Brief Summary Statement

The Cherokee Nation is the second largest Tribe in the United States with a population exceeding 250,000 and a jurisdictional area spanning over fourteen counties in Northeast Oklahoma extending over 7,000 square miles. Cherokee Nation Health Services using the new online version of the LHD Self-Assessment Tool for Accreditation Preparation did a self-assessment for accreditation and a quality improvement process. The process focused on mobilizing and planning for accreditation in five years and integrated the quality improvement process for each area into the 2009 – 2013 Strategic Goals and Objectives for Cherokee Nation Health Services.

Background

A detailed description and introduction of the Cherokee Nation is included to develop a better understanding of Native American Tribes, their needs and their vision of the future. The vision of Cherokee Nation is, "To achieve and maintain an enriching cultural identity, economic self-reliance and a strong government." The mission of the Cherokee Nation is "ga du gi": "Working together as individuals, families and communities for a quality of life for this and future generations by promoting confidence, the Tribal culture and an effective sovereign government". Cherokee is a distinct culture with its own geography, language, social organization, spiritual beliefs and practices. The Cherokee language is not only spoken, but also written using a special syllabary with 86 characters developed by Sequoyah and continues to be spoken fluently across generations. Cherokee culture thrived for thousands of years in the southeastern United States before European contact. In the 1830's, gold was discovered in Georgia and a period of Indian Removals began to make way for more white settlement. In 1838, thousands of Cherokee men, women and children were rounded up and marched 1,000 miles to Indian Territory on what is known as the Trail of Tears, to what is today the state of Oklahoma. Thousands died in the internment camps, on the trail, and after arrival. After relocation the Cherokee soon rebuilt a democratic form of government, churches, schools, newspapers and businesses. After the Civil War, more Cherokee lands and rights were taken by the government and what remained of Cherokee Tribal land was divided into individual allotments which were given to Cherokees listed in the census compiled by the Dawes Commission in the late 1890s. Descendants of those original enrollees make up today's Cherokee Nation Tribal citizenship.

In 1990, the Cherokee Nation became one of six Tribes to enter into a self-governance agreement with the federal government. This historic agreement authorized the Tribe to assume responsibility for Bureau of Indian Affairs funds that had previously been spent on its behalf by the agency, area, and central office levels. The Cherokee Nation has a tripartite form of government that includes a judicial, executive and legislative branch. The judicial branch includes the District Court and the Judicial Appeals Tribunal. The Legislative Branch is composed of 15 Tribal council members who are elected to four-year terms and represent the nine Cherokee voting districts. The Executive Branch is vested in the office of the Principal Chief. The Principal Chief is responsible for executing the laws of the Cherokee Nation and administering the daily operations of all programs and enterprises of the Tribe. The Cherokee Nation Executive Branch is divided into the Tribal

Administration Office, and two major teams; *the Resource Team* and *the Service Team.* Various programs fall under the direction of these teams and each work together to promote Cherokee confidence, the Tribal culture and an effective sovereign government.

Cherokee Nation Service Area

The Cherokee Nation has 280,847 registered Tribal members, 113,143 of whom reside within the 14 counties of the Cherokee Nation which is not a reservation but a Tribal Jurisdictional Service Area (TJSA). Cherokee Nation TJSA covers approximately 7,000 square miles of Northeastern Oklahoma. This rural area stretches from Tulsa east to the Arkansas and Missouri borders and north to the Kansas border *(see Figure 1.1)*. The Nation has a land base totaling 4,336,200 acres with a jurisdictional service area covering over 9,200 square miles. The total population within the jurisdictional area is 399,385 with 109,843 (or 27.5%) being American Indian. The total population of the jurisdictional area is 51% rural in contrast with the entire state of Oklahoma, which is 32% rural. Tribal headquarters are located in Cherokee County in Tahlequah, Oklahoma, the capital of the Cherokee Nation. Field offices are located throughout the 14-county area.

Because Cherokee Nation does not reside within reservation boundaries, a mix of local, state, Tribal, and federal laws govern the majority of areas. Quality improvements in public health will impact not only Tribal citizens but all residing in those areas. This also makes the lessons learned from this project applicable and relevant not only to Tribal populations but also to rural areas across the nation.

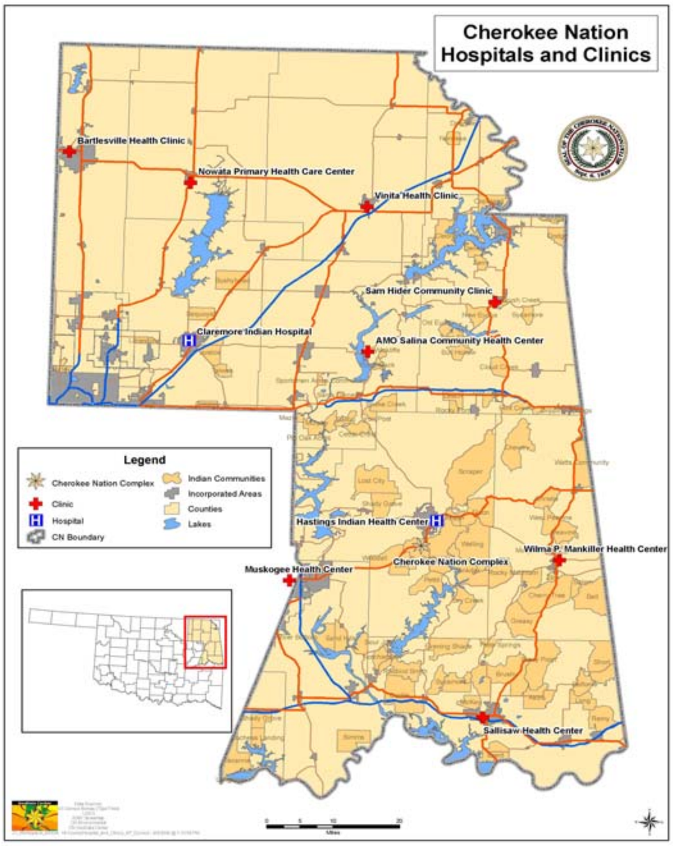

Figure 1.1

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CHEROKEE NATION™
P.O. Box 948 • Tahlequah, OK 74465-0948 • (918) 453-5000

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Chad "Corntassel" Smith
Principal Chief

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Joe Grayson, Jr.
Deputy Principal Chief

Cherokee Nation Health Services (CNHS) is the largest group within the Cherokee Nation employing over 1000 staff with an annual operating budget of over $100 million dollars. CNHS operates a fully-accredited network of one inpatient hospital, eight outpatient clinics and one employee health center. Accreditation is from the Joint Commission on Accreditation for Healthcare Organizations (JCAHO). In addition to inpatient and outpatient care, CNHS also operates a fully-accredited, residential adolescent chemical dependency treatment facility, a licensed, accredited paramedic service, and community-based health services such as public health nursing, health promotion, and behavioral health. CNHS also coordinates patient care with the one Indian Health Service (IHS) facility, Claremore Indian Hospital (CIH) in Claremore located within its service area.

The Cherokee Nation, as part of a 100-year plan for the Tribe, has adopted the use of the Balanced Scorecard system for the prioritization and evaluation of Tribal priorities. Scorecard progress is monitored and reported on a quarterly basis through the Quality Council, the governing committee with the responsibility of implementing the highest possible level of service for CNHS.

Cherokee Nation Health Services began focusing on the components of a public health program upon becoming a self-governance Tribe in 1994. Public health programs within Cherokee Nation have grown substantially since then and a repeated identified need has been to establish a more comprehensive public health infrastructure to guide and direct growth in this area. When Cherokee Nation first learned of public health accreditation it became a long range goal for our organization. In order to ensure the Cherokee Nation continues to meet the public health needs of its service population, as well as identify areas of improvement, the Cherokee Nation applied to participate in this project. By participating in this project, the Cherokee Nation intended to assess current activities related to public health, identify areas within the Cherokee Nation public health system that do not meet the areas identified under NACCHO's Operational Definition, define the operational challenges of accreditation for Tribal governments, develop a plan to strengthen areas of weakness, and determine which partnerships may be necessary to meet accreditation requirements.

The Cherokee Nation faces unique challenges in preparing for accreditation. We are a Tribal government with multiple authorities but we do not reside on a reservation as many other Tribes do across the country. We are much larger than a local health department as our service area spans 14 counties and approximately 7,000 miles. While our direct care and clinical services are limited to only Indian Health Service eligible participants, most of our public health services impact and are available to all community members. We most closely resemble a large city health department while still having a number of differences impacting our preparation.

Highlights from Self-Assessment Results

Standard/ Indicator #	Standard and Significance
VI.A.2	*Reviews polices and procedures within its legal scope of authority on a regular periodic basis* • *This was an area of weakness for Cherokee Nation Health Services and is complicated further because Cherokee Nation is not on a reservation. Review of what Tribal laws exist and where they are applicable was needed.*
i.A.5	*An electronic disease reporting system exists between the Cherokee Nation health care providers and others in the community who are potential disease reporters* • *While this continues to be an area of weakness, a policy was adopted that provides clear guidance for Cherokee Nation health care staff in regards to reporting communicable disease. This gap in our policies was discovered as a result of the self assessment.*
IV.A.6	*Partnership effectiveness in improving community health is assessed* • *Cherokee Nation Health Services piloted a partnership effectiveness survey in one of the community health programs. We partnered with the Oklahoma State Department of Health Chronic Disease Division evaluator to collect and analyze the information. Plans to evaluate partnership effectives in all community health programs is included in the 2009 Cherokee Nation Balanced Scorecard objectives.*
IV.A.1	*Cherokee Nation Health Services has a community health planning structure in place, including community partners* • *While Cherokee Nation conducts a variety of community health assessments we do not have a written plan for conducting assessments which is very necessary to ensure continuity among programs and methodology for determining priorities. As a result of the self assessment an objective to develop a written policy for community health assessments has been included in the 2009 Cherokee Nation Health Services Balanced Scorecard*
IV.E.4	*Cherokee Nation engages in public health policy development, identifying, prioritizing and monitoring public health policy issues* • *Cherokee Nation works on a variety of public health policy issues but currently does not have a public health policy agenda. As a result of the self assessment we have included an objective in the 2009 Cherokee Nation Health Services Balanced Scorecard for development of this agenda and a process to ensure it is maintained, updated, and tracked.*

Quality Improvement Process

AIM Statement: Develop a plan to prepare Cherokee Nation Health Services for public health accreditation by 2012

Cherokee Nation Health Services recognized the need to prepare for voluntary public health accreditation within the past three years. Since there is not a Tribal model to follow we used a combination of planning methods from our clinical accreditations and those utilized by other large health departments. Given the unique nature of public health accreditation and Tribal governments, the large volume of infrastructure work, and the absence of a Tribal model to follow we opted to develop an overall plan to meet accreditation within four to five years. To further demonstrate our commitment we have integrated the plan into our five year strategic plan for Cherokee Nation Health Services. Each year of the plan builds on the previous work while maintaining a realistic achievement timeline for each objective. The Cherokee Nation Health Services strategic plan is updated annually and is the foundation for our annual objectives and quality improvement plan. Annual plans are reviewed quarterly for progress by the Cherokee Nation Health Service Quality Council. Staff are evaluated annually on the work and progress achieved for each program.

Cherokee Nation regularly conducts quality improvement studies using the Plan, Do, Study, Act (PDSA) cycle in our clinical services. We use it extensively in our Innovations in Planned Care initiative and have yielded significant positive clinical indicators. For this particular project the scope of work was much broader and with fewer single issue items, as a result we did not complete a PDCA (Plan, Do, Check, Act) cycle. We do plan to use the PDCA cycle as we progress through the improvement plan. For the purpose of this project we will discuss the process of developing the improvement plan as well as the identification of challenges, barriers, and opportunities unique to Tribal governments.

Our team consisted of five directors from Cherokee Nation Health Services, input from Cherokee Nation Emergency Management team (not organizationally in Cherokee Nation Health Services), and a partnership with the local health department (Cherokee County). Since public health has traditionally not been a focus of Indian Health programs, all team members and administration were not familiar with public health accreditation. After an orientation process that included discussion of the pros/cons of public health accreditation, a process to complete self assessment was developed. Areas for improvement were multiple and team consensus was to start with the areas Cherokee Nation Health Services has programming but does not have comprehensive policies and documented processes. These areas include community health (Essential Service IV), health policy (Essential Service V & VI), and monitoring health status (Essential Service I). While the self assessment was completed for all essential services, some of the programming related to Emergency Management and Environmental Health does not fall organizationally in Cherokee Nation Health Services. We elected to wait until we have

completed improvement with the programming under our direction before we initiate efforts in those areas.

Results

CNHS developed an improvement plan based on the self-assessment of existing programs and infrastructure. The following briefly summarizes our findings for each of the essential services:

- Essential Service 1: Monitor health status to identify community health problems.

  Strengths:
  - *Multiple health information systems including a sophisticated patient records management system with capacity to generate various community health reports*
  - *Data sharing policies and procedures*
  - *Emergency Management Program (not within CNHS)*
  - *Collects large amounts of information both clinical and community*
  - *Partner with Centers for Disease Control and Prevention to collect Cherokee-specific Behavioral Risk Factor Survey (BRFS) and Youth Risk Behavioral Survey (YRBS)*
  - *Cherokee –specific Cancer Tumor Registry*

  Weaknesses:
  - *No policies and procedures for:*
    What data will be collected and how often
    Conducting community health assessments
    Stakeholder input for community health plans
    Utilization of GIS in data analysis

- Essential Service 2: Diagnose and investigate health problems and health hazards in the community.

  Strengths:
  - *Strong partnerships with local and state emergency management programs*
  - *Epidemiologist on staff*
  - *Effective childhood immunization program*
  - *Emergency Management policies and procedures*
  - *Environmental Health program in place*

  Weaknesses:
  - *Incomplete policies regarding surveillance of disease outbreak and investigation*
  - *Lab surge capacity policies and procedures do not exist*
  - *Policies do not exist regarding communication with the public in emergency*
  - *Inadequate resources for a comprehensive emergency management team*

- Essential Service 3: Inform, educate, and empower people about health issues.

  Strengths:
  - *Comprehensive health education programs in place*
  - *Programs utilizing social marketing methods*
  - *Printed materials all have Cherokee-specific format and include Cherokee language*
  - *Annual external evaluation of health education programs*

  Weaknesses:
  - *No written protocol in place for responding to specific information requests*
  - *Communication plan does not include policies on web-based information*
  - *No annual competency testing of health educators*

- Essential Service 4: Mobilize community partnerships to identify and solve health problems.

  Strengths:
  - *Community health programs work closely with Centers for Disease Control and Prevention*
  - *Community health programs have strong evaluation component*
  - *Strong involvement in community coalitions and other public health agency initiatives in community health*

  Weaknesses:
  - *Long range plan for community health programs are not in place*
  - *No written plans on dissemination of community health plans to public*
  - *No public health policy and legislative agenda*

- Essential Service 5: Develop policies and plans that support individual and community health efforts.

  Strengths:
  - *Health policy experts with legislative experience on staff*
  - *Have health policy staff stationed in same area as state legislature (easy access)*
  - *Annual organizational strategic planning process in place*

  Weaknesses:
  - *Lack of policies and procedures for health policy*
  - *Doesn't currently include the 10 Essential services in strategic planning process*

- Essential Service 6: Enforce laws and regulations that protect health and ensure safety.

  Strengths:

- *CNHS employs legal counsel to review public health policy*
- *Cherokee Nation has some public health laws*

Weaknesses:
- *Unsure of the extent of enforcement of Cherokee Nation public health laws*
- *Multiple authorities exist in one area making it difficult to determine which authority had responsibility for enforcement*
- *Large geographic area with different county and state officials in each area*
- *Cherokee Nation has limited regulatory authority in most public health matters*
- *Lack of resources to enact and enforce laws and regulations*

- Essential Service 7: Link people to needed personal health services and assure the provision of health care when otherwise unavailable.

Strengths:
- *Accredited health care system including hospital, ambulatory clinics, emergency medical services, employee clinic, and substance abuse treatment facility.*
- *Comprehensive policies for direct care programs*
- *Quality Improvement studies for direct care programs*
- *Staff dedicated to Quality Improvement for direct care*
- *Direct health care facility within 30 miles of all citizens with CN service area*

Weaknesses:
- *No policies regarding the link between our public health programs and direct care programs*
- *Limited focus on public health workforce*
- *Limited resources for public health workforce recruitment*

- Essential Service 8: Assure a competent public health and personal healthcare workforce.

Strengths:
- *Access to training opportunities via state and university avenues*
- *Staff has experience with presenting at national conferences such as APHA*
- *Partnership agreements with universities in and out of state*
- *Staff has experience working with Centers for Disease Control and Prevention, National Institutes of Health, and other federal agencies dealing with public health issues.*

Weaknesses:
- *Resources to expand public health staff*
- *Recruiting Cherokee staff who have appropriate educational background*
- *Competing with "medical model" when developing public health programs*
- *Competency testing for staff is not in place*

- Essential Service 9: Evaluate effectiveness, accessibility, and quality of personal and population-based health services.

  Strengths:
  - *Multiple programs have independent external evaluation*
  - *Programs adopt national standards such as Healthy People 2010*
  - *Programs adopt best practices and benchmarks*

  Weaknesses:
  - *No formal policies regarding evaluation of public health programs*
  - *Evaluation of key processes is not consistent*
  - *Customer satisfaction surveys are typically limited to clinical programs*

- Essential Service 10: Research for new insights and innovative solutions to health problems.

  Strengths:
  - *Partnerships with state universities to increase research capacity*
  - *Work with NIH to develop Cherokee researchers*
  - *Cherokee Nation Institutional Review Board*
  - *Increased focus on community-based participatory research*

  Weaknesses:
  - *Lack of a published research agenda*
  - *Lack of Cherokee research staff*
  - *Resources to develop a research program for CNHS*

After reviewing the strengths/weaknesses the team developed long (5 year) and short (1 year) term objectives. Below is a list of the objectives:

FY 2013 Objectives:

- *Develop a written plan to monitor health status in the Cherokee Nation according to National Public Health Performance Standards*
- *Develop a written plan to diagnose and investigate health problems and hazards in the Cherokee Nation according to National Public Health Performance Standards*
- *Develop a written plan for health policy development in the Cherokee Nation according to National Public Health Performance Standards*
- *Develop a written plan addressing laws and regulations that protect health and ensure safety in the Cherokee Nation according to National Public Health Performance Standards*
- *Develop a written plan for Evaluation of Health Services in the Cherokee Nation according to National Public Health Performance Standards*
- *Develop a written plan for Health Research in the Cherokee Nation according to National Public Health Performance Standards*

FY 09 Objectives:

- *Develop a written process for conducting community health assessments*
- *Develop a written plan for a Community Health Surveillance System*
- *Develop a definition & baseline number of community partnerships*
- *Develop a definition & baseline number of school partnerships*
- *Develop a definition & baseline number of agency/professional partnerships that address community health*
- *Develop a baseline for the amount of direct funding to school and community organizations*
- *Develop a baseline partnership effectiveness rating for Cherokee Nation Community Health Programs*
- *Develop a written plan to monitor health status in the Cherokee Nation according to National Public Health Performance Standards*
- *Develop a written plan for health policy development in the Cherokee Nation according to National Public Health Performance Standards*

Lessons Learned

During this process, one of the lessons learned was that some of the tools associated with this project were not exactly applicable to the Cherokee Nation. The Cherokee Nation assumes that other Tribal governments participating in similar efforts would have similar experiences. As an example, the Indian health system has not historically focused on public health issues such as food safety, animal control, and others. Therefore, Tribal governments may not have the capacity to meet certain accreditation requirements without partnering with federal, state, and local entities. Conversely, the Cherokee Nation and other Tribal governments provide direct health care and operate direct health care facilities which allow the Cherokee Nation to maintain public health capacity that local health departments may not have the capacity to maintain. Therefore, strong consideration should be given to encouraging mutual aid partnerships and other collaborative efforts.

Partnerships are not without challenges. While the Cherokee Nation is committed to partnering with outside entities, federal regulations/rules pertaining to compacting under the Indian Self-Determination and Education Assistance Act often present obstacles to partnering. As an example, through the compact between the Cherokee Nation and the Secretary of Health and Human Services, the Cherokee Nation is afforded protection under the Federal Tort Claims Act (FTCA) as it carries out federal programs, services, functions and activities. However, the federal government regularly attempts to narrowly apply FTCA application, thus creating a a chilling effect on partnering with outside entities as it raises the possibility of exposing the Cherokee Nation to potential claims when the Cherokee Nations provides services for certain individuals.

Another obstacle related to partnering relates to capacity and the high demand for services. Due to lack of federal resources in carrying out the federal trust responsibility to Tribal Nations, the Cherokee Nation, as well as other Tribal Nations, are unable to meet the health needs of American Indians/Alaska Natives within the system. Therefore, it is often

impractical and impossible to consider partnerships which could create additional burdens on the Indian health system.

Next Steps

The next step that the Cherokee Nation has already initiated partnerships with the Oklahoma State Department of Health, city/county health departments within the Cherokee Nation jurisdiction, and non-governmental health entities. CNHS has met with the Oklahoma State Department of Health (OSDH) to plan next steps in partnership to prepare for public health accreditation. The OSDH Office of Performance Management requested our participation in the Multi-State Accreditation Preparation project in which they are participating. We are currently working on the 2009 objectives and plan to continue preparing for voluntary accreditation in 2012 or 2013. As we proceed through the preparation we will likely identify other challenges as well as strengths related to Tribal governments and meeting accreditation standards. We will continue to document and share our findings with other Tribes, health departments, and NACCHO.

Conclusions

Tribal governments can and should participate in the voluntary accreditation process. It should be understood that partnerships are essential to the ability to meet current standards. A project to determine possible alternate standards geared toward Tribal governments and their varying roles in state and local public health matters could encourage other Tribes to consider the prospect of voluntary accreditation. Assessing and building public health infrastructure among Tribal governments can work to expand the reach of public health programming to rural areas where resources are often limited. The Cherokee Nation is pleased to have participated in this project and applauds NACCHO for the foresight to include Tribal governments in their work.

Appendices

Appendix A: Storyboard Template
Appendix B: Cherokee Nation 2009 Quality Improvement Plan