



ORGANIZATIONAL PROFILE

P.1. ORGANIZATIONAL DESCRIPTION

Mountain States Health Alliance (MSHA) is a large, well planned, not-for-profit health care system. The system provides a core of acute care, hospital-based services, and an array of supporting services to a population of over 1 million residents of southern and central Appalachia. Services are delivered through a “hub and spoke” geographic/service area represented by the MSHA Star in Figure P.1-1. The hub is Johnson City Medical Center (JCMC), a tertiary care hospital located in East Tennessee with spokes reaching out to Middle Tennessee, Eastern Kentucky, Western North Carolina, and Virginia. Services are supported by ambulatory care options such as outpatient surgery, laboratory and radiology; home health; physician practices; long-term care and rehabilitation; and community based prevention and educational activities. Mountain States Healthcare Network (MSHN), an affiliated network of 53 regional hospitals and nursing homes spanning Virginia, Kentucky, and North Carolina provides a referral network and continuum of care for regional residents and is an integral part of the hub and spoke geographic/service area.

P.1a Organizational Description

P.1a1 Main Health Care Service Offerings MSHA’s main healthcare service is acute care. Acute care services, identified based on an analysis of regional healthcare needs, are segmented into five service lines or strategic service units (SSUs): cardiovascular, oncology, ortho-neuro, behavioral health, and women’s services. Additional service lines include children’s services, general medicine, surgery, emergency and trauma care, intensive care, laboratory, pharmacy, and radiology. Acute care services are delivered primarily in hospital settings. Specialty care services in each MSHA facility are tailored to community needs and to the unique resources and strengths of the particular hospital (OC-5).

An array of other healthcare services supports MSHA’s main hospital service offerings. These services are delivered in a variety of settings including clinics and community health centers; primary care and specialty practices, and patient homes. Health advice, scheduling and referrals are

delivered by phone and via MSHA’s web site.

P.1a2 Organizational Culture “The MSHA Difference” reflects the key characteristics of MSHA’s culture (Figure P.1-2). The Mission, Vision, and Values (MVV) form the foundation of the House of Quality from which MSHA manages its business, and serve as the basis for decision-making at all levels. Four Pillars of Excellence – Clinical Effectiveness, Operational Effectiveness, Stakeholder Safety, and Service Excellence – rise from the foundation and support the organization’s strategy and commitment to excellence. The MSHA workforce (WF) is responsible for “bringing loving care to health care” by living out the Patient-Centered Care (PCC) guiding principles which drive behavioral expectations and standards and are rooted in the Appalachian tradition of caring for family and friends.

MSHA’s core competency is “bringing loving care to health care” through The MSHA Difference. This focus on the House of Quality, the MVV, PCC guiding principles, and the WF enables MSHA to deliver superior, patient centered service to the people of the region.

P.1a3 Workforce Profile The WF includes team members (TMs), physicians, volunteers, and students. MSHA has 7,813 TMs. There are 1,220 physicians and allied health providers with privileges, all of whom are credentialed according to policy by the MSHA Board of Directors. There are currently 2,826 dedicated volunteers and nearly 1,000 students each academic semester. There is also a pool of temporary employees, all of whom are required to attend orientation and are available on renewable 13-week contracts as needed. WF segments and key engagement factors are described in Figure P.1-3 and the TM demographics are listed in Figure P.1-4.

Key WF health and safety requirements, including ergonomics, infection prevention and control, hazardous materials and radiation management, and fire and emergency preparedness are addressed through systematic safety practices.

Key benefits are provided in a flexible package to meet individual needs and preferences. Employed TM and physician benefits include health, dental, vision and long-term care insurance, critical care, cancer, flexible spending

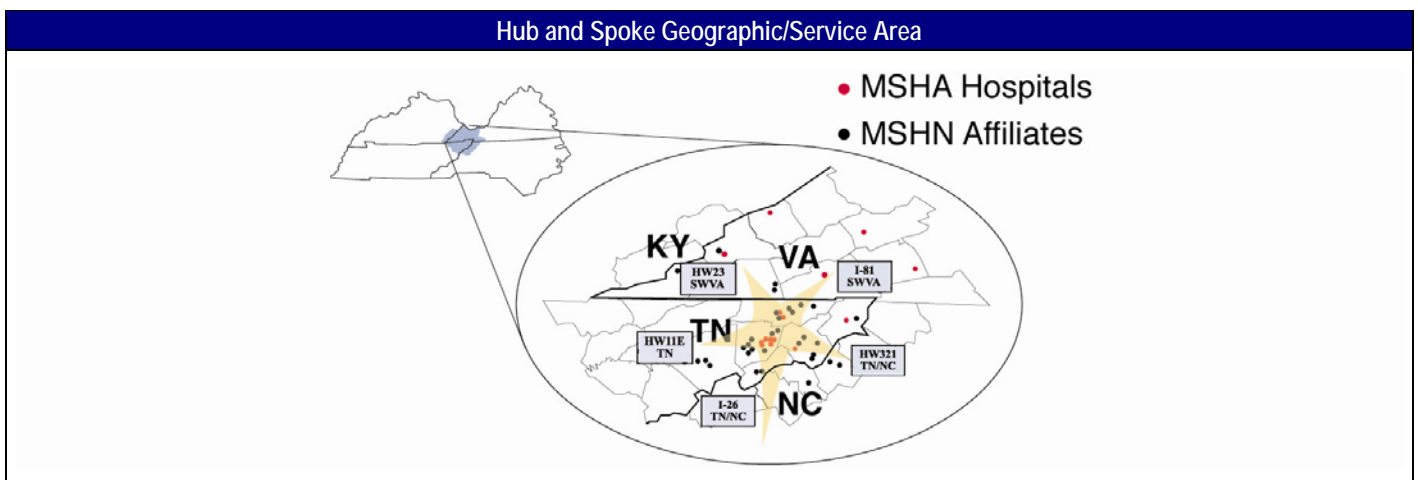


Figure P.1-1 Hub and Spoke Geographic/Service Area

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accounts, pet insurance and retirement plans. Two daycare facilities are available at discounted rates, and two large, well-equipped Wellness Centers are provided at low cost to the entire WF.

P.1a4 Facilities, Technologies and Equipment Facilities include 14 hospitals, 4 Urgent Care Centers, 4 Value Care Clinics, 10 Homecare and Hospice Centers, 4 RehabPlus Locations, the Blue Ridge Physician Group, the Blue Ridge Medical Management Corporation, 3 Mediserve Medical Equipment entities, and 2 Wellness Centers. PCC principles are integrated into facilities throughout the system, and influence room arrangements, colors, and features such as fountains and gardens in an effort to create a peaceful, healing environment.

MSHA uses advanced information system technologies to maximize efficiency, effectiveness and safety in clinical care. Project: SAFETY_{first} is a comprehensive multi-year project to improve and integrate clinical systems. MSHA partners with other health systems and services in the region such as CareSpark, a nationally recognized Regional Health Information Organization that will enable sharing of portions of medical records among the partners. A variety of other information systems support administrative and business operations. E-mail and the intranet and Internet sites facilitate communication within MSHA, and with patients and area residents.

Delivery of high-quality health care services requires the latest specialized equipment. The JCMC ICU incorporates

state-of-the-art equipment, including mobile gas and equipment columns that allow 360° access to patients and monitors. To provide the best cancer diagnosis and treatments, MSHA uses IMRT and stereotactic radio surgery and breast biopsy, HDR/LDR brachytherapy and PET/CT. High field open MRI provides excellent quality and more comfortable experiences for patients. Flow cytometry and an anatomic pathology reporting system have improved laboratory services while extensive pharmacy automation speeds medication dispensing and delivery to patients.

P.1a5 Legal and Regulatory Environment MSHA complies with appropriate health, safety, accreditation, certification, information protection, financial, human resource, and patient care laws and regulations. Aspects of the legal and regulatory environment are found in Figure P.1- 5.

P.1b Organizational Relationships

P.1b1 Organizational Structure and Governance System

MSHA's organizational structure and governance system combines a centralized strategic orientation with decentralized operational responsibilities. This system consists of a System Board of Directors (MSHA Board), Community Boards, subsidiary boards, Medical Executive Committees (MECs), and the Executive Leadership Team (ET). This governance structure assures attention to key factors that impact the systemness of MSHA, while integrating the perspectives of each facility and its

The MSHA Difference "Bringing Loving Care to Health Care"

Patient-Centered Care Guiding Principles

- All team members are considered as caregivers
- Care is based on continuous healing
- Care is customized and reflects patient needs, values and choices
- Families and friends of the patient are considered an essential part of the care team
- Care is provided in a healing environment for comfort, peace and support
- Knowledge and information are freely shared between and among the patients, care partners, physicians and other care givers
- Transparency is the rule in the care of the patient
- Patient safety is a visible priority
- All caregivers cooperate with one another through a common focus on the best interests and personal goals of the patient
- The patient is the source of control for their care

Team Members- MSHA has 7,813 employed team members.

Physicians- MSHA has 1,220 physicians and allied health professionals.



Volunteers- MSHA has 2,826 volunteers.

Students- MSHA can have over 1,000 students at any time.

Mission - Mountain States Health Alliance is committed to "Bringing Loving Care to Health Care". We exist to identify and respond to the health care needs of individuals and communities in our region and to assist them in attaining their highest possible level of health.

Vision - We passionately pursue the healing of the mind, body, and spirit as we create a world-class healthcare system.

Values:

Integrity... honesty in everything we do
 Service... with caring and compassion
 Leadership... with creativity and innovation
 Excellence... always pursuing a higher standard

Figure P.1-2 The MSHA Difference "Bringing Loving Care to Health Care"

Key WF Engagement Factors	
Segment	Engagement Factors
TMs	Recognition, cooperation in the work unit, respect
Physicians	Ability to provide quality patient care, access to state-of-the-art equipment, appropriate facilities
Volunteers	Recognition
Students	Access to applicable experiences

Figure P.1-3 Key WF Engagement Factors

community’s needs.

Boards: The 13-member System Board of Directors provides overall governance and strategic oversight. Except for the President/Chief Executive Officer (CEO), who sits on the System Board, all board members are independent volunteers. Community Boards set long range plans for the hospitals within their counties, and work closely with leaders in each hospital, who have day-to-day management responsibility. Additional subsidiary boards, such as BRMMC, MS Foundation, and MSHA Auxiliary, oversee aspects of the corporation that require separate governance structures. The System Board approves all decisions of the Community Boards and subsidiary boards.

MECs: MECs are responsible for the credentialing of physicians, nurse practitioners, and physician assistants for practice privileges. These are county-based committees

MSHA TM Demographics		
Factor	Profile	# / % of total staff – 7,813
Type of Position	Clinical	5202 / 66.6%
	Non-clinical	1973 / 25.3%
	Management	638 / 8.1%
Status	Full Time	5897 / 75.5%
	Part-time	1916 / 24.5%
Gender	Male	1558 / 19.9%
	Female	6255 / 80.1%
Race / Ethnicity	White	7552 / 96.7%
	African-American	112 / 1.4%
	Hispanic	43 / 0.6%
	Other	106 / 1.3%
Tenure	Profile	# Years
	Clinical	6 yrs.
	Non-clinical	7.53 yrs.
	Management	11.52 yrs.
Median Age	Clinical	39.2 yrs.
	Non-clinical	44.4 yrs.
	Management	46.9 yrs.

Figure P.1-4 MSHA TM Demographics

Legal and Regulatory Environment	
Body	Area
U.S. Office of Civil Rights (HIPPA)	Privacy and security of data
IRS	Not-for-profit status
State of TN/ Commonwealth of VA	Licensure/certification
Centers for Medicare and Medicaid Services (CMS)	Conditions of participation/reimbursement rules
Office of Inspector General	Physician compensation (Stark anti-kickback)
EPA	Environmental protection
OSHA/TOSHA	Team member safety
EEOC	Equal opportunity employment
Nuclear Regulatory Commission	Use of radioactive isotopes
FDA	Pharmacy/mammography
Accreditation/Certification	
Joint Commission	All hospitals
	Long term care, Lab, Home Health (SCCH)
	Primary Stroke (JCMC)
CAP	Clinical laboratories
CARF	Rehabilitation (Quillen, NCH)
CAVL	Vascular laboratories
ACSC on Cancer	Oncology
CHAPS	Home Health (except SCCH)
AASM	Sleep laboratories
AACPR	Cardiac rehabilitation
ACR	Radiology/mammography
American Osteopathic Association (AOA)	Healthcare Facilities Accreditation Program (HFAP) (NCH, DCH)

Figure P.1-5 Legal and Regulatory Environment

made up of physicians elected by members of the medical staff and are led by an elected chair. This process was established within the governance structure. Provider review and recommendation take place through the MEC to each county board. Final approval of privileges occurs at the System Board.

Executive Team: Executive leaders responsible for hospitals, SSUs, and system support services, join Chief Medical Officers and the CEO to form this component of MSHA’s governance structure. This group is responsible for both strategic and operational plans and results.

P.1b2 Key Market Segments, Patient and Stakeholder Groups MSHA identified its five SSUs as its key healthcare market segments. Its key stakeholders in these segments are patients and their families (referred to collectively as

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“patients”) as well as the local community. MSHA recognizes that patients can be further segmented based on service setting to include inpatients, outpatients, emergency, ambulatory, home health, and urgent care and physician offices; however all segments have identified the same requirements in relationship to their continuum of care. Stakeholders and their key requirements are shown in Figure P.1-6.

P.1b3 Key Suppliers, Partners and Collaborators Key types of suppliers are those who provide surgical supplies, medical devices and implants, diagnostic equipment and supplies, pharmaceuticals and pharmacy automation, dietary services, patient information systems, hospital furniture, and environmental services. Suppliers play a key role in MSHA’s delivery of healthcare services by helping address needs such as current technology, specialized services, and effective cost management. Equipment suppliers often play a role in our work systems by providing on-site support for equipment installation, and TM and physician training. A few suppliers deliver services on-site (e.g., dietary and environmental services) and are integral to service delivery processes.

Key partners include Morrison Food Services for the provision of food & nutrition services in eight MSHA facilities. This partnership has resulted in innovations in meal delivery methods. Innovation in facility cleanliness was achieved through a partnership with HHS, a relationship that has resulted in the delivery of a cleaner setting, and in an increased patient perception of cleanliness.

In addition to these partnering relationships, MSHA is part owner in Premier, a national group purchasing organization and previous Baldrige recipient with nearly 1,500 participating hospitals. By aggregating the purchasing power of its participants, Premier negotiates purchasing contracts on behalf of participants for competitively priced, high-quality products, thereby playing a key role in MSHA’s healthcare delivery processes and support services.

Through the hub and spoke geographic/service area, MSHN affiliates collaborate with MSHA to ensure that a full range of healthcare services are available and provide referrals to the system. Collaborations with research hospitals (e.g., Johns Hopkins, St. Jude’s), universities (e.g., East Tennessee State University), and participation in national improvement projects and collaboratives (e.g. QUEST) help MSHA identify innovative protocols and

Key Stakeholder Requirements	
Stakeholder	Key Requirements
Patients	Attentiveness, Information/Involvement in Decisions, Friendliness/Courtesy, Prompt Service, Coordination of Care, Skill/Competence of Caregivers, Pleasant Environment, Good Meals
Community	Availability of services, health-related education, support for community activities and development

Figure P.1-6 Key Stakeholder Requirements

Key Competitors and Collaborators		
Entity	Competitor	Collaborator
MSHN Affiliates	✓	✓
Wellmont Health System	✓	✓
Privately owned surgical and diagnostic centers	✓	✓
Home health/Hospice agencies	✓	✓
ETSU College of Medicine		✓
Blue Cross-Blue Shield		✓
BRMMC	✓	✓

Figure P.1-7 Key Competitors and Collaborators

practices to improve health care in the region and nationwide. MSHA works closely with ETSU and other colleges and universities that train nurses, physicians, and allied health professionals to build the capacity and quality of the regional healthcare workforce.

Key mechanisms for communication with suppliers, partners, and collaborators occur daily, weekly or monthly as the relationship requires through the use of e-mail, phone, the Internet, and face-to-face during site visits. These relationships are managed via formal vendor agreements and contracts. The key supply chain requirement is Fill Rates.

P.2. ORGANIZATIONAL SITUATION

P.2a Competitive Environment

P.2a1 Competitive Position Created in 1998 with the acquisition of six area hospitals, MSHA is the largest healthcare system in the region. It surpasses its primary competitor in number of hospitals (14 vs. 8) and bed size (1,706 vs. 1,276). The total service area comprises a 29-county, predominantly rural market with a stable aging population base and a projected growth rate through 2013 of 1.5%. Nearly 98% of MSHA inpatient cases come from this market – 78.9% from the eight counties in which MSHA hospitals are located and 19.0% from the counties immediately adjacent to them. MSHA continues to increase overall service volumes; and the five SSUs each lead in their individual market segments across the region. A list of key competitors and collaborators is found in Figure P.1-7.

P.2a2 Principle Factors Determining Success Factors that determine MSHA’s success relative to other healthcare organizations include a focus on The MSHA Difference; a well developed and fully deployed SPP; a commitment to continuous improvement; and a unique ability to take full advantage of the hub and spoke geographic/service area.

The MVV drive ET decision-making, and serve as the foundation for the SPP. Board members, the ET and the WF understand and internalize the MVV which are shared by the President/CEO during orientation. The MSHA Difference attracts patients, TMs, physicians, volunteers, and students, and the mission of “bringing loving care to health care” is recognized and associated with MSHA by 71% of the region’s population. The Pillar-based strategic planning process focuses the organization on activities that are

mission-driven and important to success. MSHA's commitment to continually improving quality is seen in the adoption of the Baldrige National Quality Program Health Care Criteria for Performance Excellence as the business model, and in the extensive support for quality improvement through Blueprints and PI processes. This commitment has led to gains against national benchmarks and the achievement of state and national recognition for the system (7.6a1). Through its focus on "systemness," MSHA creates standardized, system-wide processes that provide consistency and promote efficiency, while allowing facility leaders the freedom and authority needed to promote innovation and agility.

Key changes taking place that affect MSHA's competitive situation include the systematic development of the hub and spoke geographic/service area through the purchase of hospitals in core service areas, and the building of the new Niswonger Children's Hospital. Changes affecting opportunities for innovation are the design and construction of new facilities (ex. Franklin Woods Community Hospital); this facility is being built to meet LEED standards and will serve as MSHA's first "green" hospital. Changes that create opportunities for collaboration include a recent change in CEO leadership at competitor WHS. As a result, a landmark collaborative approach to Quality is being designed by two teams made up of leaders from MSHA and WHS. The MSHA/WHS Quality team has jointly produced public service messages in the community urging individuals to get flu vaccines.

P.2a3 Key Available Sources of Comparative and Competitive Data Key available sources of comparative and competitive data from within the healthcare industry and external to healthcare include: Premier, Inc, Thomson, Fitch, Standard & Poor's, NDNQI, National Consumer Research, Press-Ganey, and Morehead Associates.

Limitations to obtaining comparative and competitive data are: ❶ a lack of consistency in definitions and calculations among healthcare systems; ❷ time lags of up to a year between data collection and posting of publicly available healthcare comparisons; ❸ the strict confidentiality of most healthcare related data.

P.2b Strategic Context Strategic challenges have an influence on MSHA's ability to maintain high standards of excellence as defined by the four Pillars of Excellence (Figure P.1-2) and are addressed in the annual SPP. Primary challenges are nursing shortages and changes in reimbursement and debt.

MSHA benefits from many strategic advantages. Experienced, results-oriented leadership, effective governance, a commitment to The MSHA Difference, a focus on "systemness", and a proactive systematic SPP create a sense of purpose. The skill and work ethic of MSHA's WF, its size, wide range of services, and the hub and spoke geographic/service area make it a leader in providing healthcare services in the region it serves. Relationships – with MSHN affiliates, and other external

organizations – keep MSHA abreast of regional needs and emerging national trends in health care.

Key challenges associated with organizational sustainability include resource shortages in the areas of nursing, other human resources, and finance. Key advantages linked to sustainability are the hub and spoke geographic/service area and The MSHA Difference.

P.2c Performance Improvement System In 2002 MSHA adopted the Baldrige National Quality Program Health Care Criteria for Performance Excellence as its business model, or framework for organizational improvement. Participation in both the Baldrige and TNCPE application processes serve as the approach. By involving multiple levels of the organization in application development and resolution of opportunities for improvement, the criteria are deployed through the organization. MSHA evaluates its progress and learns from it by using the feedback report as input to strategic planning and systems improvement efforts, and has successfully integrated this organization level improvement approach by encouraging TMs to serve as national and state examiners. Over 50 TMs have served as examiners at either the state or national level.

The MSHA Blueprint Process provides the means for systematically evaluating the effectiveness of key processes. Beginning at the system level and cascading down to the level of each individual TM, leaders create annual performance plans called Blueprints. The Blueprint Process focuses performance improvement in areas of strategic importance. It also drives data selection, collection, aggregation, and analysis, facilitating management by fact, and performance measurement.

MSHA's approach to continual process improvement is Plan-Do-Check-Act. MSHA improves through the use of this systematic process and through the use of industry standard quality tools such as root cause analysis, evidence-based research, and best practice sharing. Whenever performance monitoring and review indicate that a process is not meeting customer or operational requirements, or when a benchmark has changed and a higher level of performance is required, leaders and TMs use PDCA to develop improvements. Collaborative Teams, PI Project Teams, and Individual PI Projects are MSHA's identified mechanisms to accomplish system, team or individual improvements. In 2006, MSHA's approach to process improvement was enhanced with the addition of the collaborative approach developed by the Institute for Healthcare Improvement (IHI), which includes small tests of change. Further enhancements have been made by adding TMs with extensive Lean experience as Improvement Advisors in the PI Department.