

1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?
 - 62 inpatient beds
 - 3,964 inpatient admissions
 - 34,744 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 13% of our revenue in FY10.

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. Using this model the Leadership Team meets with Medical Staff to look at strengths, weaknesses,

opportunities and threats to plan for the coming fiscal year. This information then goes to the hospital board to, along with senior leadership, finalizes the strategic initiatives for the coming year. Using this information the Community Benefits Committee and the Visions for Total Health Advisory Board determine the goals for the coming year.

The documents used by the hospital to determine community needs are:

- the health assessment publication from the health department, 2009
- 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
- Hospital Perception Survey, 2010

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
- Worcester County 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. This year the committee decided to take the health conference “on the road” and to hold it in different towns in our service each year. Having held it in the northern end of the county since its inception it will be held in the southern most town in the county in November 2010.

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
- Community transition to EMR
- Specialty services
- Cancer Care Services

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 firsthand 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. Currently we use the Lyons software CBISA system for tracking our activity. Through departmental awareness of the Community Benefit picture at Atlantic General awareness of Community Benefits is always in the forefront. 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. In FY10 we have added several primary care physicians which practice in our outlying areas. We have also forged a closer relationship with an existing ophthalmological group in the area and have enhanced the ophthalmology surgical services. One of our community affiliate surgeons began providing services in our primary care office in one of our outlying, underserved areas.

Our efforts in recruiting a Medical Oncologist have been successful and beginning July FY11 we will be able to offer cancer care services to our community.

Through EMR patient records are available for the patients regardless of which provider they see. This is not only being completed within our own primary care network but the hospital is working with community affiliate physicians to be able to equip them with the same EMR system used by the hospital.

- 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 that 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 links for information, education and resources.

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: 2009 conference
- c. Nature of evaluation: participant satisfaction survey
- d. Result of evaluation: Title of the program and focus was “The Changing Faces of Healthcare”

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

- b. Year of Evaluation: FY 2010
- c. Nature of evaluation: comparison data of problems of daily life associated with chronic disease
- d. Result of evaluation: of the 30 participants attending the program there was a self-reporting decrease of 30% to 50% in problems of daily life associated with chronic disease.

As mentioned before the Community Benefits Committee and The Visions Advisory Board are always evaluating the programs that address community benefits initiatives. Changes to programs and new programs are birthed through the direction of these committees and the strategic plans of the hospital.

3a. – Name of initiative: Speaker’s Bureau

- b. Year of Evaluation: FY10
- c. Nature of evaluation: customer service comments on speaker provided for their events
- d. Results of evaluation: comments on provided services range from good to excellent on speakers provided on various topics to local community, civic groups and businesses.

4a. – On site first aid services for athletic tournaments in the area.

- b. Year of evaluation: FY10
- c. Nature of evaluation: customer service comments
- d. Results of evaluation: very happy to have on site support for participants and families. Provide an extension of help for pre-hospital providers, visitors and residents associated with tournaments.

5a. - Blood pressure screenings in local public venues

b. Year of evaluation: FY10

c. Nature of evaluation: customer comments

d. Results of evaluation: customers extremely happy to have screenings at convenient locations. Referrals made for elevations.

6a. – Bone Density Screenings

b. Year of evaluation: FY10

c. Nature of evaluation: participant evaluations

d. Results of evaluation: 100% of those screened were extremely satisfied with the service. Almost 10% of those screened were found to be a risk for osteoporosis.

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 11.6%, more than 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. Through a grant AGH is able to provide treatment clinic for diabetes patients to educate and test for diabetes. This is offered twice a month free of charge. No income restrictions apply to the participants in this program.

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. In addition AGH opened open access care facilities in 3 Rite Aid Pharmacies in our service area. Through these we are able to offer drastically reduced priced athletic physicals to the youth in our service area.

9. Physician subsidies:

We amortized previous payouts of \$114,680, which we report on the Community benefits report. We also spent \$98,076 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 \$1,729,056 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.

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 not 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 than \$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, 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.

The hospital takes seriously its mission, vision and values; our performance appraisals are based on them. For the past several years our leadership team has had special projects they had to complete which exemplify our values.

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.