SCF Nuka Model of Care –
Built on a ‘new’ Primary Care
Platform

Changing your practice - what matters most

December 2009

Today’s Goals

- Establish that primary care is a service industry, not a product industry – which changes everything - how you measure success, train, hire, organize, reward, think.
- Share the SCF Nuka model of care as one successful redesigned model.
- Provide definition of key medical home concepts
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 no increases
- 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, Urgent Care
- Dental
- Behavioral Health – clinics, residential treatments, after-care, youth, elders
- Family Wellness Warriors – abuse and neglect treatment and prevention
- Tribal and Traditional Services
- Chiro, massage, acupuncture

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**The SCF Story at ANMC**

- Complete system redesign on Native values
  - Decrease in ER/Urgent Care over 40%
  - Decrease specialty care by over 50%
  - Decrease in primary care visits by 20%
  - Decrease in admissions and days by over 35%

- Improved health outcomes
- Improved patient & staff satisfaction indicators
Primary Care Has Failed

- The doctor’s office medical model of primary care has failed in its role in most locations across the ‘westernized’ world
- The current model most prevalent will continue to fail – wrong philosophy, wrong use of workforce, wrong design
- There are people and places redesigned around different thinking and design!
- Much is known – why not easy change?

Failed Primary Care = Failed System

- Medical care is too big and too complex with way too many services, agencies, and offerings to be left uncoordinated and without a strong navigator/coordinator role
- Doctor-centric Medical Model primary care has failed – need to rethink everything
- Poor ‘primary care’ = ineffective system
- Current model actually does HARM.
Previous Healthcare Fixes - US

- Think like a business – the market – ’80’s
- Managed Care – 80’s, 90’s
- Safety Movement – 90’s – now
- Case Management 2002-2007
- Some rumblings – Self Care, Community
- Have they resulted in fundamental transformation of healthcare?

A Snap Shot of “Transformational” Strategies – Current Version

1. Finance Reform
2. Consumer-Driven Health Care
   - Health Savings Accounts
   - High Deductible Health Plans
   - Personal Health Records
3. Information Technology
   - Electronic Health Records (EHRs)
   - Computerized Physician Order Entry (CPOE)
   - Regional Health Information Organizations (RHIOs)
4. Pay-for-Performance
5. Competition
6. Six Sigma
7. The Medical Home

There is - formal or not, stated or not - theory behind each of these. What is the theory, and is it based in data?
The result of current efforts

- Medical Model – not questioned
- Each piece of healthcare optimizing their financial position – very sophisticated financially and bankrupting society
- Better, faster, safer version of what we have – no fundamental change
- - Berwick Car Analogy -

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.
We have a choice

- Narrow healthcare expenditures back to narrowly defined illnesses caused by infectious agents or fixed by operative cures – and give back 70% of the money
- OR
- Redesign what we are doing to affect that 70% that is neither infectious disease nor easily fixed operatively
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)

What we are Taught – Diagnosis, Medications, Procedures

- Medical Care Process
  - 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
  - Then we are finished until the next visit
- This is what our work is understood to be, the product of healthcare as we learned it and as we still teach it.
Analogy - Hitting the target…

- If you are in a mechanical, manufacturing environment then hitting a target is a matter much like the throwing of 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’
- All of healthcare throws birds at targets and only thinks about the throwing part.

Reality – various ‘platforms’

- 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*
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.**
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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Components of Medical Home

- **Level One: Caring for a defined population or list – new goal**
  - Defined list – patient panel, registered list – and responsibility for the list of patients;
  - Ability to generate disease registries (ideally computerized); ability to track requirements for effective intervention; longitudinal coordinating relationships

- **Level Two: Delivering barrier free team-based care – new structure**
  - Care delivered by a team – not all doctors; all working at the top of their license;
  - Same day access – delays in access will divert to other care locations. Provision for ‘ad hoc’ contacts – e.g. after hours phone access, urgent-care/walk-in visits, email?
  - Mind and Body back together – imbedded behaviorists

- **Level Three: Redefining relationship to specialty care – new relating**
  - Redefinition of role of specialists relative to primary care;
  - Movement of care from just illness care to include secondary prevention (optimal management of already existing health issues).

- **Level Four: Shifting to delivering “health” rather than “disease care”**
  - Effective incorporation of primary prevention, including connectivity to other community resources.
  - Becoming truly customer driven more completely, self-care, family-care

Now IHI has a model to generate real system discussions…

And the possibility of real system transformation…

But it is still not easy at all….
Just Do It… Why not?

- Why not take the best known practices and design a system?
- Why not spread this system everywhere and reap the benefits?
- Why has this not already occurred?

**Why is this so hard?**

Difficulties

- Unquestioning belief in the medical model and professionalism
- Firm basis in science, technology, industrial manufacturing models, body as physical
- Many people making a whole lot of money in current system – as independent pieces
- Current system allows/supports/rewards independence and entrepreneurial thinking – no common purpose, framework, principles
- Very weak workforce and management theory, knowledge, skill in healthcare
So, then, isn’t the answer…

- Standards, Protocols, Best Practices?
- Decision support, information availability?
- Financial systems that pay for the right thing?
- Limiting access to expensive things?
- Single payer, Proven single model of delivery?

The SCF Nuka Model - briefly

- 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 by design of power and control at every level
- Optimizing messy human relationships
Where we used to be…1997

- Comprehensive budget, employed staff
- Weeks to months to get appointments
- Most acute care in ER – with 4-8hr waits
- Little coordination of care in system
- Impersonal treatment by staff often
- Different provider each visit – retelling story over and over
- Sent all over the facility for services

Old System – unhappy patients

- Doctors giving confusing and sometimes contradicting advice
- Lots of medicine
- Sent to different locations all over the hospital for one visit
- Had to retell health history every visit
- Appointments weeks before being seen
- Health is not improving
Doctors & nurses complaints

- Patients don’t follow instructions very well
- Patients don’t seem to pay attention well
- Often want natural or traditional herbal medicines
- Government programs don’t pay enough for the visit and doesn’t pay for the ‘right’ medications.
- No time in the visit to deal with all issues
- Friction between primary care and specialists
- In-hospital care disconnected from office care
- Health status getting worse

SCF VISION
A Native community that enjoys emotional, physical, mental, and spiritual wellness.

SCF MISSION
Working together with the Native community to achieve wellness through health and related services.

SCF KEY POINTS
Shared Responsibility
Commitment to Quality
Family Wellness
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 to get all of their needs addressed
- Access is optimized and waiting times are limited
- Together with the customer/owner as an active partner
- Integration of services throughout all of SCF. No more islands

Operating Principles (cont)

- One seamless system
- No duplication of services or roles and responsibilities
- Simple and easy to use systems and services
- Hub of the system is the family
- Interests of the customer/owner are placed first and the system is created around what works best for the customer/owner
- Population-based systems and services
- Services and systems are culturally appropriate and build on the strengths of Alaska Native cultures.
SCF – thinking differently

- Population based premise
- Intentional rethinking of purpose and design of entire system of care
- Implementation of entire integrated system
- Definition as a service industry
- Refocus of core of system on longitudinal relationships partnering over time.
- Public health, prevention, wellness, and medical care in one system
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 Improvement Processes and Tools**
Re-Assessment of Workflow
Business Demand Estimates

- 3,500-4,000 physical visits per year per FTE
- Process rate limited through physical visits
- 20% Medication refill of controlled diseases
- 20% Ongoing monitoring of chronic diseases

NOTE: Almost 50% encounters had some Behavioral Health component
20% Known preventive medicine interventions i.e. (mams/paps/lipid screen, vaccines)
30% New visits without a diagnosis or plan to date
10% Outside referrals
50% business volume already had known pathways or protocols i.e. (refills/chronic disease management/immunizations)
The Primary Care Team
RN Case Manager—
1. Chronic Disease Manager
2. Preventative Disease Manager

The RN’s work is extraneous to the physical visit:
- Customer-owner education
- Labs/radiology reports
- Medication refills
- Huddles
- Follow up visit requests

Certified Medical Assistant (CMA)—
- Customer-owner check-in (v/s, screenings, procedure and room setup)
- Immunizations/ Venipuncture
- Medication Administration
- Manage Daily Schedule
- Preventative Screenings (depression, smoking etc)
Behavioral Health Consultant (BHC)—
- Consultation and education to providers and case managers on behavioral health issues
- Provide psycho-educational materials and workbooks to aid in treatment and understanding
- Screening, assessment, brief intervention, education and follow-up/monitoring for patients experiencing mental/medical health issues and life stresses
- Joint visits and care conferences with provider teams for complex cases
- Consultation with specialists, referral for longer term therapeutic interventions

Dietician—
- Customer-owners can access a dietician during or after the physical visit in primary care departments (for acute or chronic conditions)
- Consult with provider teams for ongoing customer-owner conditions
- Phone consultations for those customer-owners unable to come in to the clinic
- Support of various programs including Diabetes Wellness Gathering, Diabetes Prevention Program, and Weight Management Program, etc.
Provider—

- Responsible for initial assessment and diagnosis
- Responsible for in clinic visits
- Adjusts treatment plans for known diagnosis where goals are not being met
- Helps set focus for team on priority work areas
- Sets plan for follow-up for known diagnosis where treatment is stable

Alternatives to Medical Model

- Escape the tyranny of the provider based one on one office visit
- Move beyond professional centric planning
- Move away from linear, sequential activity to parallel, circular, multidirectional thinking
- Integrated teams where each person works at the top of their license.
Redefine Work

- Move from episodic, reactive care to long-term relationship
- Move from only one-to-one visits to use of groups, phone, email, fax, home visitors
- Move from doctor-centric to team based approach in relationship
- Move to team based meetings, problem solving

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
- Integration of Social Services
- Integration of Health Education
- Optimization of Access to specialists
Some of our Improvements

- Integration of Complementary Medicine and Traditional Healing
- Clinical Pathways
- Case management and chronic illness management
  - Depression
  - Asthma
  - Chronic Pain
  - Diabetes
  - HIV

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
Performance Management

Planning Linkages
The Corporate Strategic Plan is linked and communicated all the way through the organizations through division, committee, and department annual plans and the annual employee evaluation system.

Career Paths
- Job Progressions
- Career Ladders
SCF On-Boarding
Via Orientation Programs—
- New Hire Orientation (NHO)
- Departmental Orientation (DO)
- New Manager Orientation (NMO)

Core Concepts

Guiding principles each employee should use in every interaction in order to create healthy relationships
Core Concepts

- Work together in relationship to learn and grow
- Encourage understanding
- Listen with an open mind
- Laugh and enjoy humor throughout the day
- Notice the dignity and value of ourselves and others
- Engage others with compassion
- Share our stories and our hearts
- Strive to honor and respect ourselves and others

SCF On-Boarding

Via Training & Development Programs—

- Administrative Support Training Program (ASTP)
- Certified Medical Assistant/Licensed Practical Nurse (CMA/LPN) Training Program
- Dental Assistant Training Program
- Clinical Associate Training Academy (in development)
Departments of Learning (DoL)

125+ courses—
- Accreditation
- Clinical
- Compliance
- Computers & Technology
- Customer Service

DoL Cont’d

125+ courses—
- Human Resources
- Professional & Technical Writing
- Quality Improvement
- Safety
- Wellness
Subject Matter Expert (SME) Model

DC and Employee SME Partnerships—
- Supports SCF as a Learning Organization
- SCF-customization
- Specialty of offerings
- Diversity of instructors
- Reduce contracting cost
- Employees own their own learning
- View learning as a Shared Responsibility

Human Resource Committee

- Functional Committee Structure
- Lead by needs of customers
  - Wellness Committee
  - Workforce Development Work Teams
  - Commissioned Corp Committee
Improvements – Data - Information

- Measurement and Analysis
  - Development of Balanced Scorecards and Dashboards for every department coordinated and connected throughout the organization
  - Data walls, Data Mall
  - Provider Packets and reports monthly
  - Patient Registries
  - Web based tools: Health information website for customer/owners and employees; committee manager; planning tool; and training center

The Journey

- 1995 – we have little or no data to measure our work
- 1999 – we start making large system changes but have no measures in place
  - How do we know the changes we are making are an improvement?
  - We don’t!
Phase 1 of Data Management

- A one page “dashboard” was developed and produced monthly
- Run charts developed and reported monthly

First “Dashboard” Example

Oct07 PCP Patient Activity
Counts by PCP and Clinic

<table>
<thead>
<tr>
<th>PCP last name</th>
<th>FTE</th>
<th>Total Visits</th>
<th>Visits to Clinic</th>
<th>Pct of All Visits</th>
<th>Match Adjusted for PCP Absence</th>
<th>Report Adjusted for PCP Absence</th>
<th>Match Adjusted for FMC Absence</th>
<th>Center and FMC Color FCPC</th>
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</thead>
<tbody>
<tr>
<td>Andre, Kathar</td>
<td>0.9</td>
<td>1,308</td>
<td>227</td>
<td>17.3%</td>
<td>113</td>
<td>123</td>
<td>31</td>
<td>34</td>
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<tr>
<td>Cutting, Summ</td>
<td>0.04</td>
<td>79</td>
<td>22</td>
<td>27.8%</td>
<td>5</td>
<td>28</td>
<td>4</td>
<td>32</td>
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<tr>
<td>Darius, Darius</td>
<td>0.9</td>
<td>1,172</td>
<td>258</td>
<td>21.8%</td>
<td>8</td>
<td>122</td>
<td>51</td>
<td>55</td>
</tr>
<tr>
<td>Jade, FMC</td>
<td>0.9</td>
<td>877</td>
<td>204</td>
<td>23.3%</td>
<td>3</td>
<td>173</td>
<td>108</td>
<td>115</td>
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<tr>
<td>Peach, FMC</td>
<td>0.9</td>
<td>1,122</td>
<td>157</td>
<td>14.0%</td>
<td>5</td>
<td>150</td>
<td>34</td>
<td>42</td>
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<tr>
<td>Red, FMC</td>
<td>0.9</td>
<td>832</td>
<td>160</td>
<td>19.2%</td>
<td>6</td>
<td>122</td>
<td>48</td>
<td>51</td>
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<td>Jack, Hickel</td>
<td>0.8</td>
<td>1,115</td>
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<td>17.2%</td>
<td>6</td>
<td>84</td>
<td>49</td>
<td>50</td>
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<tr>
<td>Brenda, Hinton</td>
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<td>1,058</td>
<td>237</td>
<td>22.4%</td>
<td>6</td>
<td>212</td>
<td>37</td>
<td>37</td>
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<tr>
<td>Linda, Kantor</td>
<td>1.0</td>
<td>1,374</td>
<td>224</td>
<td>16.3%</td>
<td>8</td>
<td>211</td>
<td>35</td>
<td>47</td>
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<tr>
<td>Alb, Laktonen</td>
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<td>1,170</td>
<td>250</td>
<td>21.4%</td>
<td>4</td>
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<td>69</td>
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<tr>
<td>Stev, Tierney</td>
<td>0.1</td>
<td>127</td>
<td>52</td>
<td>40.9%</td>
<td>1</td>
<td>25</td>
<td>9</td>
<td>8</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Center FM</td>
<td></td>
<td>10,212</td>
<td>1,972</td>
<td>19.3%</td>
<td>58</td>
<td>1,221</td>
<td>565</td>
<td>596</td>
</tr>
</tbody>
</table>

Match Adjusted for FCPC Absence: 1,137 | 216 | 518 | 9 | 52 | 3 | 1,935 | 80.9%

Center and FMC Color FCPC: 7,381 | 1,221 | 641 | 15 | 59 | 6 | 2,207 | 78.9%
First Run Chart Example

Phase 2 of Data Management

Provider Panel Packets were developed
- Reported to providers monthly
- Some data was very reliable, some was not
- Lists of health maintenance reminders (i.e. PAP, Mamm, CRC, Immunization, EPSDT)
- DM action list
- Pain action list
- High utilizers
- ER/Fast Track visits
- Demographics of providers panel (i.e. Male, Female, Age, etc.)
Advanced Access - system redesign

Phase 3 of Data Management

We tried to create Composite Scores for our providers but this PDSA did not work

- Too complex
- Provider staff was concerned about the reliability of some of the data
- If providers are going to be held accountable they want to know the data is 100% correct
Phase 4 of Data Management

The Data Mall

- Data is more reliable
- Data is available to all team members – Provider, Case Manager, CMA, BHC, CMS
- Reports are automated, each provider team can pull their data at the time they need it
- Clinical and Operational data is available in the same location
Phase 5 of Data Management

Provider Job Progression
- Providers must meet specific measurement requirements for advancement
  - Some measures are subjective
  - Some measures are objective

Data Mall

Sources of data
- RPMS
- Signature
- Kronos

How does the Data Mall work?
Demonstration of the Data Mall
Roll Out of Data Mall

- The plan for roll-out
- The roadblocks we ran into
- How we taught our Clinical staff to use the Data Mall as a tool to better manage their work

Tab Based Functionality
SCF Balanced Scorecard

SCF Corporate Balanced Scorecard

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Objectives</th>
<th>Measure</th>
<th>Report Period</th>
<th>SCF Score</th>
<th>Below Median</th>
<th>Median</th>
<th>Above Median</th>
<th>3 Year Trend</th>
<th>Analysis &amp; Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer/Owner</td>
<td>Improve Rating of Care (Customer Satisfaction)</td>
<td>FY2008</td>
<td>92</td>
<td>&lt; 75</td>
<td>75</td>
<td>95</td>
<td>YM</td>
<td>&quot;Edith, Alice &amp; G&quot;</td>
<td></td>
</tr>
<tr>
<td>Potential/Financial</td>
<td>Investment Earnings</td>
<td>August 2008</td>
<td>2.52</td>
<td>N/A</td>
<td>N/A</td>
<td>3.7</td>
<td>N/A</td>
<td>&quot;Edith, Alice &amp; G&quot;</td>
<td></td>
</tr>
<tr>
<td>Potential/Financial</td>
<td>Investment Earnings</td>
<td>August 2008</td>
<td>2.52</td>
<td>N/A</td>
<td>N/A</td>
<td>3.45</td>
<td>N/A</td>
<td>&quot;Edith, Alice &amp; G&quot;</td>
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<tr>
<td>Potential/Financial</td>
<td>Net Margin</td>
<td>FY2008-02</td>
<td>-4.2</td>
<td>-5</td>
<td>5</td>
<td>16</td>
<td>N/A</td>
<td>&quot;Edith, Alice &amp; G&quot;</td>
<td></td>
</tr>
</tbody>
</table>

Operational Effectiveness

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Report Period</th>
<th>SCF Score</th>
<th>Below Median</th>
<th>Median</th>
<th>Above Median</th>
<th>3 Year Trend</th>
<th>Analysis &amp; Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Innovations</td>
<td>FY2008</td>
<td>82/100</td>
<td>&lt; 75</td>
<td>&lt; 75</td>
<td>75</td>
<td>&lt; 95</td>
<td>YM</td>
<td>&quot;Edith, Alice &amp; G&quot;</td>
</tr>
<tr>
<td>Breast Cancer Screening Rate</td>
<td>FY2008</td>
<td>52/94</td>
<td>&lt; 45</td>
<td>45</td>
<td>&gt; 90</td>
<td>90</td>
<td>&quot;Edith, Alice &amp; G&quot;</td>
<td></td>
</tr>
<tr>
<td>Cervical Cancer Screening Rate</td>
<td>FY2008</td>
<td>75/94</td>
<td>&lt; 66</td>
<td>66</td>
<td>&gt; 95</td>
<td>95</td>
<td>&quot;Edith, Alice &amp; G&quot;</td>
<td></td>
</tr>
<tr>
<td>Blood Pressure 1st Measurement</td>
<td>FY2006</td>
<td>35/180</td>
<td>&lt; 180</td>
<td>180</td>
<td>&gt; 35</td>
<td>35</td>
<td>&quot;Edith, Alice &amp; G&quot;</td>
<td></td>
</tr>
<tr>
<td>Diabetic (Hemoglobin A1C &lt; 8.0%)</td>
<td>FY2008</td>
<td>60/99</td>
<td>&lt; 80</td>
<td>80</td>
<td>&gt; 60</td>
<td>60</td>
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<td></td>
</tr>
<tr>
<td>Diabetic (Hemoglobin A1C &lt; 8.0%)</td>
<td>FY2008</td>
<td>57/94</td>
<td>&lt; 75</td>
<td>75</td>
<td>&gt; 57</td>
<td>57</td>
<td>&quot;Edith, Alice &amp; G&quot;</td>
<td></td>
</tr>
<tr>
<td>Diabetic HbA1c in poor control (lower is better)</td>
<td>FY2008</td>
<td>25/22</td>
<td>&lt; 46</td>
<td>46</td>
<td>&gt; 25</td>
<td>25</td>
<td>&quot;Edith, Alice &amp; G&quot;</td>
<td></td>
</tr>
</tbody>
</table>

Work Plan Alignment with Corporate Objectives

<table>
<thead>
<tr>
<th>Code</th>
<th>Name</th>
<th>Description</th>
<th>Measurement</th>
<th>Measurement</th>
<th>Resp Person</th>
<th>Resp Person</th>
<th>Resp Person</th>
<th>Resp Person</th>
<th>Functional Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>OR1-2-01</td>
<td>Data Rti Processes</td>
<td>Improve organization performance through standardized data management process, procedures and reporting</td>
<td>% of Data Rti Processes with standard procedures in place</td>
<td>To be Determined</td>
<td>Mike Mintz</td>
<td>Mike Mintz</td>
<td>Mike Mintz</td>
<td>Mike Mintz</td>
<td>Strategy Development &amp; Planning</td>
</tr>
<tr>
<td>OR1-2-02</td>
<td>Data Rti Processes</td>
<td>Ensure data management processes and data quality are consistent with our business partners</td>
<td>Data Management Process and Data Quality Consistency with Business Partners</td>
<td>To be Determined</td>
<td>Mike Mintz</td>
<td>Mike Mintz</td>
<td>Mike Mintz</td>
<td>Mike Mintz</td>
<td>Strategy Development &amp; Planning</td>
</tr>
<tr>
<td>OR1-2-03</td>
<td>Data Rti Processes</td>
<td>Ensure data management processes and data quality are consistent with our business partners</td>
<td>Data Management Process and Data Quality Consistency with Business Partners</td>
<td>To be Determined</td>
<td>Mike Mintz</td>
<td>Mike Mintz</td>
<td>Mike Mintz</td>
<td>Mike Mintz</td>
<td>Strategy Development &amp; Planning</td>
</tr>
<tr>
<td>OR1-2-04</td>
<td>Data Rti Processes</td>
<td>Ensure data management processes and data quality are consistent with our business partners</td>
<td>Data Management Process and Data Quality Consistency with Business Partners</td>
<td>To be Determined</td>
<td>Mike Mintz</td>
<td>Mike Mintz</td>
<td>Mike Mintz</td>
<td>Mike Mintz</td>
<td>Strategy Development &amp; Planning</td>
</tr>
</tbody>
</table>
Segmentation of Data
Southcentral Foundation HEDIS Diabetes Eye Exam Scores
HEDIS Scores for the Period Ending 5/30/2000

2000 HEDIS Medicaid Percentiles: 50th %: 53.20 75th %: 62.16 90th %: 67.07

<table>
<thead>
<tr>
<th>Organization</th>
<th>Clinic</th>
<th>Team</th>
<th>Provider</th>
<th>Numerator</th>
<th>Denominator</th>
<th>% Screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Medicine</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comparison Charts to Identify Best Practices
Corporate Data Segmented by Age Groups

SCF Patient BMI Prevalence - Adults over 20

<table>
<thead>
<tr>
<th>Age Group 21 – 35</th>
<th>BMI Status</th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 - 35</td>
<td>Underweight</td>
<td>72</td>
<td>0.99%</td>
</tr>
<tr>
<td></td>
<td>Healthy</td>
<td>1740</td>
<td>23.96%</td>
</tr>
<tr>
<td></td>
<td>Overweight</td>
<td>2175</td>
<td>29.99%</td>
</tr>
<tr>
<td></td>
<td>Obese</td>
<td>3274</td>
<td>45.04%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>7581</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Group 36 – 50</th>
<th>BMI Status</th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>36 - 50</td>
<td>Underweight</td>
<td>65</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Healthy</td>
<td>2447</td>
<td>19.23%</td>
</tr>
<tr>
<td></td>
<td>Overweight</td>
<td>2039</td>
<td>31.49%</td>
</tr>
<tr>
<td></td>
<td>Obese</td>
<td>5624</td>
<td>48.48%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>6475</td>
<td></td>
</tr>
</tbody>
</table>

Provider Data Segmented by Age Group

BMI Summaries by Age Group

Totals for Age Group 21 – 35

<table>
<thead>
<tr>
<th>Age Group</th>
<th>BMI Status</th>
<th>Total</th>
<th>% of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 – 35</td>
<td>Underweight</td>
<td>3</td>
<td>145.6</td>
</tr>
<tr>
<td></td>
<td>Healthy</td>
<td>45</td>
<td>2384.5</td>
</tr>
<tr>
<td></td>
<td>Overweight</td>
<td>67</td>
<td>352.4</td>
</tr>
<tr>
<td></td>
<td>Obese</td>
<td>91</td>
<td>4137.5</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>206</td>
<td></td>
</tr>
</tbody>
</table>
## Condition Centered Action List

### Diabetes Action List

**Links to Documentation:** Report Methodology  
**Data Resolution/Error Correction Process:**

**Diabetic Patient Status as of Week Ending: 3/13/2009**

<table>
<thead>
<tr>
<th>HICN</th>
<th>Patient</th>
<th>Non-Smoking</th>
<th>Cigarette Use</th>
<th>Response Received</th>
<th>Age</th>
<th>HbA1c Result</th>
<th>HbA1c Date</th>
<th>Most Recent Date</th>
<th>LDL Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>73046</td>
<td>John Doe</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>58</td>
<td>6.7</td>
<td>2009/01/13</td>
<td>2009/01/13</td>
<td></td>
</tr>
<tr>
<td>43218</td>
<td>Jane Smith</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>62</td>
<td>6.5</td>
<td>2009/02/01</td>
<td>2009/02/01</td>
<td></td>
</tr>
<tr>
<td>52346</td>
<td>Paul Jensen</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>60</td>
<td>6.3</td>
<td>2009/03/01</td>
<td>2009/03/01</td>
<td></td>
</tr>
</tbody>
</table>

**Fictitious Patient Info**

- **Key, Patricia A**
  - Total Diabetic Patients: 47
  - HICN: 73046
  - Patient: John Doe
  - Non-Smoking: No
  - Cigarette Use: Yes
  - Response Received: Yes
  - Age: 58
  - HbA1c Result: 6.7
  - HbA1c Date: 2009/01/13
  - Most Recent Date: 2009/01/13
  - LDL Date: 2009/01/13

---

### Evidence

**Antipsychotic Metric for Glucose/HbA1C and HDL Ratio**

**Report Current as of: 10/15/2009**

<table>
<thead>
<tr>
<th>Glucose/HbA1C Count</th>
<th>HDL Count</th>
<th>% Screened for Glucose or HbA1C</th>
<th>% of Patients with HDL Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>100</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Percent of Patients Who Are Antipsychotic Medications**

- **Glucose/HbA1C**
  - Percentage: 90%
  - Patients with HDL Ratio: 90%

- **HDL**
  - Percentage: 90%
  - Patients with Glucose/HbA1C: 90%
High Utilizer Reports

Analyzing Costs

Pharmacy Avg Cost Per Patient Per Month Comparison Chart Over Last 12 Months
Access to Care

Percent Available at 08:00
Weekly Average, High and Low Percent Available for Pediatrics

Provider Availability

Total Minutes of Open and Blocked Appointments for: ROBINSON, JEAN L
As of 10/16/2009

Advanced Access - system redesign
Customer Satisfaction

Customer Satisfaction Specifics

Overall Score: 84.61

There was good teamwork among [PH] staff who cared for me: 79.17% (18 Responses)

My questions were answered in a way I could understand: 83.33% (18 Responses)

My culture and traditions were considered: 86.84% (18 Responses)

I did not have to wait too long to be seen for my scheduled appointment: 82.35% (17 Responses)
Workload

Visit Totals Grouped by Month

Clinic Visit Details by Calendar Year and Month

<table>
<thead>
<tr>
<th>Visit Year-Month Total</th>
<th>AUD</th>
<th>Comp</th>
<th>ENT</th>
<th>DM</th>
<th>ED</th>
<th>ENT</th>
<th>ER</th>
<th>PNC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1Q 2006 TOTAL</td>
<td>393</td>
<td>1318</td>
<td>7</td>
<td>40</td>
<td>757</td>
<td>9885</td>
<td>5543</td>
<td>61033</td>
</tr>
<tr>
<td>2Q 2006 TOTAL</td>
<td>267</td>
<td>1318</td>
<td>5</td>
<td>347</td>
<td>1286</td>
<td>9608</td>
<td>8979</td>
<td>19222</td>
</tr>
<tr>
<td>3Q 2006 TOTAL</td>
<td>314</td>
<td>1342</td>
<td>3</td>
<td>137</td>
<td>1540</td>
<td>8302</td>
<td>8098</td>
<td>13000</td>
</tr>
<tr>
<td>4Q 2006 TOTAL</td>
<td>323</td>
<td>1373</td>
<td>5</td>
<td>866</td>
<td>4621</td>
<td>7269</td>
<td>8136</td>
<td>9999</td>
</tr>
</tbody>
</table>

Quality Assurance Categories Metric

<table>
<thead>
<tr>
<th>Category</th>
<th>% Yes</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment of Care</td>
<td>20.1</td>
<td>102</td>
</tr>
<tr>
<td>Improving Organizational Performance</td>
<td>65.0</td>
<td>102</td>
</tr>
<tr>
<td>Infection Control</td>
<td>97.4</td>
<td>70</td>
</tr>
<tr>
<td>Management of Human Resources</td>
<td>71.4</td>
<td>105</td>
</tr>
<tr>
<td>Management of Education</td>
<td>30.0</td>
<td>52</td>
</tr>
<tr>
<td>Medication Management</td>
<td>64.0</td>
<td>103</td>
</tr>
<tr>
<td>National Patient Safety Goals</td>
<td>96.5</td>
<td>178</td>
</tr>
<tr>
<td>Patient-Centered Care and Services</td>
<td>77.6</td>
<td>537</td>
</tr>
</tbody>
</table>

QA Tracors from 1/1/2008 to 4/30/2008

Advanced Access - system redesign
Quality Assurance Category Questions Metric

<table>
<thead>
<tr>
<th>Category</th>
<th>#</th>
<th>Question</th>
<th>% Yes</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Patient Safety Goals</td>
<td>1</td>
<td>How do you identify a patient when providing care, treatment, or services?</td>
<td>61.0</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>What is your process for reviewing verbal orders or difficult results?</td>
<td>58.0</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>If you receive critical test results, and see that errors were introduced, do you know when they were introduced?</td>
<td>75.0</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Do you have a list of Do Not Use abbreviations and where it is located?</td>
<td>92.9</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Do you have a process to handle &quot;hand-off&quot; communication?</td>
<td>98.5</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>How does your program reconcile medications throughout the continuum of care?</td>
<td>98.1</td>
<td>42</td>
</tr>
<tr>
<td>Provision of Care, Treatment and Services</td>
<td>7</td>
<td>Did an assessment of hearing needs occur?</td>
<td>75.6</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Was the customer screened for suicide risk?</td>
<td>88.0</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Was a physical health assessment performed within specified time frames (24 hours after admission to inpatient or crisis stabilization within one week after admission to residential program)</td>
<td>98.0</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Was a psychological assessment completed as specified by the program/department?</td>
<td>94.9</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>Was the psychosocial assessment completed within time frame specified by the organization?</td>
<td>96.0</td>
<td>24</td>
</tr>
</tbody>
</table>

Keys to Success

- Centralization of Data (Data Marts)
- Highly Trained Analyst
- Communication between IT/IM/Clinical/Business
- Passive vs. Active Data Entry
- Easy to Use, Cost Effective, Secure Tools
- Tying Data Collection and Analysis to Strategic Objectives and Process Improvement
Next Steps

- Electronic Health Record
- Further development of the Data Mall including balanced scorecard and balanced dashboard

Listening to the Customer–10 ways

- Pt driven rather than Pt Centered
- Examples of really listening
  - Tribal Advisory Groups – VSMT, Nilavena
  - Elders Council
  - Diabetes, H. Ed, Head Start Advisory
  - Traditional Healing Elder’s Council
  - Customer Service Reps
  - Surveys, focus groups, public forums
  - Board, staff, friends, family
  - Industry standard written surveys
Operational Principles Scoring

Applying the Operational Principles to System Design Ideas

Instructions: Read each of the situations your group is assigned and complete the following table for each individually. Follow up with group discussion of each issue.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Alignment Score</th>
<th>This issue Supports the following Operational Principles (Check the box for all that apply)</th>
<th>This issue Opposes (as a leader to the following Operational Principles (Check the box for all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Alignment</td>
<td>1-3</td>
<td>Relationships... Emphasis... Locations... Access... Together... Integration... One seamless... No duplication... Simple...</td>
<td>Relationships... Emphasis... Locations... Access... Together... Integration... One seamless... No duplication... Simple...</td>
</tr>
<tr>
<td>High Alignment</td>
<td>9-10</td>
<td>Relationships... Emphasis... Locations... Access... Together... Integration... One seamless... No duplication... Simple...</td>
<td>Relationships... Emphasis... Locations... Access... Together... Integration... One seamless... No duplication... Simple...</td>
</tr>
</tbody>
</table>

Improvement Model:

From *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* by
Langley, Nolan K., Nolan T., Norman, and Provost
Continuous Improvement

Situation as it is

Tests of Change

Situation as it Should Be

Improvement

From The Improvement Guide: A Practical Approach to Enhancing Organizational Performance, by Langly, Nolan K., Nolan T., Norman, and Provost

Planning and Improvement Linkages

Planning and Improvement Linkages

August 2009

Operational Measures that monitor the day to day operations. These measures inform where improvement may be targeted. If the operational plan is used in generating core ideas, then specific measures can be used to gauge the organization's improvement efforts in relation to Baldrige Criteria.

Operational Principles

Measurement Tools Template

Change Concepts

Survey Workbook

Employee Performance Action Plan

Financial Measures Template

Double Line Box = Part of Annual Planning Tool

Blue = Improvement Tools

Green = Core foundation

Orange = Work Plans/Action Items

Rose = Employee Evaluation

Grey = Other Useful Tools

Intranet = used to communicate corporate initiatives

PDCA = Plan, Do, Check, Act (iteration)

PA = Continuous improvement

Rapid Cycle = Changes may be tested in Rapid Cycle

Rapid Cycle with input from employees/customers

Up to one cycle per quarter - changes may be tested in Rapid Cycle

PDSA = Plan, Do, Study, Act

PDSA = Plan, Do, Study, Act

BSC/DB Definitions

BSC/DB Definitions

Decision Tree

Data and Information drives all aspects of the Improvement Process and is part of all tools. Data are reviewed from five perspectives: Financial/Resource, Organizational Effectiveness, Customer, & Information (including National Research Corporation Customer Satisfaction, National Association of Public Health, BSC/DB, Media and Telecommunications, and the World Wide Web).

Advanced Access - system redesign
SCF believes that there are 4 areas in which we need to focus in order to be a high performing organization. This diagram describes those areas and the structures that support these functions. The corresponding Baldrige Criteria categories are referenced in ( ).

**Functional Structure: “Four Ovals”**

1. **Operations**
   - Operations Committee (4,5,6,7)
   - Facilities & Space Committee (6)
   - Policy & Procedure Committee
   - Quality Assurance Committee (3)

2. **Quality Assurance**
   - Accreditation Readiness Committees
   - Compliance Committee
   - Medical Control Committee

3. **Process Improvement**
   - Process Improvement Committee (2,6)
   - Data Analysis & Tracking Committees (4,7)

4. **Quality Improvement**
   - Research Oversight Committee (6,7)
   - Primary Care Business Group
   - Dental Care Business Group
   - Behavioral Health Care Business Group

5. **Dental Care Business Group**

6. **Behavioral Health Care Business Group**

7. **Primary Care Business Group**

8. **Dental Care Business Group**

Color Blue Denotes Committee Reports to VP Leadership Committee

**Baldrige Criteria Categories Referenced**

- Quality Assurance (1,2,7)
- Operations (4,5,6,7)
- Facilities and Space (6)
- Policy and Procedure (3)
- Quality Assurance (4,6,7)
- Accreditation Readiness (3)
- Compliance (7)
- Medical Control (7)
- Process Improvement (2,6)
- Data Analysis & Tracking (4,7)
- Research Oversight (6,7)
- Primary Care Business Group
- Dental Care Business Group
- Behavioral Health Care Business Group

**Rev. 05/08/07**
SCF Improvement Toolkit

- All tools are located on the SCF intranet
- Many of the tools have training classes at the Development Center
- Tools include:
  - Improvement Team Charters
  - Committee Charters
  - PDSA
  - *The Improvement Guide: Change Concepts*
  - Baldrige Using ADLI
  - Automated Annual Planning Tool
  - Measurement Rules template
  - Scorecard & Dashboard

Improvement Tools
(Under Construction)

- Lessons Learned – a web-based tool to track and documents learning from various conferences and training
- Committee Member Toolkit
Annual Planning Tool
Demonstration

Committee Manager
Demonstration
Improvement Examples

- Behavioral Based Interviews
- BHC Integration into Primary Care
- Dietitian Integration into Primary Care
- Automated Annual Planning Tool
- Department Improvement Process
- Data Mall

Employee Expectations

- Employee’s role in Quality Improvement
  - Use improvement tools in your daily work
  - Understand what measures are collected in your department and how they affect your job (and how you influence the measures!)
  - Participate in department improvement teams
  - Provide constructive feedback to others in order to improve
  - Complete online IHI Improvement Training
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….

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.
A robust medical home looks like…

- Customer-owner – they give me what I and my team have defined I need when, where, and how I want and need it.
- Customer-owner – they really know me and care about me
- Customer-owner – they listen to me, advise me, and support me on my health journey
- Customer-owner – my questions and concerns are answered, my care is coordinated, my values and goals are what drive my health plans

Side issue…

Disparities - Cultural Competency

- Fundamental Flaw
  - System has not changed – inherent values conflicts
  - 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
Cultural Competency

- Characteristics of 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
  - Individual and family define goals/success

Words matter

- Patient – full of historical baggage
- Patient compliance, non-compliance, adherence – judgmental, demeaning
- Guilt, Shame, Harassment as motivators
- Techno-lingo – medical-ese
- Impersonal labeling – diagnosis, number
- Arbitrary labeling – diagnosis – BP, gluc
Southcentral Foundation

Advanced Access - system redesign

- Visits per 1,000 PCP Patients
  - ER Patients

- PCP Patient Cohort Visits to Specialty Clinics
  - Cohort: patients empaneled since January 2000
  - Current Cohort Count: 11,229
PCP Asthma Patient Hospitalizations

Rate for Patients Age <18

Hospitalization Rate

# of Hospitalizations among Asthma Pts divided by All Asthma Pts (thus # hospitalizations per person)

Asthma patients are identified by having both an asthma diagnosis and asthma Rx during a given period.

Ryan White Program Hospitalizations

Patients Admitted to Hospital
Finishing up...learning in story

- At SCF we are an Alaska Native organization and talking story, learning in story, and connecting in story is fundamental to how we teach and learn.
- Let’s look at the story of two individual stories given to us by the IHI Triple Aim, Frank and Darryl, who are very common in all health systems…

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.

So how is Frank…

His life now..
Frank’s life now

- Frank attend elder’s lunches, plays bingo, and teases his elder worker/visitor
- Frank gets his meds in a Mediset and can describe what each are for
- Frank understands his symptoms, his weight changes, etc. and knows what to do and when to call
- Frank knows his doctor and other providers by name

Frank’s Life Now

- Frank has an end of life plan and has even planned is own memorial service
- Frank has a health plan stating his wants and wishes even when not critically ill – and laying out the way forward
- Frank knows he can get answers for questions he has today
- Frank has not called 911 in nine months and has had only one admission during that time.
Frank

- Frank has a health system where his control is recognized, encouraged, facilitated and supported.
- The healthcare system builds on what is important to Frank.
- He has personalized access designed to meet his needs and wants

Frank’s Report

- They give me what I and my team have defined I need when, where, and how I want and need it.
- They really know me and care about me
- They listen to me, advise me, and support me on my health journey
- My questions and concerns are answered, my care is coordinated, my values and goals are what drive my health plans
Primary Care Redesigned

- Rethinking purpose, workforce, system design, use of data, reward and recognition, technology, setting – everything
- Understanding that control already lies in the hands of the patient and family
- Understanding setting in community, culture, values
- Understanding responsibility to community and consequences of actions and expenditures

Characteristics of a Medical Home

- **Level One: Caring for a defined population-list – new goal**
  - Defined list – patient panel, registered list – and responsibility for the list of patients;
  - Ability to generate disease registries (ideally computerized); ability to track requirements for effective intervention; longitudinal coordinating relationship

- **Level Two: Barrier free team-based care – new structure**
  - Care delivered by a team – not all doctors; all working at the top of their license;
  - Same day access – delays in access will divert to other care locations. Provision for ‘ad hoc’ contacts – e.g. after hours phone access, urgent-care/walk-in visits, email?
  - Mind and Body back together – imbedded behaviorists

- **Level Three: Relationship to specialty care – new relating**
  - Redefinition of role of specialists relative to primary care;
  - Movement of care from just illness care to include secondary prevention (optimal management of already existing health issues).

- **Level Four: Delivering “health” rather than “disease care”**
  - Effective incorporation of primary prevention, including connectivity to other community resources.
  - Becoming truly customer driven more completely, self-care, family health.
Workforce: Nuka Skill Development

Three Areas of Competency for All:

1. **Connecting Deeply in Story - Relationship**
   1. Nuka Core Concepts (Senge S.O.L)

2. **Technical Improvement Skills - Improvement**
   1. Nuka – basic analysis, problem solving, data – PDSA, run charts, control charts, ADLI, dashboard
   2. (Brent James ATS training, IHI Imp. Advisor)

3. **Alignment, Big Picture, Context**
   1. Nuka – 4 Ovals, Operational Principles, Scorecard, Annual plan, PAP’s, cascade of functions.
   2. (Baldrige Understanding and application)

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Workforce: Nuka Team Skills

- Meeting to design, improve, review and learn – all done in integrated teams
- Job Progressions, Career Ladders
- Formal Mentorship with curricula, goals, measures, forms, advancement defined
- Network of Directors, Improvement Advisors, Improvement Specialists, Program Coordinators
- Work at top of your license
What is the Big Deal about Southcentral Foundation’s Nuka Model of Care?

Katherine Gottlieb
President/CEO

Why is it important to tell our story?

Why is it important that Alaska Native people know it is “our” story?
Child Abuse and Neglect

- Every year, approx. 8,000 children in Alaska are physically or sexually abused. This only represents reported cases that result in substantiation or indication of abuse. Numbers of unreported cases may be much higher.
- Alaska has 6 times the national average of reported child sexual assault.
- National statistics report that 1 in 4 girls and 1 in 6 boys will be a victim of sexual violence before the age of 18.

Sexual Assault

- Since 1993, Alaska has ranked 1st in the nation: highest per capita incidence of rape.
- Alaska’s rape rate is 2.2 times the national average overall.
- APD reported 297 sexual assaults in 2005.
- According to the Municipality of Anchorage, Alaska Native women comprise approximately 3.5% of Anchorage’s population, but report almost 50% of the sexual assaults.
Issues in Family Wellness

- Alaska Native people account for 19% of the statewide population but account for 44% of the suicide hospitalizations. An even greater disparity exists with the 0-19 age group where 55% of the cases were Alaska Native people. The average age of the patients was 30 years.
- According to a report prepared by the UAA Justice Center, while Native Youth account for 8.3% of all 10-17 year olds in Anchorage, they make up 18.7% of all referrals to the Juvenile Justice System.

VERSUS
Alaska Health Issues

- Alaska Native people completely redesigned the health care system in accordance with Native values, creating same-day access to care.
- The results show a decrease in ER/Urgent Care over 40%, a decrease in specialty care by about 50%, a decrease in primary care visits by 20%, and a decrease in admissions and days by 30%.

Improved Health Outcomes

- Alaska Native people have experienced a c-section rate of 11.5% (1/3rd national average).
- Alaska Native people have a childhood immunization rate of 93%.
- Alaska Native people’s management of diabetes is better (with 50% of HbA1c below 7%).
Customer and Staff Satisfaction

- In the Alaska Native health care system, operated and managed by Alaska Native people, the employee turnover rate is less than 12%.
- The customer satisfaction rate overall has averaged 91% for several years.

Training Our Own

- 100% of the Governing Boards of Southcentral Foundation are Alaska Native people.
- 62% of the Southcentral Foundation managers are now Alaska Native/American Indian people.
We Have a VOICE

- Personal interaction with staff
- Group visits
- Comment cards
- Customer satisfaction surveys
- SCF Internet
- Annual Gathering
- 24-hour hotline
- Listening Conference
- Governing board
- Advisory committees
- Focus groups
- Service agreements

The Alaska Native People

- We assume the responsibility of our own health care.
- We take the risk and responsibility.
- We do it across the entire state, the only state in the Nation to do this.
- We ask each other if we like the way health care is being delivered right now?
- We ask each other what we want changed?
- We continue talking to one another.
- We changed and redesigned the way we want our services provided.
The Alaska Native People

- We are recognized as Customers. Customers own something – they are served – they are given respect.
- We hire people to work in our system that either get this or are trainable to get it.
- We spend a lot of money to train new hires about how we provide services.
- We evaluate and monitor how employees are doing with this.
- We continue to create new ways of improvement.

Core Concepts

- ALL SCF employees
- Objectives:
  - 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
WE have groups coming to Learn From Us while we learn from them

- Indian Health Service
- Hawaii
- Canada
- Russia
- CareOregon
- New Zealand
- Kaiser Permanente
- Institute for Healthcare Improvement
- Choctaw Nation
- Seminole Indians
- Seattle Indian Health Board
- Europe

Primary Care MUST change

- 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
Ultimately primary care must…

- 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 be learning entities…
Remember…

- THEY ARE in control
- We are a service industry in primary care
- We only have hope in team based approaches – or v. small pt. panels
- 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

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!