



EBCI TRIBAL OPTION



Welcome



Objectives for Today

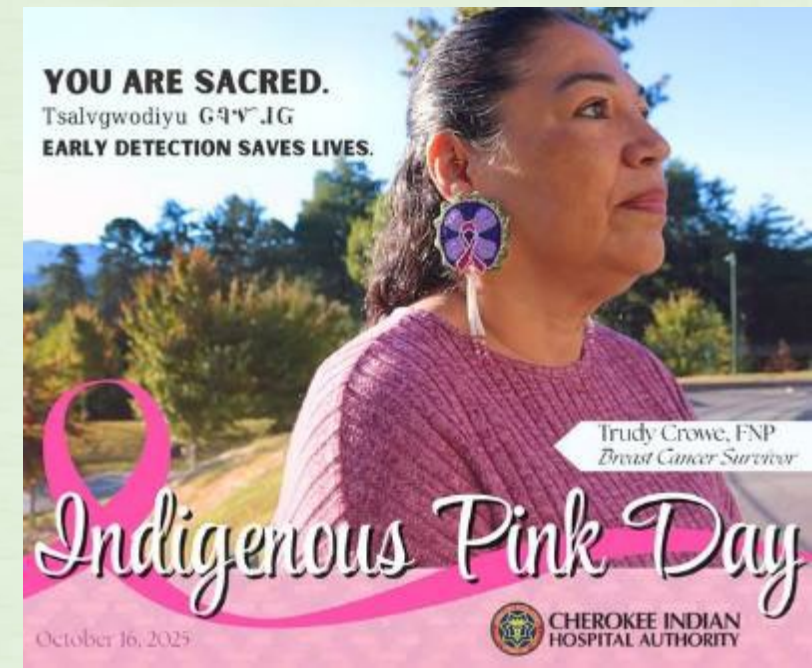
- Provide brief history of Eastern Band of the Cherokee and Cherokee Indian Hospital, including our Mission, Vision, Values and Guiding Principles
- “Why we do what we do”
- Compare the differences between traditional health care systems and integrated health systems with the contribution of care management activities
- Define integrative care team, including the support teams working within the Nuka Model
- Identify each team member and their relationship to the process of providing care in the clinical section and the care management realm.
- Be able to visualize how the team works together in the care of the patient. How does the work flow? A Day in the Life.
- Measuring success and quality





Eastern Band of the Cherokee Indians

- Descendants of the Cherokee Nation and the Oconaluftee Cherokee of 1817 and 1819
- Duly incorporated in 1889 under a corporate charter
- Enrollment today is approximately 16,000 and is at this time the only federally recognized tribe in NC
- Approximately 12,000 AI/ANs are considered active users of the Tribal Health System referred to as the Cherokee Indian Hospital Authority or CIHA
- Diabetes, Depression and Substance Use Disorders are some of the top three priorities for the Tribe
 - At least 3,000 members have been diagnosed with Diabetes
 - Approximately 4,000 have been diagnosed with Depression and or SUD

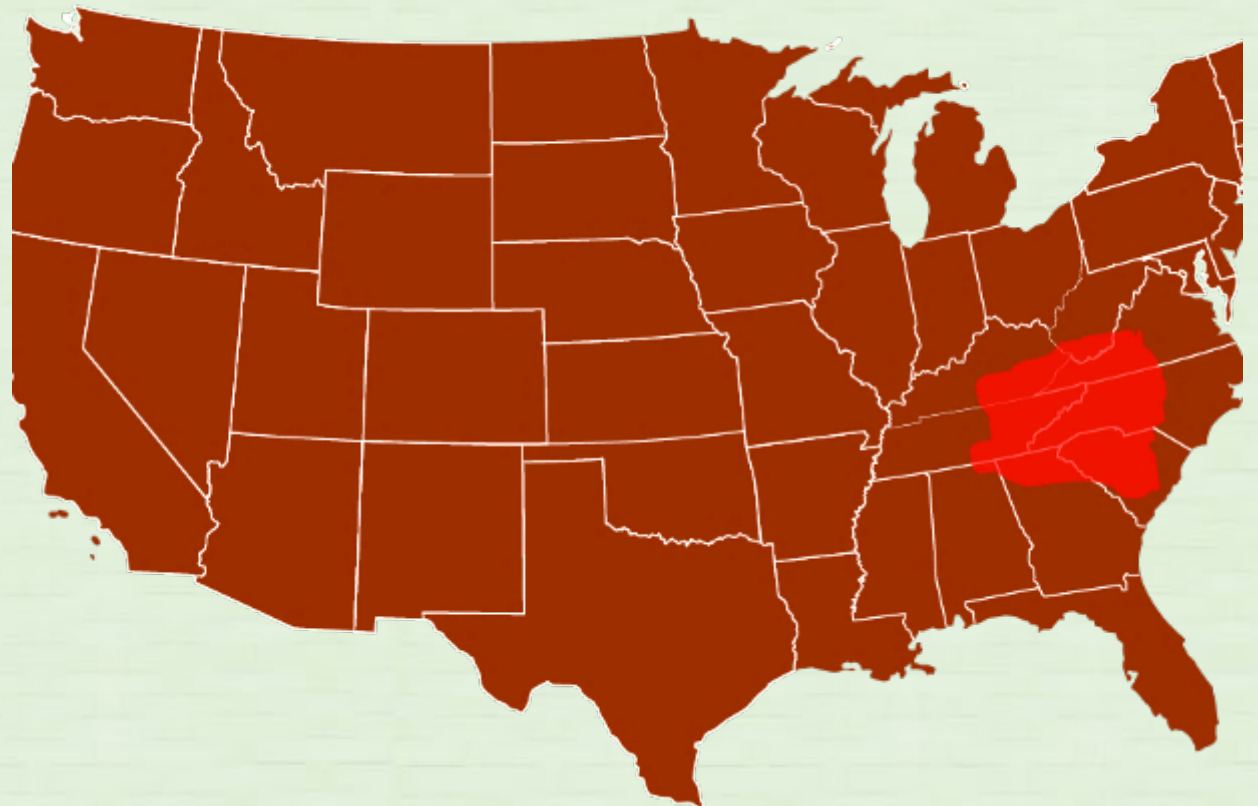




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Eastern Band of the Cherokee Indians

- The Cherokee Nation prior to removal, or the Trail of Tears, occupied 250,000 square miles in 9 states
- Now located on 56,000 acres in 5 of the western most counties known as the Qualla Boundary in Western NC comprised of descendants of the Cherokee who either hid out in the mountains during the removal or those who walked back after arrival in Oklahoma
- The boundary is not a reservation but land purchase by the remaining Cherokee and friends of the Cherokee and held in trust for them until incorporation.





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Indian Health Care: Legislative History



- AI/ANs have a unique political relationship with US founded in treaties predated the origin of the US.
- AI/ANs were forced into treaties resulting in the loss of millions of acres of land.
- In more than 22 of the treaties with the US from 1778 to 1871, the government obligated to provide health services as recompense for the forced surrender of land
- In the late 1880s AI/ANs lost even more land during the allotment error and by the early 1900s communicable disease and starvation were the leading causes of death among AI/ANs according to the Meriam Report in 1928
- The Snyder Act of 1921 is the founding authorization for provision of health services to Indians.
- Indian reorganization Act of the 1934 allowed Tribes that had formally been terminated to reorganize and regain their sovereign status because the Removal and Allotment policies had decimated the social and economic structures of Tribes leaving them in horrific conditions



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Cherokee Indian Hospital Authority (CIHA)



- Has developed and reinvented itself over the years to better serve the people
- From being as a service unit, where care was given on a first come, first serve basis, with patients waiting all day to see a provider, who may or may not be the provider you have seen in the past.
- Leaders worked to forge CIHA's own destiny with the compacted agreement in 2002, which has led to the CIHA we work in today
- Utilizing the integrated care model to provide consistency for patients and providers and to produce excellent outcomes patients.
- How did we get to where we are today?

Core Purpose

“To assure the
prosperity of the next
seven generations of the
Eastern Band of the
Cherokee Indians”



Mission and Vision

Our Vision

Our vision is to be significant in the lives of Tribal members, chosen for excellence and exceeding customer expectations, recognized for improving the health of the Eastern Band the Cherokee Indians.

Our Mission

The Mission of the Cherokee Indian Hospital is to be the partner of choice for the community by providing accessible, patient and family centered quality healthcare with responsible management of the tribes' resources.





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Our Values

- Integrity (Honest and Fair)
- Excellence (Pursuit of Perfection)
- Engagement (Emotional and Intellectual Commitment)
- Stewardship
- Group Harmony (Professional, Respectful, Supportive, Loyalty, Grace)
- Compassion
- Accountability



Guiding Principle One

U wa shv u da nv te lv:
(oo wa shuh oo da nuh tay luh)

“The one who helps you from the heart”

Cherokees have been mislead and mistreated over the centuries by opportunist disguised as well meaning subject matter experts. For this reason to be effective in this community requires genuine, evident commitment to the best interest of the community.

“This community doesn’t care what you know until it knows you care”

CIHA believes that care and service delivered most effectively is delivered from the heart.



Guiding Principles Two

To hi
(toe hee)

“A state of peace and balance”

Cherokee Believe that all things endeavor to achieve this ultimate state of peace where all things are in balance and as they should be.

CIHA believes “to hi” can only be achieved through healthy relationships, and is fundamental to living healthy lives.



Guiding Principles Three

Ni hi tsa tse li

(nee hee zah zay lee or nee hee ja jay lee)

“it belongs to you”

Cherokee like most Native Americans enjoy the first pre-purchased health care in this country. Health care was purchased by ancestors through treaties with the United States, as recompense for the atrocities that resulted from horrific “Indian Policy” in this country

CIHA believes that all health care services belong to the people and CIHA is a steward of their inheritance, charged with safe guarding it and providing it to them when and how they need it.



Guiding Principles Four

di qwa tse li i yu n(i) s di
(dee gwa shay lee ee youn sdee)

“Like family to me” “He, she, they, are like my
own family”

CIHA is committed to being the health partner
of choice for this community enjoying the
relationships found in healthy families.





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Health Improvement Initiatives

- From the Eastern Band of Cherokee Indians 2023 Tribal Health Improvement Plan
 - Substance Use and Related Issues
 - Mental Health Support and Depression Prevention
 - Violence and Abuse Prevention





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The Most Important Issues in your Community

- The EBCI 2023 Tribal Health Survey asked residents to identify the most significant health issues impacting their communities:
- Diabetes (46%)
- Substance Use (45.8%)
- Mental Health Problems (33.7%)
- Child Abuse/Neglect (29.4%)
- Domestic Violence (23.4%)
- Cancers (19.8%)
- Obesity (13.9%)
- Dental Problems (11.9%)
- Aging Problems (11.8%)
- Social Determinants of Health (7.8%)



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The 10 Most Harmful Behaviors According to the Community

Top 10 Harmful Behaviors Identified:

- Illicit Drug Use (63.5%)
- Alcohol Use (48.5%)
- Adverse Child Experiences (27.1%)
- Emotional Abuse (22.6%)
- Violence and Abuse (20.7%)
- Unhealthy Diet (16.3%)
- Behavior that promotes Racism (14.1%)
- Physical Inactivity (13.8%)
- Sexual Abuse (11.2%)
- Physical Abuse (10.1%)



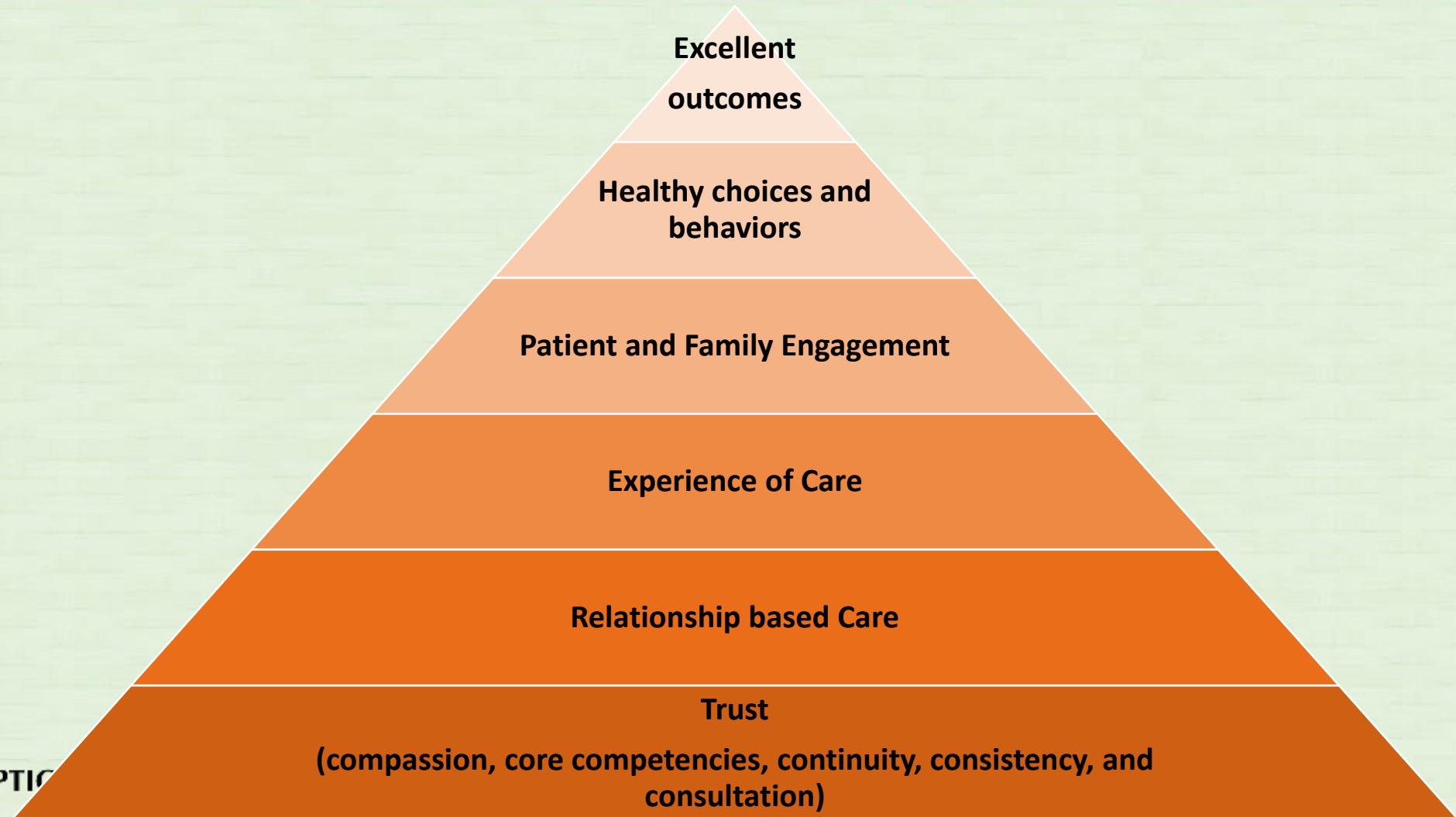
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Power of Sharing Story

- Data gives us information about the issues
- Sharing Story shows us the impact and makes the data real



How do we develop relationship? Lencioni Pyramid of Trust





SOUTHCENTRAL FOUNDATION
NUKA SYSTEM OF CARE



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Did you know?

Southcentral Foundation's Nuka System of Care is recognized as one of the world's leading models of health care redesign.

"Nuka" is an Alaska Native word that means strong, giant structures and living things. It is also the name given to Southcentral Foundation's whole health care system, which provides medical, dental, behavioral, traditional and health care support services to more than 65,000 Alaska Native and American Indian people.

In the Nuka System, strong relationships between primary care teams and patients (known as customer-owners) have helped manage chronic diseases, control health care costs, and improve the overall wellness of the people we serve. Recognizing that individuals are ultimately in control of their own lifestyle choices and health care decisions, Nuka focuses on understanding each customer-owner's unique story, values and influencers in an effort to engage them in their care and support long-term behavior change.

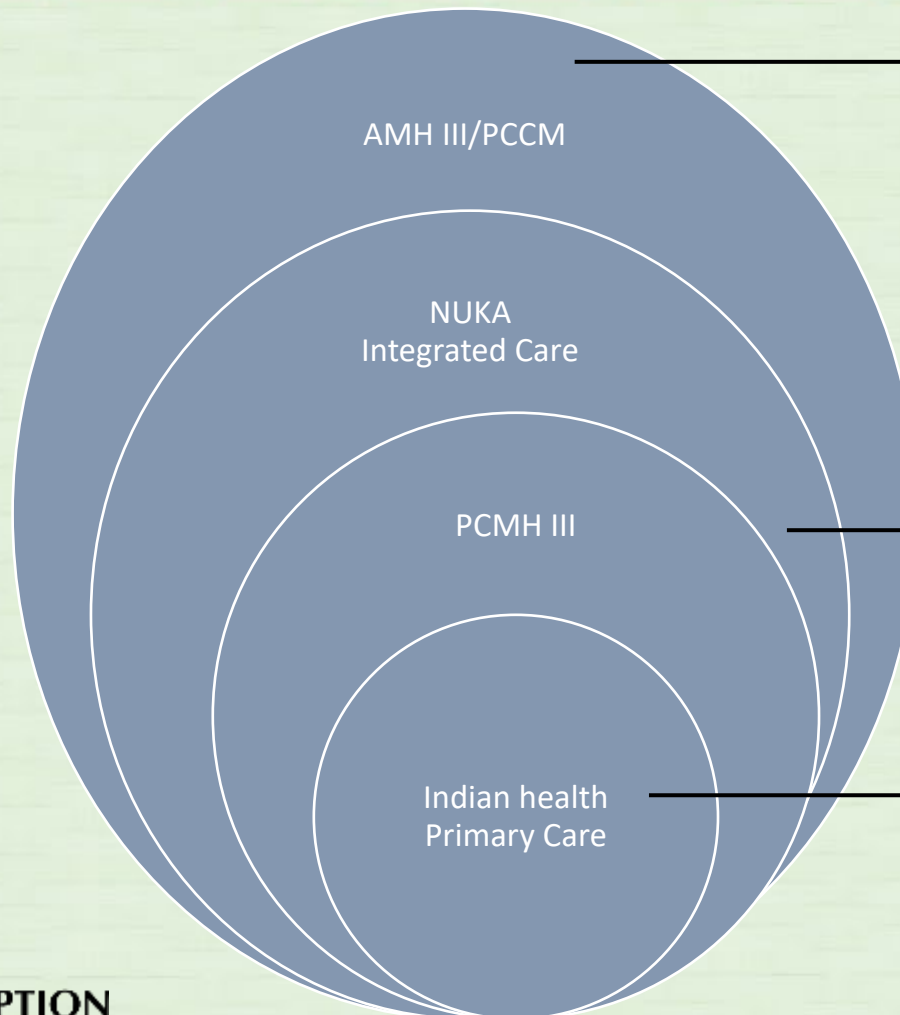
It is the Nuka system for which our CIHA Primary Care Teams are modeled after.



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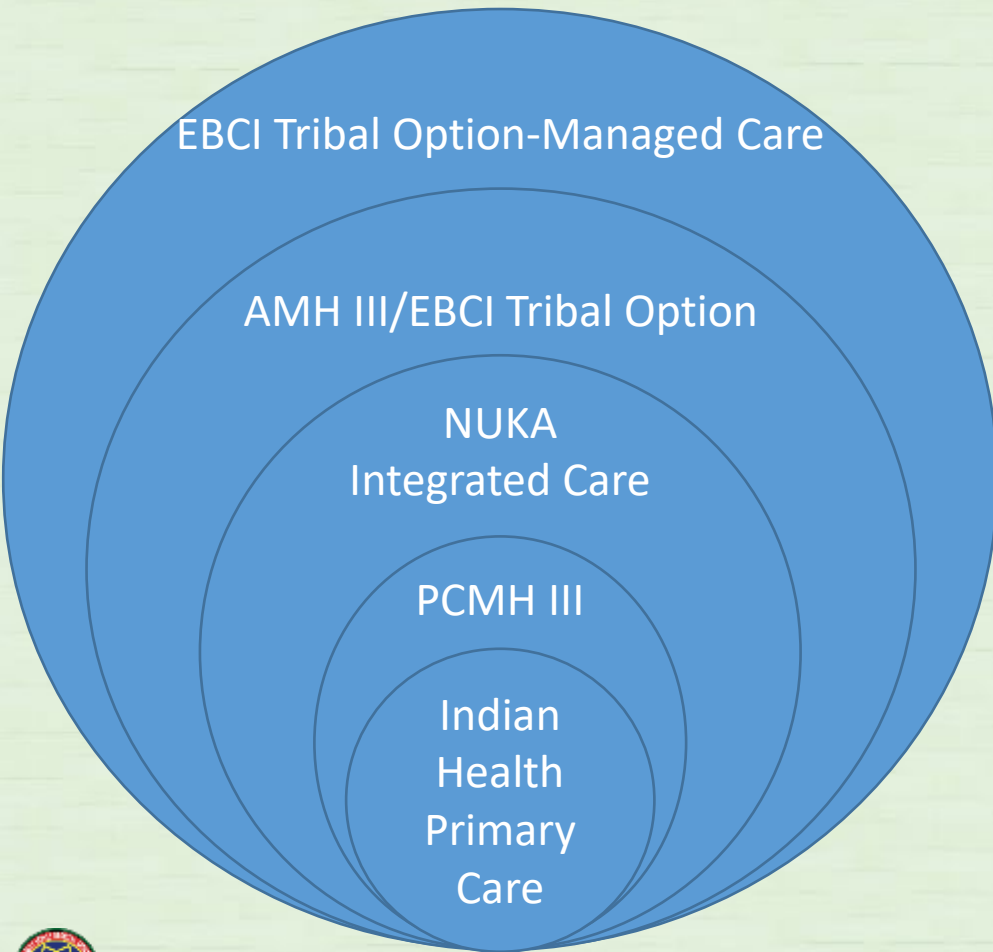
- Risk Stratification
- Active Care Management
- Transitional Care Management
- Utilization of Claims Data for Risk Strat
- Bi-directional exchange of data with NCDHB
- Meet Security Standards for data exchange
- Referrals for Specialty Care
- Utilization Review and Management (future state)
- Member services
- Provider Network Management
- Quality Monitoring

- Integrated Team Based Care (embedded shared resources)
- Reciprocal Interdependent system
- Parallel processing
- Trauma Informed
- Key workforce competencies include (empathy, compassion, and influential relationships)

- Traditional Primary Care embedded with ER, Inpatient, Clinical Support Services, Pharmacy, Behavioral Health, and Dental
- Purchased and Referred Care (referral and acquisition of specialty care from regional partners)
- RPMS (fully integrated electronic health record).



EBCI Tribal Option



The next step in our journey to ensure the prosperity of the next 7 generations of the EBCI and preserve Cherokee Culture



Primary Care Introduction to Team-Based Care

In our Primary Care, care doesn't come from just one individual or one department; it comes from many members, made up of our large interdisciplinary care team.

Patients are carefully placed at the center, surrounded by helpful, caring specialists—experts in their given fields of medicine, who work collaboratively on each patient's care.

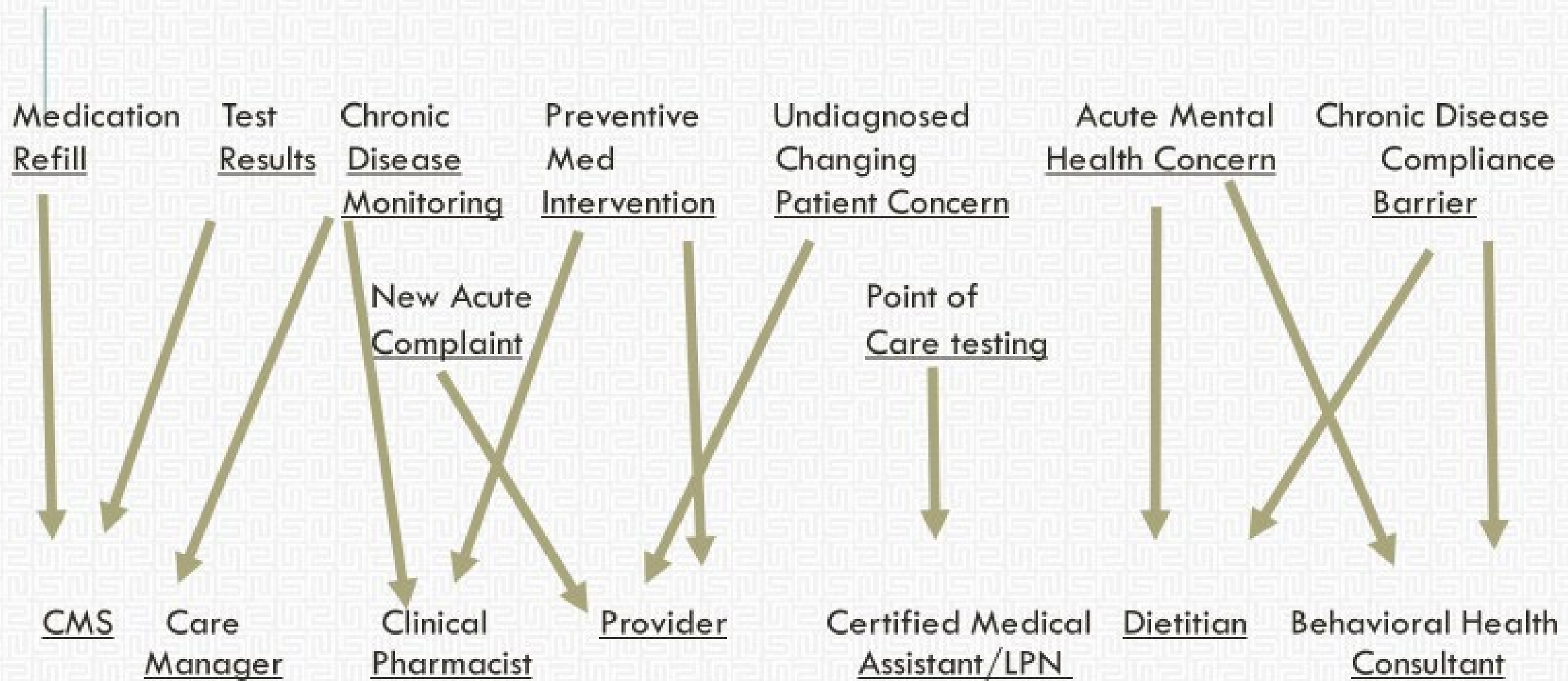
Patient's may be able to have multiple encounters with different members of the care team in one visit, depending on the complexity of their health needs.



Traditional Methods of Managing Workflow



PARALLEL WORK FLOW REDESIGN



So, Who makes up an Integrated Care Team?



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Whose yours?**

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YOUR MEDICAL HOME FOR YOUR HEALTH

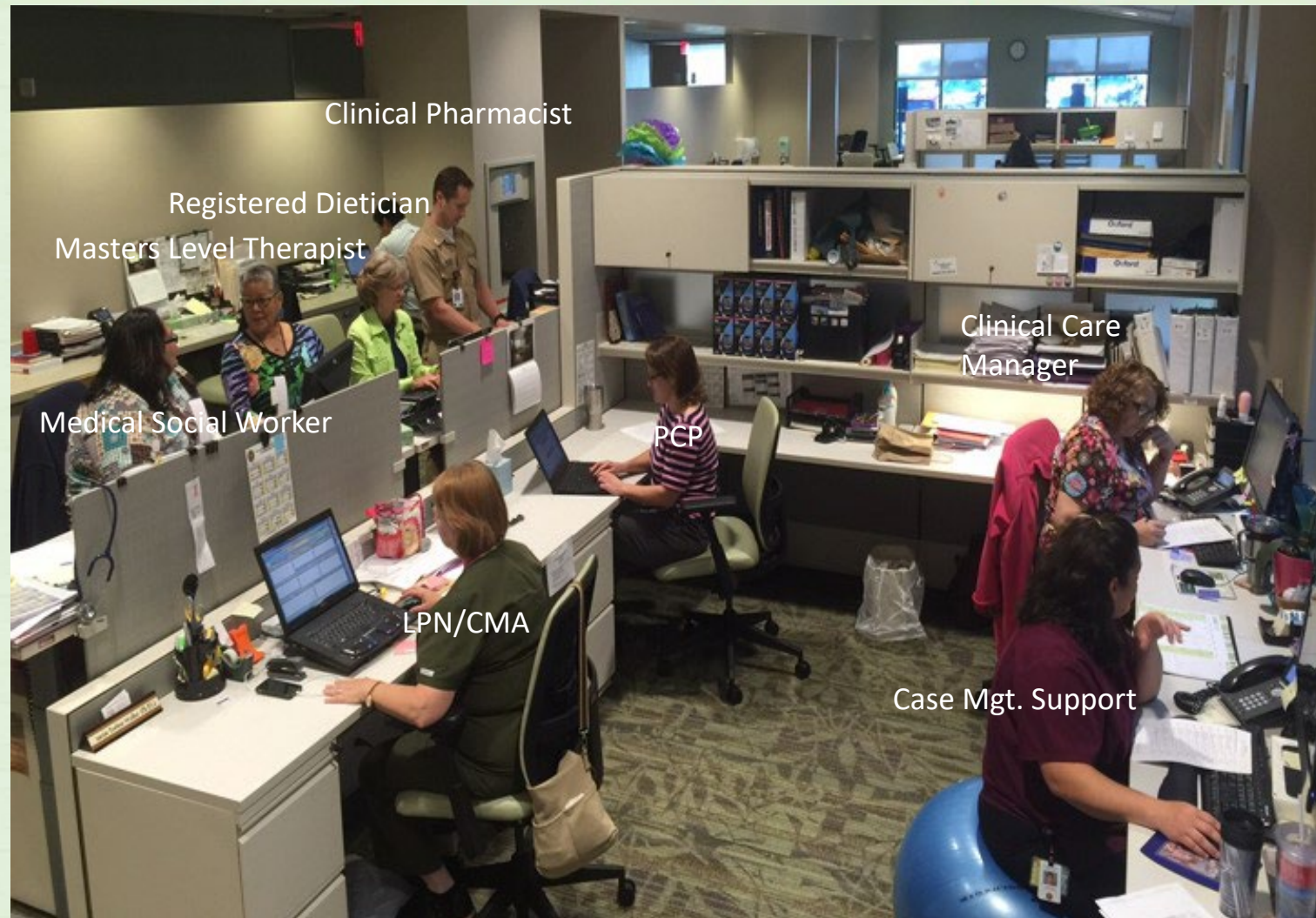


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- ❖ The team members are located in a specific location that enables them to facilitate better communication within the team.
- ❖ Clinical Care managers and Case Management Support (CMS) take the farthest seats from the exam rooms.
 - ❖ Because they are spending more time in their seats.
- ❖ Providers and LPNs/CMAs work closer to the rooms.
 - ❖ This enables them to easily move in and out of the work area.
- ❖ Support staff work closer to rooms than the Provider/LPN/CMA for quick consultation
- ❖ Tribal Option Care Managers work outside of the care team in another location or work from home.
 - ❖ If they need to come to primary care, they can use a seat along the outside perimeter of the team.



Core Team Members

- ❖ Tribal Option Care Manager – RN's, LCSWs, Qualified Health Professionals
- ❖ Provider—MD, DO, Physician Assistant, or Nurse Practitioner
- ❖ Clinical Care Manager – RN's
- ❖ LPN/CMA-Certified Medical Assistant
- ❖ CM Extenders – Care Management Extender
- ❖ CMS—Case Management Support—Clinical and Tribal Option



Primary Care Provider

- ❖ The primary care provider may be a MD, DO, PA, or a FNP.
- ❖ They are the clinical lead for the team.
- ❖ Each team has a provider that provides wellness visits, acute and chronic care visits, as well as, performing procedures such as pap smears, circumcisions, IUD placements, etc.
- ❖ In the visit, the provider concentrates more on the patient and the needs voiced rather than being the conduit for all aspects of care
- ❖ Providers may be internal to CIHA or external (when the Member has chosen an medical home outside of CIHA)



Clinical Care Manager – Registered Nurse

Lula Owl Gloyne: 1st
Eastern Band Cherokee
Nurse



The Clinical Care Manager is a Registered Nurse (RN) who provides clinical support and care management services for the members who are assigned to their specific Primary Care Provider.

Each Provider has a specific Clinical Care Manager – RN –

Currently, we have 13 Care Teams that provide primary care services to our total eligible population, which is around 12,000 members who are active in our health system.

Clinical Care Manager duties include some of the following:

- ❖ Managing the population health needs of a specific panel of patients, such as DM, HTN, BP, and SDoH needs.
- ❖ Injections, medication administration, patient education, and nurse visits for specific health-related needs.
- ❖ Answering the phones, triaging phone calls, coordinating referrals for outside providers, creating and implementing care plans, and coordinating with Tribal Option Care Managers to eliminate gaps in care.
- ❖ Serving as the team leader for the CMS, LPN/CMA, and support staff.



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Tribal Option Care Manager

The Tribal Option Care Manager can be a Registered Nurse (RN), Licensed Clinical Social Worker (LCSW), or a Qualified Health Professional. TO Care Managers provide patient-centered care for members who are at risk, or suffer from chronic disease, who are enrolled in the EBCI Tribal Option (Medicaid).

We currently serve over 5500 active members who are managed by 25 Care Managers

Tribal Option Care Manager duties include some of the following:

- ❖ Performing assessments on members to help determine any gaps in care or special health care needs. (annually and depending on changes in circumstances)
- ❖ Using those assessment findings to create patient-centered care plans to assist the member with meeting their health goals and eliminate gaps in care
- ❖ Assist Members with managing any of their chronic medical conditions, such as DM, HTN, BP, and also any Social Determinants of Health; transportation, food insecurities, heating, housing, or Behavioral Health issues such as IDD, LTSS (Long Term Support Services), Tailored Care Management eligible and those eligible for child and families services etc.
- ❖ Work with outside entities such as VAYA, Family Safety, County/State Partners, and other facilities including Tribal/Non-Tribal.



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LPN/CMA

The LPN/CMA works closely with the primary care provider to anticipate the healthcare needs of the patient.

They provide some of the following:

- ❖ Health screenings and assessments, vital signs, assists with various procedures, and immunizations.
- ❖ Calling patients with lab results, referrals, data entry for referrals and follow-up appointments, scrubbing charts for pre-visit needs, and assisting the provider with entering orders.
- ❖ They assist with care provided for the patient during in-house visits, as well as assisting the clinical care managers with outreach.



CM Extenders

The Care Management Extenders are an extension of the Tribal Option Care Manager.

They perform some of the following duties:

- ❖ Answering phone calls for the team.
- ❖ Completing yearly assessments.
- ❖ Reviewing ADTs – Admission, discharges, and transfers
- ❖ Assisting members with any gaps in care and any social determinants of health needs.



Case Management Support – Clinical and Tribal Option

The **Clinical** Case Management Support is the first line of relationship building with members.

They perform some of the following duties:

- ❖ Answering phone calls.
- ❖ Creating notes and sending them to the provider and/or the team members for follow-up.
- ❖ Creating appointments and developing schedules
- ❖ Providing reminders for appointments.
- ❖ Placing refill requests into the provider
- ❖ Assist with referrals and retrieving notes from the outside entities.
- ❖ **They are the communication hub of the team.**

The **Tribal Option** Case Management Support works as the support staff for the Care Management team.

They perform some of the following duties:

- ❖ Answering phone calls
- ❖ Faxing and retrieving critical medical documents.
- ❖ Assisting families with completing the needed documentation that may help them qualify for different programs.
- ❖ May also be used to transport members when all other transportation has failed.

Support Team

Nutritionist/ Registered Dietitian

- Schedule specialized visits for MNT, weight loss, or any SDoH related to food insecurities.
- Coordinate group meetings for those seeking weight loss surgery and for diabetic patients.
- Work with diabetic members to achieve health goals.
- Provides nutritional services in other settings (inpatient, Snowbird, Cherokee Country, community classes, support groups, etc.) as needed.
- Offers telehealth visits.

Pharmacist

- ❖ The Pharmacist provides consultation to primary care team members upon request.
- ❖ They schedule appointments for work with patients using Disease State Management protocols, which include smoking cessation, Hypertension, Anticoagulation therapy, Diabetes Care, and Medication Reconciliations, especially upon transitions of care.
- ❖ They serve as a drug information resource.
- ❖ They assist with pill counts for those on pain contracts.
- ❖ They are a resource to the team members for drug interactions, dosing, and prescribing.
- ❖ They provide tobacco cessation counseling

Support Team

Medical Social Worker

- ❖ Consult with patients on the SDoH and provide assistance with introductions for them to facilities that provide resources such as food pantries.
- ❖ Assist with completion of any paperwork needed for acquisition of resources.
- ❖ Assist with reporting of abuse or neglect for children, elders or those at risk.
- ❖ Assist with transportation issues encountered by patients, including providing transportation when necessary.
- ❖ Assisting patients who are homebound or lack means to travel to clinic with delivering medications, equipment etc. to the home.

Behavioral Health Consultant BHC

- ❖ The BHC provides consultation to primary care team members upon request.
 - ❖ The request can come from positives in screening such as the PHQ-2, PHQ-9, GAD-7, ACE, AUDIT, and/or DAST-10.
 - ❖ They also see any patient that requests to see a BHC. Patients may have had an encounter with the BHC in the past and wish to see them again or may request someone to speak with about any issue.
- ❖ The BHC is *open to* interruptions as appropriate from staff to be informed of other patients' in need of care.
- ❖ The BHC can file petitions for involuntary commitment with a magistrate, when appropriate, with the assistance of the team.
- ❖ They will also see patients as many as 6 times in clinic before referring them to Analenisgi for further treatment.



CDCES—Certified Diabetes Care and Education Specialist

- We have three CDCES—One Pharmacist-D, One RN and One Nutritionist/Dietitian
- They work together to ensure that all aspects of DM care and education are covered This may include:
 - Consultation with providers/team members for med adjustments; CBG monitoring results and suggestions for therapies moving forward; education concerning meds, CBG, goal setting, barriers to meeting goals; exercise; nutrition; process improvement PDSAs; engaging with patients in prevention strategies including gardening, plant based diets, use of complementary medicine-chiropractic, acupuncture, massage, BMI reduction, stress reduction, BHC consults,
 - SDPI Grant activities to address our Glycemic control as our Best Practice utilizing activities such as ER visit follow-ups for elevated Glucose, Group nutrition meetings tracking GPRA/Dashboard metrics, prefiling medication boxes for those with out of control A1C.....



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Activities to Facilitate Communication

- ❖ Daily Morning Huddles
- ❖ Weekly Team Huddles
- ❖ Discipline Meetings (Huddles)
- ❖ Weekly Nurse Lead meetings
- ❖ Weekly PC Leadership meetings
- ❖ Monthly Primary Care Steering Committee Meetings
- ❖ Right Way Trainings (Upon orientation and all staff already employed participate)





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A Na Le Ni Sgi- Behavioral Health Facility

- ❖ A na le ni sgi (Recovery Services Center) is our treatment center focusing on a health and substance abuse services mix.
- ❖ Providing substance abuse treatment and Medication Assisted Treatment (MAT) used in drug treatment with outpatient care.
- ❖ Families, DUI or DWI offenders, and criminal justice clients are supported for drug rehab.
- ❖ Other services include: SU Counseling - Individual, Group and Family Therapy- classes and peer support... Psychiatric Evaluation... Medication Management... Intensive Outpatient Substance Abuse Treatment



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Day in the Life

Scenario

- Patient coming in for scheduled visit for follow-up after hospitalization for Diabetes and has had two toes amputated for osteomyelitis.
- The patients A1C has been >9 for an extended period of time.
- He has not kept the last three appointments.
- Last A1C, in the hospital, was 11.
- During the AM team huddle, it was noted that the patient has had a elevated A1C and discussion with Nutrition and/or CDCES is made for the patient to be seen during visit for education and possible continuous blood glucose monitoring.
- The CMS had obtain all notes from the hospitalization after making the appointment for the visit. It is noted, in huddle, that the patient is due for diabetic foot exam and retinal screening. The JVN screener is also made aware of the patients visit time for a work-in for retinal screening.
- If the individual had not just been on Inpatient, the LPN/CMA would note if the patient was due for diabetic labs and call to ask the patient to come in early for labs to be completed.



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Day in the Life

Scenario continued

- ❖ Patient will be brought back to the exam room by the LPN/CNA
- ❖ Vital signs will be taken, screening bundle completed, and Care Needs Assessment tool completed to assess for need for care needs or gaps in care.
- ❖ Chief c/o for the visit is follow-up from hospitalization and redness at amputation site.
- ❖ The patient scores positive on the Care Needs Screening for a care needs or gaps in care, mostly related to the hospitalization. The LPN/CMA makes the RN aware and notes on the foot exam that the wounds from the amputation are reddened. RN asks for a wound care appointment for the patient. The CMS calls for the next available appointment.



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Day in the Life

Scenario continued

- ❖ During the initial visit screening, the patient is also positive on the PHQ2 and 9, indicating depression. Discussion takes place between LPN/CMA and the BHC for a drop in visit and consult. BHC to visit following the provider visit. Care Manager made aware to include in her care plan development and the provider is made aware.
- ❖ The provider is behind on the schedule, so the RN goes in and completes a disease specific assessment for care plan development, related to the positive Care Needs Screening.
- ❖ The provider visits and takes history and completes the exam and begins working on notes and orders.
- ❖ The BHC goes in to introduce himself and to discuss briefly the PHQ9 results. He ask for the patient to come back in and see him for brief visits for the next few weeks. The patient is in agreement



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Day in the Life

Scenario continued

- ❖ The nutritionist and the CDCES go into the room together and discuss the possibility of using the continuous glucose monitoring to help get the patient's sugars under control, as well as, discussing nutrition with the patient. He is in agreement. The visit is scheduled, in cooperation with the BHC visit to continue the nutrition education and evaluate the CBG results.
- ❖ This patient is staffed during the weekly team huddle and discussion is made concerning the care plan interventions, including follow up visits with BHC and Nutrition/CDCES. Also discussing the need for the wound care evaluation. Recommendations are made and plan for discussion with the patient completed
- ❖ The Care Manager calls and discusses the care plan with the patient over the phone and asks if they can join the face to face visit for discussion of the care plan during the nutritionist/CDCES and BHC in the visit. The patient is in agreement.

Day in the Life

Scenario continued

- ❖ The patient returns for his follow up visit concerning the care plan. He first visits with the Care Manager. Through the use of motivational interviewing the nurse completes the care plan, including the patients needs, wants and willingness to facilitate change. He also visits with nutrition/CDCES and BHC.
- ❖ The Care Manager completes the care plan within 14 days of the initial visit. She calls to share the care plan with the patient and mails him a copy of the plan. She schedules a follow up call for the next week to check progress on the agreed upon goals.
- ❖ The patient is again staffed at the next weeks team huddle, progress is discussed and results of visits are shared.



Day in the Life

Scenario continued

- ❖ The patient and his team continue to work on the goals they have set and progress or updates are documented.
- ❖ This continues until the goals are met and the case is closed or goals are updated as needed and the plan continues.

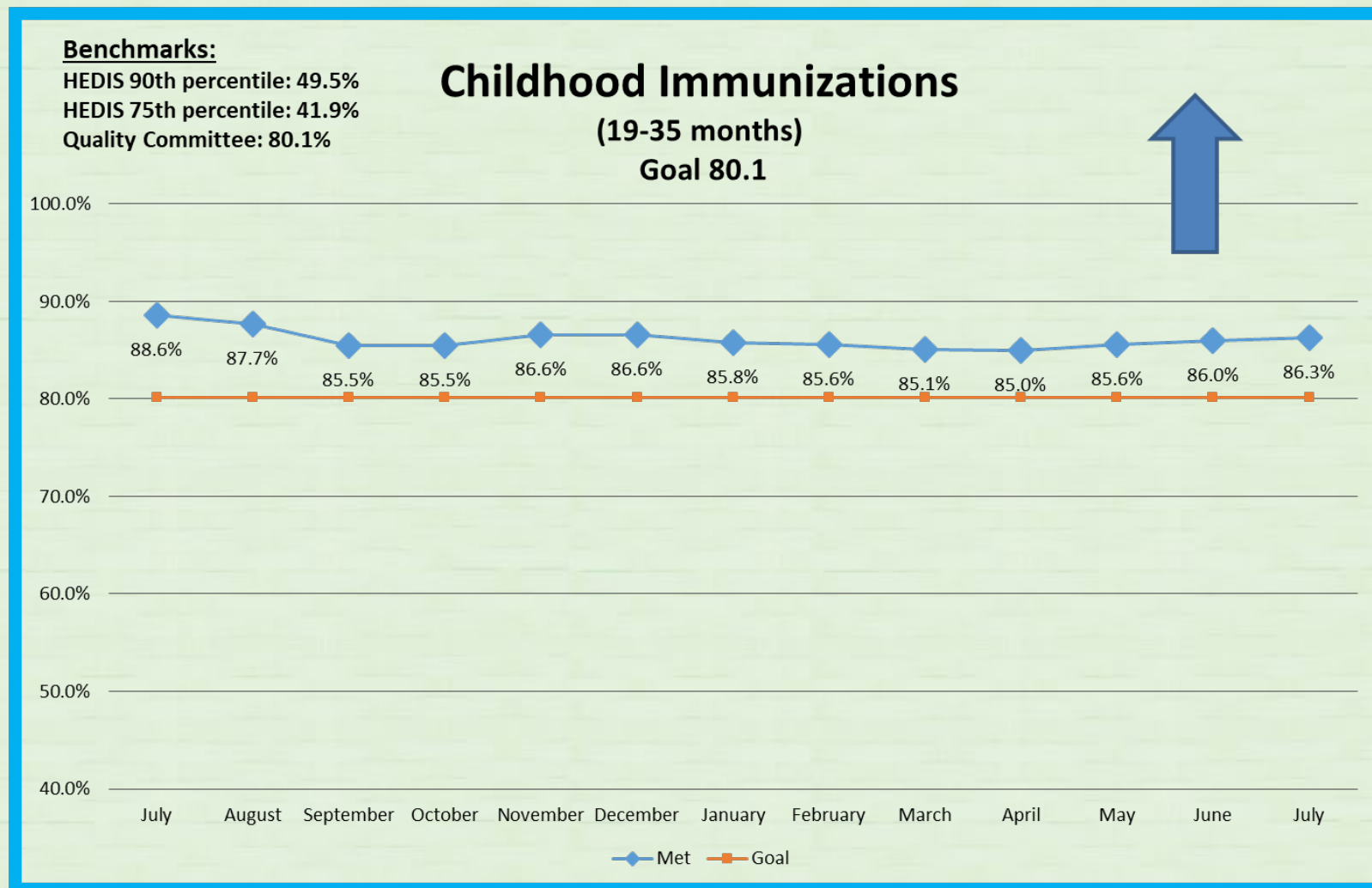
- ❖ Can you see how the Integrated team approach made a difference in the care for this individual?
- ❖ Can you see how co-location was essential in the care for this patient?
- ❖ Can you see how each discipline acted to the highest of their scope of practice and set in motion interventions for the patient that freed the provider up to focus only on the patient and their needs?

How do we measure success?

- ❖ Dashboard metrics
- ❖ GPRA metrics
- ❖ Customer testimonials
- ❖ Climate surveys
- ❖ THP-Tribal Health Survey
- ❖ EBCI TO Quality Measures
- ❖ Being the investment of choice for the tribe
- ❖ Being the provider of choice for the community
- ❖ Being the employer of choice for the region.



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SGI (Thank you) Any Questions?

Contact Information

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