Luminis Health Community Health Needs Assessment Implementation Plan FY26 – FY28

Luminis Health℠

Executive Summary

Luminis Health is pleased to provide the FY2026 through FY2028 Community Health Needs Assessment (CHNA) and Implementation Plan. This implementation plan is inclusive of all three hospitals in the health system: Luminis Health Anne Arundel Medical Center (LHAAMC), Luminis Health Doctor's Community Medical Center (LHDCMC), and Luminis Health McNew Family Medical Center, based on the CHNA for Anne Arundel County and Prince George's County. This report describes the community health needs assessment process for both counties, including its methodology and key findings. It then prioritizes those needs based on Luminis Health's True North, RISE Values, and state priorities to guide the focus of Luminis Health's implementation plan. For this report, the community is defined as Anne Arundel and Prince George's Counties, as the majority of patient discharges reside in this area. In accordance with IRS regulations, this plan has been approved by the Chief Council, the Quality, Patient Safety & Workforce Board and the CEO of Luminis Health.

Based on Prince George's County CHNA, major health concerns are chronic disease, maternal health, behavioral health, access to care, and social determinants of health. Similarly, findings from the Anne Arundel County CHNA indicate chronic disease, behavioral health, access to care, and social determinants of health as the county's significant health needs. Priority areas for Luminis Health are chronic disease, maternal health, behavioral health, social determinants of health, and access to care.

Priority	Action
Chronic Disease	Reduce prevalence and improve management of chronic disease
***Maternal Health**	Advance equitable maternal health by expanding access to maternal health services.
Behavioral Health	Increase the knowledge and accessibility of behavioral health services
Social Determinants of Health (SDOH)	Improve coordination of SDOH services
Access to Care	Improve access and timeliness of healthcare services

**Identified in Prince George's County only*

Table 1

About Luminis Health

SYSTEM OVERVIEW

Luminis Health, Inc. is a leading not-for-profit regional health system serving Anne Arundel and Prince George's counties, as well as the surrounding region. In 2019, Anne Arundel Health System, the parent organization of Anne Arundel Medical Center (AAMC) acquired Doctors Community Medical Center (DCMC) through a member substitution, and was renamed Luminis Health. The system is dedicated to advancing the health and well-being of the people and communities it serves through compassionate, equitable, and innovative care.

Mission: To enhance the health of the people and communities we serve.

Vision: Living Healthier Together.

Values: Respect, Inclusion, Service & Excellence.

Luminis Health operates more than 718 licensed beds across its three hospitals. LHAAMC in Annapolis is a 489-bed Magnet®-designated tertiary care hospital. Luminis Health J. Kent McNew Family Medical center is a 16-bed facility that provides inpatient and outpatient mental health services. LHDCMC in Lanham is a 213-bed acute care facility serving northern Prince George's County. Together, these hospitals form the foundation of a comprehensive network that includes over 100 sites of care across central and southern Maryland. The system offers a comprehensive range of services, encompassing primary and specialty care, behavioral health, ambulatory surgery, urgent care, and community outreach. As part of its population health strategy, Luminis Health integrates clinical excellence with community-based interventions to deliver accessible, high-quality care to diverse populations, regardless of their income, background, or geographic location.

CLINICAL EXCELLENCE AND RECOGNITIONS

Luminis Health delivers care across key specialty lines developed to address both clinical and community health needs, including cardiovascular care, oncology, orthopedics, maternal and women's health, behavioral health, and surgical excellence. LHAAMC is nationally recognized for clinical quality and patient experience. It holds Magnet® designation for nursing excellence, maintains consistent Leapfrog Hospital Safety Grade "A" ratings, and has been named by U.S. News & World Report as one of Maryland's top hospitals for orthopedics, gynecology, and surgery. LHDCMC has been honored by the American Heart Association's Get With The Guidelines® program for excellence in stroke and heart failure care and is recognized for its leadership in equitable community-based behavioral health. Across the system, Luminis Health has received numerous awards for clinical quality, patient safety, innovation, and health equity, reflecting its steadfast commitment to compassionate, evidence-based, and community-centered care.

MISSION AND COMMITMENT TO COMMUNITY

At the heart of Luminis Health's mission is a commitment to community. The organization believes that meaningful partnerships are crucial to enhancing population health outcomes and promoting health equity. Luminis Health collaborates with dozens of local and regional partners, community-based nonprofits, public health agencies, school systems, faith-based organizations, and national collaborators to address the social drivers of health and meet the diverse needs of those it serves. Whether co-creating behavioral health initiatives, launching school-based wellness programs, or delivering care in under-served neighborhoods, Luminis Health prioritizes community voice, trust, and long-term partnership. Community health teams are embedded in local neighborhoods, focusing on preventive care, chronic disease management, maternal health, and behavioral health, guided by a health equity framework that emphasizes inclusion, cultural responsiveness, and measurable impact. Recent initiatives include the opening of the Behavioral Health Pavilion at LHDCMC, the expansion of inpatient and outpatient psychiatric care in Prince George's County, and collaborative programming with organizations such as the Alzheimer's Association and local housing agencies to integrate social support with clinical care.

Purpose of the Implementation Plan

This Implementation Plan serves as the roadmap for Luminis Health to address the priority health needs identified in the Community Health Needs Assessment (CHNA) for Prince George's and Anne Arundel Counties. This plan will translate assessment findings into actionable strategies, guide resource allocation, continual program implementation, program development, establish accountability for addressing health disparities, and improve overall community health by focusing on measurable goals and evidence-based interventions. The plan's overarching goal is to improve health outcomes by implementing evidence-based initiatives, reducing health disparities, and enhancing health outcomes while ensuring that the Luminis Health communities have equitable opportunities to achieve their optimal level of health.

CHNA Process and Methodology

Prince George's County: The 2025 Community Health Needs Assessment (CHNA) was conducted by the Prince George's County Health Department and the four hospitals located in the County: Luminis Health Doctors Community Medical Center, Adventist Health Fort Washington Medical Center, MedStar Southern Maryland Hospital Center, and University of Maryland Capital Region Medical Center. The CHNA process was a combination of primary and secondary data sources. Primary data sources include the Community Resident Survey and key informant interviews. To ensure community perspective and perception, the core team focused on Phase 2 of the Mobilizing Action through Planning and Partnership (MAPP) Framework. The team developed a community resident survey to gather community perceptions on health status, outcomes, and disparities in Prince George's County. The survey was available in English, French, and Spanish to individuals who live, work, worship, and engage in recreation in the county. Key informant interviews were conducted to gain a deeper understanding of the trends and relationships among social determinants of health, health

outcomes, and mortality. These interviews also explored the strengths and weaknesses of existing resources that impact population health in Prince George's County. The secondary data sources were from the Maryland Health Services Cost Review Commission, Maryland Vital Statistics Annual Report, Maryland Department of Health's Annual Center Report, Behavioral Risk Factor Surveillance System, Center for Disease Control and Prevention's WONDER online Database, National Vital Statistics Report, and the Prince George's County Health Department's PGC Health Zone data site.

Anne Arundel County: Anne Arundel County: The Anne Arundel County Community Health Needs Assessment was a collaborative effort between the Anne Arundel County Department of Health, University of Maryland Baltimore Washington Medical Center, and Luminis Health Anne Arundel Medical Center. The assessment utilized both primary and secondary data. Secondary data was a crucial component of the CHNA process. More than 100 data indicators were selected for analysis from various data sources, including the Robert Wood Johnson Foundation County Health Rankings, the University of North Carolina Health Literacy Data Map, and the Centers for Disease Control and Prevention. Secondary data were categorized into six main categories and 20 detailed subcategories based on common themes. Each data measure was compared to state or national benchmarks to identify areas of specific concern for Anne Arundel County. The top community needs identified through secondary data analysis included access to healthcare, chronic disease, mental health, and social determinants of health. Primary data was collected through community-based focus groups and web-based surveys for community members and key community leaders reflecting feedback from more than 700 people who live, work, or receive healthcare in Anne Arundel County.

Additionally, the results of a survey previously conducted by the Anne Arundel County Department of Health provided feedback from over 14,000 community members on the health and needs of the county. Key leaders most frequently represented nonprofit organizations, but participants also included government officials, health professionals, and faith leaders, among others. A total of five focus groups were conducted virtually with a diverse group of community members representing various backgrounds, age groups, and life experiences. Primary data identified access to healthcare, chronic disease, mental health, and social determinants of health as top needs affecting the health and well-being of people living in Anne Arundel County.

Background of CHNA/ Key Findings

The CHNAs from both Prince George's County and Anne Arundel County provide a comprehensive overview of the health challenges faced within our communities. These include the cost of care, provider shortages, and limited access to maternal health service in Prince George's County; transportation barriers; significant challenges related to mental health and substance use; high rates of chronic illnesses including diabetes, hypertension, and obesity; and the influence of socioeconomic factors such as housing instability, food insecurity, and inequities across racial and ethnic groups. The report highlights the impact of systemic inequality in our communities and identifies opportunities for collaborative action. Key findings are identified in Figure 1.

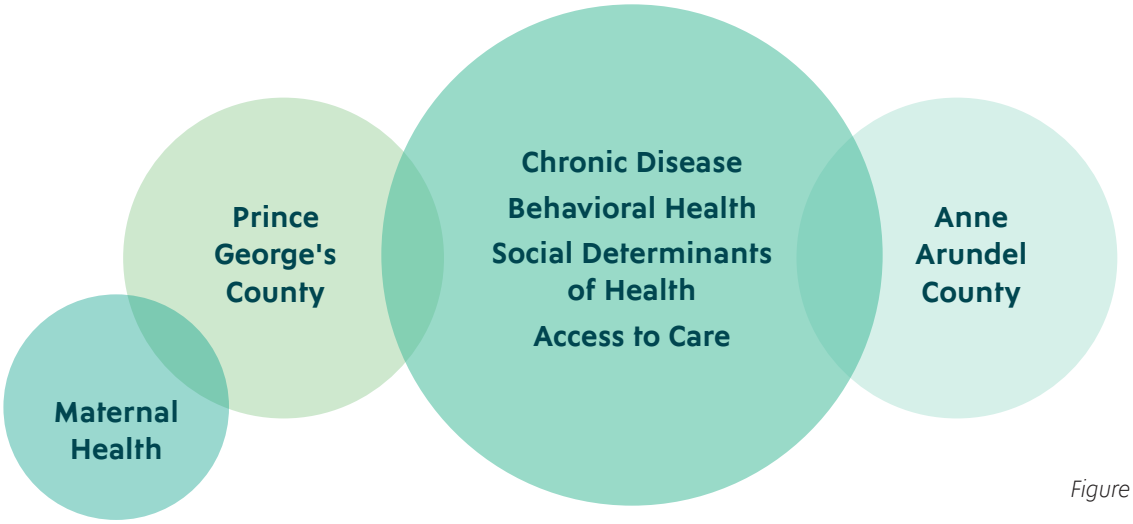

Figure 1

Although both counties identified similar priorities, the needs within these priorities differ for each county. In Prince George's County, **Social Determinants of Health (SDOH)** remain significant barriers. Income inequality, housing instability, limited transportation, and food insecurity, negatively influence health-seeking behaviors, such as poor nutrition. According to the CHNA, in 2023, 11% of residents were living in poverty. **Access to Care:** Residents face affordability challenges, inadequate insurance coverage, and a shortage of primary and specialty care physicians, as well as extended emergency department wait times, all of which limit access to care. **Chronic Disease:** Elevated rates of hypertension, diabetes, cancer, and obesity continue to disproportionately affect residents. Heart disease was identified as the leading cause of death in Prince George's County. **Maternal and Infant Health:** Disparities remain in infant mortality, preterm births, and maternal morbidity, especially among Black and Hispanic women. Eight out of ten Prince George's County residents leave the county to have a baby. **Behavioral Health:** Rising mental health concerns, substance use disorders (including opioid overdoses), and youth suicide attempts indicate urgent behavioral health needs. Many community members also report limited awareness of and difficulty navigating behavioral health services in the county.

In Anne Arundel County, **Access to healthcare** is hindered by several barriers, including long waitlists for both primary and specialty care, an inequitable distribution of provider locations across the county, and limited provider diversity, which impacts cultural competence. The cost of care was highlighted as a significant barrier for community members, including high copays, deductibles, and medication costs, with many residents having to prioritize basic needs over healthcare. Health literacy and system navigation were also identified as significant barriers to effective care. Transportation emerged as a fundamental challenge, particularly due to limited public transit options and inadequate Medicaid transportation coverage. **Behavioral Health:** Mental health and substance use issues are major concerns, with significant gaps in provider availability. The lack of culturally and linguistically diverse providers was identified as a particular barrier with a disproportionate impact on minority communities. **Chronic Health Conditions:** Health conditions such as diabetes, hypertension, cancer, and obesity are prevalent and disproportionately affecting low-income and minority communities. Emphasizing chronic disease management is complicated by various factors, including limited access to food, the scarcity of safe spaces for physical activity, and barriers to accessing consistent medical care.

Social Determinants of Health (SDOH): Housing instability, food insecurity, transportation barriers, and economic inequities, have been consistently identified as significant barriers to health. The limited availability and affordability of healthy food options, particularly in low-income communities, combined with transportation barriers make it difficult for many residents to access nutritious food and essential resources.

The findings from the CHNA reflect both the immediate needs of residents in each county and the broader structural factors that drive health disparities and health outcomes across the Luminis Health community. These findings emphasize the need for community-driven solutions, cross-sector collaboration, and long-term investment in health equity strategies

This is a continuation of the 2022 implementation plan, which focused on four priority areas: chronic disease, obesity and diabetes prevention, behavioral health, and social determinants of health based on the 2022 CHNA. The 2022 plan aimed to reduce morbidity and mortality from cancer and heart disease by increasing access to preventive screenings, expanding tobacco cessation programs, and promoting education on heart health and lifestyle management.

To address obesity and diabetes, Luminis Health expanded the Diabetes Prevention Programs in English and Spanish, enhanced mobile screening services, integrated prevention initiatives into primary care practices, and strengthened partnerships with local organizations to improve access to healthy food and physical activity.

In the area of behavioral health, the plan focused on reducing suicide rates and emergency department visits related to mental health by increasing co-occurring treatment programs, developing new outreach partnerships, and expanding inpatient, outpatient, and crisis services. This included the opening of the Behavioral Health Pavillion at LHDCMC in 2022, which provides outpatient therapy, medication management, a partial hospitalization program, and a 16-bed inpatient psychiatric unit.

To address social determinants of health, Luminis Health developed and implemented strategies to improve access to healthy food and essential resources. The Care Management and Transitions of Care teams connect patients to community resources that support chronic disease management and address food security.

This current plan continues and strengthens these efforts while integrating new initiatives aligned with the CHNA findings.

Luminis Health Priorities Based on CHNA

In alignment with the Luminis Health Annual Operating Plan (AOP), RISE Values (respect, inclusion, service excellence), True North priorities on quality, community, and population health, findings from both counties' CHNAs, and Maryland's identified metrics for the CMS AHEAD model population health accountability plan, Luminis Health has identified the following priority areas: chronic disease, behavioral health, social determinants of health, access to care, and maternal health.

LUMINIS HEALTH PRIORITIES

Chronic Disease

Goal: Reduce the prevalence of chronic disease and improve disease management.

Objective: Strengthen community-based and ambulatory efforts for the prevention and management of chronic disease.

Initiative	Target Population	Strategy	Outcomes
Enhance education and preventative screenings on breast, cervical, colorectal, and prostate cancer.	Current Luminis Health patients who are eligible and community members	Conduct proactive outreach to patients who are due for routine screenings, patients who are newly eligible based on age, and individuals in the community with limited access to care.	Increase the number of patients screened by 30% based on FY25 baseline
Participate in health promotion events hosted by community partners to provide chronic disease prevention education, early detection information, and treatment resources.	Community members	Active engagement in community events. Collaborate with current and new partners to participate in community events	Establish baseline for community engagement activities and improve engagement by 30%
Enhance screening and education for prediabetes and diabetes in both the community and hospital settings.	Current Luminis Health patients and patients within the community who meet the Centers for Disease Control and Prevention's Diabetes Prevention Program (CDC DPP) requirement.	Improve the number of individuals screened for diabetes and increase visibility of the program for patients through provider referral.	Increased number of patient screenings and educational opportunities (DPP, Workshop) by 30% based on FY25 baseline. Expand the DPP course and/or the Diabetes workshop in Spanish.

Maternal Health

Goal: Advance equitable maternal health by expanding access to maternal health services.

Objective: Expand current maternal health services to provide holistic care across prenatal, perinatal, and postnatal care.

Initiative	Target Population	Strategy	Outcomes
Expand Centering Pregnancy support throughout the Health System, including expanding bilingual Centering Pregnancy cohorts and culturally competent prenatal care.	Pregnant patients, with a focus on Spanish-speaking communities and under-served populations	Partner with community organizations, train bilingual facilitators, and integrate culturally tailored group prenatal care to improve access and outcomes.	▪ Increased prenatal care participation ▪ Improved birth outcomes (e.g., reduced preterm birth rates, higher breastfeeding rates, higher birth weights, maternal mental health outcomes) ▪ Strengthened community support networks
Implement and Scale the TeamBirth Initiative	Pregnant patients at Luminis Health	Train staff in shared decision-making and patient-centered communication during labor and delivery.	▪ Improved communication between patients and care teams. ▪ Reduced adverse birth events. ▪ Increased patient confidence and trust in care.
Strengthen Community Engagement and Education on maternal health service, care, and outcomes	New and expecting mothers within the community	▪ Host community baby showers. ▪ Partner with faith-based and community organizations to increase outreach. ▪ Provide education on breastfeeding, safe sleep, postpartum depression, Preeclampsia, gestational diabetes, and available resources.	▪ Increased community awareness of maternal and child health services. ▪ Strengthened linkages between clinical and community support. ▪ Improved early engagement in prenatal care.
Expand Access to Obstetrics (OB) Services in Prince George's County	Community members in Prince George's county	▪ Support growth of Greenbelt and Bowie OB practice. ▪ Open and operationalize the Women's Health Pavilion for OB deliveries and care at LHDCMC. ▪ Recruit additional providers and extend clinic hours for prenatal and postpartum visits.	▪ Increased access to comprehensive OB care in under-served areas. ▪ Reduced travel barriers for pregnant women. ▪ Improved continuity of care and maternal health outcomes.

Access to Care

Goal: Improve access and timeliness of healthcare services.

Objective: Increase access to screening and health education by providing affordable and community centered care.

Initiative	Target Population	Strategy	Outcomes
Improve access to screening in the Hispanic population - Breast & Colorectal Cancer Screening	LHP Hispanic Patients	▪ Educate patients, schedule screenings, reduce insurance/transportation barriers, and connect high-risk patients to resources or Ambulatory Care Management (ACM) for follow-up. ▪ Identify opportunities in the care continuum to educate and schedule patients for screenings. ▪ Reduce transportation or insurance barriers and educate patients on availability of services; connect patients to available coverage/ financial assistance. ▪ Partner with trusted Hispanic community organizations for education and awareness of cancer screening services ▪ Continue on-going efforts to recruit patients through referral process.	Decrease time to next available appointment.
Increase health access and education for youth	Youths within our Luminis Health Communities	▪ Partner with local organizations, schools, and faith-based institutions to promote preventive care and screenings. ▪ Provide brief education on nutrition, hydration, injury prevention, and mental well-being during physicals and workshops. ▪ Distribute educational materials to parents and athletes in multiple languages.	▪ Increased number of youth completing annual sports physicals. ▪ Early identification and management of potential health issues. Improved access for uninsured or under insured families. ▪ Broader community participation in annual physical events. ▪ Sustainable model for ongoing youth health promotion.
Improve access to care for residents of Anne Arundel & Prince George's Counties by optimizing provider schedules & increasing appointment availability across service lines	Community members in Anne Arundel & Prince George's Counties, with a specific focus on patients seeking primary care & specialty services, and individuals experiencing delayed access due to scheduling availability	▪ Use existing schedule utilization processes and data to increase appointment availability and reduce barriers to timely care access. Key tactics: Reduce preventable cancellations and no-shows Improve referral scheduling workflows to minimize delays	Decrease time to next available appointment
Expand Primary Care Services to improve health outcomes and reduce barriers to care in the community	Luminis and community patients	▪ Move to clinics to accommodate for community needs and ensure practice growth ▪ Open new primary care locations in under-served areas ▪ Develop culturally and linguistically appropriate educational materials. ▪ Leverage Care Connect Now for convenience and accessibility	▪ Improve timeliness to care · Reduced provider-to-patient ratios. ▪ Increased awareness of primary care services. ▪ Higher rates of preventive screenings and wellness visits

Behavioral Health

Goal: Increase the knowledge and accessibility of behavioral health services.

Objective: Expand education, access to care and strengthen community partnerships.

Initiative	Target Population	Strategy	Outcomes
Increase behavioral health education for youth and adolescence in the community	Adolescents in the community	Working with Prince George's County Public Schools (PGCPS) and other community partners	▪ To increase the knowledge of substance use and mental health disorders in the adolescent population ▪ To reach 400 unduplicated adolescents annually
To provide resources for teens who have been referred through their school safety office and teens court to assist with behavioral issues.	Community teens	▪ Connect with the school system and the county court system	▪ Increase knowledge regarding the impact of substances on the brain ▪ Enhance the teens' ability to make healthier and safer choices.

Social Determinants of Health

Goal: Improve coordination of SDOH services – Access patient SDOH needs and connect to services.

Objective: Report on the completion rate of SDOH screenings and the number of those completed that result in a referral to ACM.

Initiative	Target Population	Strategy	Outcomes
Access and impact SDOH	Luminis Health Patients and community members are participating in our mobile screenings and outreach events.	▪ Assess needs based on SDOH screening tools ▪ Establish referral network to meet SDOH needs	▪ Establish baseline of the number of patients screened and connected to services.

Summary

Luminis Health's 2026–2028 Implementation Plan serves as a strategic roadmap to reduce health disparities, improve outcomes, and promote equity across its communities. Luminis Health is positioned to address these challenges through its integrated regional care model, strategic investments, and community partnerships. The system's dual-county footprint enables seamless coordination of care across the continuum from preventive and primary care to behavioral health and inpatient services.

Investments in behavioral health infrastructure, maternal health, and chronic disease management directly align with CHNA-identified community priorities. Beyond clinical care, Luminis Health actively addresses the upstream social determinants of health, through referrals and partnerships with county health departments, housing authorities, schools, and nonprofit organizations. By embedding care teams and health educators directly in communities, the system advances equity through culturally informed outreach and patient navigation.

Guided by CHNA data and its mission to enhance community health, Luminis Health leverages its clinical expertise, regional reach, and collaborative spirit to reduce access gaps, improve behavioral and chronic health outcomes, and foster long-term community well-being. This plan remain in effect until the end of FY28, with annual progress reviews to ensure accountability and sustained impact, guiding the system's ongoing investment in community wellness and health equity.