SAFER, SMARTER, GREENER

There is a silent crisis taking place among hospitals serving the nation's rural and Native American populations. These communities are generally poor and in physically remote locations. This combination of poverty and low patient volumes makes it nearly impossible for hospitals to sustain themselves financially. Many of these facilities are in states that chose not to expand Medicaid eligibility under the Affordable Care Act, eliminating federal subsidies for some of their poorest patients. They are also experiencing lower payments from the Disproportionate Share Hospital program, which was cut under the ACA in the belief that Medicaid expansion would more than make up the difference.

As if walking a financial tight rope is not enough, these hospitals face an equally daunting crisis in maintaining the quality of care provided to their patients. The challenge, again, is rooted in economics but goes deeper. Despite myriad financial incentives to establish their careers in rural areas, doctors don’t often stay for the long term. And the skills deficit is not limited to clinical personnel. Talented business executives, with their MBAs and MHAs – common in urban and suburban hospitals – are difficult to attract to remote facilities. Real or perceived, the lack of financial and professional opportunity is a major barrier to recruitment. As a result, it is not uncommon for individuals with little business experience to rise prematurely into leadership positions in these far-flung facilities.

These are not simply administrative issues; they are systemic difficulties with tragic consequences for patients. An often-cited article in Modern Healthcare magazine reveals widespread examples of substandard care among Indian Health Service (IHS) hospitals. The IHS is a branch of the U.S. Department of Health and Human Services that provides healthcare services to Native Americans. One IHS hospital in Winnebago, Nebraska, was responsible for five preventable deaths over a multi-year period. In the wake of these disasters, the facility had its CMS accreditation revoked, making it unable to receive Medicare and Medicaid reimbursement.

To call the situation dire would be an understatement. Drastic measures are required to restore public confidence and operational viability to these embattled facilities.

More than a quarter of Native Americans nationwide are uninsured. Many don’t have money to pay for care out of pocket and don’t have access to private financial assistance programs.

MODERN HEALTHCARE, 12/3/2016
The Cherokee Nation is the largest federally recognized Native American tribe with approximately 343,101 registered tribal members. There are 207,542 enrolled Cherokees residing in Oklahoma and currently 135,559 reside within the reservation of the Cherokee Nation, the final boundaries of which were fixed by treaty in 1866. The reservation covers all of six counties and parts of an additional eight counties in northeast Oklahoma with a total area of 6,950 square miles. The Cherokee Nation and its entities operate offices, clinics, hospitals, businesses, housing additions, and casinos on fee lands, restricted individual allotments, and trust lands throughout the reservation.

Under the Indian Self-Determination and Educational Assistance Act (P.L.93-638), tribes can contract or compact services that the Indian Health Services would otherwise provide. In October of 2008, Cherokee Nation compacted the W.W. Hastings Hospital in Tahlequah, Oklahoma. With the addition of the hospital, Cherokee Nation Health Services (CNHS) became the largest tribally owned and operated system in the nation. The system includes the 58 bed hospital, eight health centers, an Emergency Medical Services (EMS), a co-educational facility for residential chemical dependency for adolescents, an accredited Public Health System and a host of specialty programs. The system has more than 1.2 million patient encounters annually and is located in the northeast corner of Oklahoma.

After the assumption, CNHS embarked on a major campaign to improve its operations. One of their first targets: their line-up of CMS accrediting bodies. Under federal ownership, the hospital and clinics had separate accrediting bodies. The new management team saw this as inefficient and costly. Put another way, they saw a huge opportunity to raise their own bar on quality and patient safety.

After careful review, Cherokee Nation decided on DNV GL's NIAHO® accreditation program, the only CMS-approved program that integrates ISO 9001 Quality Management System into the Medicare Conditions of Participation. The impact was immediate, positive and long-lasting.

“We gave up an old way of doing accreditation, from checking a box to meet standards, to truly providing safe patient care,” says Ginger Glory RN, Cherokee Nation Health’s Director of Quality Management.

In short order, Cherokee Health fully embraced ISO 9001 and its principles of continual quality improvement. Unlike other management schemes or healthcare quality initiatives, ISO 9001 encourages innovation without forcing a “one size fits all” formula on the hospital. Equally important, ISO pushes problem solving to the source of the problem, which in hospitals almost always involves nurses, techs and other staff (even housekeeping) who are normally ignored when “management” mounts a restructuring effort. ISO encourages creative thinking and staff involvement, a remarkably simple concept with breathtaking benefits for healthcare organizations used to the “our way or the highway” approach of traditional accreditation programs.

The first major change occurred in the one place in the hospital where patients are most consistently at risk for medical errors and infections: the operating room. Under ISO 9001, regular risk case reviews and internal auditing were conducted. Within a few months, the hospital was conducting about two per month. Several months later, it was much higher.

Workflows and outcomes were assessed not just in specialty care but in primary care settings as well. A chief aggravation for patients was the notoriously long wait times for appointments. Using ISO’s plan-do-check-act methodology, the problem was analyzed and solved across the system. An initiative was also launched to address cases of Hepatitis C, a serious chronic health issue among Native Americans. Within two years, half of patients age 20-69 that access the health system (around 45,000) had been tested for Hepatitis C, more than 750 positive cases received treatment with a 90% cure rate. A similar campaign is being launched to combat the region’s opioid drug epidemic.

The Cherokee Nation system is not resting on its laurels. In recent years it has expanded and built multiple new facilities. It is also working with the IHS to build a 469,000-square-foot health center on the W.W. Hastings Hospital campus. And it has deployed an electronic health records system shared among all of its facilities that is rated as stage six (out of eight) by the Health Information and Management Systems Society, indicating a high level of records digitization. In the near future, a residency program and medical school affiliated with Oklahoma State University will be in place on the hospital campus.

At the heart of these remarkable results is a single factor that drives everything. It’s not ISO. It’s not new management. It’s a willingness to change the culture of the organization. From one of “habit” to one of self-empowerment. There are no guarantees. But with a mindset of “anything is possible”, it’s amazing how often no turns into yes.