1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?
   - 62 inpatient beds
   - 3,781 inpatient admissions
   - 33,429 Emergency Room visits (significant in the services of AGH)

2. Describe the community or communities the organization serves.
   - Describe the geographic community or communities the organization serves.
   - Describe significant demographic characteristics that are relevant to the needs that the hospital seeks to meet.

Worcester County is the easternmost county located in the U.S. state of Maryland. The county contains the entire length of the state's Atlantic coast line. It is home to the popular vacation resort area of Ocean City. The county is approximately 60 miles long. According to the U.S. Census Bureau, the county has a total area of 695 square miles of which, 473 square miles of it is land and 221 square miles of it is water.

The population is approximately 49,000 residents. According to the 2006 census the median income for a household in the county was $40,650, and the median income for a family was $47,293. The per capita income for the county was $22,505. About **7.20%** of families and **9.60%** of the population were **below the poverty line**, including 17.00% of those under age 18 and 6.40% of those age 65 or over. The median age was 43 years. For every 100 females there were 95.20 males. Nearly one fourth of Worcester County residents are over 65. At Atlantic General our rate of Medicaid and self-pay patients was 12% of our revenue in FY09.

In the Worcester County Health Department report from 2005 the age-adjusted mortality rate is 800/100,000 and for the over 64 years of age population it was 4,000/100,000. Information from the same report showed the top three leading causes of death in the county were: #1 cancer, #2 cardiovascular diseases, #3 accidents.

The largest concentration of the population is in the northern part of the county where the Ocean City resort area is located and the Berlin/Ocean Pines area; which is a Mecca for retirees who live here full time or divide their time between Maryland and Florida. The population of Ocean City increases by about 100,000 during the tourist season.

3. Identification of Community Needs:
   a. Describe the process(s) your hospital used for identifying the health needs in your community, including when it was most recently done.

The hospital is currently working under the Strategic Initiatives which were developed for planning through 2010. Each year, within this framework the hospital makes plans for the upcoming year using the SWOT/GAP analysis model.

The documents used by the hospital to determine community needs are:
- the health assessment publication from the health department, 2005
- Worcester County Local Health Plan, FY 2008
- Tri-county Adolescents Association
- State of Maryland Cancer Registry
- Latest census update for income levels regarding provision of resources for financial assistance support
- Feedback from area physicians and community members
- questionnaires and evaluations from our community events
- NCR Pricker patient evaluations and feedback

Leadership members from the hospital sit on the boards of many community organizations including:
- the Local Management Board
- Public Safety Net Council
- Child Advocacy Board
- School Board
- YMCA
- Tri County Diabetes Alliance
- Chamber of Commerce of towns throughout the region
- Many Health Department councils

We also have a "Visions for Total Health Advisory Board" comprised of community providers of health related services including traditional as well as integrative health services. Through this committee we can keep our finger on the pulse of the area in which we serve. This committee gives us great feedback on services and programs that are needed, those that are working and those that aren't. It is through this committee that we put on a major health conference each year which provides health education as well as screenings.

Our auxiliary volunteers are another great resource we use for keeping our pulse on the community. We have over 400 auxillians. They are active on many committees within the hospital and also represent the hospital on community boards.

3b. In seeking information about community health needs, did you consult with the local health department?

Yes, members of the hospital staff sit on many committees and boards of the health department; Alcohol and drug council, Tobacco and Cancer Board, Community Safety Net, Disaster Preparedness, Flu. Also there are many members of the health department who sit on committees within the hospital. We work very closely with our local health department to plan services to meet community needs and decrease the duplication of services. With the recent budget cuts we are looking at services more closely with the County Health Department and our County Commissioners to eliminate duplication of services.

4. Please list major needs identified through the process explained #3.

- Access to care, not enough physicians locally
- Mental health services
- Transportation to appointments, testing and treatments
- Specialty services
- Diabetes

5. Who was involved in the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?

As mentioned previously the hospital leadership developed, in 2005 the 5 year strategic plan for the institution. Within this framework we set organizational goals each year. Because our leadership is so involved in the community through serving on boards we have a good idea of community health needs. We also have Primary Care offices throughout our primary and secondary markets which give us a first hand look at community needs. We have 193 physicians on our medical staff which gives input.

Through the SWOT/Gap model the medical staff, hospital leadership, and management determine the needs we feel most need to be addressed that year. Each individual in management and leadership develops individual and department goals and senior leadership of the hospital determines the hospital's annual goals. It is through this process that the community benefit goals are determined.

Community Benefits is addressed by every department in the hospital and all participate on some level. There is a Community Benefits Committee, with members from each department, which oversees the process. The Community Education Department provides oversight to the Community Benefits Committee and Visions Advisory Board (see question 3) as well as all hospital departments regarding community benefits. This year we began using the Lyons software CBISA system for tracking our activity. Through the process of transition to the new system we were able to identify knowledge deficits within the organization and provide the needed education. Awareness was raised of the Community Benefit picture at Atlantic General. Now that department reporters can enter data immediately after an event the data is a much better representation of what we do. The accuracy of the data collection has definitely improved since we transitioned to self-reporting on CBISA.

6. Do any major Community Benefit program initiatives address the needs listed in #4, and if so, how?

Yes, there are community benefit programs initiatives which address all the above mentioned needs:

- Access to care, not enough physicians locally
- Specialty services

AGH is always recruiting new physicians. During this year we credentialed 29 physicians, acquired **3** primary care providers, **4** nurse practitioners/physician assistants, **2** gynecologists, as well as granting admitting privileges to other community physicians. The targeted recruitment specialties FY09 were: urology, anesthesia, gynecology, psychiatry and orthopedic surgery. We were successful in bringing all but urology and orthopedic surgery.

In FY09 we also formed a Cancer committee. Through this group we were able to begin tumor boards and begin the process of recruiting a medical oncologist to join the team at AGH. This will allow us to not only diagnose cancer but to treat our patients as well. Since our community is rural this will be a great service to the residents; allowing them to stay close to home and their support system while getting treatment.

Another way we are addressing access to care is through our physician's appointment line. This is a central number where a patient can call to schedule an appointment with any AGH physician. If their usual provider cannot see them that day they will be given an appointment with another provider and their records will be temporarily transferred to assure continuity of care.

The behind the scenes process which makes this attainable is our electronic medical record system. This is a service which less than 7% of physician offices across the country can offer. We began the process last year of putting all patient records in our Atlantic General Health System offices into electronic format. This means they can be accessible to the physician at any of the outpatient offices or in the hospital for emergency room and inpatient admissions.

- Mental health services

Several members of our hospital staff are involved in the Worcester County Public Safety Net Council. This council is made up of: public health personnel, social services, crisis services, law enforcement, judicial system, detention system and community affiliates. The purpose of this council is to address the mental health needs in the county. In addressing the mental health needs there will be less unnecessary hospitalizations and ER visits as well as needless incarcerations and judicial services.

As a result of this council existing mental health services are coordinated throughout the county are being promoted to the residents. A web site has been launched, http://worcester.md.networkofcare.org where people can access many resources for information, education and resources. Also helping to meet the mental health needs AGH has expanded one of our existing outpatient buildings, Atlantic Health Center (AHC). This expansion houses a new outpatient mental health program, including counselors and a newly recruited psychiatrist.

- Transportation to appointments, testing and treatments

In providing a step in the solution to the transportation issue faced across our county we are ever increasing services throughout the area. In our county, as well as in most rural areas, people are reluctant to travel outside their immediate locale to get health services. Realizing this we believe an important part of providing care is to take as many services as possible into the communities we serve. As mentioned before we have acquired 3 primary care physicians and 4 nurse practitioners/physician assistants this year, increasing the number of patient visits that we can accommodate in our primary care offices. We have also increased our lab and imaging services offered in our most distant community in the county. Part of our goals for FY09 was to increase the offering of health screenings and education to the distant areas of the county. We have offered additional health fairs (with screenings) and education to area churches and senior center in those communities.

We have also begun the process of putting open access clinics in 3 local Rite Aid pharmacies in the outlying areas of our service area. One of the communities has no physician office in the town, this will be a definite asset to those who have transportation issues.

- Diabetes

Our Diabetes Education Department continues to offer diabetes education and counseling to our residents. In addition they participate in many health fairs, 2 community support groups and teaching classes through the health department. As mentioned before in the AHC expansion the Diabetes Education Department will be enlarging to include space for additional education and counseling services.

Two additional programs which we sponsor to address these and other community health needs is the Visions for Total Health Conference and the AARP Health Fair. Between the 2 events we served approximately 800 residents last year. At these events we provide free lab screenings for cholesterol, glucose and prostate. At these events there is health education on various topics as well as other screenings such as blood pressure, diabetes, stroke, pulmonary, body mass index, fitness and bone density. All services are free to the attendees.

Since it is never too early to begin good health habits the hospital set a goal of addressing childhood obesity in some way. We have found a program (Food Play) which we can sponsor in the local schools which teaches a positive health message including, healthy eating exercise and positive self-image. The plan is do the program in September, 2009 at the beginning of the school year. That gives the schools the rest of the year to reinforce the message using the follow-up materials given to each school.

7. Please provide a description of any efforts taken to evaluate or assess the effectiveness of major Community Benefit program initiatives.

1a. - Name of initiative: Visions for Total Health conference

b. Year of evaluation: 2008 conference

c. Nature of evaluation: participant satisfaction survey

d. Result of evaluation: Beginning in 2007 the location and time of year for the conference was changed. It was moved from the busy tourist season in Ocean City to the fall (after the season) into the local high school. This change has allowed us to serve the local community better and resulted in a higher attendance and increase in satisfaction according to the participant surveys.

2a. – Name of initiative: Living Well Chronic Disease Self Management Program

b. Year of Evaluation: FY 2009

c. Nature of evaluation: comparison data of problems of daily life associated with chronic disease

d. Result of evaluation: of the 50 participants attending the program there was a self-reporting decrease of 30% to 50% in problems of daily life associated with chronic disease.

8. Provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

The number one determined specialty gap in services in our county is mental health providers. There is one full time psychiatrist for the nearly 50,000 residents. Because many of those, in need of mental health services, end up in the emergency department at the hospital it is a drain on the system. Problems that could be handled appropriately on an outpatient mental health basis end up becoming physical problems resulting in emergency room visits and hospital admissions or social problems resulting in arrests or incarcerations. We have recently recruited a new psychiatrist and support team which will provide mental health services through our Atlantic Health Center location; this is a collaborative venture with the Health Department.

Another gap in specialty physicians is endocrinology. The diabetes rate in Worcester County is 14%, double the national rate. In this area, not even in this county, there is one endocrinologist. This puts a large burden on the primary care doctors, and diabetes programs to educate and manage diabetic patients. Because of lack of services many residents must go out of the eastern shore area for diabetic care and many go untreated or minimally managed.

In the northern part of the county the hospital has a walk-in site that treats patients and charges on a sliding fee schedule. In the next county to the southwest there is a similar medical service clinic (not run by AGH). This does somewhat serve the southern part of the county but because of the rural nature of our area and the lack of comprehensive public transportation there is still a need for more such services.

9. Physician subsidies:

We amortized previous payouts of $110,513, which we report on the Community benefits report. We also spent $222,575 on physician recruitment which we also include in the Community Benefit report.

Appendix 1

1. Describe your Charity Care Policy

Dedicated financial counselors help those who are uninsured or underinsured, with few resources on which to rely, navigate the options that may be available to them, including the available Maryland Medicaid programs. If no other financial avenues are available to a patient, he or she may apply for financial assistance for those services deemed medically necessary. We base our financial assistance on 200 percent of the poverty level guidelines set by the federal government. Financial Assistance is available to all patients who qualify. This year, Atlantic General Hospital and Health System dedicated $1,016,205 to this program.

The Charity Care information is in a brochure which can be found in all public waiting areas of the hospital and health system sites. We also run articles in our newsletters that are distributed in the homes of all residents in the county and service areas. Through the Case Management and Patient Financial Services Departments those in need are determined and guided through the process as described above.

In March, 2009 we participated in a fair which was held in our hospital lobby as part of the "Cover the Uninsured Week" to educate the public on our provision for financial assistance as well as other healthcare coverage options in the area. In August we provided

the same education at a "Reach Out to the Homeless" event which took place at the County Health Department.

As part of mandatory yearly education all associates had to complete a module on our Financial Assistance policy. This assures all associates will be aware and can assist our patients in getting the needed information.

Appendix 2

ATLANTIC GENERAL HOSPITAL/HEALTH SYSTEM

POLICY AND PROCEDURE

Appendix 2

TITLE: **FINANCIAL ASSISTANCE POLICY**

DEPARTMENT: **ADMINISTRATION/FINANCE**

POLICY:

It is the policy of Atlantic General Hospital/Health System to provide services without charge to all eligible persons who are unable to pay according to the Hospital's guidelines. Atlantic General's Financial Assistance program is granted after all other avenues have been explored, including payment arrangements or government financial assistance. A distinction is made between financial assistance and bad debts. Financial Assistance is amounts due the Hospital from patients not having the income or resources necessary to meet their responsibility to pay for their health care services within an appropriate length of time. Bad debts are amounts due from patients who are able, but unwilling to pay.

Financial Assistance will be available to all patients without discrimination on the grounds of race, color, national origin, creed.

A patient must have a valid social security number in order to be eligible for Financial Assistance.

1. AGH bases Financial Assistance on 200% of the Federal poverty guidelines (Exhibit A). Only income and family size will be considered in approving applications for Financial Assistance unless the amount requested is greater than $30,000, the tax return shows a significant amount of interest income, or the patient states they have been living off their savings accounts. If one of the above three scenarios are applicable in the application, liquid assets will be considered including checking and saving accounts, stocks, bonds, CD's, money market or any other accounts for past three months along with the past year's tax return and a credit report may be reviewed.
2. Financial Assistance can be applied to all active outstanding balances at the time of approval. Only in extraordinary circumstances will Financial Assistance be applied to a balance transferred to an agency.
3. A patient can be eligible for Financial Assistance in a catastrophic medical situation when medical liabilities are greater than 40% of the annual income or claims totally over $30,000.
4. Approvals can remain active for one year from date of application provided all information is reaffirmed. If information has changed at time of reaffirmation a new application must be submitted for approval. Medicare deductibles can be included on a previous application if service is within the same benefit year. All information must be reaffirmed. In special circumstances the committee may only grant financial assistance for accounts on the current application and not extend the financial assistance for one year.
5. Patients are not eligible for Financial Assistance if the account is for workers compensation, litigation, or the balance is pending an estate settlement.
6. If a patient is approved for Medicaid with a spend down, financial assistance can be applied to the spend down without completing the application process. A valid 216 or a screen print of the condition/occurrence code screen must be attached indicating the amount of the

    spend down. (Note: this does not grant financial assistance for a year, this automatic

    financial assistance only applies to the spend down.

7. If patients have paid any amount towards their bill prior to approval, the payment will not be
   refunded.
8. If patients do no comply with insurance requirements which results in a denial by the

   insurance company, they will not be eligible for Patient Financial Assistance.

9. If patients do not agree with the decision, they can file a written appeal to the Director of
   Patient Financial Services, who will review the documentation and make a
   recommendation to the Patient Financial Services Committee for a decision.

Patient Financial Services Procedures

1. Self pay patients or balances after insurance.
   a) It is the responsibility of the PFS (Patient Financial Services) Associate to determine that all available resources (Medical Assistance, private funding, family members, credit cards and /or payment arrangements) have been exhausted and noted on account.
   b) PFS will have the patient or representative of the patient complete a Financial Assistance Application. (Exhibit B) Applications may be accepted from the patient by telephone. PFS documents on the signature line the application was verbal.
   c) PFS updates the account to payer code PCHA (pending charity), plan code PCHA when application is completed by the patient or completed verbally over the phone with the patient/representative. The application **MUST BE COMPLETED** before using payer code PCHA. If patient/representative does not complete the application, payer is SELF. The completed original applications must be sent to the Collection Specialist in Patient Accounting via interoffice mail. A copy of the application (stamped COPY), along with the instruction letter should be provided to the patient/representative or mailed if completed over the phone.
   d) PFS must put a REGS note type, and note code **PCAC** (Patient Charity Application Completed) with date, time, and initials on all pending financial assistance accounts.
   e) If patient applies for Medical Assistance and completes our Financial Assistance application at the same time, use payer code PEND for primary and PCHA for secondary.
   f) If patient has applied for Medical Assistance and approved, our Financial Assistance should be removed from payer except in the case of PAC, then CHAR stays as primary payer.
   g) If patients are not eligible based on income, but an extenuating circumstance applies, an application with all supporting documentation can be referred to the Committee for review and a recommendation to the Director of Patient Financial Services to forward to senior leadership.

Procedures for Pending Applications

1. The Collection Specialist must follow guidelines below on the applications received:
   a. Accounts Balances of $0-$500 no reminder call to patient
   b. Account Balances of $500-$1000 1 reminder call to patient
   c. Account Balances of $1000-$3000 2 reminder calls to patient
   d. Account Balances > $3000 3 reminder calls to patient
2. The patient receives statements based on the schedule below if documentation is not received accounts will automatically transfer to collection agency.
   a. 2 days Summary Bill
   b. 4 days Statement 1
   c. 20 days from Statement 1 (24 days) Statement 2
   d. 20 days from Statement 2 (44 days) Statement 3 **FINAL NOTICE**
   e. **10 days from Statement 3 the system will pre-list (Bad Debt pre-list) the account.**
   f. **7 days from pre-list the system will transfer the account to Collection Agency.**
3. If patient is uncooperative or cannot be located and does not return supporting documentation within 30 days, Collection Specialist may forward account to collection agency prior to completion of the statement cycle for non-compliance. Collection Specialist places account in F/C BMAN and changes payer over ride flag to Y.
4. Messages generated on the statements:
   a. **Statements 1 and 2 message** – Thank you for utilizing the services of Atlantic General Hospital. Please return all required documentation for your Financial Assistance application or remit payment today. If information is not returned you will be ineligible.
   b. **Statement 3 message** – This is your final notice. Your account is past due and full payment is required. If payment is not received within 10 days your account may be referred to a collection agency.
5. Accounts may be put on bad debt hold at the discretion of the Collection Specialist if he/she believes the patient/representative needs additional time to send documentation. Accounts are placed on bad debt hold by:
   a. Entering Collection Status Code BDHD on an account.

Application Requirements

1. Family size – a family unit is defined as all exemptions filed on the income tax return filed for the individual filing the application whether or not they were the individual filing the return or listed as a spouse or dependent.   For homeless persons or in the event that a family member is not obtainable, the family unit size will be assumed to

be one. If a tax return has not been filed, then income from all members living in the household must be submitted

2. Income – Income is to be determined for the **entire family unit**. It should be supplied for the twelve months preceding the request or for the three months preceding the request. If 3 months is used, multiply the 3 month annual income by four to calculate the annual income. Income must be verified through a recent pay stub **and** the previous years' tax return. The annual income or the annualized income will be compared to 200% of the Federal Poverty Guidelines (Exhibit A) to determine eligibility. If anyone in the family unit owns a business, the net income from the business will be used for the calculation. If anyone in the family unit owns a business, current information must be submitted for business income and expenses. If current income and expenses are not available, the previous year tax return 1040 and Schedule C must be submitted.

3. For each family member receiving unearned income the following must be submitted with the application.
    1) Proof of Social Security Benefits
    2) Proof of Disability Benefits
    3) Proof of Retirement/Pension Benefits
    4) Proof of Veterans Benefits
    5) Proof of Child Support.

4. If anyone in the family unit is not working or has unreported income a signed notarized

    statement must be provided by the individual or a letter from a Government Agency that is

    providing financial information indicating the amount of the unreported income and/or the

    employment status.

5. The amount requested is greater than $30,000, interest income is significant, or the patients

    state they are living off their savings, bank statements, copies of CD's, and bonds must be

    provided.

6. If the tax return shows IRA or annuity distributions, the amount will be included in the income calculation unless the patient can prove the funds have been eliminated.

7.   After the application is received the Collection Specialist reviews the application and if eligible completes the Approval of Financial Assistance Form. (Exhibit D) If the **patient** is eligible the Collection Specialist forwards the application for approval. Prior to sending the application for approval the Collection Specialist will EVS to insure the patient does not have Medicaid.

8.   A decision will be rendered within 15 working days of receipt of a completed application.

9.   The Collection Specialist notifies the patient of the decision for Financial Assistance in writing (Exhibit E or F).

Approval

a)   The Collection Specialist completes the Approval of Financial Assistance Form (Exhibit D) and refers the form for the following authorized signatures:

Less than $2,000	Director of Patient Financial Services
$2,000 - $5,000	CFO/Vice President of Finance
Over $5,000	CEO/President
Over $30,000	Committee Chair and senior leadership

b)   If the amount requested is greater than $30,000 the application and supporting documentation will be forwarded to the Patient Financial Assistance Committee for recommendation to senior leadership. All recommendations and decisions will be made on a case by case basis based on the documentation provided.

c)   After the Financial Assistance Application has been approved, the Collection Specialist allowances off the appropriate amount to procedure code: 1031098

d)   The Collection Specialist documents the system and indicates the patient was approved for Financial Assistance and the date of approval.

e)   The Collection Specialist updates all accounts with payer code CHAR (Financial Assistance), plan code CHAR, and enters the effective and termination date of the Financial Assistance on the payer screen. Collection Specialist must be sure the history account has the payer code CHAR listed.

f)   The Collection Specialist monitors accounts using a worklist identifying all accounts where CHAR is secondary and the primary insurance has paid.

g)   Financial Assistance approvals and supporting documentation will be filed by month and maintained for a period of ten years.

h)   Once applications are approved the Collection Specialists forward the applications with supporting documentation to the General Clerk for storage and retention.

i)   The General Clerk balances the Financial Assistance Allowances to the monthly TRANSMTH01 report and provides the report to the Manager for review. The General Clerk files the TRANSMTH01 report showing transaction code 1031098 with the monthly Financial Assistance approvals.

Reaffirmation

a) If the patient presents for any additional services during the year approval period, the Registrar pulls forward the payer information and payer code CHAR will be present. Registrar verifies the approval dates are within the range of the approval period. The registrar affirms whether or not the patient's information has remained the same. If the information is the same then the registrar will answer "Y" to the reaffirmation question on the payer screen. If information has changed or date of service is outside the approval period, the patient must reapply for Patient Financial Assistance.

b) If patient returns within the year approval period for inpatient stay or surgical service, patient must be re-evaluated for Medical Assistance and notes posted on account. If the patient was previously approved and has an account greater then $30,000 within the one year eligibility, a recalculation must be done with liquid assets.

c) Once the CHAR payer code is on the account the system will automatically write off the balance at time of billing to code 1031098.The Collection Specialist reviews daily the automatic contractual write off report (PBRP110-001) to insure that the reaffirmation questionnaire is completed on the payer screen, and the account date of service is within the effective/termination dates of the 180 day approval period. If the questionnaire has not been answered the Collection Specialist must contact the patient. If CHAR is secondary on the account the Collection Specialist reverses the automatic write off pending outcome of primary payer.

d) To complete the reaffirmation, Section 4 must be followed and the Reaffirmation form (Exhibit C) must be completed for all accounts greater than $2000. For accounts less than $2000 the Collection Specialist must complete the Patient Financial Assistance confirmation (Exhibit G) indicating all information has been confirmed and forward to the Director of Patient Financial Services for approval.

Appendix 3

2. Describe the hospital's mission, vision, and value statements.

Our President and CEO Michael Franklin, FACHE, recently said it best in an "On Call" article, "Achieving our Vision "To be the leader in promoting access to healthcare services…" and our Mission"…to improve individual and community health" means we must continue to courageously address issues that plague all communities, and create solutions for our community. More people are being diagnosed with chronic conditions, which can lead to a decline in the quality of life and is causing the exponential climb in healthcare costs experienced by families. While the incidence of chronic care is trending up, people are also living longer and are much more active longer. How do we help those

families who live in our community manage the health care needs of 3 and 4 simultaneous generations? Such issues affecting the future of the quality of life in our community require strong leadership and foresight from those who have the responsibility for ensuring that these threats are curtailed." ("On Call", Fall 2008).

In summary our Vision, Mission and Values are to provide quality healthcare to the residents of the area and to improve their lives through education, service and care of their health needs. Our patients are in the center of our values through: personalized attention, financial accountability, our respect, kindness, integrity, honesty, trust, education, meeting community needs, teamwork, partnerships and patient safety.

Appendix 4

Appendix 4

ATLANTIC GENERAL HOSPITAL/HEALTH SYSTEM

POLICY AND PROCEDURE

TITLE:	**MISSION STATEMENT, STATEMENT OF VALUES, AND** ETHICAL COMMITMENT
DEPARTMENT:	**ADMINISTRATION**

POLICY:

It is the policy of Atlantic General Hospital/Health System to maintain a Mission Statement, Statement of Values, and Ethical Commitment for the organization. This will be reviewed annually by the leadership and Board of Directors with approved changes made and communicated. The Mission Statement will be posted prominently throughout the organization.

Atlantic General Hospital and Health System

VISION

To be the leader in promoting access to healthcare services for the residents and visitors of Worcester County and the surrounding region.

MISSION

To provide quality care, personalized service and education to improve individual and community health.

VALUES

These values serve as the foundation for achieving our mission.

- ◆ *Dedication to patient safety*
- ◆ *Respect and kindness*
- ◆ *Community commitment*
- ◆ *Honesty, integrity, and trust*
- ◆ *Personalized attention*
- ◆ *Partnership and teamwork*
- ◆ *Financial accountability*
- ◆ *Continued learning and improvement*

These values are honored in all we do for our patients, visitors, medical staff, associates, partners and volunteers.

Ethical Commitment

To conduct ourselves in an ethical manner that emphasizes a basic community service orientation and justifies the public trust.