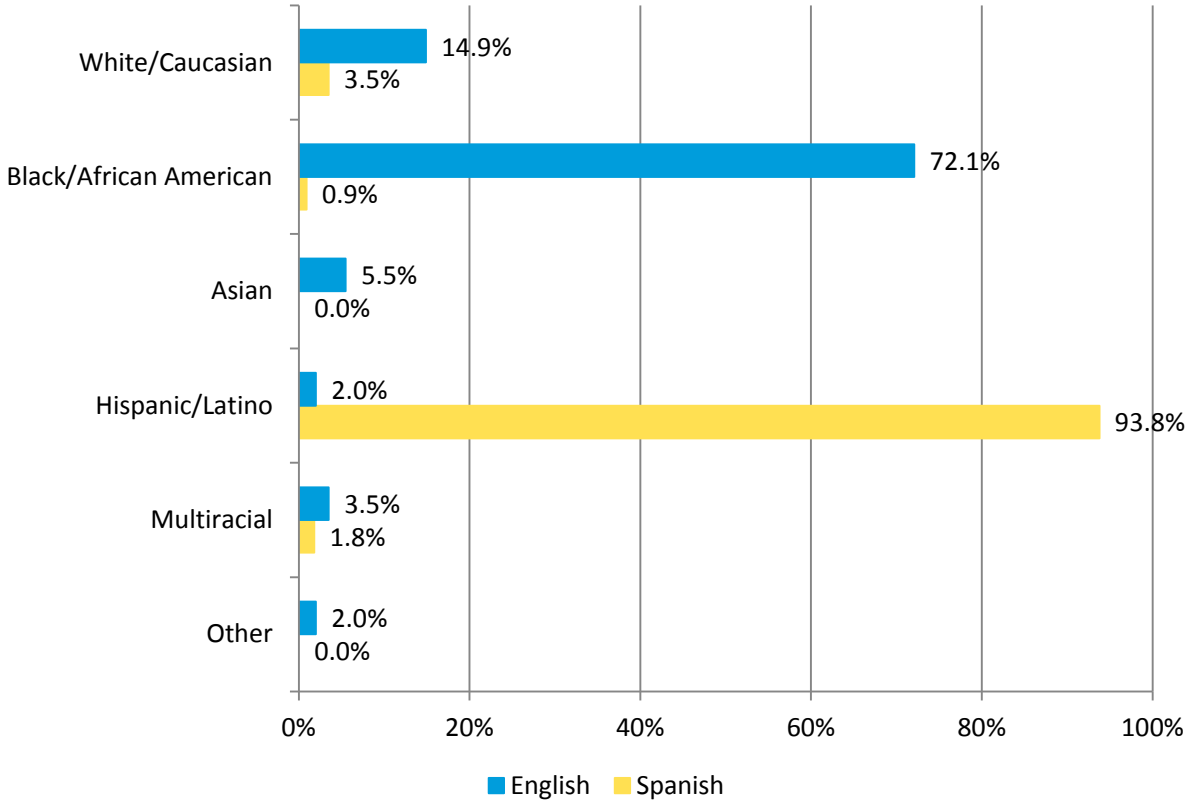
Community	English Participants	Spanish Participants
Accokeek	2	0
Adelphi	0	2
Beltsville	2	1
Bladensburg	1	3
Bowie	11	2
Brentwood	0	1
Camden	1	0
Capitol Heights	3	1
Cheltenham	1	0
Cheverly	2	1
Clinton	6	0
College Park	8	0
Deer Park	3	0
District Heights	4	1
Dodge Park	1	0
Fairwood	1	0
Fort Washington	13	1
Glenarden	2	1
Glenn Dale	1	0
Glensford	1	0
Greenbelt	8	2
Greenbriar	1	0
Hyattsville	12	26
King Square	0	1
Lake Arbor	1	0
Landover	5	5
Landover Hills	1	1
Langley Park	0	1
Lanham	7	7
Largo	1	0
Laurel	4	1
Maple Ridge	1	0
Marlton	1	0
Millwood Waterford	1	0
Mitchellville	3	0
Mount Rainier	0	1
New Carrollton	5	4
Northridge	1	0

Community	English Participants	Spanish Participants
Oxford Run	1	0
Oxon Hill	2	5
Prince George's County	14	3
Riverdale	3	16
Riverdale Park	1	0
Riverhill	1	0
Rose Valley	1	0
Seabrook	1	0
Seat Pleasant	1	0
Silver Spring	0	1
Suitland	1	1
Summerfield	1	0
Summit Creek	1	0
Tantallon	1	0
Temple Hills	3	0
Ternberry	1	0
University Park	10	0
Upper Marlboro	14	0
Westchester Park	2	0
Willow Hills	1	0
Woodland	0	1

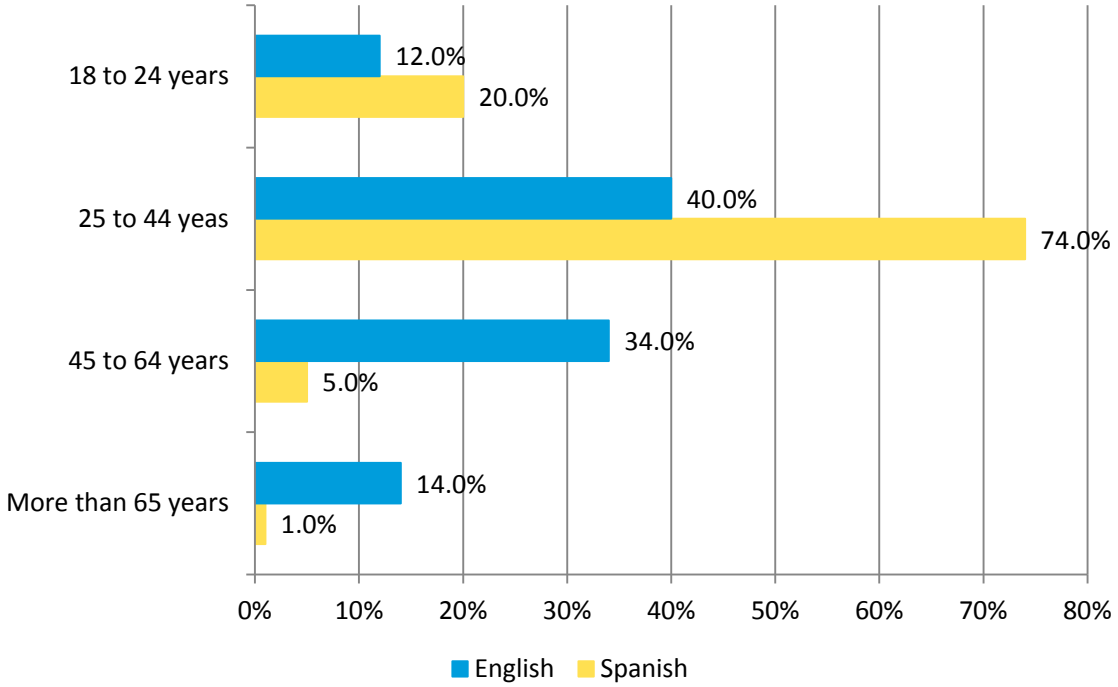
□uestion 1□: What is your gender□ (N□English 200 responses; N□114 Spanish responses)



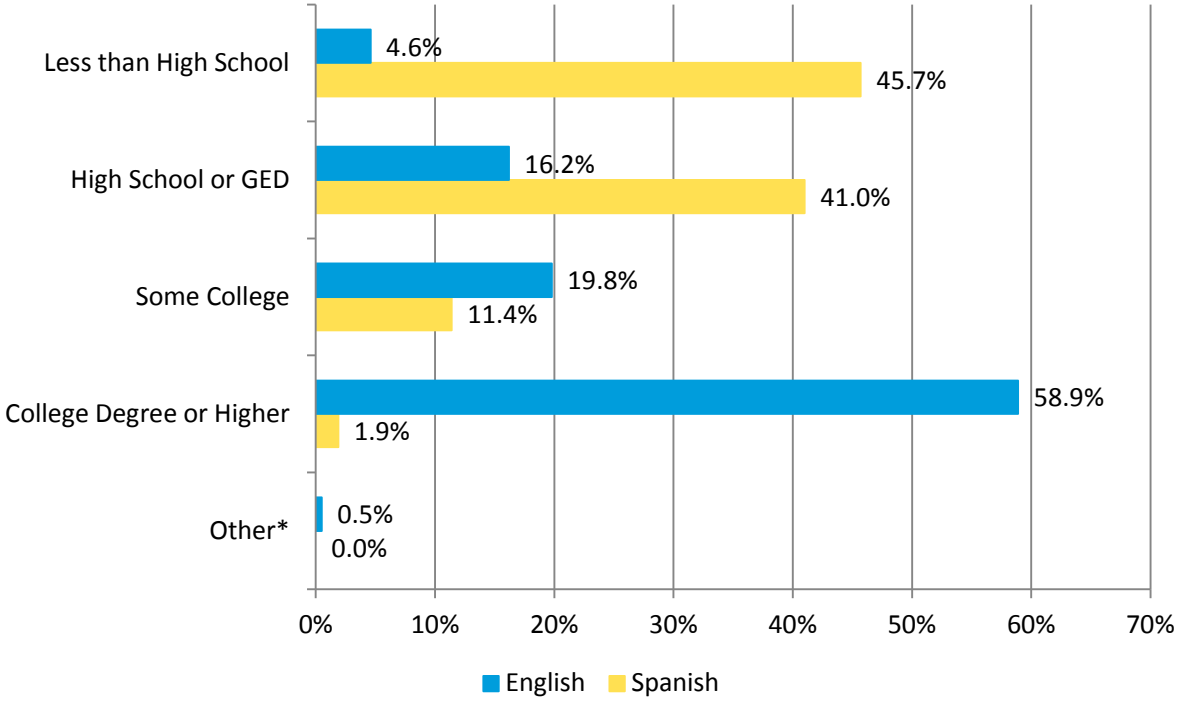
□uestion 1□: What race/ethnicity best identifies you□ (N□201 English responses; N□113 Spanish responses)



Question 1: How old are you? (N=200 English responses; N=100 Spanish responses)

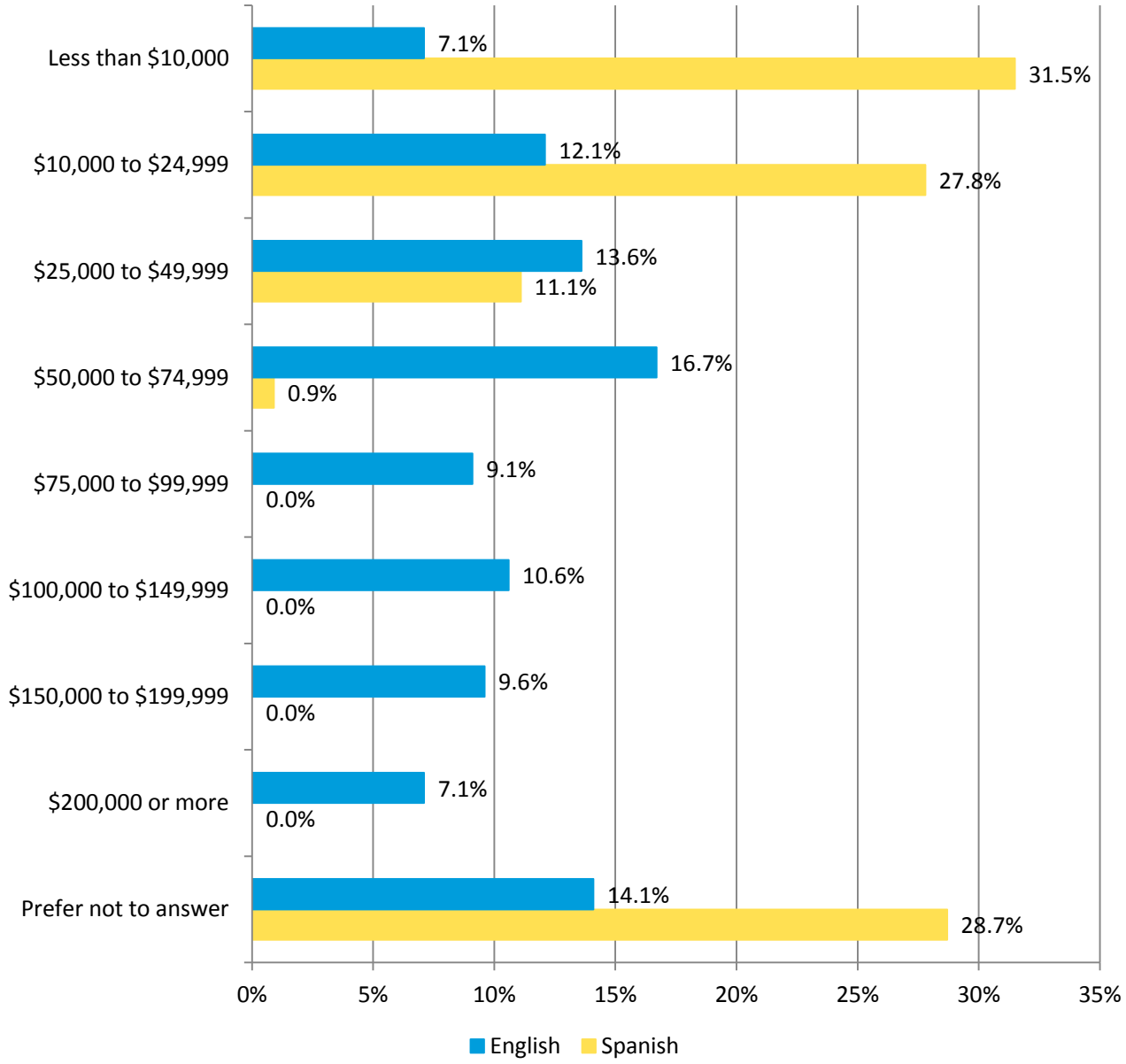


Question 1: What is the highest level of education you completed? (N=197 English responses; N=105 Spanish responses)



*Other included trade school

□**uestion 1**□**:** What is your annual household income□ (N□198 English responses; N□109 Spanish responses)



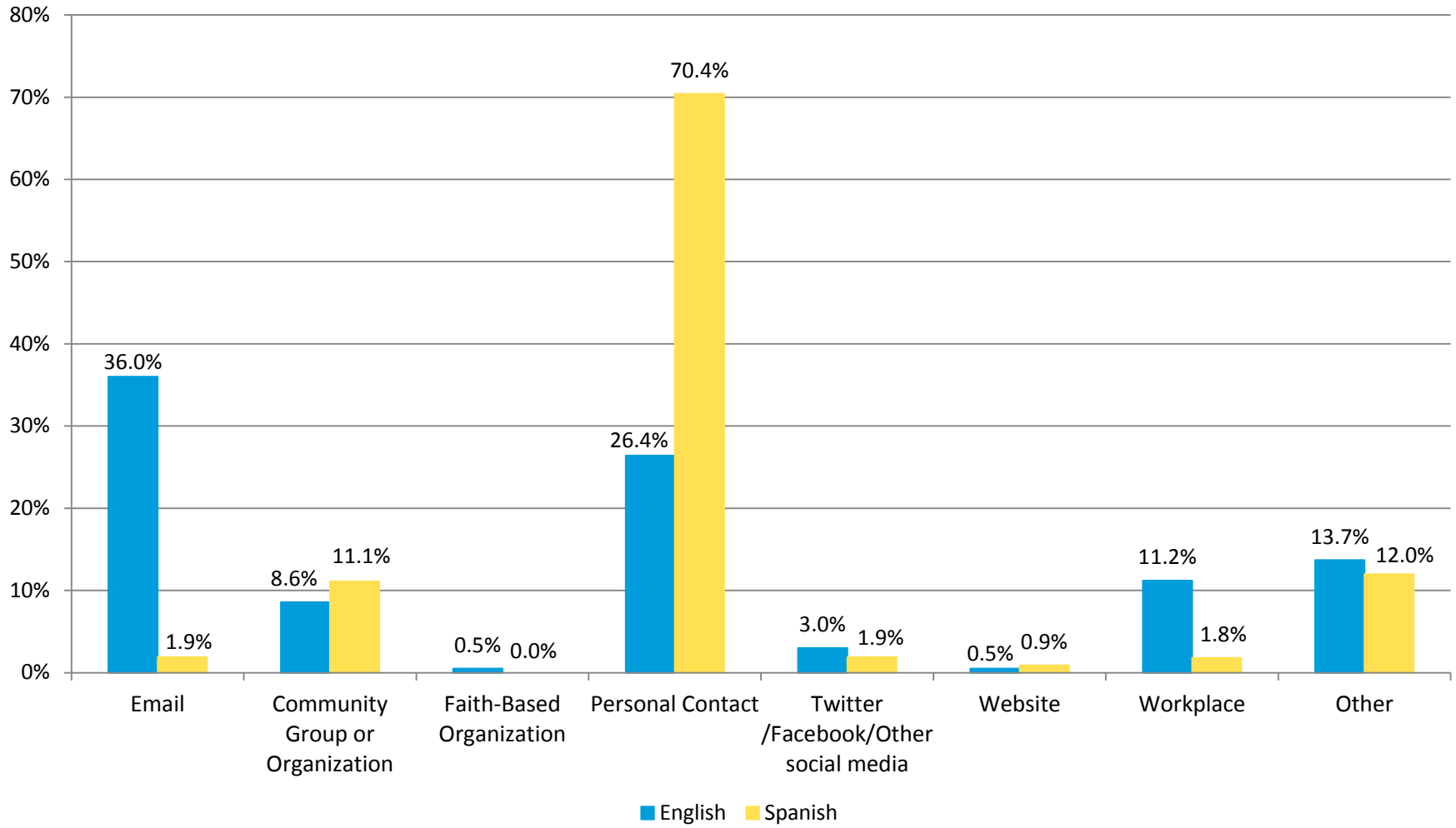
□**uestion 20:** What country were you born in□ (N□195 English responses; N□110 Spanish responses)

Community	English Participants	Spanish Participants
Afghanistan	4	0
Burma	1	0
Cameroon	9	0
Central Africa	1	0
Chad	1	0
China	3	0
Congo	1	0
Ecuador	0	1
El Salvador	0	62
Finland	1	0
Germany	1	0
Ghana	2	0
Guatemala	1	16
Guinea	1	0
Honduras	0	16
India	2	0
Jamaica	2	0
Mexico	1	14
Nigeria	9	0
Okinawa	1	0
Philippines	2	0
Russia	2	0
Senegal	1	0
Sierra Leone	2	0
South America	2	0
Tanzania	1	0
Trinidad	1	0
USA	143	1

□**uestion 21:** What language do you speak at home□ (N□198 English responses; N□109 Spanish responses)

Community	English Participants	Spanish Participants
Bimese	1	0
Chinese	3	0
Dari	1	0
English	169	2
English & Creole	2	0
English & Another	1	0
English & French	2	0
English & Scoalt	1	0
English & Finnish	1	0
English & Spanish	2	5
English & Toruba	1	0
French	2	0
Hindi	1	0
Krio	1	0
Pashto	1	0
Persian	2	0
Spanish	4	102
Swahili	1	0
Yoruba	2	0

□uestion 22: How did you receive this survey□ (N□197 English responses; N□108 Spanish responses)



F**or English participants, "Other" included**: health clinics; health center;, healthcare provider; hospital; medical centers; dentists offices; emergency rooms; health department; immunization center; MD Health Teen Center.

F**or Spanish participants, "Other" included**: the hospital; health clinics; and he health department.

PRIORITIZATION PROCESS

Introduction

Prince George□s County conducted the first ever joint Community Health Needs Assessment (CHNA) with a partnership between five local hospitals and the Health Department. This core team began the process of collecting primary and secondary data to describe the residents and health needs in the county. This data was planned to be used during the prioritization process to determine the overall county health priorities. The core team planned for broad community participation for the prioritization process to ensure residents were well represented, with the goal of consensus for shared community priorities. The prioritization meeting took place on April 22, 2016 with 40 participants.

Participants

The Prince George□s County Health Department developed a list of prioritization participant roles using the CHNA key informant interviews as a starting point, with additions recommended by the consultant who conducted the interviews and Health Department leadership. Overall, 32 participant roles were recognized as necessary for adequate community representation during the prioritization process. Participants were selected to fill the specified roles as recognized leaders in the community, and each hospital provided representatives for their services area. A list of participant roles, individuals selected to fill those roles, and participation in the prioritization process is included in **Attachment A**. To ensure participation, an invitation and reminders about the meeting were sent by the Prince George□s County Health Officer.

Process Summary

To make the best use of a one day prioritization meeting and ensure adequate discussion time for the issues, the core CHNA team selected ten issues to consider during the prioritization meeting using the primary and secondary data collected during the CHNA process:

- Asthma
- Cancer
- Diabetes
- Heart Disease
- HI□
- Hypertension/Stroke
- Mental Health
- Obesity
- Substance Use
- □iolence/Domestic □iolence

The selection process and issues not selected were presented to the participants, with time for discussion to acknowledge the challenges of these issues that was tracked through a □parking lot□.

An agenda for the prioritization process meeting is included in **Attachment** □. The prioritization process began with an overview of the purpose of the CHNA, the steps taken to ensure community input in the process, and a data overview of the ten selected issues (**Attachment C**). The data overview included both the primary and secondary data collected during the CHNA process, as well as an active discussion by the participants who contributed information for the population they represented in their role. The presentation also included a discussion that **any prioriti□ed health issue must include consideration of the social determinants of health, which were ac□nowledged as a significant factor for health disparity and poor outcomes in the county□□he social determinants of health were framed as: Economic Stability, Education, □eighborhood and □uilt Environment, Social Community Context, and □ealth and □ealth Care□**

Each issue was also presented as a handout of the data available (example in **Attachment D**) that included the population affected, known disparities, and how we compare to the state, neighboring jurisdictions, and U.S., where possible. Participants posed questions, provided insight for the population represented, provided anecdotal examples and discussed data limitations, including the lack of data for specific populations, the challenges with obtaining data for services provided in Washington D.C. to our residents, and potential biases in how information such as death certificate and hospital diagnoses are determined, for example.

Prince George□s County Health Department hired a consultant, Ribbon Consulting Group (Linda Scruggs and Ebony □ohnson) to facilitate the prioritization process. The process was designed around consensus building and ensuring the community representation at the table was heard during the process. The consultants led the group through an initial prioritization with each participant given six stickers (dots). Each of the ten health issues was written on flip chart paper posted in the room, and participants were instructed to place the dots on the issues based on the trend, prevalence, severity of the issue, preventability, and comparison with state and national goals, as well as their knowledge of the county□s population; the instructions also specified that up to two dots could be placed on one issue. The dots were counted to determine the top six issues to focus on for the afternoon session.

The initial results were in order by number of □dots□:

1) Mental Health
2) Diabetes
3) Obesity
4) Hypertension/Stroke
5) Heart Disease
6) Asthma
7) Cancer
8) □iolence/Domestic □iolence
9) HI□
10) Substance Use Disorder

The results were reviewed, and the consultant led the group in a discussion about the issues not included in the top six. Participants were then given one additional dot and were instructed to place it on their top priority for the four issues ranked the lowest; this plus the group discussion resulted in cancer and violence/domestic violence being included for prioritization. The consultant then led the group in discussing the reduced list of issues, and

participants were encouraged to share their concerns of the population they were representing.

The final first round results that the group decided to further consider were:

1) Mental Health
2) Diabetes
3) Obesity
4) Hypertension/Stroke
5) Heart Disease
6) Asthma
7) Cancer
8) □iolence/Domestic □iolence

Discussion about the priorities focused on how mental health is overarching, and intersects with overall health and an individual□s perception and judgment. The group also discussed how many of the top issues were related through a cardio-metabolic lens, and that identifying diseases with common causes and symptoms can help to reduce the collective impact.

In the afternoon session, a second round of prioritization was completed with participants each receiving four dots to place on the remaining issues and instructions that only one dot could be used per issue. The results of this second round were (in order):

1) Mental Health
2) Obesity
3) Diabetes
4) Cancer
5) Heart Disease

with Hypertension/Stroke, Asthma, and □iolence receiving fewer votes. Through the following discussion, participants considered grouping Hypertension/Stroke with Heart Disease as overall cardiovascular health. This led to a further focus on the commonalities between the issues, and came to a consensus of two priority □groups□□□**he final groupings were agreed upon by nearly all participants, and included:**

1) □**ehavioral □ealth:** Mental Health, Substance Use, Domestic □iolence/□iolence
2) □**etabolic Syndrome:** Obesity, Diabetes, Heart Disease, Hypertension/Stroke

The participants also viewed the remaining issues of Cancer, Asthma, and HI□ as □stand-alone□issues that would need to be considered individually. The participants reviewed the voting and discussion for these issues, and determined that an additional community priority would be:

3) **Cancer**

The overall consensus building process included discussion about the priorities, limitations, and need within the county (included in **Attachment E**). Issues that affected the represented populations that were not included in the prioritization process were also discussed and captured through use of a "parking lot" and by staff taking notes throughout the process.

Parking Lot

Throughout the process, the consultant encouraged participants to document and discuss health issues not included in the prioritization process. These issues included:

- Dental
- Sexually Transmitted Infections
- Maternal and Child Health
- Dementia/Alzheimer's
- Injury
- Disability
- COPD
- Lead
- Kidneys

The parking lot was discussed and reviewed for clarity and to access value for the prioritization process. It was determined that some of the parking lot areas would combine into other health areas, and others would be discussed in the future and considered within individual organizations and agencies. Overall, dental health was the issue most discussed, and several participants shared the challenges faced by the residents they serve to obtain dental care.

Conclusion

The participants were asked to continue to represent county residents beyond the prioritization meeting to monitor the progress for the CHNA plans and implementation for the selected priorities, and were asked about the frequency of meetings to review progress. The suggested meeting frequency included:

- Once per year (5 participants)
- 2 Times per year (9 participants)
- 4 Times per year (8 participants)
- Monthly (1 participant)

Overall, participants widely recommended ongoing updates, a focus on preventive care, and continued dialogue, education and coordination of resources and partnerships.

Attachment A: Prioriti□ation Participants and Roles Represented

Name	Organization	Title	Category Represented	Attended
Kleinman, DDS, MScD, Dushanka	University of Maryland School of Public Health, Department of Epidemiology and Biostatistics	Associate Dean for Research and Professor	Academia	Yes
Terry, Milly	African Women's Cancer Awareness Association		African Immigrants	Yes
Grant, Teresa	PGC Department of Family Services	Community Developer/Program Manager	Aging Services	Yes
Carvana, Anthony	Community Counseling and Mentoring Services, Inc.	Executive Director	Behavioral Health	Yes
McDonough, Mary Lou	PGC Department of Corrections	Director	Criminal Justice System	Yes
Howell, Michelle	The ARC	Director, Quality Advancement & Nursing	Disabled Community	Yes
Shiver, Sanders	PGC Public Schools	Program Manager	Early Childhood	Yes
Hoban, Evelyn	PGC Health Department	Associate Director	Environmental Health	Yes
Hall,PhD, MPH, Clarence	PACANet USA	President	Faith-based Leaders	Yes
Belon-Butler, Elana	PGC Department of Family Services	Director	Family Services	Yes
Gomez, Maria	Mary's Center	CEO	FQHC/Community Clinics	Yes
LoBrano, MD, Marcia	Community Clinic, Inc.	Chief Medical Officer	FQHC/Community Clinics	Yes
Malloy, Colenthia	Greater Baden Medical Center	Executive Director	FQHC/Community Clinics	Yes
Matthews, Saundra	Community Clinic, Inc.	Nursing Director	FQHC/Community Clinics	Yes
Demus, Leslie	Heart to Hand	Community Health Worker	Frontline/Grassroots	Yes
Spann, Monica	PGC Health Department Health Enterprise Zone	Community Health Worker	Frontline/Grassroots	Yes

Name	Organization	Title	Category Represented	Attended
Aldoory, PhD, Linda	University of Maryland, Department of Communication	Associate Professor	Health Literacy	Yes
Wilson, Alicia	La Clinica del Pueblo	Executive Director	Hispanic Population	Yes
Moore, Major Elaine	PGC Police Department	Major	Law Enforcement	Yes
Cooper, MD, Carnell	Dimensions Healthcare System/Prince George's Hospital Center	Chief Medical Officer, Dimensions Healthcare System & VP, Medical Affairs, Prince George's Hospital Center	Medical Provider	Yes
Hall, MD, Trudy	Laurel Regional Hospital Center	VP, Medical Affairs	Medical Provider	Yes
Johnson-Threat, MD, Yvette	Medstar Southern Maryland Hospital Center	VP, Medical Affairs	Medical Provider	Yes
Moore, Sherri	Doctors Community Hospital	Development Officer	Medical Provider	Yes
Smith, MD, Sharnell	Ft. Washington Medical Center/Nexus	General Surgeon	Medical Provider	Yes
Sullivan, Tiffany	Dimensions Healthcare System	VP, Population Health	Medical Provider	Yes
Waters, MD, JD, FCLM, Victor	Ft. Washington Medical Center/Nexus	Chief Medical Officer	Medical Provider	Yes
Proctor, Natalie StandingontheRock	Wild Turkey Clan, Cedarville Band of Piscataway Conoy	Tribal Chairwoman	Native Americans	No
Dodo, Kodjo	PGC Health Department, WIC Program	Program Chief	Nutrition	No
Hewlett, Elizabeth	Maryland National Park and Planning Commission	Chairwoman	Parks and Recreation	Yes
Bryant, Tracy	United HealthCare Community Plan	Community Development Specialist	Payer	Yes
Moorehead, Creighton	Norvartis (formerly with Kaiser)	Pharmacist	Pharmacy	Yes
Amin, Mena	The Community Foundation, Prince George's County	Program Officer	Philanthropy	Yes
Barron, Erek	House of Delegates	Delegate	Policymaker	Yes
Owusu-Acheaw, Pokuaa	For Senator Joanne Benson	Staff Member	Policymaker	Yes
Creekmur, Pamela B.	PGC Health Department	Health Officer/Director	Prince George's Health Action Coalition	Yes

Name	Organization	Title	Category Represented	Attended
Harrington, David	PGC Chamber of Commerce	President	Private Business	No
Carter, MD, PhD, Ernest	PGC Health Department	Deputy Health Officer	Public Health Professionals	Yes
Brown, Eric	PGC Department of Housing and Community Development	Director	Public Housing Authority	No
Wood, Dennis	PGC Fire/EMS Department	Deputy Fire Chief	Public Safety/EMS	Yes
Frankel, Brian	PGC Fire/EMS Department	Asst. Chief, Emergency Medical Services	Public Safety/EMS	Yes
Bates, RN, MS, Karen	Office of School Health, Prince George's County Public Schools	Nursing Supervisor	School Health	Yes
Brown, Gloria	PGC Department of Social Services	Director	Social Services	Yes
Bruce, Geralyn	PGC Dept. Public Works & Transportation	Acting Chief, Transit Services	Transportation	Yes
Snowden, Carol Lynn	PGC Department of Family Services	Community Developer/Program Manager	Veterans	Yes

Attachment □: Prioriti□ation Agenda

Prince □eorge□s County

Community □ealth □eeds Assessment
Prioriti□ation Session

Friday April 22, 2016
8:30 AM – 3:30 PM
Prince George□s County Health Department
1801 McCormick Drive
Largo, MD 20774

A□E□DA

□:□0 A□ □ □:00 A□	Registration□Continental □rea□fast
□:00 A□ □ □:□0 A□	Introduction□Expectations for the Day
□:□0 A□ □10:□0 A□	Data Overview
10:□0 A□ □10:□□ A□	□rea□
10:□□ A□ □11:□□ A□	Prioriti□ation Round I
12:00 A□ □12:□□ P□	Lunch
12:□□ P□ □2:00 P□	Prioriti□ation Round II
2:00 P□ - 2:1□ P□	□rea□
2:1□ P□ □ □:□0 P□	Prioriti□ation Round II
□:□0 P□	Closing

Attachment C: Prioriti□ation Presentation

1. Background:

2011 Local Health Improvement Plan

1. Access to Care
- ACA Capital Connector Entity
- HEZ
- Collaboration with FQHCs/Providers

2. Chronic Diseases with Focus on Obesity
- Be a Part of the Healthy Revolution /HEAL
- On the Road Diabetes Program
- Step It Up initiative

3. Birth Outcomes (Infant Mortality)
- Infant at Risk Program

1. Background:

2011 Local Health Improvement Plan

4. HIV/STI/TB
- Routinizing Testing
- Linkage to care

5. Safe Physical Environments
- Health Impact Assessments
- Pedestrian Injury Education

6. Safe Social Environments
- Overdose Prevention Program
- Safe Neighborhoods Gun Violence Program

1. Background:

- UMD Transforming Health: Public Health Impact Study (2012) focus on healthcare services
- Primary Healthcare Strategic Plan (2015) also focused on healthcare services

2. The CHNA Process

- CHNA are an IRS requirement for hospitals
- CHNA are a requirement for public health accreditation

But most importantly…….

2. The CHNA Process

- It's time: communities and their needs change
- Responsibility to understand the needs of the community we serve
- Shared ownership of the community's health
- Community engagement is critical
- Community partner engagement is critical

2. The CHNA Process: What are the pieces

- Demographics and Population Description
- Health Indicators
- Key Informant Interviews (N=24)
- Community Expert Survey (N=92)
- Community-at-large Survey (N=225 English, N=124 Spanish)
- Resources and Assets Inventory

2. The CHNA Process: What are the pieces

- Prioritization Process
- Implementation
- Monitoring and Evaluation

3. Prioritization Process

- Data-driven
- Representative of the community
- Diverse stakeholder engagement
- Result in comprehensive community priorities
- Used to guide and help implement plans

3. Prioritization Process

Looking at the data:

- Magnitude of the Problem
- Trend
- Severity/consequences
- Perceived Preventability
- National/State Goals
  - HP 2020
  - Maryland SHIP

4. Social Determinants

- Economic Stability
  - Poverty, Employment, Food Security, Housing Stability
- Education
  - High School Graduation, Higher Education, Language and Literacy, Early Childhood and Education Development
- Neighborhood and Build Environment
  - Access to Healthy Foods, Housing Quality, Environmental Considerations, Crime

4. Social Determinants

- Social and Community Context
  - Social Cohesion, Civic Participation, Perceptions of Discrimination and Equity, Incarceration, Institutionalization
- Health and Health Care
  - Access to Healthcare, Access to Primary Care, Health Literacy

Health Issues for Prioritization

- Asthma
- Cancer
- Diabetes
- Heart Disease
- HIV
- Hypertension/Stroke
- Mental Health
- Obesity
- Substance Use
- Violence/Domestic Violence

What Was Not Selected:

- Maternal/Infant Health
- STIs
- Infectious Disease
- Dental Health
- Dementia/Alzheimer's
- Unintentional Injuries
- Disabilities
- Lead Poisoning
- Kidney Disease

Asthma

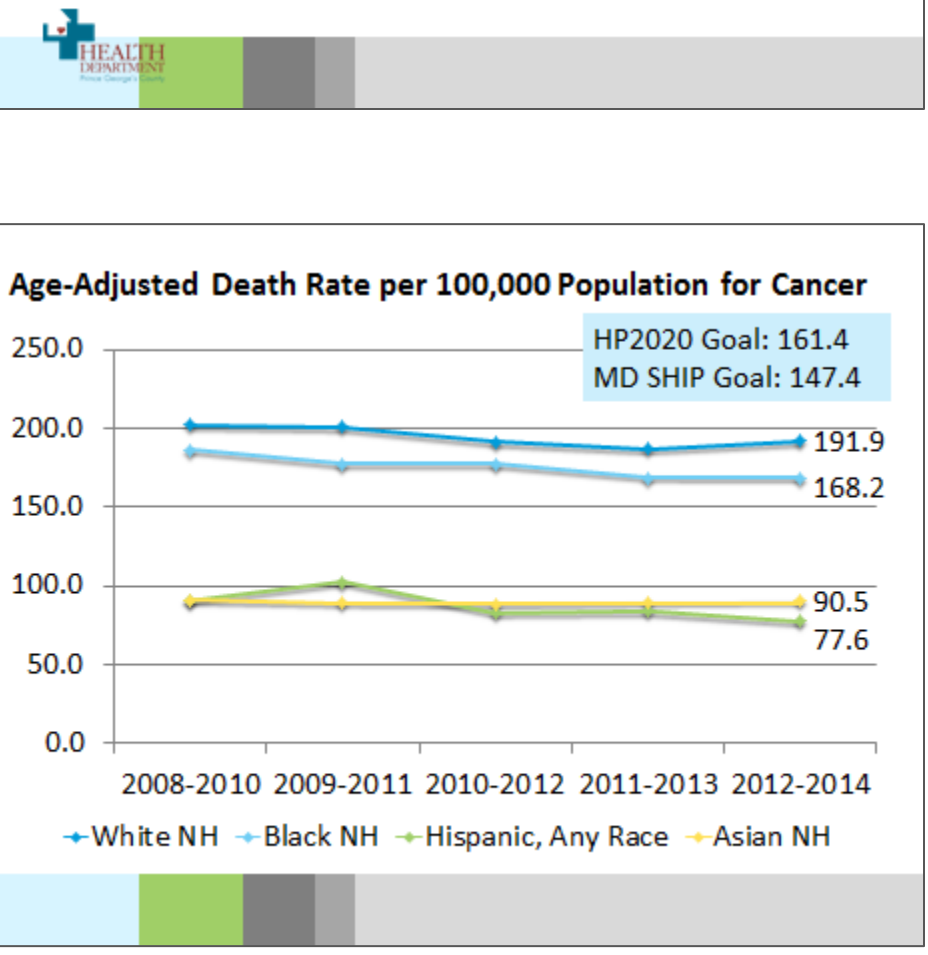
- 14.3%, or nearly 100,000 of adults are estimated to have asthma (MD 2014 BRFSS)
- 13.9% of children are estimated to have asthma (MD 2013 BRFSS).
- 16.7% of Black, non-Hispanic (NH) adults are estimated to have asthma compared to 10.0% of White, NH adults.
- More females (18.5%) than males (9.6%) are estimated to have asthma

Age-Adjusted Hospitalization Rate due to Pediatric Asthma, 2010-2012

Demographic	Hospitalizations per 100,000 Population <18 Years
Race and Ethnicity	
White, non-Hispanic	5.4
Black or African American	18.5
Asian or Pacific Islander	6.3
American Indian or Alaska Native	33.6
Age Group	
0 to 4 Years	26.9
5 to 9 Years	20.7
10 to 14 Years	9.4
15 to 17 Years	2.9
TOTAL	**16.2**

Cancer

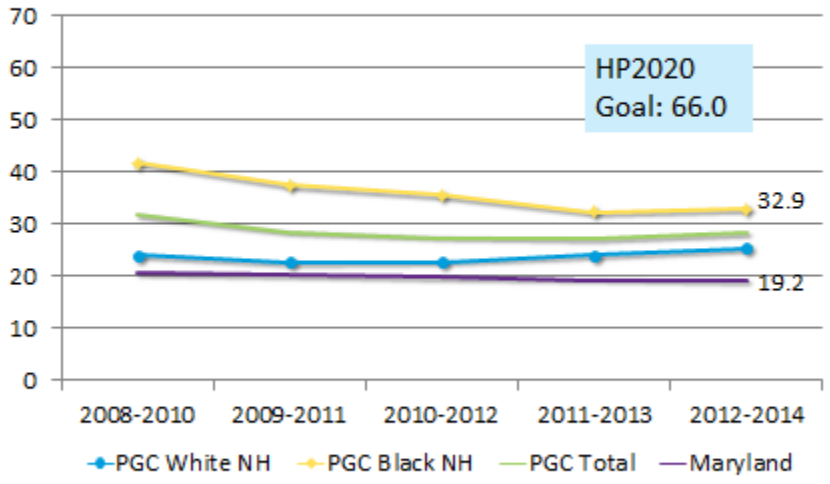
- In 2011, 3,235 residents were diagnosed with cancer in the county, and the cancer incidence rate was 390.0 per 100,000 residents
- In 2011, men had a much higher cancer incidence rate (475.5) than women (333.1)
- In 2011, Black residents had the highest cancer incidence rate
- In 2014, there were 1,349 deaths from cancer in the county, which accounted for one out of every four deaths



Diabetes

- Estimated 11.5% of adult residents (78,525) and nearly as many with pre-diabetes
- One in three residents over 65 has diabetes
- All community input noted diabetes as a leading issue (or the leading issue) in the county

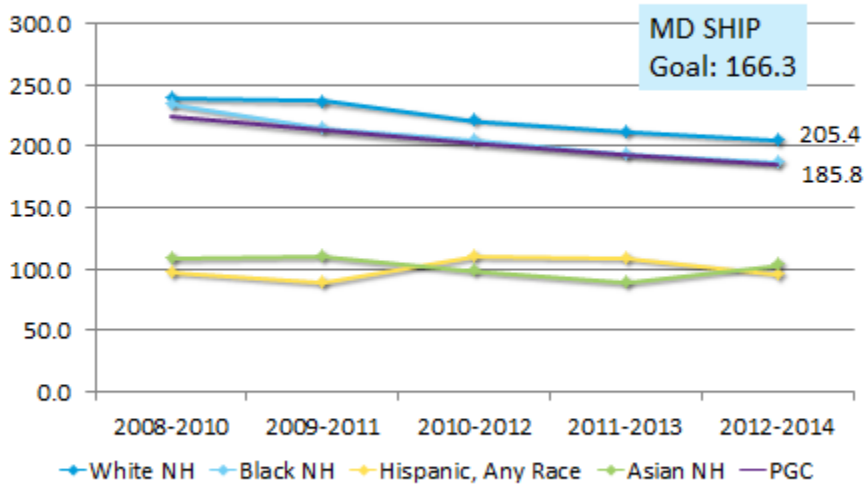
Age-Adjusted Death Rate per 100,000 Population for Diabetes, 2008-2014



Heart Disease

- Leading mortality rate in the county, and second highest by number (24% of deaths)
- Men have a higher mortality rate than women (233.5 versus 150.9)
- Black non-Hispanic residents have a higher ED Visit Rate for Heart Disease, but White, non-Hispanic residents have a higher mortality rate

Age-Adjusted Death Rate for Heart Disease per 100,000 Population, Prince George's County

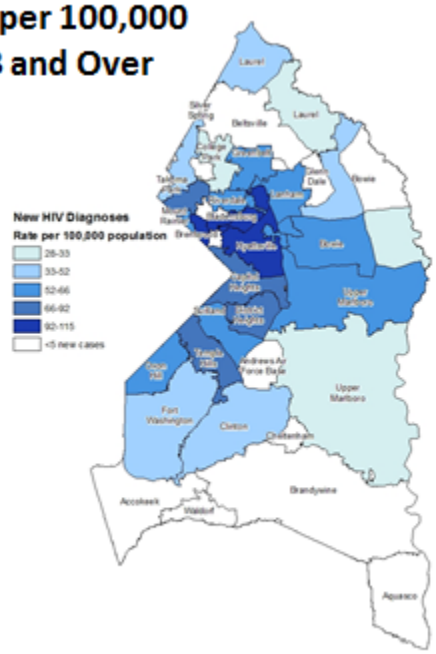


HIV

- 418 residents were diagnosed with HIV in 2013, a rate of 56.2 per 100,000.
  - From 2009 to 2013, new cases in Baltimore City and Washington, D.C. fell by 40%; the county only saw a 12% reduction
- 73% of new cases were men
- 85% of new cases were Black, non-Hispanic

2013 New HIV Cases per 100,000 Population, Age 13 and Over

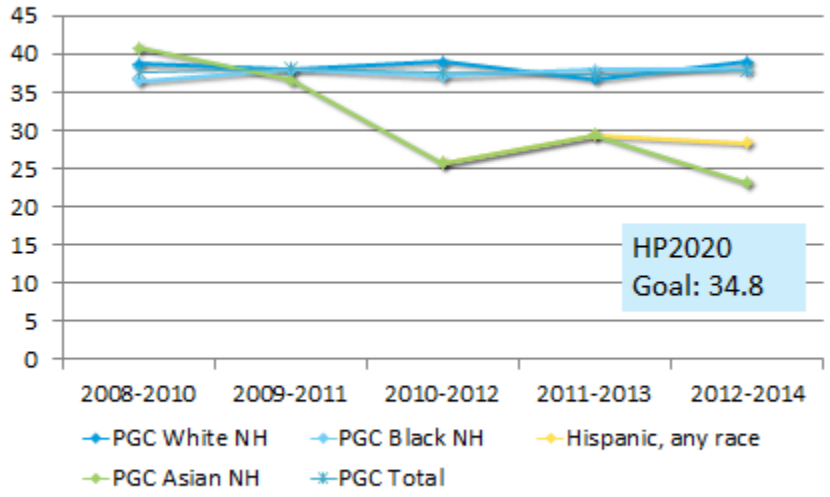
Maryland SHIP Goal: 26.7



Hypertension and Stroke

- Overall, 37.9% (252,160) of adults are estimated to have hypertension in the county
- Over 75% of residents aged 65+ and nearly half (47.8%) of adults ages 45 to 64 are estimated to have hypertension
- Black, not-Hispanic residents have more than double ED visit rate compared to the next closest group (White, not-Hispanic), but their mortality rate is about the same
- 279 residents died from strokes in 2014

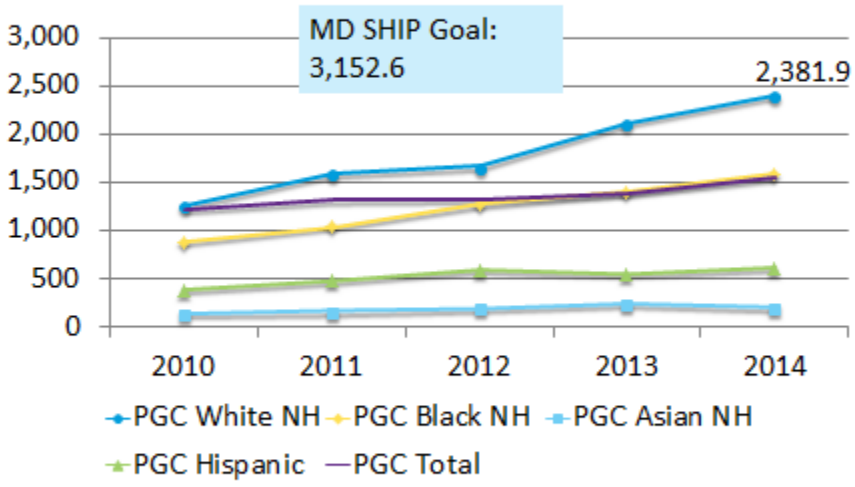
Age-Adjusted Death Rate per 100,000 for Stroke, Prince George's County



Mental Health

- 10.9% (74,502) of residents reported experiencing at least 8 days of poor mental health during the last 30 days (2014 MD BRFSS)
- In 2014, there were 51 suicide deaths in the county.
- White non-Hispanic residents had a higher Emergency Department (ED) visit rate related to mental health conditions compared to other county residents.
- The suicide rate was also higher among White non-Hispanics compared to other county residents.

Age-Adjusted Rate of Emergency Department* Visits per 100,000 Population Related to Mental Health Conditions, 2014



Obesity

- 34.2% (218,270) of adults in the county are estimated to be obese, and an additional 34.1% are considered to be overweight. (2014 MD BRFSS).
- More females (40.4%) than males (27.5%) are estimated to be obese.
- In 2013, 52.6% (310,107) of adults did not meet physical activity recommendations
- In 2013, 13.7% of high school students were considered obese .

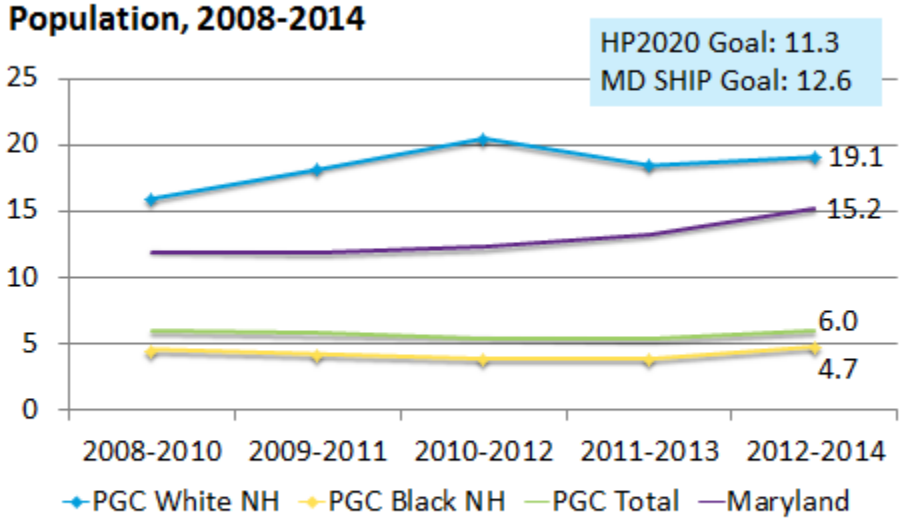
Percent of Adults Who Are Obese, 2014
Healthy People 2020 Goal: 30.5%

	Prince George's	Maryland
Overall	34.2%	29.6%
Sex		
Male	27.5%	27.8%
Female	40.4%	31.3%
Race/Ethnicity		
White, non-Hispanic	34.6%	27.9%
Black, non-Hispanic	38.9%	39.1%
Hispanic	20.9%	22.6%
Age Group		
18 to 44 Years	25.9%	25.8%
45 to 64 Years	42.8%	34.8%
Over 65 Years	42.9%	29.0%

Substance Use Disorders

- In 2014, 14% of county residents reported binge drinking, and 4.5% indicated they chronically drink (BRFSS).
- There were 855.6 Emergency Room visits per every 100,000 county residents in 2014.
- In 2013, 13.3% of high school students reported using tobacco.
- White non-Hispanic residents had a higher Emergency Department (ED) visit rate and higher drug-induced death rate compared to other county residents.

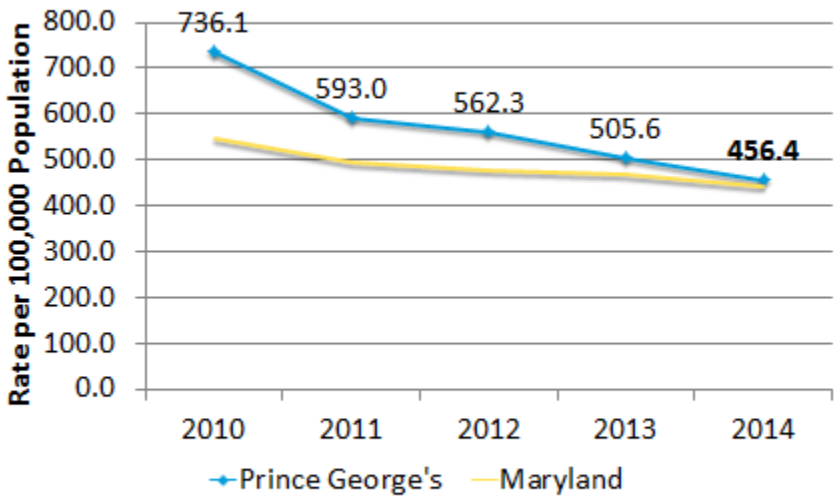
Age-Adjusted Drug-Induced Death Rate per 100,000 Population, 2008-2014



Violence/Domestic Violence

- There were 4,490 violent crimes (includes homicide, rape, robbery, and aggravated assault) in 2014, and 66 residents in the county died by homicide. (MD Vital Statistics).
- In 2014, there were 2,083 reports of domestic violence in the county . (Maryland Network Against Domestic Violence).
- From July 2014 to June 2015 there were 14 domestic violence-related deaths. (Maryland Network Against Domestic Violence).

Violent Crime* Rate, 2010 to 2014



Attachment D: Data Summary Example

Cancer

Overview	Prince George's County
What is it?	Cancer is a term used for diseases in which abnormal cells divide without control and can invade other tissues; there are more than 100 kinds of cancer.
Who is affected?	In 2011, 3,235 residents were diagnosed with cancer in the county, and the cancer incidence rate was 390.0 per 100,000 residents. In 2014, there were 1,349 deaths from cancer in the county, which accounted for one out of every four deaths.
Prevention and Treatment	According to the CDC, there are several ways to help prevent cancer: • Healthy choices can reduce cancer risk, like avoiding tobacco, limiting alcohol use, protecting your skin from the sun and avoiding indoor tanning, eating a diet rich in fruits and vegetables, keeping a healthy weight, and being physically active. • The human papillomavirus (HPV) vaccine helps prevent most cervical cancers and several other kinds of cancer; the hepatitis B vaccine can lower liver cancer risk. • Screening for cervical and colorectal cancers helps prevent these diseases by finding precancerous lesions so they can be treated before they become cancerous. Screening for cervical, colorectal, and breast cancers also helps find these diseases at an early stage, when treatment works best. Cancer treatment can involve surgery, chemotherapy, radiation therapy, targeted therapy, and immunotherapy.
What are the outcomes?	Remission (no cancer signs or symptoms); long-term treatment and care; death.
Disparity	Overall, men had a higher cancer incidence rate (475.5) than women (333.1), and Black residents had a higher rate (393.4) compared to White and Asian residents in 2011 (Source: 2014 MD Cancer Report). Men also had a higher mortality rate at 197.7 compared to women (143.9), and Black residents had a slightly higher mortality rate (165.7) compared to White residents (161.7). By cancer type, Black residents in the county had higher incidence and mortality rates for breast, colorectal, and prostate cancers.
How do we compare?	Prince George's County 2011 age-adjusted cancer incidence rate was 390.0 per 100,000 residents, much lower than the state at 440.7; other Maryland counties range from 387.4 to 553.7 (2014 MD Cancer Report). The age-adjusted death rate for the county from 2012-2014 was 156.5, compared to Maryland at 162.0 with a range of 121.7 to 208.5 across the counties. The county is similar to the state for cancer screening.
Key Informant Interviews	Cancer was not specifically noted in the interviews.
Community Expert Survey	85% of respondents indicated cancer was a major or moderate issue in the county. Cancer was ranked as the fifth most important health issue.
Community-at-large Survey	66% of English survey participants and 62% of Spanish survey participants indicated cancer is at least a major or moderate problem in the county. Cancer was ranked as one of the top 5 health issues.

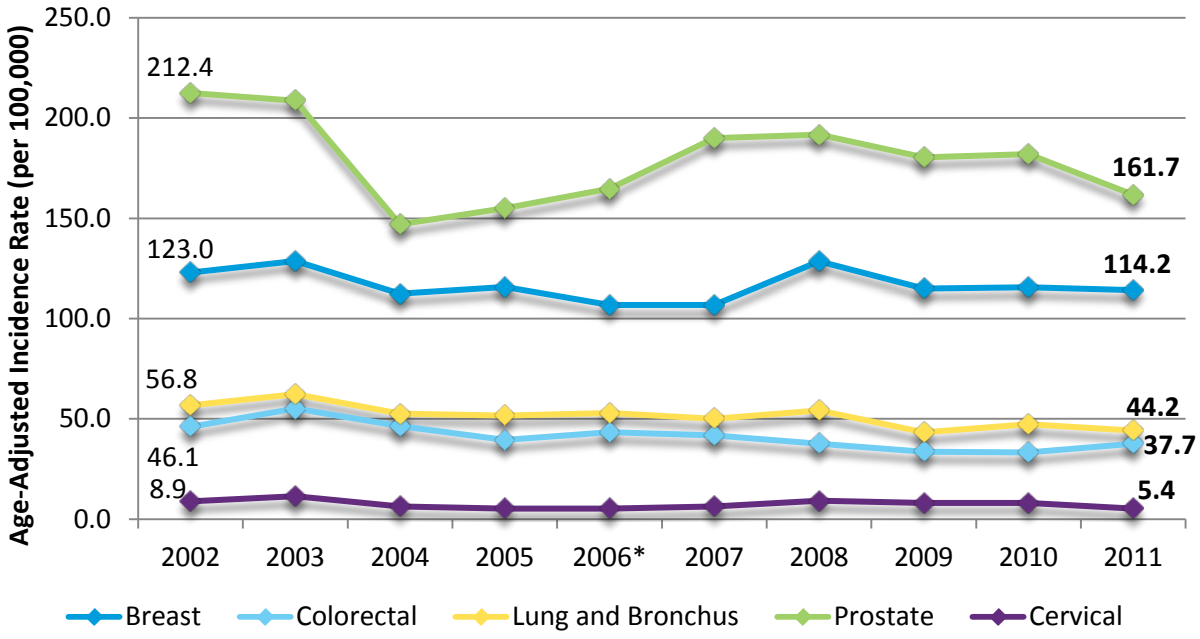
Cancer

Cancer Age-Adjusted Incidence Rates per 100,000 Population, Prince George's County

Year	All Sites	Breast	Colon	Lung and Bronchus	Prostate	Cervical
2002	435.0	123.0	46.1	56.8	212.4	8.9
2003	463.0	128.7	55.1	62.4	208.7	11.4
2004	386.3	112.4	46.4	52.6	147.0	6.4
2005	386.3	115.8	39.5	51.7	155.0	5.3
2006*	364.4	106.8	43.4	53.0	164.7	5.3
2007	409.8	106.8	41.7	50.1	189.9	6.3
2008	429.1	128.6	37.7	54.2	191.7	9.2
2009	387.6	115.0	33.7	43.3	180.4	8.2
2010	403.5	115.6	33.3	47.4	182.0	8.2
2011	390.0	114.2	37.7	44.2	161.7	5.4

* 2006 incidence rates are lower than actual due to case underreporting
Data Source: Maryland Department of Health and Mental Hygiene, Annual Cancer Report, 2006-2014

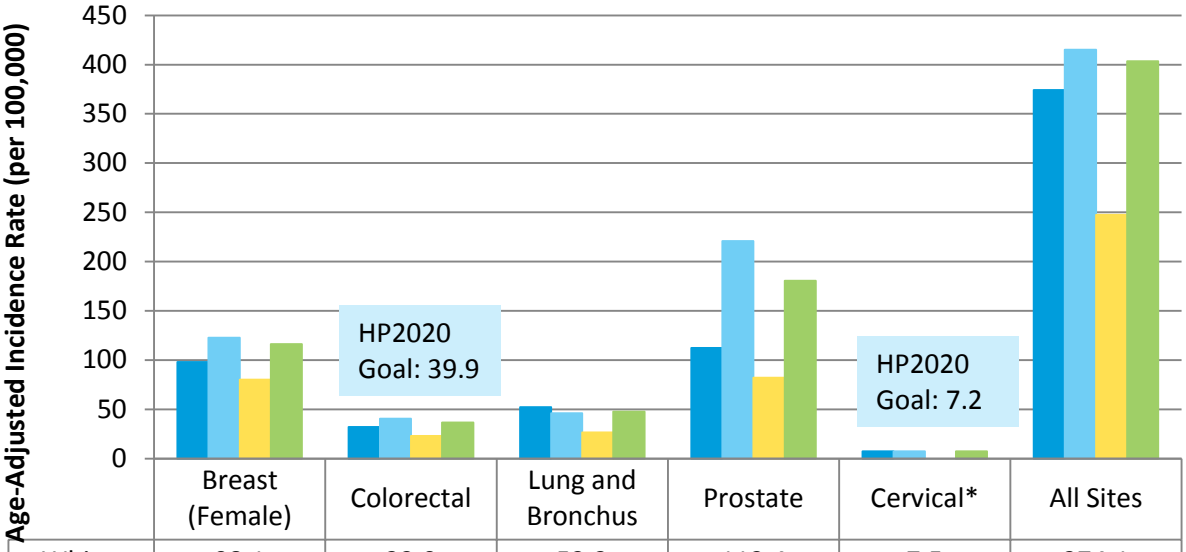
Cancer Age-Adjusted Incidence Rates by Type, Prince George's County, 2002-2011



*2006 incidence rates are lower than actual due to case underreporting
Data Source: Maryland Department of Health and Mental Hygiene, Annual Cancer Report, 2006-2014

Cancer

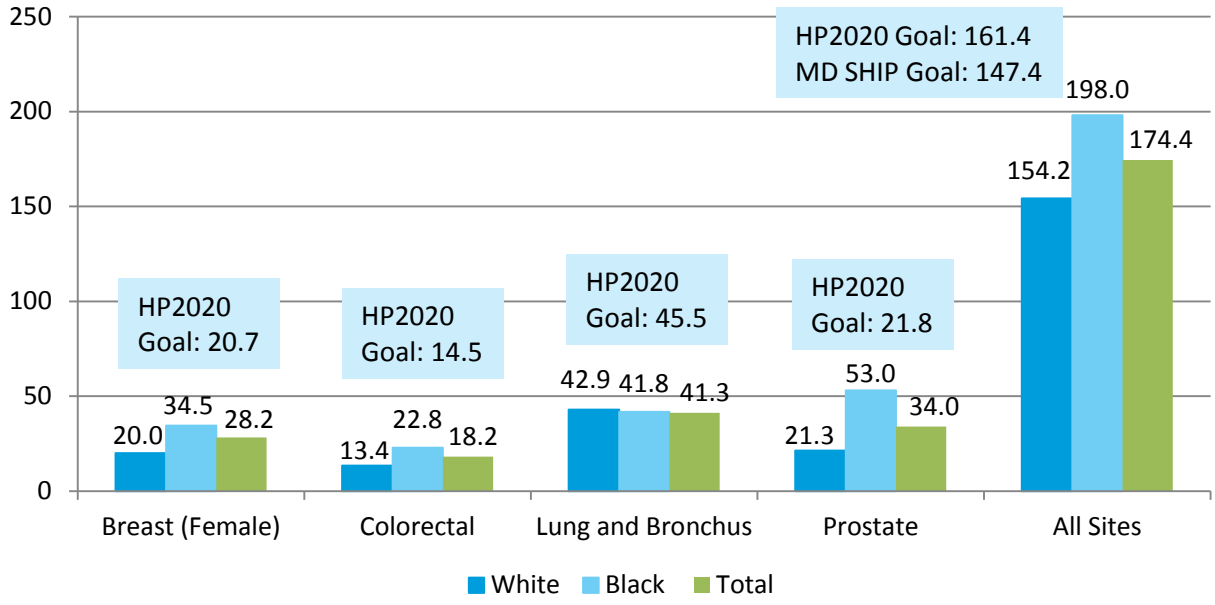
Cancer Age-Adjusted Incidence Rates by Race, Prince George's County, 2007-2011



	Breast (Female)	Colorectal	Lung and Bronchus	Prostate	Cervical*	All Sites
White	98.1	32.0	52.3	112.4	7.5	374.1
Black	122.7	40.4	45.9	220.8	7.4	415.0
Asian/PI	80.1	22.9	26.6	82.2		247.4
All Races	116.1	36.7	47.7	180.4	7.4	403.5

*Cervical cancer age-adjusted incidence rate unavailable for Asian/PI.
Source: Maryland Department of Health and Mental Hygiene, Annual Cancer Report, 2014
Individuals of Hispanic origin were included within the White or Black estimates and are not listed separately

Cancer Age-Adjusted Mortality Rates by Race, Prince George's County, 2007-2011

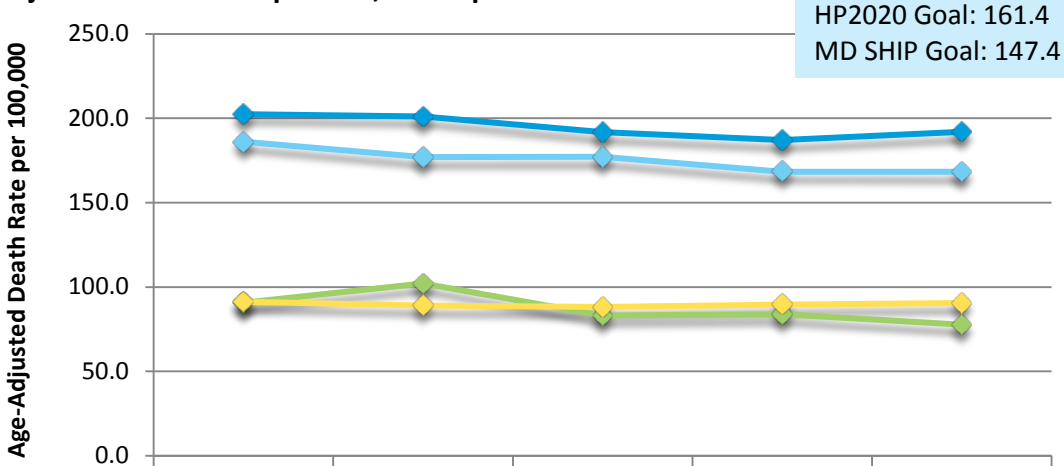


Source: Maryland Department of Health and Mental Hygiene, Annual Cancer Report, 2014
Individuals of Hispanic origin were included within the White or Black estimates and are not listed separately; Asian/Pacific Islanders were omitted due to insufficient numbers.

Cancer

Age-Adjusted Death Rate per 100,000 Population for Cancer

HP2020 Goal: 161.4
MD SHIP Goal: 147.4



	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014
White NH	202.3	200.9	191.6	187.0	191.9
Black NH	186.0	176.9	177.0	168.6	168.2
Hispanic, Any Race	90.7	101.9	83.0	83.7	77.6
Asian NH	91.2	89.0	88.1	89.5	90.5

Data Source: CDC, National Center for Health Statistics, CDC WONDER Online Database

Residents Lacking Cancer Screening, Prince George's County, 2014

Cancer Screening	Target Group	Total Population	Percentage not Screened	Estimated Population not Screened
Prostate Specific Antigen (PSA) in past 2 years	Men 40 years and older	183,641	**51.0%**	**93,657**
Colorectal Cancer Screening with Sigmoidoscopy or Colonoscopy in past 2 years	Men and women 50 years and older	277,992	**41.0%**	**113,977**
Mammography in past 2 years	Women 50 years and older	155,596	**16.3%**	**25,362**
Pap Smear in the past 3 years	Women 18 years and older	368,450	**22.9%**	**84,375**

Source: 2014 Maryland BRFSS, DHMH www.marylandbrfss.org; 2014 1-Year Estimates, U.S. Census Bureau, Table B01001 www.census.gov

Attachment E: Prioriti□ation Process Discussion □otes

□*iscussion after □ata Presentation*□

Data □eeds and Observations

- Need for data from private providers and community health centers
- Need data from Urgent Care Centers
- Need information on children and health disparities
- Need data about Youth; Youth Risk Behavioral Survey (YRBS) data is not always routinely available (supposed to be collected every other year)
- Demographic designations in data collection tools may vary from the way respondents self-identify, and racial categories are too broad to capture the diversity within the county
- Mental Health data need to be broken into sub-groups. Mental health is too broad to understand all the issues
- Need measures of unmet need and gaps
- Need to look at health trends in children as predictors for health disparities in adults
- White men are most studied, and have the widest and best data sets
- Much current health data reflects deaths rates; need data on living cases across disparities
- Need to track the correlation between HI□ and incarceration
- Data doesn□t support high use of opioids in the county; PCP usage is high and a problem
- HI□ incidence still trends younger in the county, but nationally HI□ is becoming more of a problem in the older population

Insight Shared by Participants about their Service Population

- Immigrant communities may be missing from data reporting due to lack of insurance and inability to access health services or ED visits
- Undocumented PG residents may obtain services in DC where there is wider availability of immigrant-centered services
- There is likely a higher rate of women dying from heart disease that is undiagnosed. Many Black women are dying with significant heart damage. However, it is not being listed as the primary cause of death
- There is a lot of people who move in and out of various jurisdictions and seek health services in various settings for varied lengths of time
- Mental health / Suicidal ideations may be overlooked. May manifest with other presentations (self-medication, abuse, etc.)
- Mental illness is cross-cutting issue
- Hard to decouple substance abuse and mental health
- Lot of underreporting of substance abuse
- Many people have many health issues that are undiagnosed

- Culture is a key consideration - For some communities it is perceived as healthy / prosperous to be a bit overweight
- Uninsured is a social determinant that must be considered (approximately 10% of county residents are uninsured)

Additional Discussion

- Diverse communities need to be at the planning tables from the beginning
- Transportation needs to be a part of the equation
- Need more support for F□HC□s and private providers to come into PG County

□iscussion after Prioriti□ation Round □□

Discussion about □ighest Ran□ed Issues

- Mental health is tied into perception, judgment
- Mental health was good to be highly selected
- Mental health is overarching. Hard to discuss any other health issues if people are not thinking clearly; votes demonstrate that everyone sees the intersection
- Cardio-metabolic lens. We can identify diseases with common risk factors to try to reduce the collective impact;

Discussion about Lower-ran□ing Issues □ran□ed □-10□

- □iolence and Domestic □iolence are connected to the entire household, and have long-term and far-reaching effects.
- HI□ has potential to be successful with the HI□ education and prevention components
- HI□ is important because it is connected to STI□s
- HI□ and substance use are connected to all of the health issues
- Surprise that cancer was rated so low given the data just presented; discussion that cancer may have ranked lower because it already receives a lot of attention

Closing □iscussion after Prioriti□ation Round □□

- We have to treat the *reason* for the illness.
- Any intervention has to be broad enough to have an impact on the issues and the cause
- Obesity and diet impacts the gamut of health

- □eep obesity in the conversation. Can be good for adults and pediatric patients. Discussing obesity can lead to discussions on heart disease, diabetes, hypertension □ stroke
- Need data on co-morbidities that occur with the prioritized issues
- Dental needs to be added across clusters (dental impacts cancer, surgery, elderly, maternal health, school)
- Need to address preventable deaths (asthma, suicide)
- Asthma is being treated but underreported

Additional feedback/recommendations received from participants during the day included:

- Using the Public Health Information Network (PHIN)
- Need for expanded funding
- Recommendation to pursue alternative services outside of the criminal justice system to address mental health crisis or substance abuse issues

Prince □eorge□s County
Resources and Assets, 201□

NAME	ADDRESS	ZIP CODE	TELEPHONE	POPULATION	Access	Advocacy & Legal Services	Awareness and Health Promotion	Case Management, Navigation or Care Coordination Services	Crisis, Emergency, or Financial Assistance Services	Disability Services	Early Childhood	Education and Self-Management	Food and Nutrition Services	Health Services	Housing	Prevention Services	Recreation and Physical Activity	Referral Services	Research	Screening & Testing	Senior Services	Support Groups, Counseling, and Recovery Services	Youth Services	SERVICES
Access to Wholistic and Productive Living Institute, Inc.	3611 43rd Avenue	20722	240.467.6215	General population			X					X				X			X					services in tobacco control, community participatory research, consulting, trainings, health disparities (infant mortality, cardiovascular disease, obesity, hypertension, cancer) prevention, promotion, interventions/policy and advocacy
Adam's House	5001 Silver Hill Rd	20746	240.492.2510	Male and female ex-offenders		X	X	X	X			X				X				X		X		individual and group counseling, HIV/AIDS & STI testing, health education, crisis intervention, family court services, and anger management
Adelphi/Langley Park Family Support Center	8908 Riggs Rd	20783	301.431.6210	Residents of Adelphi/Langley Park communities							X	X						X						education, employment readiness and links to community services. Emphasis on family literacy and parent/child activities
Adult Protective Services	925 Brightseat Rd	20785	301.909.2228	Adults residing in Prince George's County		X	X														X			provides protection and remedial activities on behalf of elders and dependent adults unable to protect their own interests
Adventist Community Services of Greater Washington	501 Sligo Avenue	20910	301.585.6556	General population								X	X											food bank, nutrition services, education services
Advocates for Youth	2000 M St. NW, STE 750	20036	202.419.3420	Adolescents		X	X					X											X	efforts that help young people make informed and responsible decisions about their reproductive and sexual health
Affiliated Sante' Group—Lanham	4372 Lottsford Vista Rd.	20706	301.429.2171	General population				X	X			X		X								X		manages mental health outreach, psychiatric recovery services, and crisis services
Affordable Behavioral Consultants	1400 Mercantile Lane, Suite 206	20774	301.386.7789	General population										X								X		Outpatient mental health counseling and treatment
Ager Road United Methodist Church	6301 Ager Road West	20782	301.422.2131	General population									X											food bank and nutrition services
Aging and Disabilities Resource Services Division: PGC Department of Family Services	6420 Allentown Road	20748	301.265.8450	Older adults		X	X	X	X	X		X	X	X		X		X			X			Health promotion and disease prevention, disease management education, meals and nutrition, at home assistance, subsidies, legal assistance, and senior care
Alcoholic Anonymous—Greater DC area			202.966.9115	General population with alcohol addiction issues														X				X		12-step programs for alcoholism
Alek's House	4200 Forbes Boulevard, Suite 122	20706	301.429.6100	General population																				counseling and therapy services for individuals, couples and families in and around Lanham, MD
American Cancer Society	7500 Greenbelt Center Drive, Set 300	20770	202.483.2600	General population		X	X					X				X			X			X		Education, advocacy, and services related to cancer prevention and control
American Diabetes Association: National Capital Area	1400 16th Street Northwest #410	20036	202.331.8303	General population		X	X					X							X					Provides resources on diabetes and diabetes prevention, including weight management information, nutrition education materials/information, and physical activity information on the website and in print.
American Heart Association-Maryland	217 E. Redwood St., 23rd Floor	21202	410.685.7074	General population		X	X					X				X			X					Advocacy, awareness, education, policy development, prevention, and research related to cardiovascular disease
American Lung Association in Maryland	211 E. Lombard St., #260	21202	202.747.5541	General population		X						X							X					Education, advocacy, and research related to lung disease
American Rescue Workers	716 Ritchie Road	20743	301.336.6200	General population					X			X	X									X		Christian addiction recovery services, food services, disaster relief, and continuing education
American Stroke Association-Maryland	218 E. Redwood St., 23rd Floor	21203	410.685.7075	General population		X	X					X				X			X					Advocacy, awareness, education, policy development, prevention, and research related to stroke
Anacostia River Trail System			301.699.2255	General population													X							Natural area parks and conservation sites
Application Counselor Sponsoring Entity by the MHBE			855.642.8572	Uninsured residents	X													X						To assist in enrolling individuals in Maryland Health Connection
Aquasco Farm	16665 Aquasco Farm Road	20608	301.627.6074	General population													X							Natural area parks and conservation sites
Arc Of Prince George's County	1401 McCormick Drive	20774	301.925.7050	Developmentally disabled residents and their families	X	X	X	X		X		X				X		X				X	X	advocacy, information and referral, and direct service through residential programs, day services, children's services, in-home supports, Career Counseling services, and case management
Arms Reach Foundation, Inc.	7700 Old Branch Ave, Suite B-104	20735	301.599.4101	General population										X								X		Psychiatric rehabilitation, therapeutic mentoring and group therapy
Ayuda, Inc.	1707 Kalorama Ave, NW	20009	202.387.4848	Immigrants residing in DC, Maryland and Virginia		X																		legal, domestic violence, and social services to immigrants

NAME	ADDRESS	ZIP CODE	TELEPHONE	POPULATION	Access	Advocacy & Legal Services	Awareness and Health Promotion	Case Management, Navigation or Care Coordination Services	Crisis, Emergency, or Financial Assistance Services	Disability Services	Early Childhood	Education and Self-Management	Food and Nutrition Services	Health Services	Housing	Prevention Services	Recreation and Physical Activity	Referral Services	Research	Screening & Testing	Senior Services	Support Groups, Counseling, and Recovery Services	Youth Services	SERVICES
Baden Community Center	13601 Baden-Westwood Rd	20613	301-888-1500	General population													X				X		X	Basketball courts, fitness room, gymnasium, picnic pavilion, playground, playing fields, licensed before and after school kids care program, Xtreme teens program
Battle-Carreno Clinical Services, LLC	14440 Cherry Lane Ct	20707	240.294.4129	General population										X				X				X		mental health counseling and treatment
Beacon House	601 Edgewood Street, NE	20017	202.529.7376	At-risk children, ages 5-18 years old, who reside in and around the Edgewood Terrace community in Ward 5													X						X	Provides free recreational, physical activity, and sports programs.
Beginning Again Therapeutic Counseling Services	8288 Telegraph Rd, Suite A	21113	301.875.4387	women and children										X				X				X		mental health counseling and treatment
Behavior Support Services			877.413.3088	Developmentally disabled residents and their families	X	X		X	X	X				X				X						DDA funded program to provide behavioral consultation, staff augmentation and emergency services
Bellydancers of Color: MamaSita's Cultural Center	6906 4th Street, NE	20012	202.545.888	Residents of African American, Hisp/Lat, Pac Island, Asian, Nat Am, Rom, Mid Eastern, Mediterranean, and/or E. Indian background													X							Organizes bellydancers of color for physical activity.
Beltsville Community Center	3900 Sellman Rd	20705	301-937-6613	General population													X						X	Athletic fields, fitness room, gymnasium, picnic area, Seniors programs, Xtreme Teens programs, pre-school room
Berwyn Heights Community Center	6200 Pontiac St	20740	301-345-2808	General population													X						X	Athletic field, fitness room, gymnasium, tennis courts, Seniors programs, Xtreme Teens program
Bethel House	6810 Floral Park Rd	20613	301.372.1700	General population					X				X									X	X	emergency food pantry, financial aid for rent and utilities, domestic violence and sex abuse counseling, NA meetings, youth mentoring
Better Choices, Better Health Arthritis				General population								X												education and self-management program for individuals with arthritis
Better Choices, Better Health®- Diabetes or Healthier Living with Diabetes				General population								X												education and self-management program for individuals with diabetes
Billingsley Point	6900 Green Landing Road	20772	301.627.0730	General population													X							Natural area parks and conservation sites
BiNet USA	4201 Wilson Blvd, #110-311	22203	800.585.9368	LGBTQ individuals		X	X					X				X								educational information regarding sexual orientation and gender identity with an emphasis on the bisexual and pansexual and allied communities
Bladensburg Community Center Park	4500 57th Ave	20710	301-277-2124	General population													X				X		X	Outdoor basketball courts, crafts, fitness, and game room, gymnasium, Xtreme Teens program, after-school program
Bladensburg Waterfront Park	4601 Annapolis Rd	20710	301.779.0371	General population													X							Natural area parks and conservation sites
Bowie Community Center	3209 Stonybrook Dr	20715	301-464-1737	General population													X						X	Gymnasium, meeting rooms, game room, Kids Care, Xtreme Teens program
Bowie Crofton Pregnancy Clinic	4341 Northview Dr	20716	301.262.1330	Women	X		X	X				X		X		X		X		X				Free, confidential health services related to pregnancy and sexual health concerns, including free pregnancy tests, ultrasound, abortion information, and STD/HIV testing and treatment.
Bowie Health Center	15001 Health Center Drive	20716	301.262.5511	general population										X										Freestanding Emergency Medical Facility
Bowie Pantry and Emergency Aid Fund	3120 Belair Drive	20715	301.262.6765	General population																				food bank and nutrition services
Bowie Youth And Family Services	2614 Kenhill Drive	20715	301.809.3033	Residents of Bowie community										X		X						X	X	mental health counseling and treatment, drug and alcohol prevention
Brentwood Foursquare Gospel Church	3414 Tilden Street	20722	301.864.1176	General population																				food banks and nutrition services
Building Better Caregivers Online				General population			X					X										X		education services for caregivers of people with traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), dementia, or other diagnosed memory impairments
Building Futures	1440 Meridian Place NW	20010	202.639.0361	Individuals with HIV/AIDS											X			X				X		housing and supportive services to persons living with HIV/AIDS
Calmra	5020 Sunnyside Ave, Ste. 206	20705	301.982.7177	Residents with cognitive disabilities						X				X	X									community and residential services for developmentally disabled adults
Camp Springs Senior Activity Center	6420 Allentown Road	20748	301.449.0490	Seniors ages 60+ years old								X					X				X			Offers fitness programs and health education classes, information, and referrals.
Cancer: Thriving and Surviving				Cancer survivors																		X		Educational program about life after cancer treatment

NAME	ADDRESS	ZIP CODE	TELEPHONE	POPULATION	Access	Advocacy & Legal Services	Awareness and Health Promotion	Case Management, Navigation or Care Coordination Services	Crisis, Emergency, or Financial Assistance Services	Disability Services	Early Childhood	Education and Self-Management	Food and Nutrition Services	Health Services	Housing	Prevention Services	Recreation and Physical Activity	Referral Services	Research	Screening & Testing	Senior Services	Support Groups, Counseling, and Recovery Services	Youth Services	SERVICES
Capital Area Food Bank	645 Taylor Street, NE	20017	202.526.5344	General population																				food bank and nutrition services
Capital Area Food Bank: Operation Frontline Program	4900 Puerto Rico Avenue, NE	20017	202.644.9800	General population									X											Cooking-based nutrition program that focuses on teaching cooking skills, nutrition basics, and food budgeting.
Capital Region Health Connection			240.773.8250	Residents of Montgomery and Prince George's Counties	X																			Enrolling individuals into qualified health plans
CASA de Maryland	8151 15th Avenue	20883	301.270.8432	Latino residents of Prince George's County	X																			Latino and immigration advocacy-and-assistance organization
Catholic Charities of Baltimore	320 Cathedral St	21201	410.547.5490	Children and families, seniors, immigrants, people living in poverty, and individuals with intellectual disabilities		X	X	X	X	X		X	X	X	X	X								Health services, education, food, foster care, residential services, shelters, crisis intervention, family navigator services, homeless services, and services for older adults
Catholic Charities: Archdiocese of Washington	924 G Street, NW	20001	202.772.4300	General population					X															food bank and emergency aid
Catholic Charities: Langley Park	7949 15th Avenue	20883	301.434.6453	General population					X															food bank and emergency aid
Cedar Heights Community Center Park	1200 Glen Willow Dr	20743	301-773-8881	General population													X				X		X	Dance and fitness room, gymnasium, preschool room, photography dark room, Xtreme Teens program, Seniors program
Cedarhaven Fishing Area	18400 Phyllis Wheatley Boulevard	20608	301.627.6074	General population													X							Natural area parks and conservation sites
Center For Healthy Families	4200 Valley Drive, Room 0142	20742	301.405.2273	General population										X								X		couple and family therapy clinic
Center For Therapeutic Concepts	1300 Mercantile Lane	20774	301.386.2991	General population										X				X				X		Outpatient mental health clinic and psychiatric rehabilitation program for adults and children
Central Baptist Church	5412 Annapolis Rd	20712	301.699.5886	General population																				food bank and nutrition services
Centro De Apoyo Familiar	6801 Kenilworth Ave	20737	301.328.3292	Latino families		X	X					X	X			X								The Comida Sana-Vida Sana/Healthy Eating-Healthy Living program provides healthy eating education and access to healthy food and other resources, primarily among Latinos and other low income immigrant communities.
Cheltenham Wetlands Park	9020 Commo Rd	20623	301.627.7755	General population													X							Natural area parks and conservation sites
Chesapeake Bay Critical Area Tour	16000 Croom Airport Road	20772	301.627.6074	General population													X							Natural area parks and conservation sites
Cheverly Health Center	3003 Hospital Drive	20785	301.583.7752	General population			X	X				X		X		X		X		X				Health services, family planning, STI/HIV/TB screening and treatment services, immunizations, health education, behavioral health services, and dental care
Children and Parents Program	501 Hampton Park Blvd	20743	301.324.2872	General population			X	X	X			X		X		X		X		X		X		addiction, mental health, rehabilitative and case management services to adult women, including pregnant women and women with children
Children, Youth and Families Division: PGC Department of Family Services	6420 Allentown Road	20748	301.265.8446	Children and families		X										X		X				X	X	After school programs, gang prevention, Children in Need of Supervision, Teen Court, Truancy Prevention Initiative, kinship care, home visiting, Local Access Mechanism, Local Care Teams, and Healthy Families
Children's Development Clinic: Prince George's Community College	301 Largo Rd, CE-123	20774	301.322.0519	Children 0–12 experiencing developmental delays						X	X	X		X									X	services for children in the areas of motor, language, reading and social skills
Children's National Medical Center: Upper Marlboro Outpatient Clinic	9400 Marlboro Pike, Ste 210	20772	301.297.4000	Children and adolescents	X		X				X	X	X	X		X							X	Outpatient specialty health services for children and adolescents
Church of Living God	1417 Chillum Rd	20883	301.559.8893	General population																				food bank and nutrition services
City of College Park Seniors' Program: Attick Towers	9014 Rhode Island Avenue	20740	301.345.8100	Senior residents of the city of College Park			X					X				X					X			Offers periodic Presentations on Senior Topics in Safety, Wellness, and Health.
City of College Park Seniors' Program: Spellman House	4711 Berwyn House Road	20740	301.220.0037	Senior residents of the city of College Park			X					X				X					X			Offers periodic Presentations on Senior Topics in wellness and health.
Clearwater Nature Center	10999 Thrift Rd	20735	301.297.4575	General population													X							Natural area parks and conservation sites
Clinton Baptist Church	8701 Woodyard Rd	20735	301.868.1177	General population																				food bank and nutrition services
Clyde Watson Boating Area	17901 Magruder's Ferry Road	20613	301.627.6074	General population													X							Natural area parks and conservation sites
College Park Community Center Park and Youth Soccer Complex	5051 Pierce Ave	20740	301-441-2647	General population													X						X	Dance and fitness room, gymnasium, soccer fields, teen room, after-school program, Xtreme Teens program

NAME	ADDRESS	ZIP CODE	TELEPHONE	POPULATION	Access	Advocacy & Legal Services	Awareness and Health Promotion	Case Management, Navigation or Care Coordination Services	Crisis, Emergency, or Financial Assistance Services	Disability Services	Early Childhood	Education and Self-Management	Food and Nutrition Services	Health Services	Housing	Prevention Services	Recreation and Physical Activity	Referral Services	Research	Screening & Testing	Senior Services	Support Groups, Counseling, and Recovery Services	Youth Services	SERVICES
College Park Youth And Family Services	4912 Nantucket Road	20740	240.487.3550	Residents of College Park										X				X				X		community outreach and family counseling
Columbia Park Community Center Park	1901 Kent Village Dr	20785	301-341-3749	General population													X						X	Gymnasium, office space, after-school programs, Xtreme Teens program
Community Advocates For Youth: Counseling Center	1300 Caraway Ct	20774	301.390.4092	General population		X	X	X	X			X				X								Provides victim advocacy and support services, crisis intervention, and community education
Community Clinic, Inc.	7676 New Hampshire Avenue	20912	301.431.2972	General population				X			X	X		X		X		X		X		X		medical, behavioral health, and WIC services
Community Clinic, Inc.	9001 Edmonston RD, STE 40	20770	240.790.3325	General population				X			X	X		X		X		X		X		X		family planning, prenatal care, and WIC services
Community Clinic, Inc.	9220 Springhill Lane	20770	240.624.2278	General population				X			X	X		X		X		X		X		X		Medical, Dental and Behavioral Health services
Community Counseling & Mentoring Services	1300 Mercantile Lane	20774	301.583.0001	General population			X	X						X		X		X		X		X	X	comprehensive mental health services including assessments, intervention and consultation, to children, adolescents and their families
Community Crisis Services, Inc.	PO Box 149	20781	301.864.7095	General population			X		X			X		X		X						X		crisis intervention and suicide prevention through outreach and 24-hour hotline services
Community Education Group	3233 Pennsylvania Ave SE	20020	202.543.2376	General population			X					X				X								HIV/AIDS awareness, education and prevention
Community Health Empowerment Through Education and Research (CHEER)	8545 Piney Branch Rd, STE B	20910	301.589.3633	General population			X					X				X			X					community health improvement education and research
Community Hospices of Maryland	11785 Beltsville Dr, STE 1300	20705	301.560.6000	General population										X										hospice
Community Legal Services Of Prince George's County	PO Box 734	20738	240.391.6370	low-income residents	X	X																		lawyer-referral organization matching low income clients with lawyers who would provide free advice.
Community Outreach and Development Corporation (CDC)	4719 Marlboro Pike, STE 104	20743	301.404.1551	general population		X		X	X		X	X	X											community development; early childhood development programs; food, clothing, financial assistance, and linkages to community-based services
Compassion Power	14817 Kelley Farm Road	20874	301.921.2010	men and families										X		X		X				X		anger management services and emotional abuse counseling
Contemporary Family Services	6525 Belcrest Rd	20782	301.779.0258	Families and children					X		X			X				X				X	X	Mental health services for foster children, foster families, and family psychiatric care
Cora B. Wood Senior Center	4009 Wallace Road	20722	301.699.1238	Seniors ages 60+ years old													X				X			Exercise classes provided by the National Institutes of Health Heart Center at Suburban Hospital
Cornerstone Baptist Church	3636 Dixon Street	20748	301.894.7998	General population																				food bank and nutrition services
Cosca Regional Park	11000 Thrift Rd	20735	301.868.1397	General population													X							Natural area parks and conservation sites
Crescent Ridge Adult Day Health	7001 Oxon Hill Rd	20745	301.567.1885	adults and seniors																	X			elder care
D. Leonard Dyer Regional Health Center	9314 Piscataway Road	20735	301.856.9520	General population			X	X			X	X		X		X		X		X		X	X	Health services, family planning, STI/HIV/TB screening and treatment services, immunizations, health education, behavioral health services
Damien Ministries	2200 Rhode Island Ave NE	20018	202.526.3020	People living with HIV/AIDS				X														X		Food bank, medical nutrition services, medical case management, and spiritual retreats
Deerfield Run Community Center	13000 Laurel-Bowie Rd	20708	301-953-7882	General population													X						X	Ball fields, basketball courts, classroom space, fitness and game room, gymnasium, playground, pre-school room, after-school program, Xtreme Teens program
Depression and Bipolar Support Alliance: Beltsville			301.937.6024	Individuals with depression and bipolar disorder and their families																		X		support groups
Destiny, Power & Purpose	4917 Marlboro Pike, Ste. 101	20743	301.420.2383	General population				X								X						X		ATR Care Coordination Agency for Prince Georges County; recovery and re-entry support services
Dimenions Healthcare System - Dimensions Healthcare Associates	7350 Van Dusen Road, Suite 260/Suite 350	20707	301.618.2273	general population			X							X		X				X				comprehensive healthcare services in the areas of dental care, women's health, men's health and family medicine to include pediatric health
Dimensions Healthcare System - Dimensions Healthcare Associates - Dr. Craig Persons	7501 Greenway Center Drive, Suite 220	20770	301.618.2274	general population			X							X		X				X				comprehensive healthcare services in the areas of dental care, women's health, men's health and family medicine to include pediatric health
Dimensions Surgery Center	14999 Health Center Drive	20716	301.809.2000	general population										X										Ambulatory surgical services
Dimensions Healthcare System - Family	2900 Mercy Lane	20785	301.618.2273	General population	X		X	X				X		X		X		X		X				comprehensive healthcare services in the areas of women's health,
Dimensions Healthcare System - Family	5001 Silver Hill Rd	20746	301.618.2273	General population	X		X	X				X		X		X		X		X				comprehensive healthcare services in the areas of dental care,
Dimensions Healthcare System - Rachel H.	3601 Taylor Street, Suite 108	20722	301.927.4987	Residents ages 55 years and older			X					X		X							X			Primary and continuing comprehensive medical and nursing services

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Dimensions Healthcare System - Wound	7400 Van Dusen Road	20707	301.725.4300	general population			X					X		X		X								health service dedicated to caring for persons with wounds that have
Dinosaur Park	13201 Mid-Atlantic Boulevard	20708	301.627.1286	General population													X							Natural area parks and conservation sites
District Heights Family And Youth Services Center	2000 Marbury Dr	20747	301.336.7600	General population				X				X				X		X					X	counseling program dedicated to promoting responsible behavior and appropriate family management skills
Diversified Counseling Service	9131 Piscataway Rd	20735	301.856.4477	General population										X									X	individual, group and couples counseling.
Doctors Community Hospital	8118 Good Luck Road	20706	301.552.8661	General population			X					X		X		X		X		X				Services including emergency care, inpatient care, preventive services, outpatient rehabilitation, and a comprehensive range of specialty services
Doctors Community Hospital-Support Groups	8119 Good Luck Road	20707	301.552.8662	General population																		X		Support group services for a comprehensive range of conditions and experiences
Dueling Creek Natural Area in Colmar Manor	Lawrence St	20722	301.927.2163	General population													X							Natural area parks and conservation sites
Educare Resources Center	107 Bonhill Drive	20744	301.203.0293	Mentally or developmentally disabled residents						X														services for more independent mentally and developmentally disabled who need supportive living services
Elizabeth House, FISH of Laurel	PO Box 36	20707	301.776.9296	General population																				food bank and nutrition services
Engaged Community Offshoots, Inc. aka ECO City Farms	6010 Taylor Road	20737	301.288.1125	general population									X											seeks to enhance food security, safety and access, to improve nutrition and health, to preserve cultural and ecological diversity, and to accelerate the transition to an economy based on preservation, recycling and restoration
Essential Therapeutic Perspectives	8100 Professional Place, Suite 205	20735	301.577.4440	children, adolescents, and families										X								X		behavioral and mental health care, including psychiatric rehabilitation
Evelyn Cole Senior Activity Center	5720 Addison Road	20743	301.386.5525	Seniors ages 60+ years old								X					X				X			Offers fitness programs and health education classes, information, and referrals.
Evergreen Health	7501 Greenway Center Drive, Suite 600	20770	240.542.0170	General population	X			X						X		X		X				X		non-profit insurance cooperative; primary care, care coordination, wellness services, preventive care, and behavioral health services
Fairland Regional Park	13950 Old Gunpowder Rd	20707	301.362.6060	General population													X							Natural area parks and conservation sites
Faith Community Baptist Church	13618 Layhill Rd	20906	301.460.8188	General population																				food bank and nutrition services
Family and Medical Counseling Service, Inc.	2041 MLK Jr Ave SE	20020	202.889.7900	Medically underserved community	X		X					X		X		X		X		X		X		Community health center providing medical, mental health, substance abuse education, treatment and referral services
Family Behavioral Services	6475 New Hampshire Ave, STE 650	20783	301.270.3200	General population, but specializes in adolescents				X						X		X						X		Consultation, case management, evaluations, medication monitoring, and individual, family or group counseling
Family Crisis Center of Prince George's County	3601 Taylor St	20722	301.779.2100	Individuals and family members affected by domestic violence		X			X			X				X								domestic violence victims and offenders, anger management counseling, emergency shelter, and legal advocacy
Family Matters of Greater Washington: Oxon Hill Center	6196 Oxon Hill Road	20745	301.839.1960	Youth, families and senior citizens		X		X	X		X					X		X			X	X	X	Provides assistance to children, youth, families and seniors with programs, including: therapeutic and traditional foster care; youth development programs; mental health/counseling services; psychiatric rehabilitation services, psychiatric assessments and medication management
Family Outreach Center of Ebenezer AME Church	7800 Allentown Rd	20744	301.248.5000	General population																				food bank and nutrition services
Family Service Foundation, Inc.	5301 76th Avenue	20784	301.459.2121	individuals with developmental disabilities and/or severe mental illness						X														mental health services, substance abuse counseling; community residential programs; and day habilitation
Family Services Foundation	8101 Sandy Springs Rd, STE 104	20707	301.317.0114	Developmentally disabled residents and their families						X														health and supportive services for developmentally disabled residents
First Baptist Church of Suitland	5400 Silver Hill Road	20747	301.735.6111	General population																				food bank and nutrition services
First Baptist of Upper Marlboro	7415 Crain Highway	20772	301.952.0117	General population																				food bank and nutrition services
First Metropolitan Facilities	5801 Allentown Rd	20746	301.316.2717	Children with developmental disabilities and their families						X													X	wraparound services for children with developmental disabilities
First New Horizon Baptist Church	9511 Piscataway Rd	20735	301.856.9177	General population																				food bank and nutrition services

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First United Methodist Church of Hyattsville-HIV/AIDS Awareness Ministry	6201 Belcrest Rd	20782	301.927.6133	General population			X									X				X				Hosts community group events as well as a free HIV/STI testing clinic once a month on the third Saturday of the month from 1 to 3 p.m.
Forestville New Redeemer Baptist Church	7808 Marlboro Pike	20747	301.736.4488	General population																				food bank and nutrition services
Fort Lincoln Medical Center	4151 Bladensburg Rd	20722	301.699.7700	General population			X					X		X		X				X				Family medicine physicians and other healthcare professionals providing comprehensive health care services for all members of the family, from prenatal and pediatric to geriatric care.
Fort Washington Forest Community Center	1200 Fillmore Rd	20744	301-292-4300	General population													X						X	Arts and crafts room, computer lab, fitness room, gymnasium, teen lounge area, fitness classes, Xtreme Teens program
Fort Washington Medical Center	11711 Livingston Rd	20744	301.292.7000	General population			X					X		X		X								37-bed acute care hospital with comprehensive services including: diabetes education, emergency care, general surgery, imaging, inpatient care, nursing services, orthopedics and preventive screenings
Fort Washington Medical Center-Diabetes Center	11711 Livingston Road	20744	240.766.4197	General population								X					X					X		Support services, education and referrals for the prevention and control of diabetes
Fort Washington Medical Center-Health Screenings	11711 Livingston Road	20744	301.686.9010	General population			X					X				X				X				Screening programs for prevention, detection, and intervention
Fran Uhler Natural Area	10300 Lemons Bridge Road	20720	301.627.6074	General population													X							Natural area parks and conservation sites
Freedom Way Baptist Church	1266 Benning Road	20743	301.736.0184	General population																				food bank and nutrition services
Galilee Baptist Church	2101 Shadyside Avenue	20746	301.420.5013	General population																				food bank and nutrition services
GapBuster, Inc.- Riverdale Office	6200 Sheridan St	20737	301.779.4252	Youth and young adults																			X	after-school tutoring, leadership development, college preparation and drop-out prevention programs
Gerald Family Care	4744 Marlboro Pike	20743	240.670.1003	Medically underserved residents	X		X					X		X		X		X		X				providing a full range of preventive, primary care, and wellness services
Gethsemane United Methodist Church	910 Addison Road South	20743	301.336.1219	General population																				food bank and nutrition services
Glassmanor Community Center Park	1101 Marcy Ave	20745	301-567-6033	General population													X						X	Fitness room, football/softball fields, game room, gymnasium, office space, playground, tennis court, after-school program, camps, mentoring, Xtreme Teens program
Glenarden/Theresa Banks Complex	8615 McLain Ave	20706	301-772-3151	General population													X				X		X	Arts and crafts room, basketball courts, computer lab, game room, fitness room, gymnasium, imagination playground, lighted tennis courts, picnic area, softball field, Xtreme Teens program, Seniors program
Glenn Dale Community Center Park	11901 Glenn Dale Boulevard (Rte 193)	20769	301-352-8983	General population													X				X		X	Arts and crafts room, fitness room, gymnasium, multipurpose room, office space, pre-school room, Xtreme Teens program, Seniors program
Global Vision Community Health Center	9171 Central Ave. Suite B11 and B12	20743	301.499.2270	Medically underserved residents	X		X					X		X		X		X		X				providing a full range of preventive, primary care, and wellness services
Good Luck Community Center Park	8601 Good Luck Rd	20706	301-552-1093	General population													X				X		X	Basketball courts, dance/multipurpose room, fitness room, gymnasium, imagination playground, picnic area, pre-school program, softball field, teen room, tennis courts, camps, Xtreme Teens program, Seniors program
Governor Bridge Natural Area & Canoe Launch	7600 Governor Bridge Rd	20716	301.627.6074	General population													X							Natural area parks and conservation sites
Greater Baden Medical Services	1458 Addison Rd. S	20743	301.324.1500	Medically underserved residents	X		X					X		X		X		X		X				Federally Qualified Health Center (FQHC) providing a full range of preventive, primary care, and wellness services
Greater Baden Medical Services: Women, Infants and Children Clinics	1458 Addison Rd. S	20743	301.324.1873	Medically underserved residents			X				X	X		X										nutrition and wellness services
Greenbelt Assistance In Living Program	25 Crescent Road	20770	301.345.6660	Senior citizens residing in the City of Greenbelt																	X			Support services to aid senior citizens living in place
Greenbelt Cares Youth and Family Service Bureau	25 Crescent Rd	20770	301.345.6660	General population					X					X								X		counseling program dedicated to promoting responsible behavior and appropriate family management skills; crisis counseling
Greenbelt Park	6565 Greenbelt Rd	20770	301.344.3948	General population													X							National Park services
GW Healing Clinic: Bridge to Care Clinic	3003 Hospital Drive	20785	301.583.3108	Medically underserved residents	X		X					X		X		X		X						Primary care clinic run by volunteers and students from George Washington University School of Medicine

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Gwendolyn Britt Senior Activity Center	4009 Wallace Road	20722	301.699.1238	Seniors ages 60+ years old								X					X				X			Offers fitness programs and health education classes, information, and referrals.
Harmony Hall Regional Center	10701 Livingston Rd	20744	301-203-6040	General population													X				X		X	Art gallery, fitness room, John Addison Concert Hall, multipurpose room with stage, play field, pre-school room, Southern Area Admin offices, Harmony Halls Seniors program, Teen programs
Harvest Temple Church of God	6608 Wilkins Place	20747	301.420.1417	General population																				food bank and nutrition services
Healthcare Dynamics International (HCDI)	4390 Parliament Place, Suite A	20706	301.552.8803	Providers and Health Systems			X					X												patients, caregivers and communities to collaborate to create healthier
Healthy Teens Center	7824 Central Avenue	20785	301.324.5141	Adolescents and young adults	X		X					X		X		X						X	X	reproductive health services, education and counseling services, youth and family mental health services
Heart to Hand	1300 Mercantile Lane, Suite 204	20774	301.772.0103	Residents with, or at-risk for, HIV/AIDS	X	X	X	X				X		X		X		X		X		X		support services to those with HIV/AIDS and other health disparities, including screening, support groups, case management, advocacy and treatment
Heartland Hospice care: Beltsville	12304 Baltimore Avenue	20705	866.834.1528	Individuals and families with end-of-life needs										X										Hospice services
Therapeutic Foster Care	3919 National Drive Suite 400	20866	301.495.0923	and Juvenile Services										X	X					X		X	X	living for pregnant and parenting teen mothers, and therapeutic foster
Help By Phone	PO Box 324	20738	301.699.9009	General population																				food bank and nutrition services
Henson Creek Trail			301.699.2255	General population													X							Natural area parks and conservation sites
Hillcrest Heights Community Center Park	2300 Oxon Run Dr	20748	301-505-0897	General population													X				X		X	Baseball field, computer lab, dance and fitness room, gymnasium, multipurpose room, playgrounds, teen lounge, tennis court, Xtreme Teens program, Seniors program
Homes for Hope	3003 G St SE, Apt A	20019	202.582.0169	Homeless individuals		X		X							X							X		services to initiate and promote the transition from homelessness to productivity and independence
Hope House Treatment Center	429 Main St	20707	301.490.5551	Individuals with narcotics addiction										X								X		Inpatient substance abuse treatment
House of Ruth of Maryland	2201 Argonne Drive	21218	240.450.3270	Individuals affected by domestic violence		X																		legal and advocacy services
Hunter Memorial	4719 Silver Hill Rd	20746	301.735.5761	General population																				food bank and nutrition services
Huntington Community Center	13022 8th St	20720	301-464-3725	General population													X				X		X	Arts and crafts room, basketball court, conference room, fitness room, gallery space, multipurpose room, playground, afterschool programs, Seniors programs, Xtreme Teens program
ICAC Inc.: Oxon Hill Food Pantry	4915 St. Barnabas Rd	20757	301.899.8358	General population																				food bank and nutrition services
Identity-Crossroads Youth Opportunity Center	7676 New Hampshire Ave	20912	301.422.1279	Youth involved with gangs or at risk for gang involvement																		X	X	interventions for gang-involved youth and youth at risk for gang involvement
Indian Queen Recreation Center	9551 Fort Foote Road South	20744	301-839-9597	General population													X						X	Athletic fields, basketball court, classroom space, gymnasium, playground, afterschool programs, Xtreme Teens program
Institute for Family Centered Services-MENTOR Maryland	4200 Forbes Blvd	20706	301.577.7931	Children and adolescents					X					X								X		Therapy Services, hourly support services, family centered treatment, wraparound service, and crisis intervention
Institute For Life Enrichment	4700 Berwyn House Rd	20740	301.474.3750	General population										X								X		psychotherapy and psychological services
Jericho City of Hope	8501 Jericho City	20785	301.333.0500	General population																				food bank and nutrition services
John E Howard Senior Activity Center	4400 Shell Street	20743	301.735.2400	Seniors ages 60+ years old								X					X				X			Offers fitness programs and health education classes, information, and referrals.
John E. Howard Community Center Park	4400 Shell St	20743	301-735-3340	General population													X				X		X	Athletic fields, gymnasium, game room, multipurpose room, picnic area, playground, tennis court, Xtreme Teen program, Seniors program
Judy Hoyer Center	8908 Riggs Road	20783	301.445.8460	Pre-kindergarten aged children							X													promotes school readiness through early childhood care and education as well as family support and health programs.
Jug Bay Natural Area	16000 Croom Airport Road	20772	301.627.6074	General population													X							Natural area parks and conservation sites
Kentland Community Center Park	2411 Pinebrook Ave	20785	301-386-2278	General population													X				X		X	Athletic fields, basketball courts, fitness and game room, golf training center, multipurpose room, picnic pavilion, playground, tennis courts, after-school program, Xtreme Teens program, Seniors program
Korean Community Services Center of Greater Washington	6401 Kenilworth Avenue	20737	301.927.1601	Asian Americans and new immigrants		X	X					X												Social, wellness, advocacy, education, and development services

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La Clínica del Pueblo	2831 15th Street, NW	20009	202.462.4788	Latino and immigrant populations	X	X	X	X				X		X		X		X		X		X		Federally qualified health center providing culturally appropriate clinical, mental health and substance abuse services; community health action; and interpreter services
Lake Arbor Community Center	10100 Lake Arbor Way	20721	301-333-6561	General population													X				X		X	Arts and crafts room, computer lab, dance and fitness room, gymnasium, multipurpose room, patio area, Xtreme Teens program, Seniors program
Lake Artemesia in Berwyn Heights and College Park	Berwyn Rd & 55th Avenue	20740	301.627.7755	General population													X							Natural area parks and conservation sites
Lakewood Family Clinic	1400 Mercantile Lane, Suite 180	20774	301.925.7022	General population	X		X		X			X		X		X					X			Provides comprehensive family care, with special programs for immigrants, homeless individuals, and individuals in crisis
Lambda Center	4228 Wisconsin Avenue, NW	20016	202.885.5610	LGBTQ individuals	X	X								X								X		mental health and substance abuse treatment services for the LGBT community, sliding scale
Langley Park Community Center	1500 Merrimack Rd	20784	301.445.4508	General population									X											food bank and nutrition services
Langley Park Senior Activity Center	1500 Merrimac Drive	20783	301.408.4343	Seniors ages 60+ years old								X					X				X			Offers fitness programs and health education classes, information, and referrals.
Lanham Church of God	9030 Second St	20706	301.340.8888	General population									X											food bank and nutrition services
Largo/Perrywood/Kettering Community Park School Center	431 Watkins Park Dr	20774	301-390-8390	General population													X				X		X	Arts and crafts room, dance and fitness room, game room, gymnasium, multipurpose room, pre-school area, showering areas, Xtreme Teens program, Seniors program
Larking Chase Care and Rehabilitation	15005 Health Center Drive	20716	301.805.6070	general population										X										Long-term care and rehabilitation
Latin American Youth Center-Langley Park (Maryland Multicultural Youth Center)	7411 Riggs Road, Suite 418	20783	301.431.3121	Latin American Youth	X	X	X	X				X			X			X				X	X	Counseling services, and case managers assist students with matters ranging from housing assistance, transportation, child care referrals
Latin American Youth Center-Riverdale (Center for Educational Partnership)(Maryland Multicultural Youth Center)	6200 Sheridan St	20737	301.779.2851	Latin American Youth	X	X	X	X				X			X			X				X	X	Counseling services, and case managers assist students with matters ranging from housing assistance, transportation, child care referrals
Laurel Advocacy & Referral Services (LARS)	311 Laurel Ave	20707	301.776.0442	Low-income and homeless individuals					X								X							utility assistance, referrals for addiction treatment and counseling
Laurel Regional Hospital	7300 Van Dusen Rd	20707	301.497.7914	general population	X		X		X			X		X		X				X				acute-care community hospital
Laurel Regional Hospital-Al-Anon	7300 Van Dusen Rd	20707	301.497.7914	general population																		X		Support program for family members of alcoholics
Laurel Regional Hospital-Alcoholics Anonymous	7300 Van Dusen Rd	20707	301.497.7914	general population																		X		Alcoholics Anonymous
Laurel Regional Hospital-Bipolar Support Group	7300 Van Dusen Rd	20707	301.497.7914	general population																		X		Bipolar Support Group
Laurel Regional Hospital-Childbirth Education Classes	7300 Van Dusen Rd	20707	301.497.7983	general population			X					X	X			X								Childbirth Education Classes
Laurel Regional Hospital-Diabetes Management Program	7300 Van Dusen Rd	20707	301.618.6555	general population			X					X	X			X								Diabetes Management Program
Laurel Regional Hospital-HeartSaver First Aid/CPR	7300 Van Dusen Rd	20707	301.497.7917	general population			X									X								CPR and Lifesaver Training courses
Laurel Regional Hospital-Nar Anon	7300 Van Dusen Rd	20707	301.497.7914	general population																		X		Support program for family members of individuals addicted to narcotics
Laurel Regional Hospital-Narcotics Anonymous	7300 Van Dusen Rd	20707	301.497.7914	general population																		X		Narcotics Anonymous
Laurel Regional Hospital-Rehabilitation Sharing Group (strokes and longtime illness)	7300 Van Dusen Rd	20707	301.497.7914	general population																		X		Support group for individuals undergoing long-term rehabilitation
Laurel Regional Hospital - Sleep Wellness Center	7300 Van Dusen Rd	20707	301.725.4300	general population			X					X		X										Comprehensive diagnostic and treatment program for patients suffering sleep-related health issues.
Laurel Regional Hospital-Smoking Cessation Program	7300 Van Dusen Rd	20707	301.618.6363	general population								X				X						X		Smoking Cessation
Laurel-Beltsville Oasis Youth Services Bureau	13900 Laurel Lakes Ave, STE 225	20702	301.498.4500	Children and youth up to age 18										X		X		X		X		X		Counseling for children and their families, anger management, parenting education, trauma treatment, substance abuse screening, referral to services, and crisis intervention

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Laurel-Beltsville Senior Activity Center	7120 Contee Road	20707	301.206.3350	Seniors ages 60+ years old								X					X				X			Offers fitness programs and health education classes, information, and referrals.
Maple Springs Baptist Church	4131 Belt Rd	20743	301.735.1020	General population									X											food bank and nutrition services
Marlow Heights Community Center Park	2800 St. Clair Dr	20748	301-423-0505	General population													X				X		X	Game and fitness room, playground, picnic area, tennis courts, Seniors program, Xtreme Teens program
Martha's Closet	5601 Randolph St	20784	301.262.3744	General population									X											food bank and nutrition services
Maryland Crime Victims Resource Center	1001 Prince George's Blvd, Set 750	20774	301.952.0063	Victims of crime		X																X		legal and advocacy services for victims of crime, including counseling, criminal justice education, community education, policy advocacy and court accompaniment
Maryland Disability Law Center	1500 Union Avenue	21211	800.233.7201	Individuals with disabilities		X				X														Free legal services to Marylanders of any age with all types of disabilities, who live in facilities, in the community or who are homeless
Maryland Division Of Rehabilitation Services	4451 Parliament Place	20706	301.306.3600	Individuals with disabilities		X				X														Programs and services that help people with disabilities go to work or stay independent in their homes and communities
Maryland Legal Aid Bureau	6811 Kenilworth Ave	20737	301.927.6800	Financially qualified residents and residents over 60		X																		Free civil legal services, including consumer rights, housing, elder rights, farmworker rights, benefits, employment, family and healthcare
Maryland Medicaid Pharmacy Program	201 W. Preston St.	21201	877.463.3464	Individuals eligible through Medical Assistance Program, HealthChoice, Family Planning Program, and Medicare Part D dual eligible	X									X										Pharmacy Services
Maryland National Guard-Family Assistance Center	18 Willow St.	21401	410.266.7514	Service members and military family members		X			X									X				X		Crisis intervention, legal resource information and referral, financial resource information and referral, Tricare information, ID cards and Deers information, and Community resource information and referral
Mary's Center	8908 Riggs Road	20783	301.422.5900	Medically underserved populations	X		X	X				X		X		X		X		X				Federally Qualified Health Center providing comprehensive, integrated set of health care, education and social services to help individuals and families achieve physical and mental health
Medstar-Southern Maryland Hospital Center	7503 Surratts Rd	20735	855.633.0205	General population					X					X		X								A range of medical and surgical specialties including emergency department and critical care services, outpatient radiology, surgical services, sleep disorders center, adult inpatient and day treatment mental health program, asthma and allergy center, physical and occupational therapy, cardiac care, orthopedics, and an oncology program
Melwood	5606 Dower House Road	20772	301.599.8000	Children, youth and adults with disabilities		X				X		X					X	X				X	X	Workforce development, therapeutic services, day-services, transition assistance, and services for veterans
Mental Health Association of Prince George's County	5012 Rhode Island Avenue	20781	301.699.2737	Individuals and families affected by mental illness		X	X					X												information, education and advocacy regarding mental illness
Metropolitan Mental Health Clinic	96 Truman Drive, Ste. 250	20774	301.324.0600	General population										X								X		Outpatient Mental Health Clinic and psychiatric rehabilitation program
Mission of Love	6180 Old Central Avenue	20746	301.333.4440	General population									X											food bank
Mount Calvert Historical and Archaeological Park	16801 Mount Calvert Road	20772	301.627.1286	General population													X							Natural area parks and conservation sites
Mount Rainier Nature and Recreation Center	4701 31st Place	20712	301.927.2163	General population													X							Natural area parks and conservation sites
Mt. Calvary Church	6700 Marlboro Pike	20747	301.735.5532	General population									X											food bank
Narcotics Anonymous: Referral Line			888.319.2606	Individuals with narcotics addiction																		X		support groups for recovering addicts
National Alliance for the Mentally Ill, Prince George's County	8511 Legation Road	20784	301.429.0970	Individuals and families affected by mental illness		X						X		X				X				X		Support, education, and advocacy related to mental illness
National Church of God	6700 Bock Road	20744	301.567.9500	General population									X											food bank and nutrition services
National Kidney Foundation-Maryland	1301 York Rd, STE 404	21093	410.494.8545	General population		X	X					X							X					Advocacy, education, patient services and research related to kidney diseases
New Revival Kingdom Church	7821 Parston Drive	20747	301.736.4535	General population									X											food bank and nutrition services

NAME	ADDRESS	ZIP CODE	TELEPHONE	POPULATION	Access	Advocacy & Legal Services	Awareness and Health Promotion	Case Management, Navigation or Care Coordination Services	Crisis, Emergency, or Financial Assistance Services	Disability Services	Early Childhood	Education and Self-Management	Food and Nutrition Services	Health Services	Housing	Prevention Services	Recreation and Physical Activity	Referral Services	Research	Screening & Testing	Senior Services	Support Groups, Counseling, and Recovery Services	Youth Services	SERVICES
North Brentwood Community Center Park	4012 Webster St	20722	301-864-0756	General population													X				X		X	Fitness and game room, gymnasium, playground, shower areas, tennis courts, Seniors program, Xtreme Teens program
North Forestville Community Center	2311 Ritchie Rd	20747	301-350-8660	General population													X				X		X	Gymnasium, multipurpose room, tennis court, community park and trails, Xtreme Teens program, Seniors program
Oakcrest Community Park School Center	1300 Capitol Heights Blvd	20743	301-736-5355	General population													X						X	Athletic fields, basketball courts, classrooms, community room, dance and fitness room, gymnasium, playground, summer camps, Xtreme Teens program, Prince George's County Boys and Girls Club
On Our Own of Prince George's County	10007 Rhode Island Ave	20740	301.699.8939	Adults with mental illness								X			X							X		self-management and recovery services for individuals with mental illness
Oxford House, Inc.	1010 Wayne Ave, STE 300	20910	800.689.6411	Individuals recovering from drug and alcohol addiction								X			X	X						X		Sober living facilities: democratically run, drug free, and self-supporting
Palmer Park Community Center Park	7720 Barlowe Rd	20785	301-773-5665	General population													X						X	Basketball court, computer lab, dance and fitness room, game room, gymnasium, playground, tennis court, Xtreme Teens program
Patuxent Community Center	4410 Bishopmill Dr	20772	301-780-7577	General population													X						X	Basketball court, gymnasium, multipurpose room, Xtreme Teens program, fitness classes
Patuxent River 4-H Center	18405 Queen Anne Road	20774	301.218.3079	General population													X							Natural area parks and conservation sites
Patuxent River Park	16000 Croom Airport Road	20772	301.627.6074	General population													X							Natural area parks and conservation sites
People Encouraging People	337 Brightseat Rd	20785	301.429.8950	Disabled residents and their families										X								X		Treatment, rehabilitation and support services for those with severe mental illness.
Peppermill Village Community Center Park	610 Hill Rd	20785	301-350-8410	General population													X						X	Athletic fields, basketball court, fitness room, game room, gymnasium, playground, tennis courts, trail with exercise stations, Xtreme Teens program, fitness classes, Seniors program
Potomac Landing Community Center Park	12500 Fort Washington Rd	20744	301-292-9191	General population													X						X	Basketball court, classroom space, football field, gymnasium, playground, Xtreme Teens program, fitness programs
Pregnancy Aid Center	4809 Greenbelt Rd	20740	301.441.9150	Low-income women, adolescents and newborns	X	X	X							X		X		X		X		X		Women's health clinic providing pregnancy, perinatal, cancer screening, Medicaid Assistance, counseling, birth control, STI, and teen services
Prince George's County Health Department	1701 McCormick Drive	20774	301.883.7879	Residents of Prince George's County	X		X	X			X	X		X		X		X	X			X	X	comprehensive public health services addressing family health, maternal and child health, immunizations, behavioral health, infectious diseases, environmental health, health access, health disparities, and overall health and wellness
Prince George's Child Resource Center	9475 Lottsford Rd, STE 202	20774	301.772.8420	Children, parents, and childcare providers		X	X					X												Support services to families, and training to child care providers, parents and human services workers
Prince George's Community College: Health Education Center	301 Largo Road	20774	301.336.6000	PGCC students, faculty and staff	X		X					X		X		X		X		X				Services that promote prevention, increase healthy lifestyle choices and prevent disease
Prince George's County Boys and Girls Club	7833 Walker Drive, Suite 430	20770	301.446.6800	Youth ages 5–18													X						X	Enrichment activities for youth ages 5–18
Prince George's County Department of Family Services	6420 Allentown Road	20748	301.265.8401	General population	X		X			X		X		X		X	X	X			X		X	Composed of three administrations that serve the aging, mentally-ill, disabled and children, youth and families in need of support and resources
Prince George's County Department of Parks and Recreation	6600 Kenilworth Avenue	20737	301.699.2255	General population								X					X							Fitness, recreation, and educational resources
Prince George's County Department of Parks and Recreation Community Centers	6600 Kenilworth Avenue	20737	301.699.2255	Residents and non-residents of Prince George's County													X				X		X	43 community centers located through the county offer a variety of recreation and fitness activities.
Prince George's County Department of Social Services	805 Brightseat Rd	20785	301.209.5000	General population	X	X	X	X	X	X		X	X	X		X		X			X		X	Intervention services that strengthen families, protect children and vulnerable adults, encourage self-sufficiency and promote personal responsibility
Prince George's County Department of Social Services-Child, Adult & Family Services	807 Brightseat Rd	20787	301.909.7002	Children and families		X	X	X	X			X						X				X		Services designed to assist the family develop new ways of communicating, coping with and overcoming barriers to their well-being

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Prince George's County Department of Social Services-Community Services	805 Brightseat Rd	20785	301.909.7000	General population					X				X		X									Housing and homeless, emergency shelter, energy program, food, and volunteer services
Prince George's County Department of Social Services-Family Investment Division	808 Brightseat Rd	20788	301.909.7003	General population	X				X		X		X	X	X								X	Program services include: Emergency Assistance, Food Supplement, Medical Assistance, Child Care Subsidy, and Temporary Cash Assistance.
Prince George's County Department of Social Services-Medical Assistance Program	806 Brightseat Rd	20786	301.909.7001	General population	X									X										Assistance may include payments for doctor's visits, exams, prescription costs, hospital bills, payment of Medicare premiums,
Prince George's County Public Schools Food and Nutrition Services	13300 Old Marlboro Pike, Room 8	20772	301.952.6580	Students attending Prince George's County Public Schools							X		X											Provides a total learning environment that enhances the development of lifelong healthy habits in wellness, nutrition, and regular physical activity.
Prince George's County Public Schools-Special Education Office	1400 Nalley Terrace	20785	301.618.8300	Individuals with disabilities attending Prince George's County Public Schools and their families	X					X	X	X											X	continuum of services to fully engage all students in the program of instruction
Prince George's County Sports and Learning Complex	8001 Sheriff Rd	20785	301.583.2400	General population								X					X							Fitness and educational resources
Prince George's Hospital Center	3001 Hospital Drive	20785	301.618.2000	general population			X					X		X				X		X				acute care teaching hospital and regional referral center
Prince George's Hospital Center- Alcoholics Anonymous	3001 Hospital Drive	20785	301.618.2112	general population																		X		Alcoholics Anonymous
Prince George's Hospital Center- Women's Heart Seminar Support Group	3001 Hospital Drive	20785	301.618.2449	general population																		X		Support Group for women with heart disease
Prince George's Hospital Center-Childbirth Education Classes	3001 Hospital Drive	20785	301.618.3275	general population			X					X				X								Childbirth Education Classes
Prince George's Hospital Center-Diabetes Management Program	3001 Hospital Drive	20785	301.618.6555	general population			X					X		X		X								Diabetes Management Program
Prince George's Hospital Center-Free HIV Testing Program	3001 Hospital Drive	20785	301.618.2487	general population										X						X				HIV Testing
Prince George's Hospital Center-Preemie Support Group	3001 Hospital Drive	20785	301.618.3280	general population										X		X						X		Parents of children born pre-maturely
Prince George's Hospital Center- Perinatal Diagnostic Center	3001 Hospital Drive	20785	301.618.3542	general population								X		X										In/outpatient referral Center providing the highest consultative services to those mothers who have medical complications prior to pregnancy.
Prince George's Hospital Center-Smoking Cessation Program	3001 Hospital Drive	20785	301.618.6363	general population			X					X		X		X						X		Smoking Cessation
Prince George's Hospital Center-Stroke Support Group	3001 Hospital Drive	20785	301.618.2024	general population																		X		Support group for stroke survivors, familes, friends and care givers
Prince George's Hospital Center-Survivors of Rape and Sexual Abuse Support Group	3001 Hospital Drive	20785	301.618.3154	general population																		X		Survivors of Rape and Sexual Abuse Support Group
Prince George's Hospital Center- Domestic Violence and Sexual Assault Center	3001 Hospital Drive	20785	301.618.3154	General population		X		X	X					X				X		X		X		Offers full range of services to victims/survivors of domestic violence and sexual violence to include crisis intervention, folow up counseling, forensic exams, victim advocacy and community education
Prince George's Plaza Community Center	6600 Adelphi Rd	20782	301-864-1611	General population													X				X		X	Fitness center, gymnasium, meeting room, multipurpose room, Xtreme Teens program, recreations programs, Seniors program
Progressive Life Center	8800 Jericho City Drive	20785	301.909.6824	Individuals and families with mental health needs				X						X								X	X	nonprofit, human services organization geared to serve children, youth and families through care management services, individual, family, and group counseling.
QCI Behavioral Health	9475 Lottsford Rd	20774	301.636.6504	Individuals, children and families with mental health needs	X		X	X	X			X		X		X						X		SPMI, SED, mobile services, includes service in shelters, step down
Rachel H. Pemberton Senior Health Center	3601 Taylor St., Set 108	20722	301.927.4987	Residents ages 55 years and older			X					X		X							X			primary and continuing comprehensive medical and nursing services
Renaissance Treatment Center	8001 Sheriff Road	20785	301.583.2400	Individuals with addiction and mental health needs								X		X		X		X				X		Addiction and mental health related programs

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Rims Center For Enrichment And Development	1895 Brightseat Road	20785	301.773.8201	children, adults, and families coping with mental illness								X		X		X						X		comprehensive mental and behavioral health care services through outpatient mental health clinic and psychiatric rehabilitation program
Rising Star Holy Temple	5312 Sheriff Road	20743	301.773.9655	General population									X											food bank and nutrition services
Rollingcrest/Chillum Community Center Park	6120 Sargent Rd	20782	301-853-2005	General population													X				X		X	Cardio fitness room, craft room, game room, gymnasium, meeting room, pre-school room, after-school program, Xtreme Teens program, Seniors program
RX for Healthy Weight Management: Capital Area Food Bank	645 Taylor Street, NE	20017	202.526.5344	Low-income overweight or obese Latino/Hispanic children			X						X			X							X	Provides free nutrition education classes for children, whose families are also involved. Topics include food preparation, healthy eating behavior, budget food shopping, and food safety. The first half of the class focuses on nutrition education, while a cooking demonstration takes place during the second half of the class. Two hour weekly classes for six weeks.
Saint Hugh of Grenoble Church	135 Crescent Road	20770	301.474.4322	General population									X											food bank and nutrition services
Salvation Army Adult Rehabilitation Center	3304 Kenilworth Avenue	20781	301.277.7878	Adults with substance or alcohol addiction	X		X					X				X						X		occupational work therapy, educational tutoring, counseling, and housing for addicts
Salvation Army of Prince George's County	4825 Edmonston Rd	20781	301.277.6103	Individuals and families in crisis	X		X	X	X					X		X						X		support services for individuals and families in crisis: addiction, emergency response, health services and family tracing
School House Pond in Upper Marlboro	14100 Governor Oden Bowie Drive	20772	301.627.7755	General population													X							Natural area parks and conservation sites
Seat Pleasant Activity Center	5720 Addison Rd	20743	301-699-2544	General population													X				X		X	Basketball courts, fitness room, game room, gymnasium, kitchen, multipurpose room, playground, Xtreme Teens program, Seniors program
SEED Food Distribution Center	6201 Riverdale Road	20737	301.458.9808	General population									X											food bank and nutrition services
Sexual Minority Youth Assistance League	410 7th St, SE	20003	202.546.5940	LGBTQ individuals		X	X					X										X	X	creates opportunities for LGBTQ youth to build self-confidence, develop critical life skills, and engage their peers and community through service and advocacy
Shabach Ministries	2101 Kent Village Drive	20785	301.322.9593	General population									X											food bank and nutrition services
SHARE Food Network	3222 Hubbard Road	20785	301.864.3115	General population									X											food bank and nutrition services
Sharing Pantry: Saint Pius X Parish	3300 Moreland Place	20715	301.262.2141	General population									X											food bank and nutrition services
South Bowie Community Center Park	1717 Pittsfield Ln	20716	301-249-1622	General population													X				X		X	Computer lab, community garden, conference room, gymnasium with basketball courts, fitness room, imagination playground, therapeutic sensory room, after-school programs, Xtreme Teen program, Seniors program, workshops
Southeast Church of Christ	3601 Southern Avenue	20746	301.423.2320	General population									X											food bank and nutrition services
Southern Regional Technology and Recreation Complex	7007 Bock Rd	20744	301-749-4160	General population													X				X		X	Adult and teen cafes, computer lab, dance studio, fitness room, gymnasium, multipurpose room, outdoor patio, recording studio, rock climbing wall, seminar rooms, science lab, teen fitness room, health and wellness classes, summer day camps, Xtreme Teens program
St. Ann's Center for Children, Youth and Families	4901 Eastern Avenue	20782	301.559.5500	Women and children			X		X		X	X		X	X	X				X		X	X	Housing and support programs, services for pregnant and parenting young women, child care, and education and employment services
St. Bernadine of Siena Catholic Church	2400 Brooks Drive	20746	301.736.0707	General population									X											food bank and nutrition services
St. Camillus	1600 Camillus Drive	20903	301.434.8400	General population									X											food bank and nutrition services
St. John's Episcopal Church	9801 Livingston Rd	20744	301.248.4290	General population									X											food bank and nutrition services
St. Margaret's Food Pantry	408 Addison Rd South	20743	301.366.3345	General population									X											food bank and nutrition services
St. Mark the Evangelist Catholic Church	7501 Adelphi Rd	20783	301.422.8300	General population									X											food bank and nutrition services
St. Paul's United Methodist Church	6634 St. Barnabas Rd	20745	301.567.4433	General population									X											food bank and nutrition services

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Start Early, Start Right: The Family Place	3309 16th Street, NW	20010	202.476.5539	Latino children ages 1-5 and their families			X					X	X			X	X							Offers a free obesity prevention/reduction program. Program consists of weekly classes that provide individual family counseling, behavior modification techniques, and information about nutrition, physical activity, and weight management. One parent attends each class session. Classes for parents are in Spanish; classes for children are in English. Both parents need to be Latino.
Stephen Decatur Community Center	8200 Pinewood Dr	20735	301-297-4648	General population													X				X		X	Basketball court, fitness and game room, gymnasium, playground, tennis courts, after-school programs, seniors program, Xtreme Teens program
Suitland Bog	6000 Block Suitland Rd	20747	301.627.7755	General population													X							Natural area parks and conservation sites
Suitland Community Park School Center	5600 Regency Ln	20747	301-736-3518	General population													X				X		X	Art room, basketball courts, computer room, conference room, fitness room, game room, gymnasium, kitchen, playground, science room, tennis courts, Kids Care, Xtreme Teens program
Takoma Park Food Pantry	7001 New Hampshire Ave	20912	240.450.2092										X											food pantry
Temple Hills Community Center Park	5300 Temple Hill Rd	20748	301-894-6616	General population													X				X		X	Fitness and game room, gymnasium, meeting room, multipurpose room, playground, tennis courts, Kids Care, Seniors program, Xtreme Teens program
The Center: A Home for GLBT	1111 14th St NW, Set 350	20005	202.682.2245	LGBT individuals	X	X	X					X				X		X		X		X		four core areas of service: health and wellness, arts & culture, social & support services, and advocacy and community building
TOPS Club Weight Loss Program: Grace Lutheran Church	2503 Belair Dr	20715	301.262.6447	Ages 9 years old to adults			X					X	X	X		X								Provides support system for people trying to lose weight naturally as well as by surgical means. Includes physical activity information, nutrition education, and weight management assistance. Nutrition education includes lessons on portion control and food planning, among other lessons.
Transition Center At Prince George's House	603 Addison Road South	20743	301.808.5317	Homeless individuals			X	X	X			X		X	X	X						X		Emergency shelter; Transitional housing; Meals; Housing Counseling; Substance Abuse Counseling; Mental Health Counseling; Career Counseling & Training Services.
Tucker Road Community Center Park	1771 Tucker Rd	20744	301-248-4404	General population													X						X	Fitness room, gymnasium, meeting room, picnic area, playground, showering areas, tennis courts, Kids Care program, Xtreme Teens program
United Communities Against Poverty	1400 Doewood Lane	20743	301.322.5700	General population									X											food bank and nutrition services
United Methodist Church of the Redeemer	1901 Iverson St	20748	301.894.8622	General population									X											food bank and nutrition services
University of Maryland: University Health Center	University of Maryland	20742	301.314.8180	Faculty, staff and students at the University of Maryland, College Park			X					X		X		X						X		Clinical, mental health, health promotion, and wellness services
Upper Marlboro Community Center Park	5400 Marlboro Race Track Road	20772	301-627-2828	General population													X						X	Activity room, athletic fields, fitness room, gymnasium, meeting room, playground, pre-school room, racquetball courts, tennis court, Kids Care program, Xtreme Teens program
Us Helping Us: People Into Living	3636 Georgia Ave, NW	20010	202.446.1100	Black, gay men				X						X		X				X		X		Prevention, HIV/STI screenings, case management, mental health services, support groups and women's services
Vansville Community Center	6813 Ammendale Rd	20705	301-937-6621	General population													X						X	Athletic fields, L.E.E.D. certified building, fitness room, gymnasium, storage area, tennis courts, Kids Care program, Xtreme Teens program
VESTA	9301 Annapolis Rd	20706	240.296.6301	adults with persistent mental illness, children, and veterans				X				X		X	X			X				X		rehabilitation programs, residential services, supported housing, outpatient mental health services and veterans services
Veterans Affairs (VA) Outpatient Clinic: Greenbelt	7525 Greenway Center Drive	20770	301.345.2463	Veterans	X	X	X	X		X		X		X		X		X		X		X		Primary and preventative care, comprehensive women's health care, audiology and mental health services
Veterans Affairs (VA) Outpatient Clinic: Southern Prince George's County	5801 Allentown Rd	20746	301.423.3700	Veterans	X	X	X	X		X		X		X		X		X		X		X		Primary and preventative care, comprehensive women's health care, audiology and mental health services
Walker Mill Garden Outreach Center	6974 Walker Mill Rd	20743	301.808.0096	General population									X											food bank and nutrition services
Walker Mill Regional Park	8840 Walker Mill Rd	20747	301.699.2400	General population													X							Natural area parks and conservation sites
Washington, Baltimore, & Annapolis Trail			301.699.2255	General population													X							Natural area parks and conservation sites
Watkins Regional Park	301 Watkins Park Drive	20774	301.218.6700	General population													X							Natural area parks and conservation sites

NAME	ADDRESS	ZIP CODE	TELEPHONE	POPULATION	Access	Advocacy & Legal Services	Awareness and Health Promotion	Case Management, Navigation or Care Coordination Services	Crisis, Emergency, or Financial Assistance Services	Disability Services	Early Childhood	Education and Self-Management	Food and Nutrition Services	Health Services	Housing	Prevention Services	Recreation and Physical Activity	Referral Services	Research	Screening & Testing	Senior Services	Support Groups, Counseling, and Recovery Services	Youth Services	SERVICES
Whitman-Walker Health	1701 14th St NW	20009	202.745.7000	General population with expertise in LGBT and HIV/AIDS care	X	X	X	X						X		X		X		X		X		Community health center serving the greater Washington, DC area, including individuals who face barriers to accessing care
William Beanes Community Center Park	5108 Dianna Dr	20746	301-568-7719	General population													X						X	Classrooms, gymnasium, playground, tennis courts, Kids Care, Xtreme Teens program
Women, Infants & Children: Prince George's County Health Department	7836 Central Avenue, STE A	20785	301.856.9600	General population			X				X		X			X								promote mother and child welfare and healthy behaviors
Woodrow Wilson Bridge Trail			301.699.2255	General population													X							Natural area parks and conservation sites
YMCA-Bowie (Trinity Lutheran Church)	6600 Laurel Bowie Road	20715	301.262.4342	General population			X					X				X	X				X			Provides physical activity opportunities, adult education classes, including health and wellness education programs with nutrition education, and health screenings.

EXHIBIT 11

Precision Orthopedics & Sports Medicine
www.precisionorthomd.com
14201 Park Center Dr. #410 Laurel, MD 20707
P: 301-498-0383 | F: 240-712-5052

March 27, 2018

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Dear Mr. Steffen

I am writing on behalf of Precision Orthopedics and Sports Medicine. I write on behalf of my group of orthopedic surgeons to express our full support for the University of Maryland Capital Region Health's request for an exemption to convert University of Maryland Laurel Regional Hospital to a freestanding medical facility with two ambulatory surgery operating rooms, which will be called the "UM Laurel Medical Center."

UM Laurel Regional Hospital has been the anchor surgical facility for my group of surgeons for the past 6 years. Our main office is across the street from the current facility and we provide the majority of ambulatory and urgent orthopedic surgery for this community. Precision orthopedics in the past four years has added an additional 5 surgeons who primarily perform surgery at UM LRH. Due to the quality of service, staff competencies and patient centered care, we will continue to support the orthopedic surgical services there.

Table 1 shows my group's volumes during the last three years.

Annual Outpatient Cases by Location
FY 2015-2017
Cases / Minutes

Physician	FY 2016	FY 2017	FY 2018 YTD (8 months)
Bhatnagar	276 / 22,346	232 / 16,798	133 / 9,446
Thompson (2/2016)	78 / 7,831	198 / 16,499	140 / 11,785
Poehling-Monaghan (1/2017)	0	38 / 3,695	74 / 7,057
Berkenblit (11/2017)	0	0	29 / 3,124
Total	354 / 30, 177	468 / 36,992	376 / 31,412

I believe that the volumes projected by University of Maryland Capital Region Health accurately reflect the number of incremental new cases that will be performed at UM Laurel Medical Center as a result of increased access to operating room time for orthopedic surgery.

Sincerely,

Rishi Bhatnagar, MD

CHILDREN'S
DENTISTRY AND ORTHODONTICS

March 27, 2018

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Dear Mr. Steffen

I am writing on behalf of Children's Dental Office. I write on behalf of my group of pediatric dental surgeons to express our full support for the University of Maryland Capital Region Health's request for an exemption to convert University of Maryland Laurel Regional Hospital to a freestanding medical facility with two ambulatory surgery operating rooms, which will be called the "UM Laurel Medical Center."

There is a severe shortage of surgical capacity for pediatric dental surgery which impacts the state's most vulnerable patients. This has caused delay in treatment which can be cause of morbidity and mortality in the pediatric and special needs adult patients. Currently, surgeons in our group must perform surgery at a variety of hospitals which only provide us with periodic operating room time. We have consolidated our surgical volume at the UM Laurel Regional Hospital and have added eight more dentists to our group to accomplish this need.

Table 1 shows my group's volumes during the last three years.

Annual Outpatient Cases by Location
FY 2015-2017
Cases / Minutes

Physician	FY 2016	FY 2017	FY 2018 YTD (6 months)
Camper	103 / 8386	66 / 5237	36 / 2,962
Ellington	37 / 3778	31 / 3117	35 / 3,253
Stovall	3 / 380	19 / 1943	22 / 2,426
Buckle	0	45 / 3659	77 / 5,331
Jee			1 / 146
Total	143 / 12,544	161 / 13,956	171 / 14,118

I believe that the volumes projected by University of Maryland Capital Region Health accurately reflect the number of incremental new cases that will be performed at UM Laurel Medical Center as a result of increased access to operating room time for pediatric dental surgery.

Sincerely,

Jerome S. Casper, DMD

Waugh Chapel
2410 Evergreen Road, Ste. 101
Gambrills, MD 21054
phone: 410.721.3393

Jerome S. Casper, D.M.D
www.childrensdentaloffice.com

Olney
2923-D Sandy Spring Rd.
Olney, MD 20832
phone: 301.924.5500

EXHIBIT 12

WILMOTSANZ

March 8, 2018

Jeffrey L. Johnson
Senior Vice President, Strategic Planning & Business Development
University of Maryland Capital Region Health
3001 Hospital Drive
Cheverly MD 20785

Re: UM Laurel Regional Hospital
Conversion to Freestanding Medical Facility

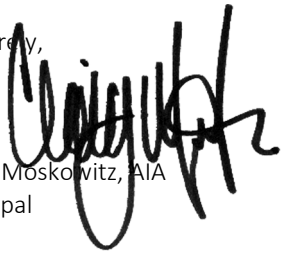
Dear Mr. Johnson:

The above-referenced freestanding medical facility project includes two outpatient general operating rooms and the associated patient and staff support spaces.

To the best of our knowledge, information, and belief the design for the project complies with Section 3.7 of the 2014 Guidelines for Design and Construction of Hospitals and Facilities – The Facilities Guidelines Institute (the FGI Guidelines).

If you have any questions or concerns, please feel free to contact me directly.

Sincerely,



Craig Moskowitz, AIA
Principal

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