Eastern Band of Cherokee Nation: Macro Vision, Micro Changes

Sometimes, it can seem like a long way from the hospital boardroom to the exam room. In the boardroom, it's easier to visualize the ideal, talk in generalities, and plan an approach. But on the frontlines of health care, ideals, generalities and plans are replaced with real-life people who don't fit neatly into categories and don't always follow the expected path. Like a game of telephone, the mission and strategy of an organization can get jumbled on the way from board member to administrator to manager to clinician on the frontlines.

For Cherokee Indian Hospital in Cherokee, NC, participating in the Improving Patient Care (IPC) Collaborative since 2009 has given the hospital a way to transform broad organizational objectives into strategies and approaches that can be carried out on a provider-to-patient level and affect significant improvements in patient outcomes.

IPC helps translate a macro vision into micro-level changes that lead to better patient care.

Cherokee Indian Hospital (CIH) is the primary medical provider for the 14,000 members of the Eastern Band of Cherokee Indians who live in a five-county area of western North Carolina. With a 20-bed inpatient unit, an emergency department, and a variety of outpatient primary care and specialty care clinics at three locations, CIH logs more than 22,000 primary care visits and approximately 20,000 emergency department visits each year.

Building on Prior Success

CIH had made significant strides in improving patient care before joining IPC. It had a strong, dedicated, and a diversified board already in place, a deep commitment to systematic improvement, and care teams already formed for delivering outpatient care. Participating in the collaborative built on these prior successes.

"We were already qualitatively focused and quantitatively driven," says Casey Cooper, CEO of the Hospital. "IPC affirmed and validated some of the things that we were already doing. It gave us frameworks to better organize [the hospital] … . IPC was a performance enhancer for us; it helped us accelerate existing performance gains."

In 2004, Cherokee Indian Hospital moved to a care team model for primary care. Instead of operating as "one big clinic" with providers, nurses, and other personnel, CIH moved to smaller care teams with two or three providers supported by nurses and other staff. This turned out to build a more cohesive staff that worked more efficiently and effectively. "When we were all just one big team, we weren't one big happy family," pediatric nurse Rita McMichael, RN, remembers. "But when we divided into pods, things changed for the better. We were more organized, and we were held accountable."

CIH began tracking more than 300 clinical measure and reporting outcomes on a monthly basis in 2005 using the IHS Resource and Patient Management System. As a result, screening rates rose dramatically: from 2004 to 2008 domestic violence and alcohol screenings rose from fewer than 5 percent to about 80 percent and tobacco use screening nearly doubled. In 2008, Cherokee Indian Hospital won the prestigious Davies Award for health information technology innovation from the Healthcare Information and Management Systems Society.

Transformational Thinking

Going into IPC, the Cherokee Indian Hospital's strategic plan focused on hospital finances and

operational indicators like volume and length of stay. While these statistics are important for the financial health of the institution, they may not have much to do with the health of the community.

IPC helped the Hospital shift focus from patient volume to patient outcomes. "We are actually measuring the organization's performance—as well as the individual providers' and nurses' performance—based on how well we're controlling people's blood sugar, blood pressure and cholesterol and how well we're screening for cancer," Cooper explains. "Those are transformational decisions that don't have a payback for decades to come."

This fits right in with the Cherokee philosophy. Like other Tribal communities, the Eastern Band of the Cherokee Nation is a collective culture, focused on the welfare of the community more than the hospital's financial prosperity, says Cooper. IPC's focus on population health and experience of care "is very consistent with community culture."

Seeing that connection between community culture, strategic goals, and the day-to-day work of clinicians and other health care staff makes it easier to carry out CIH's mission and vision. "A real grounded framework like [IPC] helps you to transcend the stress and the pressure of day-to-day transactional decisions and make real 100-year decisions for the organization," Cooper says.

Tracking Success

The data-tracking emphasis in IPC also helped connect patient-level interactions with the overall goals of the health system. Having a quality Resource and Patient Management System in place facilitated this aspect of the program.

The most relevant numbers required by the Government Performance and Results Act (GPRA) are reported on a dashboard and in an open forum that all staff are encouraged to attend. GPRA scores are also reported for each care team and even on individual performance appraisals. Looking at those numbers and comparing them to other Tribal and national averages gives CIH a measure for success, and it helps the Hospital see where it is making progress and where it is lagging behind.

And reporting those numbers publically gives people a personal stake in making sure they're as good as they can be. "Everyone is responsible for the quality of care that we provide here," says Glenda Jarrett, RN, director of outpatient care at CIH. "We're working on quality every day."

A lot of that work takes place in the daily huddle, an IPC-introduced idea that Jarrett says has increased the effectiveness and focus of the care teams. Most care teams at Cherokee Indian Hospital now meet either after the last patient in the afternoon or before the first patient each morning.

If a GPRA number is trending lower than expected—say, immunization rates for children or colorectal cancer screenings for adults—then staff members start investigating the roots of the problem. Using the IPC-recommended Plan-Do-Study-Act technique, staffers are able to translate the numbers into positive change for patients. Mini tests of different approaches offer the opportunity to try out new ideas on a small scale before rolling them out to the institution at large.

Another move helps make this thinking and brainstorming time possible; in 2009, all clinical staff (except certified nursing assistants) moved to 10-hour shifts. This gives staff enough time to meet, hash out ideas, and review patient needs and still get to the day's paperwork and phone calls. (In fact, those phone calls are even more efficient, because clinicians are less distracted by other patients and more patients are home in the evenings.)

Brainstorming Solutions

At the daily huddles, Jarrett points out the areas for improvement and then solicits ideas from her staff. “Basically, she says to the staff, ‘Okay, on the national level, we’re not moving this dot in comparison to the other Tribes. What can we do tomorrow in outpatient clinic to move this dot?’” Cooper explains.

In the case of the immunization rates, the pediatric care team tried several approaches to bring its rates up from 50 percent. The team held evening clinics and in-school clinics. Using the Electronic Health Record (EHR), the team identified who on the day’s roster was due for shots and made a note to remind clinicians to offer the immunizations. The team also checked CIH records against the state immunization registry, because children sometimes have received immunizations at another clinic or provider and their parents have forgotten to notify CIH. The team also made targeted phone calls to parents and other family members. If that didn’t work, the team asked staff if anyone knew the family; it’s a small enough community that there’s a good chance someone might actually feel comfortable talking to family members about bringing in the child for overdue shots. Now, CIH’s immunization rates are higher than 90 percent.

To increase colorectal cancer screening rates, the staff came up with the idea to offer gift cards for the first 50 patients who turned in their Fecal Occult Blood Test cards. Based on last year’s success, the Hospital received a grant to up the number of gift cards to 100.

CIH’s micro system care team is currently focusing improving A1C (blood glucose) levels for patients with diabetes. The team invites patients with levels greater than 10 to come in for weekly group appointments that include a half hour of group instruction with a nutritionist or diabetes educator. Patients bring in their glucometers, and results are entered in the EHR to identify problems and trends. Medications are adjusted as needed. Patients get a one-on-one appointment with a provider every other visit. So far, 10 to 15 patients have shown up each week, and A1C rates are improving.

Each month, when the GPRA numbers are reported in these areas, the staff can see the results of its hard work. And, everybody else does, too. “What outpatient does is looked at by everybody,” says Jarrett. That includes the hospital staff, the executive board, and the Tribal authorities. “We don’t have time to goof off. We have to work on our numbers everyday that we’re here.” Because those numbers aren’t really numbers; they’re patients. “It’s not just about numbers,” says Jennie Rostell, RN, adding, “When you get those numbers up, that’s more patients that we’ve actually taken care of.”