The SCF Nuka Model of Care:

Customer Driven - Community Owned

Donna Galbreath MD
Douglas Eby MD MPH
Objectives

Describe the SCF Nuka Model of Care and why it matters as an example of a community with disadvantages taking control and creating world class excellence.

To understand what is wrong with healthcare and what must change.

To show the SCF Nuka Model of Care as a successful, sustained model of customer driven care.
Southcentral Foundation

- 25 years of history
- Innovative, relationship based, customer driven systems
- 1,400 staff – 140,000 statewide clients
- 55,000 local clients including 10,000 in over 50 remote villages
- Poorly funded by I.H.S. with minimal increases-2% total/yr – less per capita/yr
- Expanding local population (7%/yr)
Alaska Native Medical Center

- 150 Bed Hospital
- Over 400,000 outpatient visits last year
- Local primary care, regional community hospital, and tertiary care statewide hub
- Level II Trauma Center, Magnet Status
- Combined project of SCF and ANTHC
- Full system – includes medications, etc.
Southcentral Foundation

- Medical Services – Primary Care, Women’s Health, Pediatrics, Optometry
- Dental
- Behavioral Health – clinics, residential treatments, after-care, youth, elders
- Family Wellness Warriors – abuse and neglect treatment and prevention
- Tribal Doctors and Traditional Services
- Chiropractor, massage, acupuncture
Why listen to our story

- Evidenced-based generational change reducing family violence
- 50% drop in Urgent Care and ER utilization
- 53% drop in Hospital Admissions
- 65% drop in specialist utilization
- 20% drop in primary care utilization
- 75-90%ile on most HEDIS outcomes and quality
- Childhood immunization rate of 93%
- Diabetes with 50% of HbA1c below 7%
- Employee Turnover rate less than 12% annualized
- Customer and staff overall satisfaction over 90%
- In an urban Alaska Native community with huge challenges
The US Congress Said…

- From the time of European occupation and colonization through the 20\textsuperscript{th} century policies and practices of the Unites States caused and/or contributed to the severe health conditions of Indians.”

- If the people receiving the health service are involved in the decision making processes, better yet, if they own their own health care – programs and services have a potential for enhancement and the people and their health statistics will improve.
Our Choice

- The Alaska Native people were given this choice and we chose to assume the responsibility for our own health care
  - Total Redesign - Change everything
  - Keep the best of Modern Medicine
  - Change the basis to Alaska Native Values and Wisdom of the Elders
  - Put the Customer-Owner in control at all levels of the system
25 Years Ago

- Began the process of assuming the role from Indian Health Service
- Poorly funding, poor infrastructure
- Mechanical, linear, manufacturing models
- Bureaucratic system – slow decision process
- Weak Primary Care capability
- Everyone unhappy – community, clinical staff, leadership
Medicine as a choice

- Medical School – cultural shock
- Residency - better
- Work 1st 15 years and last 5
Re-remembering

- We are our own healing
- We move as a people/tribe where we want to go
- We know our identity, uniqueness
- We are the pure descendents
- We walk along side and allow choice
- Healing the spirit world wide is about relationship
SCF – Redefining the Base

- From 1980’s – focus on the customer
- 1998-99 – 6 month process of deep listening to customer and staff
- 1999 – redefined Vision, Mission, Key Points, Operational Principles
- 2000 – launch of redesigned primary care
- Since – continual principle driven design
Mission, Vision, Values and Culture

- **Mission:** Working together with the Native Community to achieve wellness through health and related services
- **Vision:** A Native Community that enjoys physical, mental, emotional and spiritual wellness

Katherine Gottlieb, MBA
President and CEO
Key Points

- **Shared Responsibility**
  We value working together with the individual, the family, and the community. We strive to honor the dignity of every individual. We see the journey to wellness being traveled in shared responsibility and partnership with those for whom we provide services.

- **Commitment to Quality**
  We strive to provide the best services for the Native Community. We employ fully qualified staff in all positions and we commit ourselves to recruiting and training Native staff to meet this need. We structure our organization to optimize the skills and contributions of our staff.

- **Family Wellness**
  We value the family as the heart of the Native Community. We work to promote wellness that goes beyond absence of illness and prevention of disease. We encourage physical, mental, social, spiritual and economic wellness in the individual, the family, the community, and the world in which we live.
SCF Operating Principles

- **Relationships** between the customer-owner, the family, and provider must be fostered and supported.
- **Emphasis on wellness** of the whole person, family, and community including; physical, mental, emotional, and spiritual wellness.
- **Locations** that are convenient for the customer-owner and create minimal stops for the customer-owner.
- **Access** is optimized and waiting times are limited.
- **Together with** the customer-owner as an active partner.
- **Intentional whole system design** to maximize coordination and minimize duplication.
Operating Principles

- **Outcome** and process measures to continuously evaluate and improve
- **Not** complicated, but simple and easy to use
- **Services** are financially sustainable and viable
- **Hub** of the system is the family
- **Interests** of the customer-owner drive the system to determine what we do and how we do it
- **Population**-based systems and services
- **Services** and systems build on the strengths of Alaska Native cultures.
How to deploy in design...

- Good Diagnosis – now what is the treatment plan??
- Many organizations have nice, community based, health oriented Visions and Missions – but how to ‘change everything’ – not just lip service
- How to have customer ownership become customer driven design – really…
Control: Who really makes the decisions

1. Control – who makes the final decision influencing outcome?
2. Influences – family, friends, co-workers, religion, values, money
3. Real opportunity to influence health costs/outcomes – influence on the choices made – behavioral change
4. Current model – tests, diagnosis, treatment (meds or procedures)
Hitting the target…

- If you are in a mechanical, manufacturing environment then hitting a target it a matter of throwing a rock – figuring out speed, trajectory, etc.
- If you are in a messy, human, complex, adaptive environment – it is like throwing a bird at a target – it is all about the ‘attractor’
- Medicine throws birds at targets and only thinks about the throwing part…
Some simple rules for improvement

- Get together and have dialogues
- Complexity
- Multidimensional improvements with target focus
- Creativity
- An allowing/positive environment
- Chaos
- Experimenting

Certainty or Agreement

Low

Protocols & Stds

High

Low complexity - variables

High
What we are Taught – Diagnosis, Medications, Procedures

- Medical Care Process – linear, objective
  - Signs and Symptoms – history and PE
  - Leads to Differential Diagnosis
  - Leads to ordering tests for more info
  - Leads to Definitive Diagnosis
  - Results in medications, procedures, and advice

- This is what our work is understood to be, the product of healthcare as we learned it and as we still teach it.
Reality

- Health is a longitudinal journey
  - Across decades
  - In a social, religious, family context
  - Highly influenced by values, beliefs, habits, and many ‘outside’ voices.
- Office visits are brief, reactive stop-gaps
- Hospitalizations are brief, intense interruptions
- **MUST** fix basic, underlying primary care platform first or nothing else will work well
Purpose of Primary Care

- We are a Service Industry – NOT a product industry – coaching, teaching, partnering are central – pills and procedures supportive

- Changes what we think we do, who we hire, how we train, how we structure, how we reward, and how entire system is constructed as a system.

- We must optimize relationship – personal, trusting, accountable – minimize barriers
Reality

- Healthcare has several ‘platforms’
  - ICU/ER/OR – high tech, linear, mechanical
  - Procedures – linear, mechanical
  - Consultative – time limited, acute issue focused
  - Longitudinal relationship over time – chronic conditions, outpatient, residential, behavioral health, primary care

- One size does not fit all – first two are product, manufacturing efforts – second two are service and knowledge efforts primarily
Current Popular ‘Solutions’

- Six Sigma/Lean
- Pay for Performance
- Baldrige
- Self Care
- Medical Home
- Accountable Care Organizations
- Patient Safety Movement

-- All are useful, but limited capability if fundamental platform not rethought
Frank

Frank is a 79 year old widower with Chronic Obstructive Pulmonary Disease (COPD), Heart Failure and Diabetes. He lives alone. Frank is very anxious as he is often very breathless and feels unable to manage. He has phoned the practice of his primary care physician on several occasions requesting a home visit and over the last year he has frequently been taken to the local emergency department, after he has dialled 911. He has been admitted to hospital on 7 occasions in the last year and now keeps a small packed suitcase by his chair.
Frank’s Diagnosis

- COPD
- CHF
- Diabetes

Frank’s Healthcare providers
- Primary Care, Cardiologist, Pulmonologist, Endocrinologist, Nutritionist, Physical Therapist, Pharmacist, Home Health.
Realities about Frank

- Frank IS in control
  - Getting and taking meds
  - Using inhalers
  - Eating, sleeping, exercising, socializing
  - Calling 911
- Frank is costing a great deal of money
- Frank is getting worse
- No one ‘knows’ Frank
Nuka – a different look at Frank

- **Primary Diagnosis**
  - Anxiety, Loneliness/isolation, insecurity, confusion, dependency, lack of confidence
- **Secondary Diagnosis**
  - COPD, CHF, Diabetes
- **Primary interventions**
  - Personal care coordination, integration of care by PCP team, determination of motivators, behavioral based motivational interventions, consolidation of meds/tx.
Health System Design

How would you organize these components to produce optimal outcomes, and why?

Draw a diagram that shows them all in relationship to each other as an intentionally defined system.
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Rethinking the basic platform

- If the goal is population health over time
- The major variables we can affect relate to chronic conditions, habits, choices, optimizing impact of treatments.
- Then…the backbone **MUST be effective, longitudinal, personal coaching, teaching, supporting, coordinating relationship.**
- Office visits, procedures, hospitalization become episodes of care only.
Evidence-Based Health System Design

Note: The “Medical Home” is likely not the “primary care” that we currently have.

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The SCF Nuka Model

- Defining the purpose – relationship over time
- Understanding complexity science - principles
- Moving from product to service as the fundamental base of entire system
- Optimized primary care with redefined entire system on that ‘new’ backbone/platform
- Customer driven design – reallocation of power and control at every level
- Optimizing messy human relationships
Some of our Improvements

- **Microsystem Optimization - teams**
  - Primary Care: Physician, RN, Certified Medical Assistant, CM Support, Behaviorist, Dietician, Pharmacist, office redesign
  - Behavioral Health: Physician, Master Level Therapist, Case Manager
  - Human Resources: HR Generalist and Assistants – Same day service, etc.

- **Behavioral Health Consultants**

- **Standardize and spread improvement processes and tools - structural**

- **Massive investment in workforce and improvement capability**
The Integrated Care Team

- PCP – primary care provider-doc, NP/PA
- Nurse Case Manager
- Case Management Support
- Certified Medical Assistants
- Behaviorists
- Dieticians
- Pharmacist (partially implemented)
- Nurse Midwife (partially implemented)
- Coverage NP/PA/CM’s
- Co-located Psych (pending)
- Coders, data entry, etc.
- Front Desk
Traditional Methods of Managing Work Flow

- Preventive Med Intervention
- Chronic Disease Monitoring
- Medication Refill
- New Acute Complaint
- Test Results

Customer Customer Customer Customer Customer

Provider

- Customer
- Customer
- Customer
- Customer
- Customer

Healthcare Support Team
- Case Manager
- Mental Health Provider
- Referral to Specialist after Assessment
- Certified Medical Assistant
- Dietician
- Clinical Pharmacist
Parallel Work Flow Redesign

Medication refill

Chronic disease monitoring

Management of study / test results Info

Undiagnosed or changing new consumer concern

Preventive intervention

In clinic point of care testing

Chronic Disease Compliance Barriers

Acute Mental Health Concern

Healthcare Support Team

Case Manager
Clinical Pharmacist
Provider
Certified Medical Assistant
Dietician
Behavioral Health Consultant

Customer
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Customer
Some Improvement Specifics

- Advanced Access – appointments when the customer wants – same day primary care
- Max Packing
- Service Agreements
- Behavioral Health Redesign
- Hospitalists in Pediatrics and Internal Medicine
- Bring services to them – BH, Dietician, Pharmacist, Midwife
- Data Mall, Improvement Specialists
- Facility Design
Family Wellness Warriors Initiative

Goal: To end Domestic Violence Child Sexual Abuse and Child Neglect in this generation

Objectives:
- Call out the Warriors
- Methods to counter and break the silence
- Restructure systems
- Establish safe adults and environments
- Enhance existing resources and develop collaborations
Core Concepts

- ALL SCF employees
- Understand how we impact others by:
  - Understanding your relational style
  - Understanding how your experiences contribute to how you approach others
- Learn how to articulate your story from the heart
  - Understand the power of empathy and compassion for your self and others
Clinical Mentors

- Partially implemented only – physician, nurse, etc. mentors
- Commitment to full, deep training by outside mentoring systems and experts.
- One mentor for every three clinical staff
The Pathway Home
Dena A Coy
Customer Ownership:

What does it mean?

- Customer Governance
- Customer-owners in senior management and all levels of management
- Interpret into structural designs
- Workforce reflective of community
- Clinical relationship based on dignity, respect and trust
- Support customer’s plan for health
- Evaluate success based on customer perspective and values
Deep listening – 10 ways

- Multiple geographic advisory councils
- Focus Groups
- Comment cards
- Customer Satisfaction surveys
- SCF internet
- Annual Gathering
- Individual in depth interviews
- Elder Council
- Listening Conference
- Governing board
- Staff Interactions
- Service agreements
- Individual complaints
- Relatives and friends of staff
- Customer Service staff
Excludes Newborns and Delivery Moms. Denominator PCP patients includes non-village patients with visit during past two years. Includes LOS >1 day only to adjust for introduction of “Observation Hospitalization”.
PCP Patient Visits to Specialty Clinics per 1000

Visit Count to Specialty Clinic

Anchorage Area Patients
Childhood Immunizations

Native ownership begins

Better

Year
Percent with Immunization

Percent with Immunization

Patients Age 3 to 27 Months
Customer Satisfaction
Workforce Development

- Workforce Development
  - Up front training for CMAs and Admin Support
  - Native professional development
  - Hiring Practices – Same Day, behavioral
  - Orientation and Mentoring intentionally
  - Employee Development Center
  - PAP’s, Job progressions, career ladders
  - Summer and winter interns
- Key – all staff ‘expert’ in improvement
Improvements – Data-Information

- Balanced Scorecards and Dashboards for every department coordinated and connected throughout the organization
- Data walls, Data Mall – unblinded, benchmarked continually updated, eliminates need for registries, more important than Electronic Health Record
- Web based tools: Health information website for customer/owners and employees; committee manager; planning tool; and training center
Taking this further....

- What we do now.....
  - Vision, Mission, KP’s, Principles lead to....
  - Four Corporate Goals lead to...
  - Corporate Initiatives lead to....
  - Division, committee, dept initiatives lead to...
  - Annual plans lead to...
  - Individual Performance Action Plans....’
  - And all lead to ongoing reporting, dashboards, and scorecards....
SCF believes that there are 4 areas in which we need to focus in order to be a top performer organization. This diagram describes those areas and the structures that support these functions.

<table>
<thead>
<tr>
<th>Functional Area</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Operations</td>
<td>Focused on ensuring the effective day to day operations of programs. Includes: HR, Finance, Customer Service, supporting PI, QI and QA, processes and initiatives, and ongoing evaluation of individual and department performance in Ops, PI, QI and QA.</td>
</tr>
<tr>
<td>Quality Assurance</td>
<td>Focused on ensuring compliance with standards. Includes: Regulatory compliance (JCAHO, OSHA, HIPAA, PCOT), Patient Safety and Environment of Care, Maintenance of ongoing evaluation of clinical standards and practice, credentialing and licensure, and risk management.</td>
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<tr>
<td>Quality Improvement</td>
<td>Focused on improving the clinical or educational quality of SCF. Includes: Developing, piloting, deploying, and spreading of targeted clinical or educational systems improvements, and education on best practices.</td>
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<tr>
<td>Performance Improvement</td>
<td>Focused on improving systems and processes to support programs. Includes process and office redesign.</td>
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</tbody>
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Baldrige Categories are identified:
Category 1 - Leadership
Category 2 - Planning
Category 3 - Customer Focus
Category 4 - Knowledge Management
Category 5 - Staff Focus
Category 6 - Process Management
Category 7 - Performance Results
Disparities - Cultural Competency

- Fundamental Flaw
  - System has not changed – inherent values conflict between medical model and people
  - Culture competency is still just a veneer applied to a health system that is based on values that are in fundamental conflict with the cultures in the communities being served.
  - In order to truly be Culturally Competent MUST put culture in the center/core and add services to it – not the other way around
  - This only happens with customer control – macro and microsystem levels
Cultural Competency

- True cultural competency
  - Staff make-up is representative of community – phone, front desk, professionals
  - Leadership are from the community – Board, executives, managers
  - When, where, how, and by whom services are delivered are mostly determined by the individual and family receiving them
  - Self & family care is central but supported
  - Individual and family define goals/success
Words matter

- Patient – full of historical baggage
- Patient compliance, non-compliance, adherence – judgmental, demeaning
- Guilt, Shame, Harassment as usual motivators
- Techno-lingo – medical-ese – all over
- Impersonal labeling – diagnosis, number
- Arbitrary labeling – diagnosis – BP, gluc, chol
- MUST move to asset based, partnering, supporting, respectful words, models, and structures
Nuka Model – System Components

1. Changed Philosophy
2. Expanded ‘Medical Home’ Platform
3. Integrated Care Team Members and Roles
4. Workforce Emphasis
5. FWWI, Core Concepts
6. Use of Data
7. Functional Structure
8. Tools, Methods, Cascade, Planning
9. Deep Listening, Cultural competency
10. Traditional Healing/Complementary Medicine
11. Facility Design
Nuka Model – summary

1. Relationships – trusting personal partnerships
2. Customer Driven – Alaska Native values
3. Same Day Access
4. Max Packing
5. Working at the top of your license in team
6. Service Agreements
7. Job Progressions, Career Ladders, Mentoring
8. Giving Story, Receiving Story
9. Accountable Performance
10. Putting services into culture
11. Asset Based positive approaches
12. Operational Principles
Primary Care MUST change

- Most failed part of the system – is primary care’s fault – quit playing the victim!!
- The entire medical system depends on primary care working well
- Primary care is a set of functions, roles and responsibilities – not a specific medical discipline
- Most Medical Home designs will not transform the system
- Quality, Safety, Cost, Satisfaction, Outcomes – and Health - depend on PC
- Society’s well being also depends on PC
Every patient has a right to...

- Coordinated, integrated, safe, optimized basic health care services
- Individuals who know them who they can rely on to answer questions, advise on care issues, and help navigate the system
- Clear, personalized health plans
- Support in achieving health goals and optimizing medical treatments, including coordinating care across boundaries
- All done building upon values and assets of pt.
Ultimately primary care – and all of healthcare - must...

- Be customer driven and community controlled
- Have the ability to meet the individual where they are – in terms of self care, family care, values, culture, education, literacy level, social complexity.
- Have the ability to identify motivators, values, impediments to change.
- Have the ability to motivate, inspire, inform, organize, listen, partner.
Ultimately primary care…

- Will not be a ‘Medical Home’ – but a set of functions and relationships built optimally into everyday life.
- Will allow for there to be various ways of providing these functions and relationships and they will continually improve and evolve
- Will focus on the household and the whole person – meeting them where they are – values, locations
- Will be learning entities…
Remember...

- THEY ARE in control already – we just have to build around this reality
- We are a service industry across our base, especially in primary care
- We only have hope in team based approaches – or v. small pt. panels (not scalable?)
- Longitudinal relationship only works with unimpeded access – time, place, language, attitude, culture, gender, etc.
- They must define and ‘own’ the goals, success, what is of value – macro and micro
In their words...

- Customer-owner – *they give me what I and my team have defined I need when, where, and how I want and need it...in a safe, effective, and optimized way...*

- Customer-owner – *they really know me and care about me*

- Customer-owner – *they listen to me, advise me, and support me on my entire health journey*

- Customer-owner – *my questions and concerns are answered, my care is coordinated, my values and goals are what drive my health plans*
Thank You!
Quyana (Central Yup'ik)
Maase' (Tanana Athabaskan)
Ana-ba-see (Koyukon Athabaskan)
Quyanaq (Inupiaq)
Gunalché'esh (Tlingit)
Ha'w'aa (Haida)
Qagaasakung (Aleut)

Thank You!