

ATLANTIC GENERAL 2020 VISION

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Atlantic General Hospital/Health System “2020 Vision”

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I. Executive Summary

Continuing to build upon our Mission “To create a coordinated care delivery system that will provide access to quality care,” the AGH 2020 Vision will drive strategic decisions



toward integration beyond the acute care facility. These decisions will build upon the current investments in developing community-based care delivery systems that incorporate primary care, specialty care, and care management of chronic conditions through our PCMH. Accomplishing our Vision will require disciplined investment of time and resources in the “Right” principles:

Right Care - Patient/Family Centric, Error Free, Primary Care Provider-Driven, Timely Delivery, Best Practice Protocols;

Right People – Needs-Based Provider Recruitment, Service Orientation, Right Training, Continuous Learning;

Right Place – Appropriate Distribution of Primary Care, Availability of Specialists, Telemedicine, Community-Based vs. Hospital Based;

Right Partners – Advanced Acute Care Referral Relationships, Rehabilitation Care, Long-Term Care, Home Health Care, Supportive Care/Hospice, Mental Health Care, Accountable Care;

Right Hospital – The Right Leader for Coordinated Quality Care in our Community.

Our “2020 Vision” will build upon our distinctive competencies to create a new system of health. Investment in technology-based solutions will facilitate care being distributed more evenly throughout our region, creating equity in access to all. Building upon our health literacy initiatives and our relationship with the Worcester County Health

Department, AGH will be a leader in addressing the individual factors that affect health promotion and prevention of disease. Continuing to promote health care interventions driven by patient-centered values to improve individual function and well-being will result in improved quality of life for those who choose to live in our community.

II. **Mission/Vision/Current State**

Mission: To create a coordinated care delivery system that will provide access to quality care, personalized service and education to improve individual and community health.

Vision: To be the leader in caring for people and advancing health for the residents of and visitors to our community.

- ***CURRENT STATE***

Atlantic General Hospital/Health System (AGH/HS) is a not-for-profit community hospital organized under the Internal Revenue Service (IRS) code 501(c)(3), and it fully incorporates related entities such as the Atlantic ImmediCare (AIC). The Atlantic General Hospital Foundation (Foundation), the Atlantic General Hospital Health System (AGHS), and the Atlantic General Hospital Auxiliary (Auxiliary) are all part of the Atlantic General Hospital Corporation (AGH).

Through the AGHS entity, AGH/HS employs over 50 physicians and providers in the hospital and throughout the region at 14 different locations. As a separate corporation, AIC provides walk-in primary care services 7 days per week in partnership with Rite Aid pharmacies in Ocean Pines and Millsboro, DE, and in Ocean City between Memorial Day and Labor Day. AGH/HS has recently purchased property in West Ocean City to provide capacity for expanding primary and specialty services to that growing segment of the community.

The Foundation and the Auxiliary provide significant non-operating benefits to AGH/HS. In 2014, the Foundation raised over \$1 million to support programs and operations of AGH/HS, and AGH/HS continues to have the second largest, single hospital Auxiliary in the state of Maryland. The benefits of the Auxiliary result from tens of thousands of volunteer hours, and over \$110,000 annually in donated income from programs such as our AGH Thrift Shop.

AGH/HS serves a geographic region that extends from the Indian River Bay in southeastern Sussex County, DE, to the northernmost part of Accomack County, VA. The service area is very sensitive to the seasonal influx of resort vacationers between Memorial Day and Labor Day each year, where the regional population expands from

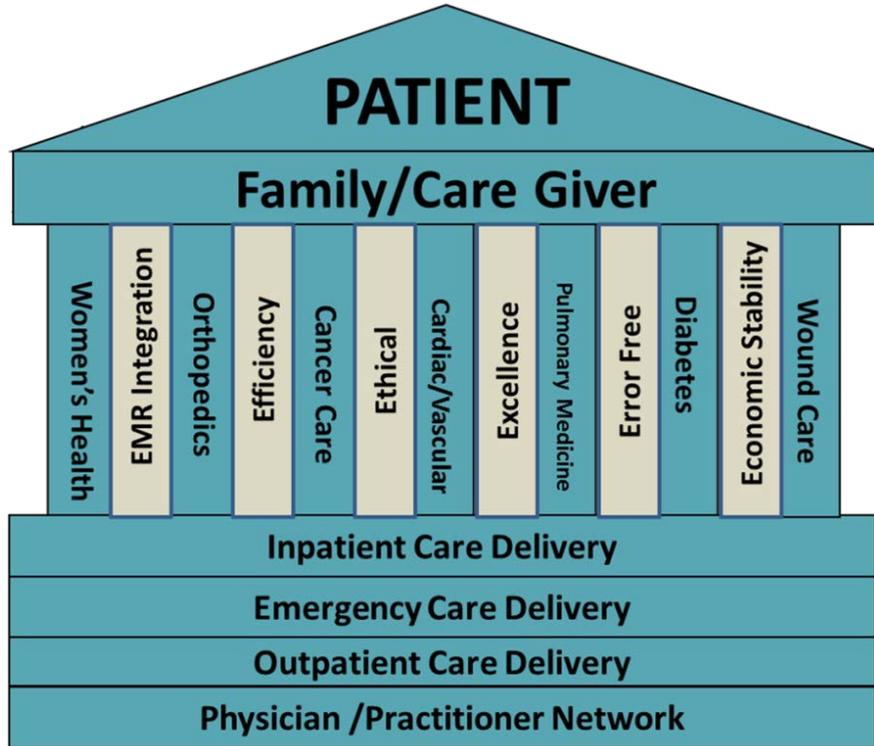
approximately 100,000 to approximately 500,000. This seasonal flux creates unique challenges for the healthcare services in the region, and significantly influences the labor industry¹.

The hotel, restaurant and tourism industries provide a significant income and tax base for

the region. From a wider perspective, the predominant industries are related to agriculture, poultry, and the seafood/waterman industries. The service industry impacts the economy in the region through education/schools, healthcare, and local/regional government. With a population mix of nearly 25% 65 years of age and older, there are workforce and skilled labor challenges and a disproportionate tendency toward service industry employment versus manufacturing or technology. The overall influence of this regional mix is a lower than average educational status, even though income averages are relatively higher. This regional economic mix creates unique challenges for the health and healthcare in the community².

During the past five years, AGH/HS has been deploying our “E” Strategy – developing the operational environment and principles that will support AGH/HS meeting the needs of our community. The “E” Strategy supported the investment in EMR Integration, Efficiency, Ethical choices and care delivery models, Excellence in service delivery and

“E” Strategy 2011 - 2015



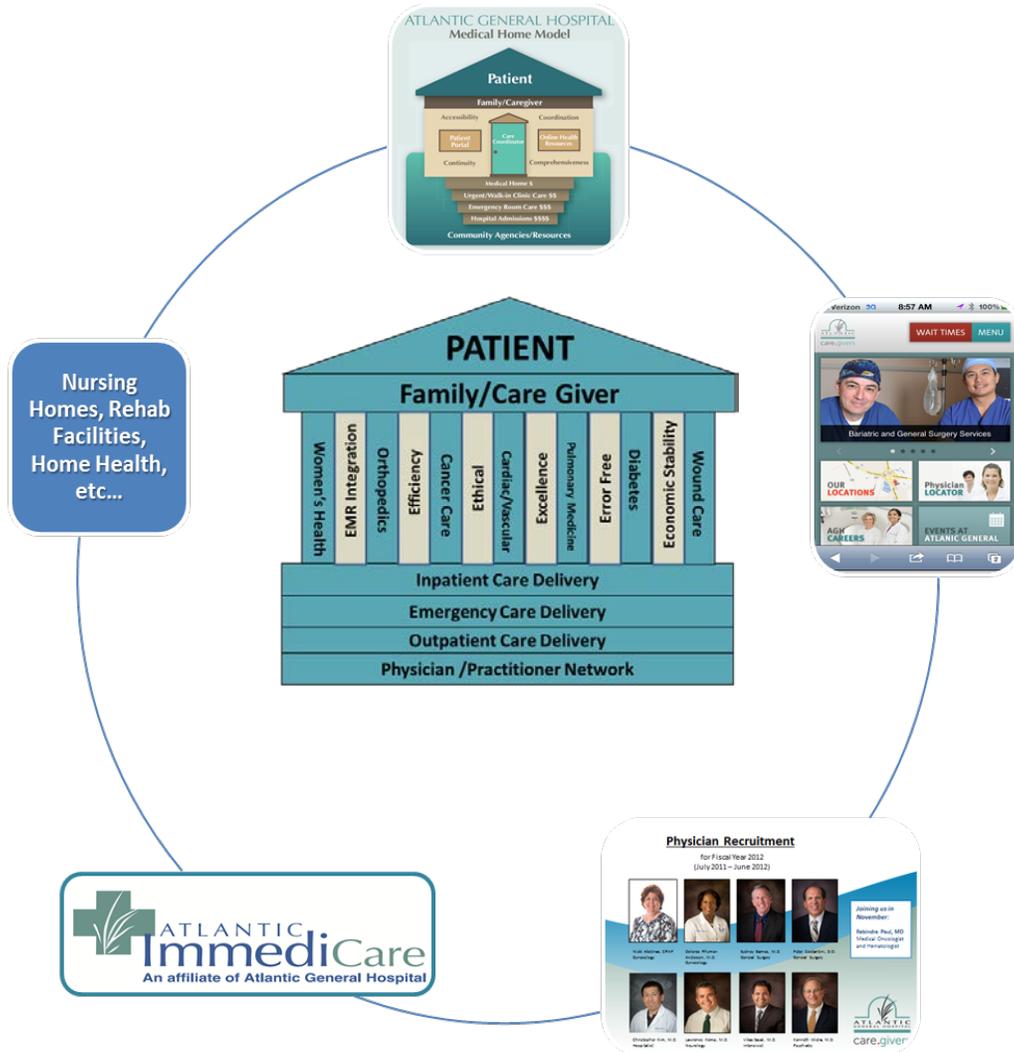
¹ U.S. Census Bureau. (2013). State and County Quick Facts. Washington, D.C.: U.S. Department of Commerce.

² Goeller, D. R. (2012). *Community Health Improvement Plan (CHIP) 2012-2017*. Snow Hill, MD: Worcester County Health Department.

operational performance, Error Free in care delivery to our patients, and Economic Stability of our organization to be here in the future for our community.

These principles supported the hospital/health system structure that we had been creating since 2005, and were principles founded in the health care environment of the time.

Up until 2014, the system of care in Maryland and throughout the U.S. was a hospital-centric model of care delivery. In our community and in Maryland, AGH/HS was often a leader in advancing this model of care design, incorporating advanced supportive structures to channel patients to our hospital services. Our design of this community



model was successful for the era, and afforded us the resources to continue to advance the care delivery in the region.

2014 has ushered in a new era for healthcare delivery. Maryland has adopted the most progressive plan for changing the healthcare financing model, with an attempt at designing a value-based versus volume-based hospital payment system that results in achievement of the “Triple Aim” in healthcare – improve the health of the population, enhance the patient care experience, and reduce the cost of care.³ This radical redirection in healthcare delivery in Maryland, and the overall impetus for moving toward a future in healthcare that is unmapped – Patient Protection and Affordable Care Act of 2010⁴ (PPACA) - present a new challenge for AGH/HS to redistribute healthcare resources toward a different care delivery system for the future.

To begin the process of visioning the new “future”, AGH/HS completed a *Community Health Needs Assessment* (CHNA) in 2013, in accordance with the new federal regulations. The results of the CHNA have been reviewed with members of the community through our Board of Trustees’ Planning Committee to identify priorities to be addressed. In addition, AGH/HS has engaged the medical staff leadership, the Board of Trustees, and the executive leadership team to assess the current state by evaluating the following 10 strategic questions:

A. What are the primary community health needs?

Based upon the prioritized CHNA, there are significant health and healthcare improvement needs around the following:

- Obesity
- Diabetes
- Access to Care
- Cancer
- Cardiovascular Disease
- Mental Health

The Board Planning Committee has identified the need to develop community-focused measures associated with these health improvement needs. The goal is

³ Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The Triple Aim: Care, Health, And Cost. *Health Affairs*, 27(3), 759-769.

⁴ U.S. Congress. (2010). Patient Protection and Affordable Care Act. Washington, D.C.

to develop indicators that can measure community improvements in the following:

- Type II Diabetes
- Obesity Rate
- Acute Care Hospital Admission Rate
- Tobacco Use Rate
- Incidence of Heart Disease
- Self-Reported “Well-Being”
- Suicide Rate
- Screening Rate for Key Conditions (Mammography, Colonoscopy, etc...)
- Patient Portal Use

In addition to healthcare needs for the community, an independent study of the presence of key medical staff and specialties in the region was performed by AmeriMed Consulting in September, 2013, and was augmented with medical staff interviews. With the changes in healthcare delivery – essentially, ensuring the availability of care in non-hospital settings as well as hospital-based care – hospitals have become the *de facto* leaders alongside the county health departments in assuring the redesign of care in the community. This includes having a medical staff development plan that presents the physician/provider needs for the community, and that invests in the infrastructure to address those needs. Below are the identified physician shortages in our community in alphabetical order:

- Allergy/Immunology
- Anesthesiology
- Cardiology
- Dermatology
- Endocrinology
- Family Medicine
- Gastroenterology
- General Surgery
- Geriatric Care
- Gynecology
- Hematology/Oncology
- Infectious Disease
- Internal Medicine
- Neurology

- Otolaryngology (ENT)
- Pain Management
- Pediatrics
- Plastic Surgery
- Psychiatry
- Radiology
- Rheumatology
- Urology

AGH/HS will develop an annual “Medical Staff Development Plan” in conjunction with the Medical Staff Leadership to address the recruitment and retention of physicians to the community. In addressing the above shortages in physicians in our community, the “Medical Staff Development Plan” evaluates current delays in patients obtaining appointments to see primary and specialty care physicians/providers. AGH/HS also evaluates the effects of physician/provider shortages on the quality of health and healthcare outcomes in the community.

Complicating AGH/HS’s ability to address these needs is the community’s infrastructure:

- 75% of the population growth in the region predicted to be 65 years of age and older, creating workforce challenges to continue meeting the geriatric health and healthcare needs of this population.
- Advanced information systems technology that can potentially increase the efficiency of healthcare delivery systems are very difficult to operate in this region, due to the lack of sufficient information technology (IT) infrastructure.
- The rural/remote nature of the population distribution around the region, outside of the Berlin/Ocean Pines/Ocean City area. This mix of population characteristics has been shown to increase the variation in health and healthcare in a regional population, and to have an adverse impact on health-related measures⁵.

⁵ Herrin, J., St. Andre, J., Kenward, K., Joshi, M. S., Audet, A.-M. J., & Hines, S. C. (2014). Community Factors and Hospital Readmission rates. *Health Services Research*, 1-20.

B. What are the long-term financial and clinical goals?

The future of community health and healthcare delivery must include an alignment of clinical and financial goals to ensure the achievement of the “Triple Aim” of high quality (improving the health of communities and the outcomes of healthcare services), low cost (reducing the overall cost of healthcare in the community), and a good patient experience (satisfaction with care delivery, convenience, etc.).⁶

The introduction of the Affordable Care Act (ACA), signed into law in March 2010, was intended to bring quality and affordability to healthcare services for all Americans. This created an opportunity and a need to redefine our care delivery model by moving services to a more ambulatory and more affordable setting. The resulting response to the ACA and the move of services to an ambulatory venue created more volume in the outpatient environment. As a result, Maryland’s Health Services Cost Review Commission (HSCRC) responded by negotiating a new “Medicare Waiver” formula to include both inpatient and outpatient activity. This new waiver is part of a five year experiment or pilot program with the Centers for Medicare and Medicaid Services (CMS) and became effective January 1, 2014. As a result, the HSCRC expects Hospitals to reduce hospital volumes and the resulting costs through better management of population health. In response to this new mandate, the HSCRC has developed new “global” revenue models to constrain hospital charges/costs while encouraging and rewarding hospitals to keep patients well and reduce unnecessary hospital inpatient admissions and outpatient services/tests.

AGH has negotiated with the HSCRC to enter a Global Budget Revenue (GBR) model. Under a GBR agreement, the hospital’s revenue is fixed for a given period of time (i.e. an upcoming rate year), based not on explicit links to a specific population, but on its previously approved budget and revenue history trended forward. AGH’s fiscal year 2013 will be used as the base year for the GBR agreement. To ensure financial success under a fixed revenue model, AGH/HS must embrace strategic initiatives that support the achievement of the Triple Aim.

⁶ Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The Triple Aim: Care, Health, And Cost. *Health Affairs*, 27(3), 759-769.

C. Would the organization be included in a narrow/preferred network by a health insurer based on cost and quality outcomes?

AGH has historically maintained a “top 5” position in cost per case-mix adjusted equivalent inpatient admission (EIPA), relative to all other Maryland Hospitals. Additionally, AGH has achieved the top spot on the Maryland Hospital Acquired Conditions (MHAC) for 65 potentially preventable complications that occur in hospitals. AGH/HS has developed an advanced Patient Centered Medical Home (PCMH) that is an attractive component of our care delivery system. AGH/HS employs a network of primary and key specialty physicians throughout the region, and this integration between hospital and physicians is attractive to insurers.

On the other hand, AGH/HS is located in a relatively rural region, with a low concentration of population and healthcare services. AGH is the only hospital in Worcester County. AGH does not offer all of the services necessary for a completely closed network – especially obstetrics, cardiac interventional capabilities, etc... For a narrow network with insurance companies or self-insured employers, AGH/HS would be a strong choice for inclusion with another tertiary center. Given the current environment and the current distribution of providers in this region, it is unlikely that this will be a pervasive insurance strategy here.

The southeastern portion of Sussex County, DE is a more unique situation. While it is encompassed in our primary and secondary service areas, the state boundary has created a barrier for AGH to participate in state governmental plans (i.e. Medicaid HMOs). AGH has attempted to present a compelling case to the Medicaid administrators in Delaware, but the Maryland “all-payer” regulatory structure has created a barrier to negotiating rates. This presents a referral risk for hospital inpatient and outpatient care.

D. Is there a healthy physician-hospital organization?

Generally, AGH/HS enjoys a strong positive relationship with physicians in the community, based upon physician responses to interviews and responses to surveys^{7,8,9}. AGH/HS has established varying formal structures related to

⁷NDNQI . (2013). *Nursing Satisfaction Survey*. NDNQI.

⁸ Press Ganey. (2013). *Physician Partnership Survey*. Press Ganey.

physician relationships, ranging from employment of primary care physicians throughout the region, employment of key specialties to stabilize the acute care environment (hospitalists, intensivists, anesthesiologists), and other key specialties in the community (gynecology, general surgery, neurology, dermatology, pulmonology and urology). In addition to the employment model, AGH/HS has established other relationship models that have engaged independent community physicians in collaboration with AGH.

As demonstrated in our Physician Partnership Survey conducted by Press Ganey in November, 2013, and as demonstrated in the facilitated discussions of the results of this survey at the annual Board of Trustees/Medical Staff Leadership Retreat in February, 2014, significant opportunity for AGH/HS alignment with physicians lies in enhancing the infrastructure around electronic medical records (EMR). This opportunity exists in all areas – employed community-based physicians, hospital-based physicians, and independent physicians. The current EMR environment, and the necessary “feeder” systems to support the electronic environment, stands out as the largest detractor from a healthier physician-hospital organization.

Other opportunities to enhance the physician-hospital relationship, as demonstrated in the surveys and in the structured discussions, are through strengthening of the primary care network in our community (e.g. more primary care capacity) and enhancing the specialty care support in the community. Physicians are frustrated at times with the lack of available appointment times for primary care visits for referrals, or with patients seeking care in the emergency room due to the inability to see their physician in a timely fashion. These examples of inefficiencies in the healthcare system in the community related to lack of access in key areas increases the frustration level of physicians working in our community.

E. How much financial risk is the organization willing or able to take?

The hospital payment system in Maryland has undertaken a statewide demonstration project with the federal government, designed to create a predictable cost structure for healthcare in the state. Currently, hospital revenue has been “capped” on an annual basis through the GBR system, which pre-establishes the total hospital revenue that can be charged by a Maryland

⁹ RKM Research & Communications. (2013). *Community Perceptions Survey*. RKM Research & Communications.

hospital for a given fiscal year. Under the GBR payment system, hospitals will be incentivized to reduce potentially avoidable utilization (PAU) in efforts to improve community health.

This new environment incentivizes and encourages investment in the transitions of care into non-hospital, non-rate-regulated environments of care. These could be existing hospital-based programs, or they could be new programs for meeting the needs of the community. Under the existing system, the hospital subsidizes a significant portion of the non-rate-regulated care delivered through our health system. Investment in care systems outside of the hospital must be self-sustaining in the future, and must help defray the costs of care that are currently subsidized by the hospital.

AGH currently enjoys a financial balance sheet that is relatively healthy, with primary ratio indicators being equal to or better than the average Maryland hospital. Cash reserves at the end of FY 2014 were 71 days cash on hand, a cash flow margin of 7.4%, and earnings before interest, taxes, depreciation and amortization (EBITDA) of 8.4%. With the revenue constraints of the GBR system, AGH/HS will need to make operational changes to continue being successful.

Given this economic outlook, AGH will need to be thoughtful and deliberate in assuming risk with future investments. Rather than investments leading to growth in hospital-based services, capital investments will need to be focused on system improvements/efficiency, relocation of services to a non-hospital environment, or new non-acute-care hospital services that generate returns to contribute to the overall support of services in the region. Resources will also need to be channeled toward changing, enhancing or adding services in the community that reduce PAUs and reduce demand for the acute-care hospital services, thus providing margin capacity under the GBR system.

While AGH has debt capacity due to the reduction in long-term debt service related to the 2010 bond placement, this capacity must be managed judiciously with the unpredictability of future revenue under the GBR system. Master facility plans may require collaboration with the AGH Foundation and the community, to formulate philanthropic support of these high capital cost initiatives. AGH has not conducted a major gift campaign in over a decade, so this may be a timely opportunity for financing these programs.

Finally, successful financing of the future healthcare system under the new payment structure may require collaboration and partnerships with other acute

care or non-acute care organizations to mitigate financial risk associated with investment in new services. Creating a community model for improving population health will require investment in enhanced services in the community. AGH/HS may not have the core competencies necessary for successful operation of such services, and investment in these programs without necessary competencies will increase risk associated with successful performance. Financial risk mitigation for service expansion in the community may necessitate establishing relationships with other entities to ensure success.

The new healthcare financing system in Maryland changes the future landscape for risk tolerance of Maryland hospitals. Constrained revenue throughout the hospital enterprise will require investments in programs and services that result in the reduction of demand for hospital services. Constrained hospital revenue also fosters investment in non-acute care hospital service offerings that provide additional sources of revenue. Under the GBR system, investment in non-growth oriented capital that improves operational efficiencies may prove to provide a greater return on investment than new hospital-based programs. The new environment creates less tolerance for risk, and greater demand for seeking alternative sources of revenue to support investment in new programs to serve the community.

F. What sustainable factors differentiate the organization from current and future competitors?

- Key Differentiators
 - Location
 - Small Size (an advantage - this has been mentioned repeatedly lately from physicians and others as a benefit)
 - “High touch” atmosphere
 - Personal relationships in the community
 - Attractive and clean facilities
 - Consistent messaging in the community – reinforcement of market share and advantages
 - Convenience/Efficiency (e.g. “30 Minute Promise”)
 - Prevention programs (e.g. Bariatrics)
 - Adaptability
 - Patient satisfaction
 - Quality of certain services (potential for “halo effect”)
 - Not overextended in rate-regulated space (Hospital “right sized”)

- Detractors from Competitive Advantages
 - Naming of our Health System practices
 - Need something different
 - Need something that portrays convenience
 - But, need to maintain affiliation identity with AGH
 - Depth of coverage/staffing/recruitment capabilities
 - Proximity to/community relationships with Baltimore/D.C./Philadelphia
 - Limited affiliations for tertiary care
 - Scale due to size
- Notes/Other Comments
 - Need to focus on Primary Care Physicians
 - Can we market/create a “Convenience/Service Guarantee” system-wide?
 - “Convenience” outweighs seeing “own” physician. “I’m sick, can I get in to see *someone*?”
 - Connectivity between AIC and AGHS – importance of the centralized, integrated medical record

G. Are the organization’s data systems robust enough to provide actionable information for clinical decision making?

AGH/HS has established a partnership with Allscripts as the primary vendor for clinical systems throughout the hospital and physician offices. While the initial phases of this partnership strategy have facilitated AGH/HS success in obtaining all of the possible federal grant funding support through “Meaningful Use” of the systems, lack of integration of the systems and the patient data within the systems creates inefficiencies.

As demonstrated through the responses to the Physician Partnership Survey and the ensuing discussions and feedback sessions, system integration with actionable information for clinical decision making is a key weakness for AGH/HS. This weakness affects the ability to become more efficient in care delivery, requiring duplication of entry of information, difficulties in the transfer of care from one level to another, and risk of errors in maintenance and use of patient information. This is also a key factor inhibiting closer relationships with the medical staff.

Most agree that migration to EMR is necessary (in fact one physician leader commented that the EMR was “the best thing that ever happened in this

hospital.”) The predominant issues preventing a robust-enough system for the future are:

- Illogical workflow in some systems
- No centralized data repository
- Inconsistency in training and levels of competency working in systems by clinicians
- Process steps can delay patient care
- Patient information flow from one level of care to another (or, lack thereof)
- Lack of feedback from the system – lack of reports/data output
- Lack of integration with financial systems and clinical systems
- EMR not fully deployed in all clinical areas.
- Disconnect between data needs and data outputs

H. Does the organization have sufficient capital to test and implement new payment and care delivery models?

Maryland’s new payment system was enacted effective January 1, 2014. The new model, which is made possible by the authority granted to the Center for Medicare and Medicaid Innovation under the Affordable Care Act, will change the basis for Medicare’s participation in Maryland’s system. In place of the limit on per-admission payment, the new model focuses on overall per capita expenditures for hospital services, as well as on improvements in the quality of care and population health outcomes. For five years beginning in 2014, Maryland will limit the growth of per capita hospital costs for all payers, including the growth of costs of both inpatient and outpatient care, to 3.58%, the 10-year compound annual growth rate of the per capita gross state product. Maryland will also limit the annual growth of Medicare’s per capita hospital costs to 0.5% less than the actual national growth rate per year for 2015 through 2018, thereby saving Medicare at least \$330 million over the next 5 years¹⁰.

In addition, Maryland has set the goal of reducing its unadjusted all-cause, all-site hospital readmission rate for Medicare beneficiaries to the national mean over five years by surpassing the improvements that are occurring in other states. The state has established a readmission-reduction program based on

¹⁰ Rajkumar, R., Patel, A., Murphy, K., Colmers, J. M., Blum, J. D., Conway, P. H., et al. (2014). Maryland's All-Payer Approach to Delivery-System Reform. *The New England Journal of Medicine*, 1-3.

payment levels per 30-day episode that have shown some impressive initial results. Similarly, Maryland will measure its performance on prevention of 65 potentially preventable conditions associated with hospital care and seek a cumulative aggregate reduction of 30% on these measures over five years. In this area, the state has tied increasing amounts of revenue to performance on measures of both absolute and relative quality of care. CMS will conduct a rigorous evaluation of the model that examines its effects on the total cost of care, quality, access, and patient experience.

Given this new environment of quality measures and reimbursement, AGH/HS will be challenged to adapt care delivery to accommodate the reimbursement restrictions. AGH/HS implemented a Patient-Centered Medical Home (PCMH) model in 2012, utilizing \$1.1 million in federal grant dollars to build the necessary infrastructure to create this program through 2015. AGH/HS has achieved PCMH Level 2 Recognition from the National Committee for Quality Assurance (NCQA), which demonstrates significant adaptation to the new models of care necessary to be viable in the future.

AGH/HS's ability to successfully navigate the momentum of change happening in these environments will rest on our ability to continue to seek and obtain alternative funding sources such as grants, and our ability to establish relationships with other providers (hospital, physician, post-acute, etc...) that facilitate AGH/HS's transition to the "new model". Currently, AGH/HS has sufficient capital capacity to meet the investments to achieve success in the new model, but the pace of the constraints and the pace of the necessary investments will challenge the tenuous nature of the capital availability.

I. Does the organization have strong capabilities to deliver team-based, integrated care?

While AGH/HS possesses many of the qualities and has clear structural processes to move in this direction, we do not currently have strong capabilities to deliver team-based integrated care across our system and the patient care continuum. Because AGH/HS does not have affiliations or ownership with many of the services on the continuum, AGH/HS needs to have the ability to work towards successful partnership relationships with many non-owned services such as skilled-nursing facilities, home health etc., which may require creativity in aligning incentives.

Although departments within the hospital and health system could be described as having strong, team-based care, there are still silos that need to be broken down. In our most recent Associate Pride Survey (2013), data showed that “good cooperation between departments” had a significant opportunity for improvement. According to the 2012 Culture of Safety Survey, teamwork within units continues to show improvement from 2011 and scores high (84%). However, teamwork across hospital units shows decline at only 59% with the lowest scores in coordination. Hospital handoffs and transitions between team members is showing improvement but remains at only 38% reporting positive results. Coordinated, patient centered working relationships with inpatient and ambulatory care offices, and with inpatient and external health services, also need improvement. In our opinion, effective and timely communication is likely the largest barrier to this in the current environment. Significant contributors to communication breakdown include the absence of integrated electronic systems, service line care planning versus patient centric care planning and a lack of effective common goals relative to outcomes between services.

Areas of innovation, creativity and solutions for minimizing waste across the value stream are areas that will need to improve to meet the new demands. We need to believe we can achieve the change, and then hardwire our successes so that they can expand into other areas so that we are continually learning, deploying and redeploying to other areas. We need to stop functioning and competing for resources as departmental/service silos in order to achieve organizational success towards our mission and financial success.

Considering the impact of health care reform:

Theoretically, newly insured people will have better access to primary care and will take the necessary steps to improve their overall health status and reduce utilization of high cost services that result from failure to address health issues in the early stages. The entire healthcare delivery system previously with the hospital at its center must be redesigned to truly achieve the implementation of VALUE versus VOLUME. The ability to truly manage population health will be dependent on close working relationships and affiliations with other organizations, particularly post-acute care providers, which are often the source of unnecessary hospital admissions, re-admissions and ER visits. Community partnerships with the faith-based community, PCMH, our local health department, and the public school system have shown great promise in managing the future health of our communities.

J. Is the organization proficient in program implementation and quality improvement?

Achievement for long-term care delivery and operational performance will require a high degree of skill in program implementation and quality improvement. Process analysis across clinical areas, rapid cycle improvement, and standardization will be key factors for future successes. Competitors and regulatory agencies are gathering and acting upon data at increasing speed. Recent program implementations, such as PCMH, or the Kennedy Krieger Institute partnership, have been implemented quickly, efficiently and have had great performance gains. These programs benefited from having a structured delivery plan.

The Quality Committee structure has elevated the process for monitoring and the accountability for changing standards around quality improvement activities successfully. Inconsistencies in our current system, including out-of-budget-cycle initiatives, lack of thoroughly documented plans for all programs, and a coordinated standard communication system, are examples of opportunities for improvement. The organization does value each implementation as an opportunity for learning. AGH/HS will need to integrate/standardize program implementation and quality improvement across the continuum, and augment current processes. Defining and documenting organizational objectives and vision for programs at the onset, and then requiring controls to keep improvement projects on course towards their objectives is also identified as an opportunity for improvement.

III. ENVIRONMENTAL ASSESSMENT

Annually, the organization engages in a strategic planning process in order to reevaluate organizational priorities and realign resources to ensure the accomplishment of identified critical objectives. Under the direction of the Planning Committee of the Board of Trustees, and with participation from Medical Staff, Leadership and the community, recommendations are set forth in regard to physician recruitment, programs, services, and building projects ensuring that they are in accord with the AGH/HS Vision/Mission.

As the starting point to the planning process, AGH/HS conducted an environmental assessment in order to ascertain the sustainability of strategic decisions, address the interrelationships of

AGH with certain external stakeholders and identify the presence of internal barriers to success. The external environmental assessment included a series of discussions with stakeholders (e.g., hospital leadership, planning committee members, medical staff, and community members), demographic research, and an analysis of upcoming regulatory changes both in Maryland and surrounding states. The internal environmental assessment, in addition to these stakeholders, included an employee satisfaction survey and a SWOT (strengths, weaknesses, opportunities, threats) analysis.

A summary of significant findings from each segment of the environmental assessment is presented below.

External Environment

Community Health Needs Assessment

In 2012, AGH in coordination with local health departments, neighboring hospitals and community stakeholders, conducted a community needs assessment. The needs assessment is a primary tool used by AGH to determine its community benefit plan, which outlines how the Hospital will give back to the community in the form of health care and other community services to address unmet community health needs. This assessment incorporates components of primary data collection and secondary data analysis that focus on the health and social needs of our service area. In addition a community survey was designed to obtain feedback from the community about health related concerns. The Community Health Needs Assessment (CHNA) was approved by the AGH Board of Trustees in May 2013, and it has many strategic implications.

The specific health needs identified by the CHNA include: Obesity, Access to Care, Heart Disease, Cancer, Diabetes, High Blood Pressure, Dental Health, Communicable Disease and Mental Health. These were prioritized based on the following criteria: size and severity of the problem, health system's ability to impact, and availability of resources that exist locally to address the problem. Based upon those criteria, the following areas were prioritized as "most important" for the hospital to address: obesity, diabetes, access to care, cancer, cardiovascular disease and mental health.

An implementation Plan was formulated with the Priority Areas, Goals, Objectives and Measurements. Ongoing monitoring can be found on the Atlantic General Hospital website.

Hospital Industry

The American Hospital Association, a leading professional association that seeks to promote quality health care provision by hospitals and health care networks through public policy and

providing information about health care and health administration, provides a synopsis of the current and upcoming trends in the hospital industry in their *2014 Environmental Scan*¹¹.

These included:

- Rise in chronic conditions
- Necessitating patient engagement & shared decision making
- Short supply of mental illness treatment resources
- Medicare profitability
- Changing reimbursement methodologies
- Driving efficiency
- Provider accountability for cost and quality of care
- Aligning providers as business partners
- Care coordination across the healthcare provider spectrum
- Transparency of cost, quality, and community benefit data
- Integral use of data
- Optimization of Health Information Technologies
- Population Health management
- Projected provider shortages
- High-cost advances in medical technology and pharmaceuticals
- Growth in telemedicine
- Growing interest in workplace wellness

Regulatory Environment

In the healthcare sector, the regulatory agencies and their requirements have long been burdensome. That is never more apparent than now, in the various changes both federally and statewide. Besides the typical CMS, The Joint Commission, Maryland regulations, HIPAA, and day to day legal standards, hospitals face the implementation of ICD-10, increased quality reporting oversight, and information technology security – all with reduced financial resources from governmental payment sources. The largest change in how Maryland Hospitals are reimbursed came with the federal government approving the newly designed Maryland Medicare Waiver. As stated from a Maryland Hospital Association’s press release¹²,

“... the new waiver has been to creatively build on the state’s current system, which was designed to ensure access to care for all who need it regardless of their ability to pay, stability for the state’s health care system, and accountability and transparency in how the system is working, while complying with provisions under state law that call for efficiently operated hospitals to be financially sound. The new agreement updates the system to focus on spending targets that are tied to the state’s economic growth,

¹¹ American Hospital Association. (2013). *2014 Environmental Scan*. Washington, D.C.: American Hospital Association.

¹² Maryland Hospital Association. (2014). *Federal Government Approves Historic Proposal*. Elkridge, MD: Maryland Hospital Association.

innovative tools to help hospitals achieve those targets while delivering the highest quality care, and the time to thoughtfully implement the changes required to be successful.”

The long term financial success of this new reimbursement system is still in debate.

Health Care Reform

Hospitals are going to be paid based on keeping the people they serve healthy and with that industry leaders state that investments in primary care services, patient-centered medical homes, and care coordination that have doctors work with nurses and case managers to meet a patient’s needs will be the new norm. Accountable Care Organizations have increased with shared-savings programs, offering a network a set payment to serve a defined population and allowing them to split any savings with the entity making the payment — provided they meet certain quality standards.

Internal Environment

Interviews were conducted by the CEO/President with key medical staff, leadership, and community leaders that focused on their perspective of facilitating change across multiple dimensions. These included:

- What does the hospital or care system want to achieve in the long term for care delivery and operational performance?
- What is the impact of Maryland/national health care reform on the organization?
- Who are the current and future competitors and how are they evolving?
- What other community organizations can the hospital or care system collaborate with?
- What are the current and projected sources of revenue, profitability and cash flow, and how are these projected to change over time?
- Is the organization’s workforce team oriented with a demonstrated history of collegial relationships?
- Are the current facilities designed for the future in terms of expansion or reconfiguration for different services?
- How much risk is the organization willing to take?
- What are the organization’s measurable milestones for the next one to three to five years?

The Planning Committee of the Board of Trustees cited access to the hospital through insurance networks with location, size, personal relationships with people in community, and the attractiveness of the building being important to their families and businesses. A strong recommendation was made that we need to focus on increasing the awareness of AGHS primary care locations and availability, and we should make a “service level guarantee” for all AGH/HS service locations that is similar to the successful “30 Minute ER Promise”.

In addition to personal meetings, 2013 served as a tri-survey year for community perception, physician engagement, and medical staff development planning. These provided valuable information on physician recruitment needs which has been discussed in length in the “Current State”. The following areas of concentration were prioritized by attendees at the 2014 Board of Trustees/Medical Staff Leadership Retreat and incorporated in the SWOT section:

- Grow Primary Care
- Communications through the organization/system (retention issue)
- EMR
- Financial Security
- Community “Feel”
- Facility Improvements
- ER Expansion
- Cancer Care Alliances
- Clinical Affiliations
- Women’s Health Center
- Expand Centers of Excellence (i.e. cardiology)
- Continuum of Care Services.

IV. Strengths, Opportunities, Weaknesses and Threats (SWOT)

The SWOT analysis, developed in conjunction with AGH/HS leadership and Medical Staff leadership, reveals that AGH/HS has solid core competencies that can be leveraged in order to build and chart its future direction. Among the key strengths are: the skilled and versatile staff throughout the organization; and the ability to respond timely to changing demands (although challenged by the current organizational structure that creates a “silo” or straight line orientation and less effective “patient-centered” resource utilization.) In the coming years we will be faced with significant budget constraints, necessitating the re-prioritizing and streamlining of work processes. Opportunities exist for the hospital to expand beyond its current hospital-centric focus on acute care services, and begin to develop a patient- and community-centered coordinated care delivery model that results in improved community health and wellness.

AGH/HS SWOT ANALYSIS	
<p style="text-align: center;">STRENGTHS</p> <ul style="list-style-type: none"> ❖ Exceptionally strong ratings/rank for Emergency Room ❖ Community Involvement in System Design ❖ Regional Buying Group Participation ❖ Alignment of Incentives across all staff & leadership levels ❖ Number of providers & geographical locations ❖ Personal Touch ❖ Patient Centered Medical Home ❖ Telemedicine usage ❖ Dedicated staff, strong positive view of nursing by physicians ❖ Improved awareness of hospital services in community ❖ Collaborative with Public Health Dept. ❖ Numerous high performing Quality of Care items 	<p style="text-align: center;">WEAKNESSES</p> <ul style="list-style-type: none"> ❖ Single oncology physician ❖ Result reporting ❖ Care Transitions ❖ IT limitations including infrastructure, security and differing platforms ❖ Clinical Analytics ❖ 24/7 Availability of services ❖ Dedicated Cardiovascular providers / services ❖ Shift from primary focus on acute care inpatient ❖ Hospitalist shortages ❖ Capital funding ❖ Ease of practice with EMR
<p style="text-align: center;">OPPORTUNITIES</p> <ul style="list-style-type: none"> ❖ Health Literacy ❖ Community based PHI ❖ Communication on Cost cutting opportunities ❖ Transparency in best practice comparative data ❖ Organizational relationships with other healthcare entities ❖ Widen use of telemedicine ❖ ACO involvement ❖ Medical Staff Development ❖ Community Health Improvement ❖ Retail Pharmacy ❖ Women's Health ❖ Provider communication/collaboration 	<p style="text-align: center;">THREATS</p> <ul style="list-style-type: none"> ❖ Clinical Documentation / ICD-10 Implementation ❖ New regulatory statutes for reimbursement ❖ Provider recruitment ❖ Connectivity / speed ❖ Freestanding Ambulatory Care Centers ❖ Readmissions ❖ Reduced availability to federal & private funding ❖ Financial sustainability of the hospital industry ❖ Beebe gain in recognition in same market ❖ Political and economic climate

V. Healthcare Industry and Market Analysis

At a healthcare forum on September 3, 2014 that included a panel discussion with top industry leaders, such as CMS Administrator Marylin Tavenner, the CEO of one of the largest insurers in the U.S. (WellPoint) stated, “...the country is in the midst of a ‘revolution’ in its healthcare delivery system.”¹³ Historically, revolutions have resulted in significant, rapid improvements in the production and distribution of commerce. The Industrial Revolution resulted in large-scale manufacturing of products, and the need to expand markets to lower costs of goods pressed the development of transportation and shipping systems. The ensuing Communications or Information Revolution has resulted in the quantum improvements of worldwide system communications to facilitate the further improvements in distribution of goods. These revolutions have ultimately resulted in the significant reduction in costs of goods, the expansion

¹³ Demko, P. (2014). *What's Healthcare's Future? CMS' Tavenner, WellPoint CEO Swedish Try to Answer*. Chicago, IL: Modern Healthcare.

of improved production and distribution systems, and better lives for consumers. How can a Healthcare Revolution follow these same paths?

The Merriam-Webster definition for “revolution” is: “A sudden, radical, or complete change;” or “Activity or movement designed to effect fundamental changes in the socioeconomic situation.”¹⁴ With its passing of Congress and survival of Supreme Court challenges, the ACA has become a catalyst for the Healthcare Revolution. The “fundamental change in the socioeconomic situation” in a Healthcare Revolution is the creation of a healthy society that requires much less expenditure of income on healthcare services.

According to industry analysts and experts, “In the midst of healthcare reform, hospitals and health systems are witnessing nothing less than a transformation of the industry that now is looking to hospitals to identify and proactively influence the health and wellness of a larger – if not the entire – community population. New dynamics that will impact hospital management and a fundamental shift from a decades-long fee-for-service model to a value-and accountability-based model include:

- All providers will be expected to take on more accountability and accept more financial risk;
- Hospitals must improve outcomes and reduce episodes of costly critical and acute care;
- Medicare reimbursement will depend on *preventing* hospital-acquired infections, *reducing* unnecessary readmissions and *adhering* to rigorous standards;
- Hospitals will logically become the central coordination point.”¹⁵

Maryland’s new hospital payment system and goals to reduce hospital costs to Medicare patients by at least \$330 million by the year 2019 is a demonstration of hospitals becoming “the central coordination point” for the Healthcare Revolution. The quality goals associated with Maryland’s agreement with the federal government in this demonstration project are centered on the “Triple Aim” goals of improved health of the population, enhanced patient care experience, and reduced cost of care. The primary tenet connecting the drivers of the Healthcare Revolution is the vision of “Population Health”.

In 2003 “Population Health” was described as a “relatively new term that has not yet been precisely defined.”¹⁶ Kindig and Stoddart proposed the following definition for Population

¹⁴Merriam-Webster, Incorporated. (2014). Retrieved September 11, 2014, from Merriam-Webster.Com: www.merriam-webster.com/dictionary/revolution

¹⁵ Aegis Health Group. (2012). *Healthcare's Rising Crescendo: Population Health Management*. Brentwood, TN.

¹⁶ Kindig, D. M., & Stoddart, P. (2003). What Is Population Health? *American Journal of Public Health*, 380-383.

Health: “The health outcomes of a group of individuals, including the distribution of such outcomes with the group.” They created a simple model to depict this definition:

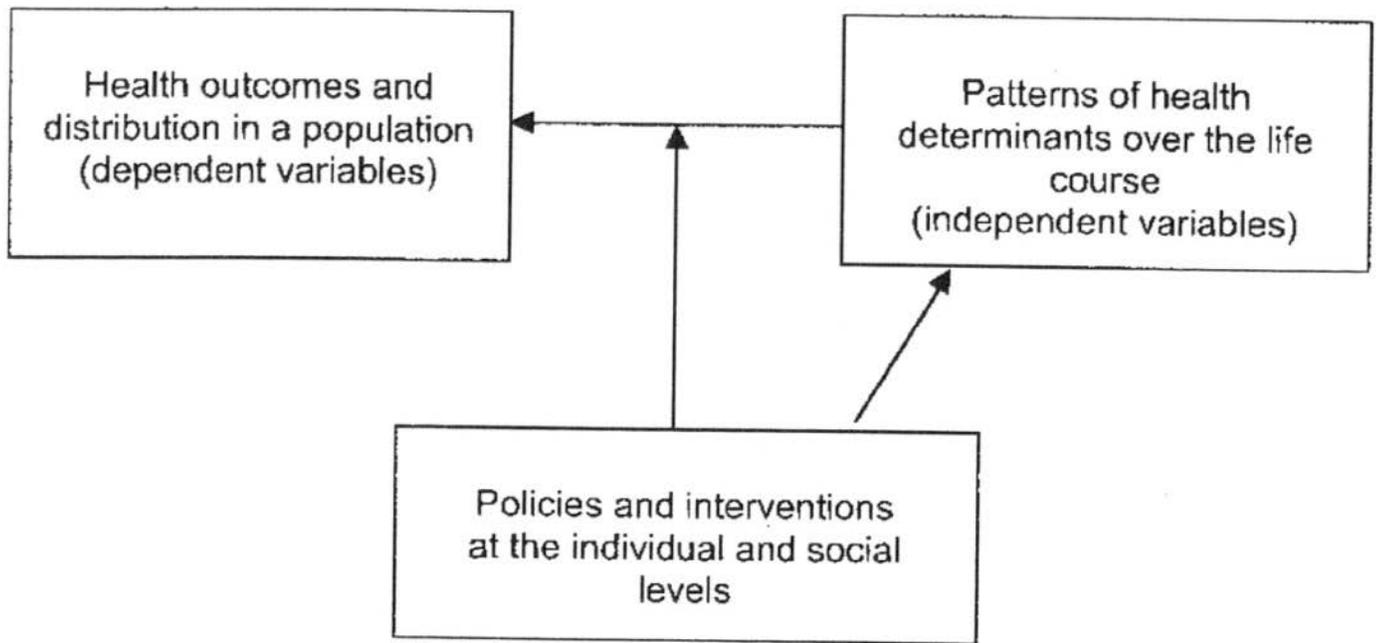
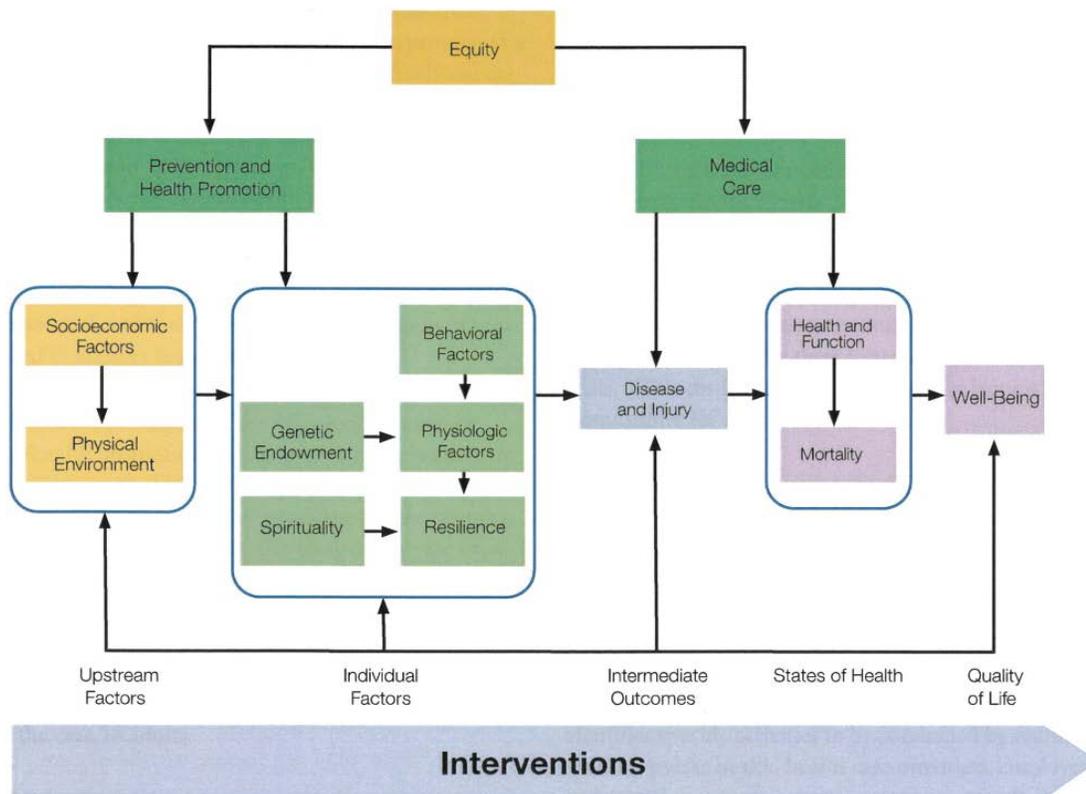


FIGURE 1—A schematic definition of the field of population health.

The Institute for Healthcare Improvement (IHI) has created a model depicting the interrelatedness of various community factors on the health of a particular population.¹⁷

Figure 1. IHI Population Health Composite Model



Source: Adapted from Stiefel M, Nolan KA. Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012. (Available on www.IHI.org)

As the model shows, medical care interventions are a small part of the overall population health picture. Yet, the primary focus of government, U.S. industry, and individuals is the hospital industry’s impact on the population health model, resulting from a implementation of strategies to achive the Triple Aim.

Returning to the discussion on industry revolutions, the key driving forces behind the Industrial Revolution and the Communication/Information Revolution were providing access to products through improved distribution channels. This also forced revolutionary improvements in the manufacture and quality of products, due to the influence of market competition that was not previously present. Similarly, the Triple Aim goals to achieving the “product” of Population

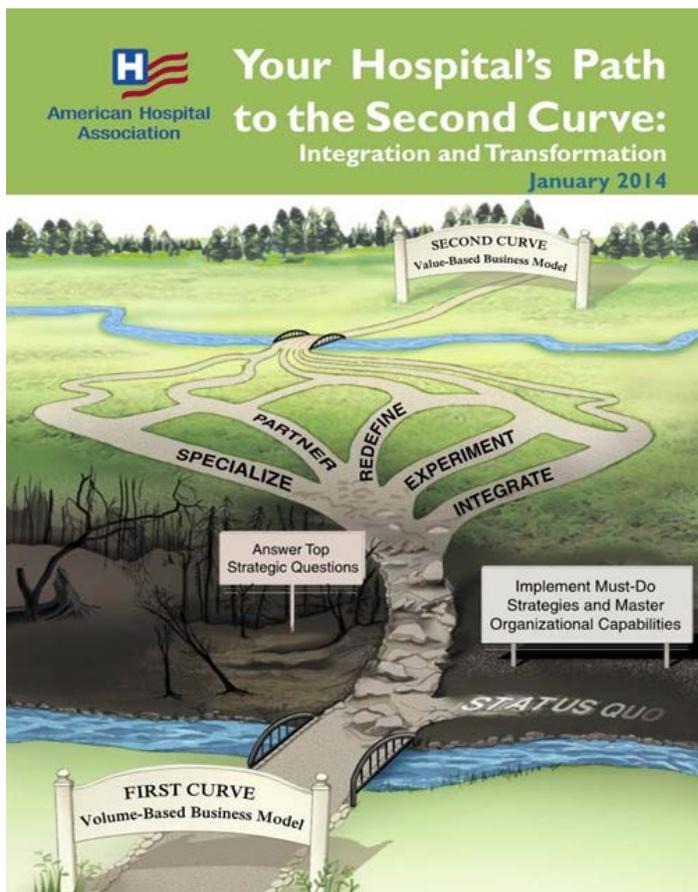
¹⁷ Cited in: Stoto, M. A. (2013). *Population Health in the Affordable Care Act Era*. Washington, D.C.: AcademyHealth.

Health are experiencing the same forces as other “markets”. The resulting phenomenon is healthcare becoming a “retail” market.

What is the evidence of this “retailization” of healthcare? A list of recent market events includes the rise of insurance exchanges, high-deductible health plans that cause individuals to consider choices based upon cost, leading to price and quality transparency demands. Further, there is a proliferation of disruptive healthcare market entrants reshaping the choices individual healthcare consumers have: mobile health apps, freestanding diagnostic centers, and primary care at WalMart to name a few. This evidence suggests that tomorrow’s market may be dominated by nimble, low-cost, convenient solutions. Can “Population Health” and “Retail Healthcare” coexist?

According to the Healthcare Advisory Board, there are three particular strategic objectives that are relevant in both: convenient access, lean cost structures, and a smart partnership

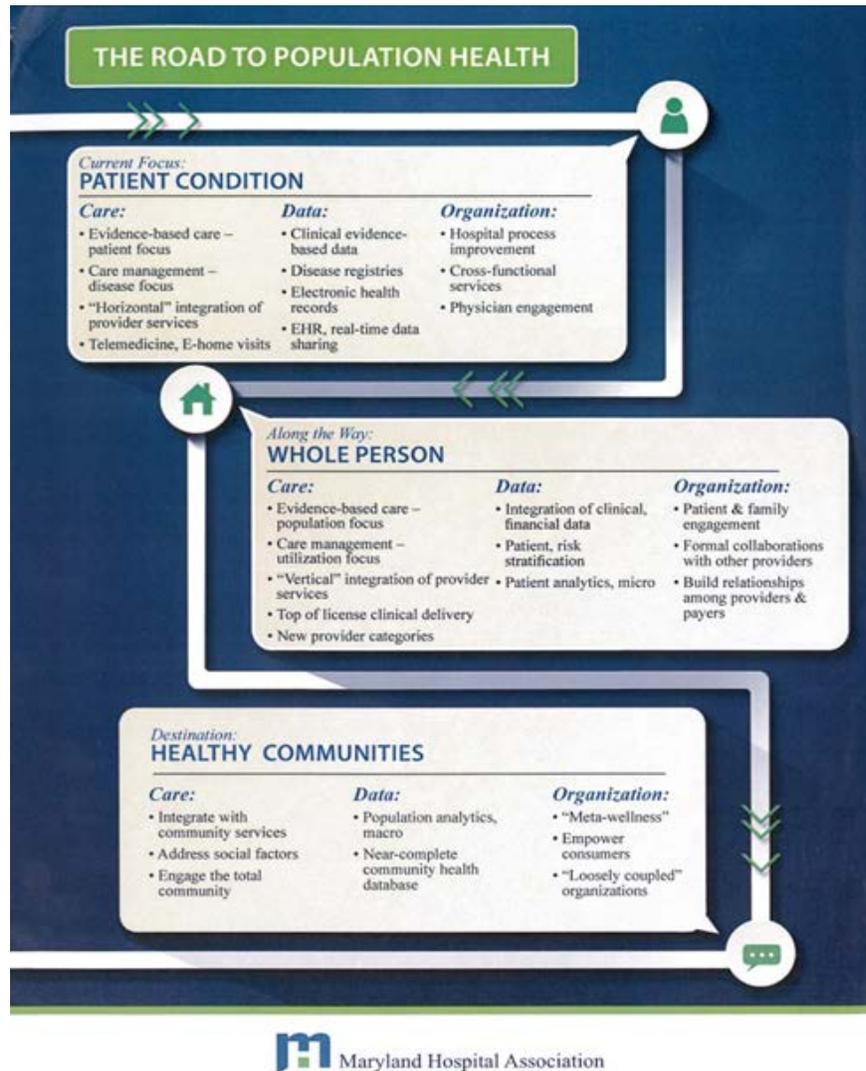
strategy.¹⁸ Convenience has increasing value in today’s society for access to a product, while improved convenience will also improve population health by making it easier for a patient to comply with a prescribed treatment plan. Price is always important in a retail environment, and if one considers the IHI Population Health Model previously mentioned, the top box “Equity” is driven by reducing cost-based barriers to healthcare in communities. Finally, smart partnerships from a retail perspective means integrated networks of convenient locations that represent most of the types of care one would need. From a population health perspective, coordination of care across the various settings – hospitals, nursing homes, outpatient clinics, etc... - means less errors and integrated delivery to



¹⁸ Umansky, B. (2014, August 15). *The Best of Both Worlds: 3 Things Retail and Population Health Have in Common*. Retrieved September 11, 2014, from Advisory Board.Com: <http://www.advisory.com/Research/Health-Care-Advisory-Board/Blogs/At-the-Helm/2014/08/Retail-vs-population-health>

ensure achievement of the optimal health goals.

The American Hospital Association (AHA) and the Maryland Hospital Association (MHA) have each developed strategic models to assist hospitals in moving toward these endpoints. Each clearly establish a similar vision of the future – the AHA a “Value-Based Business Model” for hospitals, and the MHA a “Destination: Healthy Communities”.



depicts an unclear path, and multiple paths, toward the vision, since this is a direction hospitals have never taken. The MHA path is a little clearer, demonstrating the incremental steps necessary to eventually arrive at our “Healthy Community” destination. While these hospital industry visions for the future incorporate the key components of the Triple Aim, the variation in the visions have similarities to the Population Health/Retail dynamic.

Our environmental analyses above and the industry analyses provide direction for AGH/HS toward a new strategic goal. In the early stages of

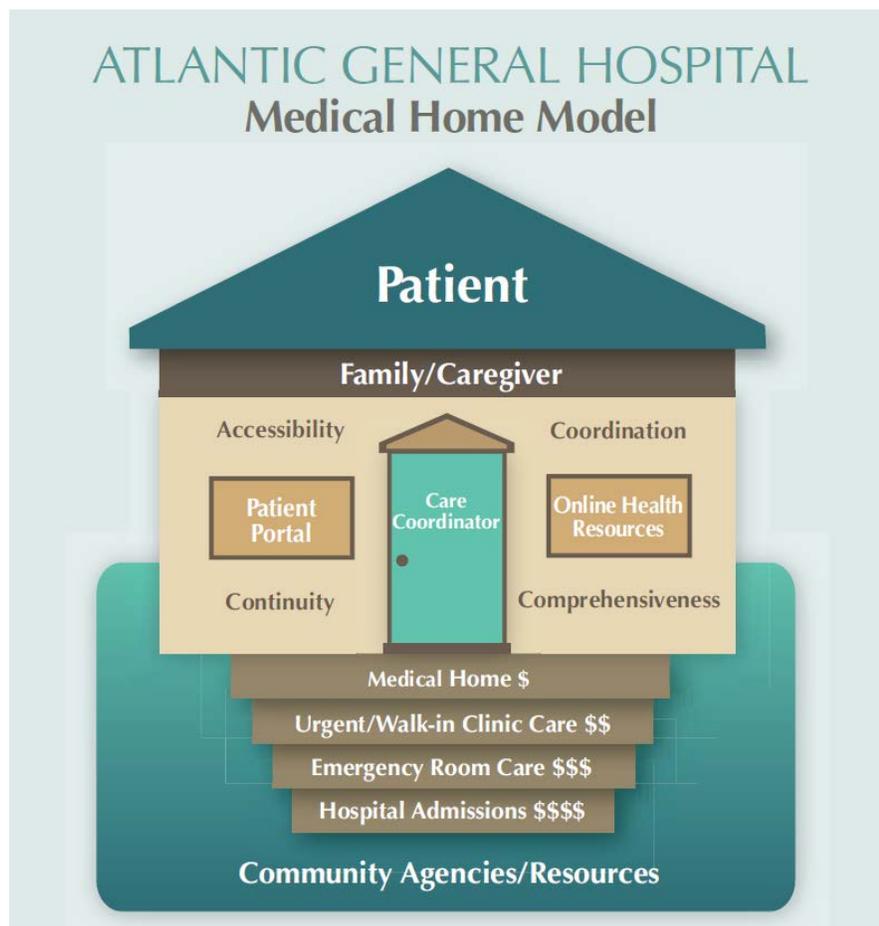
revolutions, the most efficient pathways to achieving the fundamental change desired are not evident. Although, in the Healthcare Revolution, the fundamental change as a vision for healthcare is more clearly evident – population health, enhanced patient care experience, and reduced cost of care – the Triple Aim.

VI. AGH/HS DISTINCTIVE COMPETENCIES/COMPETITIVE ADVANTAGES

AGH/HS has implemented strategic initiatives over the past decade that position the organization relatively well for the Healthcare Revolution. We have adopted service and convenience initiatives in our “30 Minute ER Promise”, in Atlantic ImmediCare clinics, and in the development of the RediScripts pharmacy. AGH/HS has historically enjoyed relatively high patient satisfaction scores and strong improvement in community perception surveys, while regularly performing at or near the top in quality metrics in the state. Finally, AGH has improved cost per episode of care, making AGH one of the lower cost hospitals for care in the state.

We have had great recent success in expanding the Health System to have more primary care and specialty care available *in our community* than ever in our 21 year history. AGHS practitioners are present in 14 locations throughout the region. We have created partnerships with physicians and other organizations to create mutually beneficial, high-performing programs like the Endoscopy Center and the Wound Care Center. We have created new services to improve the health of our community, such as our Bariatric Center and our Infusion Center.

AGH/HS has moved down the path toward population health management through the development and implementation of community-focused initiatives such as the PCMH. This team-based model of care delivery in the community has demonstrated significant reductions in healthcare expenditures, and improvement in the health status of patients. We have initiated efforts to advance the health of our communities through development of the



Health Literacy project in the Worcester County Public Schools, and through our Faith-Based Initiative with local church leaders.

AGH/HS has demonstrated the unique ability to nimbly advance toward achieving the retail delivery and population health goals of the Healthcare Revolution, while advancing the technical infrastructure to create an efficient, data-driven and coordinated environment for the delivery of care. We have attained Level I and Level II Meaningful Use goals set by the federal government, and we are not far away from integrating our information systems for the care of our patients and the management of our systems.

AGH/HS competitive advantages lie in our demonstrated ability to envision what the future will demand of us. AGH is relatively small, but this size provides an advantage in the emerging retail environment. We are a community hospital that is a part of the community – our staff “know” the patients, and we have established a service-oriented culture of patient-centered care.

VII. AGH/AGHS 2020 Vision

Our direction forward requires 20/20 vision – we must be able to see our destination clearly, because our pathway to reach that destination is not well marked and non-existent in many areas. We must hold tightly to the values that have guided our steps so far:

VALUES (Putting “PATIENTS” at the Center of our Values)

- P** Patient safety first
- A** Accountability for financial resources
- T** Trust, respect & kindness
- I** Integrity, honesty & dignity
- E** Education – continued learning & improvement
- N** Needs of our community – Participation & community commitment
- T** Teamwork, partnership & communication
- S** Service & personalized attention

These values are honored in all we do for our patients, visitors, medical staff, associates, partners and volunteers. These values support the published visions for the future of hospitals and healthcare providers: the vision of services being delivered in a patient-centered fashion that results in improved health. Patient Safety is our first value – our primary value. One of the most important guidelines for patient safety is avoiding medication errors. For decades this has been guided by the principles of the “5 Rights”: right drug, right patient, right dose, right route, at the right time.¹⁹

¹⁹ Institute for Safe Medication Practices. (2007, January 25). The Five Rights: A Destination Without a Map. *ISMP Medication Safety Alert!*

ATLANTIC GENERAL 2020 VISION

care.coordination

VISION

To be the leader in caring for people and advancing health for the residents of and visitors to our community.

MISSION

To create a coordinated care delivery system that will provide access to quality care, personalized service and education to improve individual and community health.



Allowing our values to guide our patient-centered vision to the future, and using our competitive advantages as the force providing our momentum toward our vision, AGH/HS will successfully continue to provide excellent service to our community.

Continuing to build upon our Mission “To create a coordinated care delivery system that will provide access to quality care,” the AGH 2020 Vision will drive strategic decisions toward integration beyond the acute care facility. These decisions will build upon the current investments in developing community-based care delivery systems that incorporate primary care, specialty care, and care management of chronic conditions through our PCMH.

Accomplishing our Vision will require disciplined investment of time and resources in the “Right” principles:

Right Care - Patient/Family Centric, Error Free, Primary Care Provider-Driven, Timely Delivery, Best Practice Protocols;

Right People – Needs-Based Provider Recruitment, Service Orientation, Right Training, Continuous Learning;

Right Place – Appropriate Distribution of Primary Care, Availability of Specialists, Telemedicine, Community-Based vs. Hospital Based;

Right Partners – Advanced Acute Care Referral Relationships, Rehabilitation Care, Long-Term Care, Home Health Care, Supportive Care/Hospice, Mental Health Care, Accountable Care;

Right Hospital – The Right Leader for Coordinated Quality Care in our Community.

Our “2020 Vision” will build upon our distinctive competencies to create a new system of health. Investment in technology-based solutions will facilitate care being distributed more evenly throughout our region, creating equity in access to care. Building upon our health literacy initiatives and our relationship with the Worcester County Health Department, AGH will be a leader in addressing the individual factors that affect health promotion and prevention of disease. Continuing to promote health care interventions driven by patient-centered values to improve individual function and well-being will result in improved quality of life for those who choose to live in our community.

During this revolutionary time for health and healthcare in our country and in our community, developing the right vision and the right strategy for AGH to survive and thrive in the new environment is essential. AGH is well positioned and financially sound. Our disciplined

approach to capital investment and growth for our community has developed core competencies in AGH to successfully navigate the unmapped direction toward creating an optimal environment in our community for population health. Our “2020 Vision” will provide the clarity in directing our efforts over the next several years, creating a system of health for a lifetime in our community.

