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

Changing your practice - what matters most

December 2009

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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

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- 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.

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- 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

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
- Now – Six Sigma, TPS, flow, reliability, spread, bundling, P4P, E.H.R
- Have they resulted in fundamental transformation of healthcare?

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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?

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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 <u>what we have</u> – no fundamental change
- - *Berwick Car Analogy* -

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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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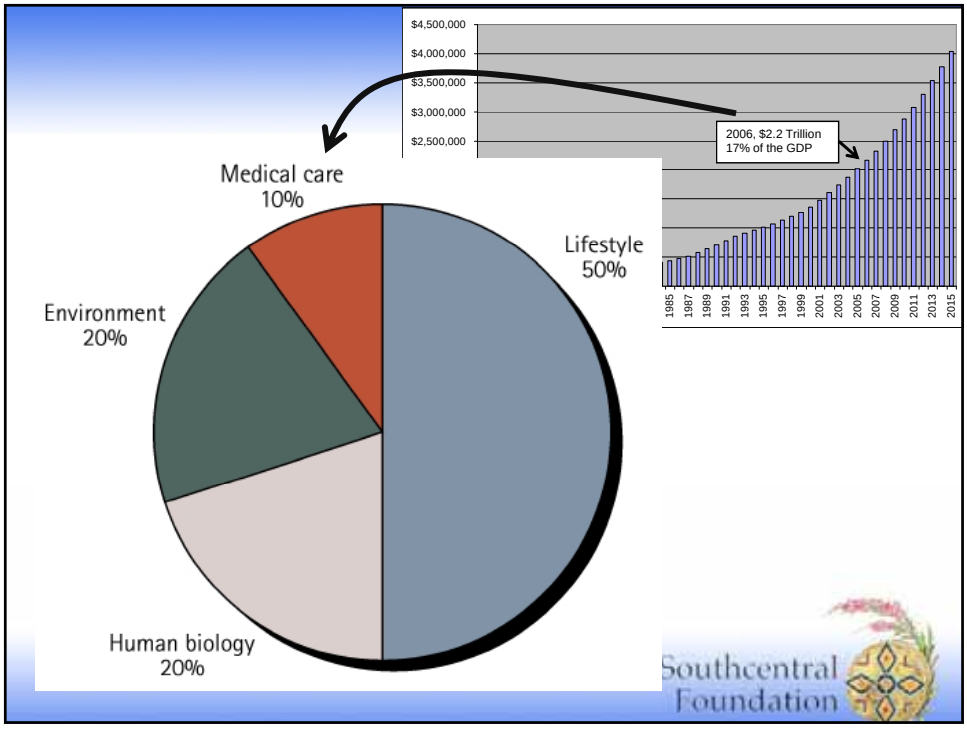

We have a choice

- 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

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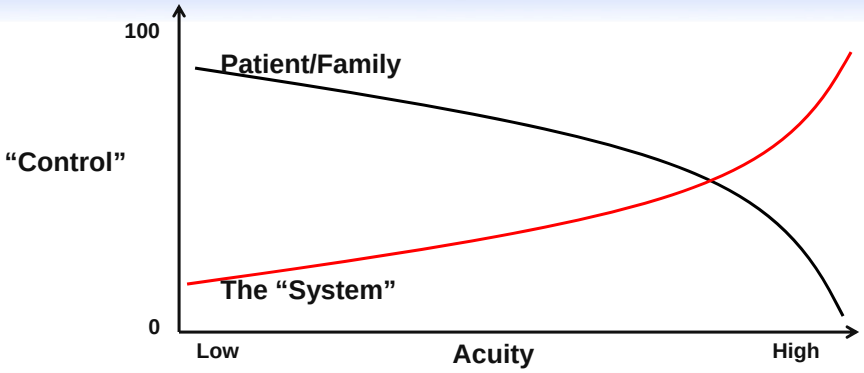
Control: Who really makes the decisions



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)**

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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.

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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…

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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***

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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.

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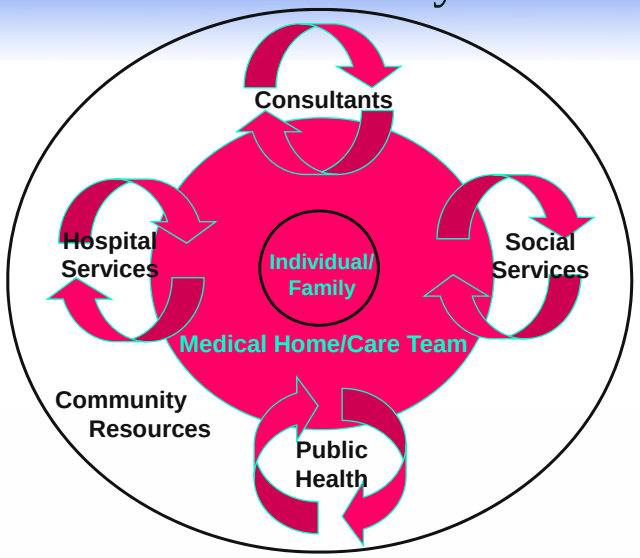
Evidence-Based Health System Design



Note: The "Medical Home" is likely not the "primary care" that we currently have.
© The Trust for Healthcare Excellence's Better Health Initiative

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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-inn 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

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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….

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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?***

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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

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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

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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

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SCF Operating Principles

- **R**elationships between the customer/owner, the family, and provider must be fostered and supported
- **E**mphasis on wellness of the whole person, family, and community including; physical mental, emotional, and spiritual wellness
- **L**ocations that are convenient for the customer/owner and create minimal stops for the customer/owner to get all of their needs addressed
- **A**ccess is optimized and waiting times are limited
- **T**ogether with the customer/owner as an active partner
- **I**ntegration of services throughout all of SCF. No more islands

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Operating Principles (cont)

- **O**ne seamless system
- **N**o duplication of services or roles and responsibilities
- **S**imple and easy to use systems and services
- **H**ub of the system is the family
- **I**nterests of the customer/owner are placed first and the system is created around what works best for the customer/owner
- **P**opulation-based systems and services
- **S**ervices and systems are culturally appropriate and build on the strengths of Alaska Native cultures.

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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

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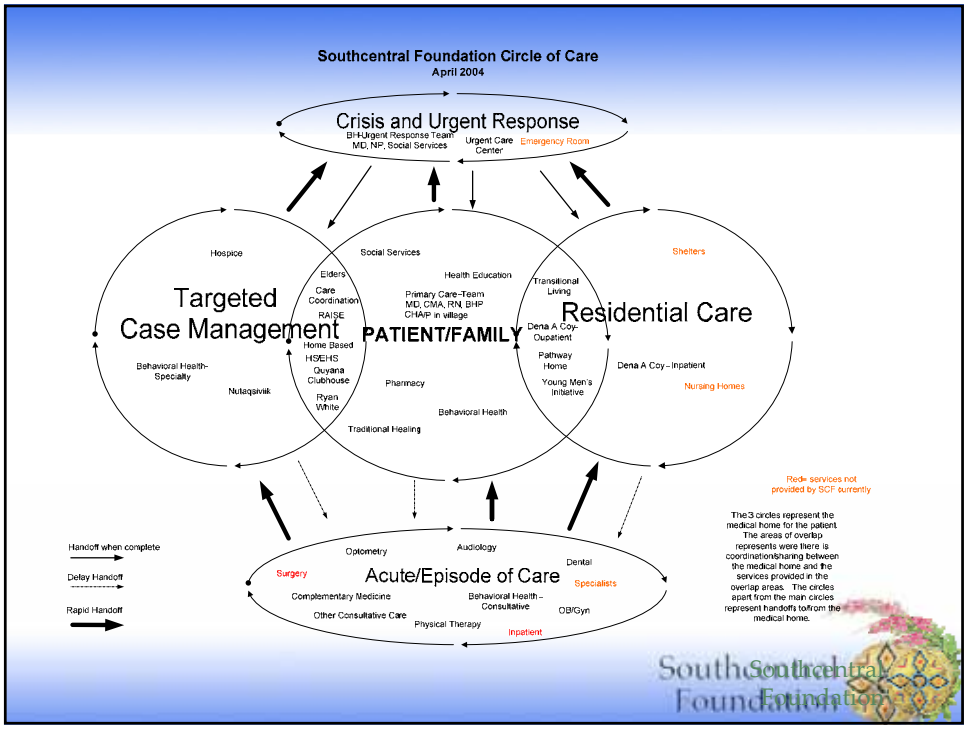

Some of our Improvements

- 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

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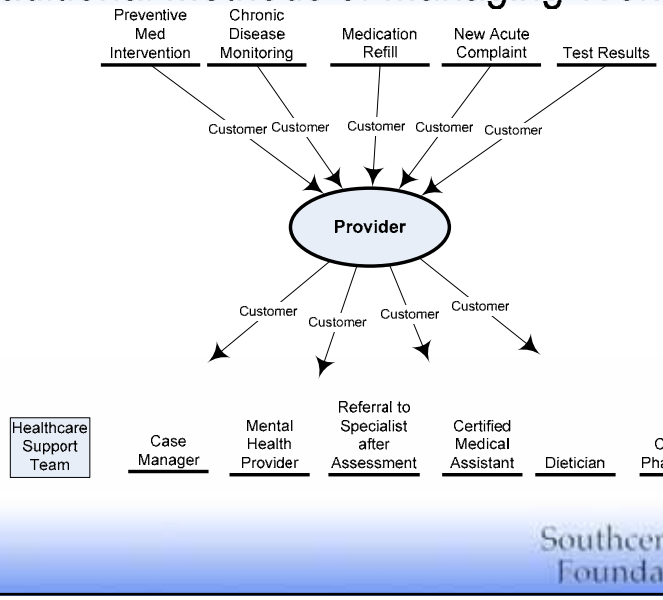
Traditional Methods of Managing Work Flow



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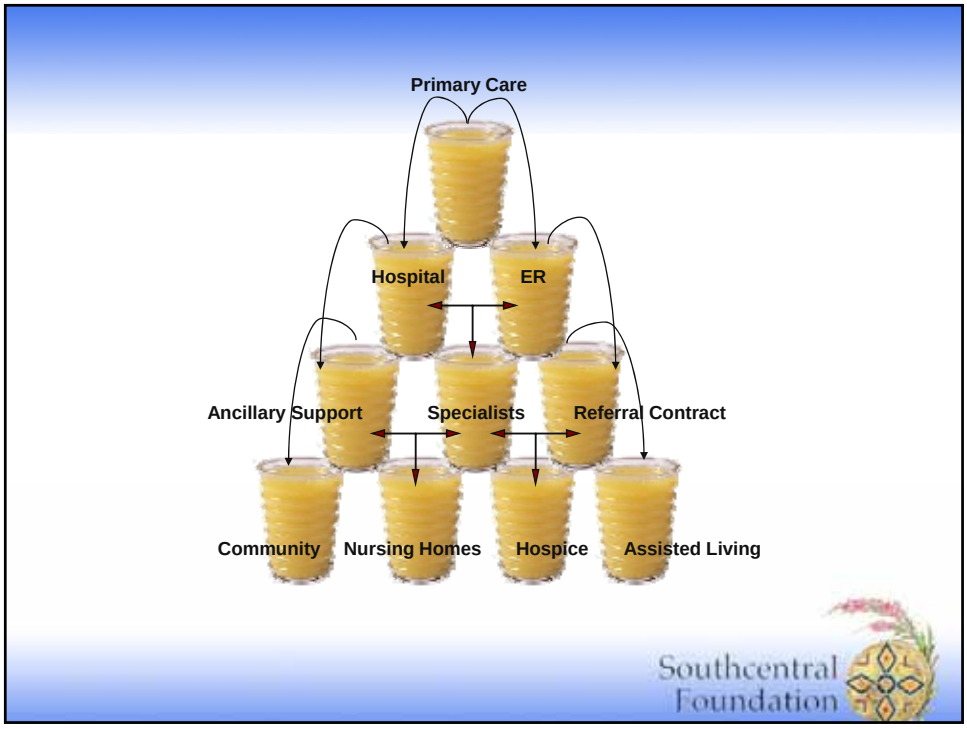

Re-Assessment of Workflow Business Demand Estimates

- 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

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- 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 ie. (refills/chronic disease management /immunizations)

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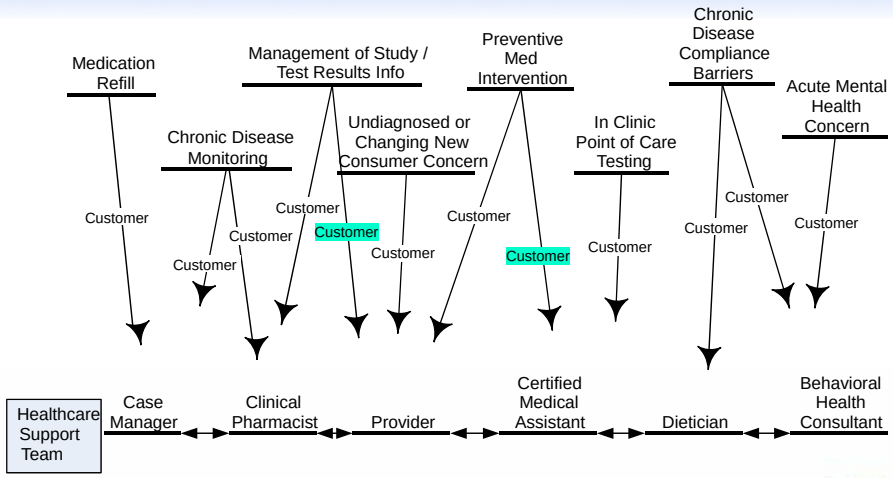
Parallel Work Flow Redesign



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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

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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)

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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

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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.

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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

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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.

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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

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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

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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

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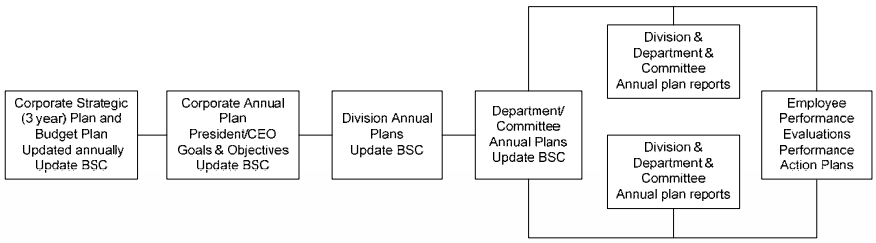
Performance Management

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.



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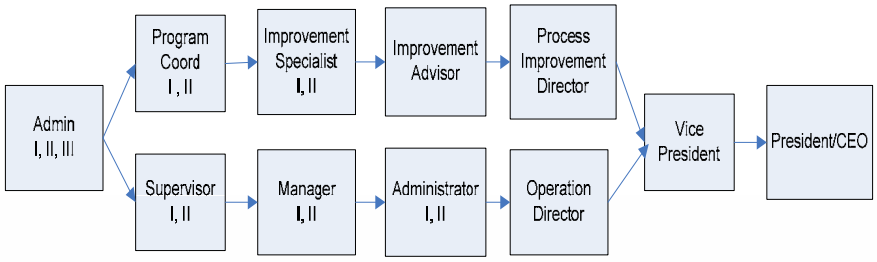
Career Paths

- Job Progressions
- Career Ladders



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SCF On-Boarding

Via Orientation Programs—

- New Hire Orientation (NHO)
- Departmental Orientation (DO)
- New Manager Orientation (NMO)

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Core Concepts

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

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Core Concepts

- **W** ork together in relationship to learn and grow
- **E** ncourage understanding
- **L** isten with an open mind
- **L** augh and enjoy humor throughout the day
- **N** otice the dignity and value of ourselves and others
- **E** ngage others with compassion
- **S** hare our stories and our hearts
- **S** trive to honor and respect ourselves and others

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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)

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Departments of Learning (DoL)

125+ courses—

- Accreditation
- Clinical
- Compliance
- Computers & Technology
- Customer Service

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DoL Cont'd

125+ courses—

- Human Resources
- Professional & Technical Writing
- Quality Improvement
- Safety
- Wellness

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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

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Human Resource Committee

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

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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

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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!

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Phase 1 of Data Management

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

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First "Dashboard" Example

Oct07 PCP Patient Activity

Counts by PCP and Clinic

		Patients				Visits															
PCPName	FTE	Pts on the 1st	Pts W Clinic Visit	Pct of Panel W Visit	Pts Hsptlzd	To PCP	Team PCP	Team Support	Nurse Clinic	Non Team FMC	Clinic Swap	Total Visits to Clinic	Pct to PCP	Pct of All Visits	ER	ERPt	UCC	UCCPt	WH Pap MAM BC	Type 3 Visits	P 1000 to Type 3
ANDRE,KATHAR	0.9	1,286	219	17.0%	10	197	27	71	3	7	1	306	85.3%	81.0%	31	27	71	65	16	43	33
CUTTING,SUMM	0.04	79	22	27.8%	1	28	2	5	0	1	0	36	90.3%	87.8%	6	2	5	5	0	3	38
DAVIS,DARIUS	0.9	1,172	255	21.8%	8	253	51	115	1	13	2	435	79.8%	88.4%	49	42	55	51	11	37	32
FMC,JADE	0.9	877	204	23.3%	3	0	108	173	1	16	0	298	0.0%	88.7%	24	22	38	34	8	29	33
FMC,PEACH	0.9	1,122	157	14.0%	5	0	84	150	3	11	0	248	0.0%	83.8%	33	29	48	42	9	23	20
FMC,RED	0.9	832	160	19.2%	6	0	108	122	1	6	0	237	0.0%	81.2%	32	27	55	48	12	20	24
HICKEL,JACK	0.8	1,115	192	17.2%	6	84	49	123	6	7	3	272	60.0%	83.7%	45	35	50	41	10	48	43
HINTON,BREND	0.9	1,058	237	22.4%	6	212	37	92	0	12	0	353	81.2%	88.5%	23	22	46	44	18	32	30
KANTOR,LINDA	1	1,374	224	16.3%	8	211	35	84	1	9	0	340	82.7%	86.7%	60	49	52	47	21	54	39
LAKTONEN,ALB	0.9	1,170	250	21.4%	4	211	55	112	2	10	0	390	76.4%	85.0%	44	36	69	61	11	52	44
TIERNEY,STEV	0.1	127	52	40.9%	1	25	9	39	2	0	0	75	73.5%	91.5%	8	6	7	6	5	11	87
Total Center FMC		**10,212**	**1,972**	**19.3%**	**58**	**1,221**	**565**	**1,086**	**20**	**92**	**6**	**2,990**	**65.0%**	**85.6%**	**355**	**297**	**496**	**444**	**121**	**352**	**34**
Match Adjusted for PCP Absence						**1,137**	**216**	**518**	**9**	**52**	**3**	**1,935**	**80.9%**								
Center wo FMC Color PCP		7,381				1,221	265	641	15	59	6	2,207	**79.0%**								

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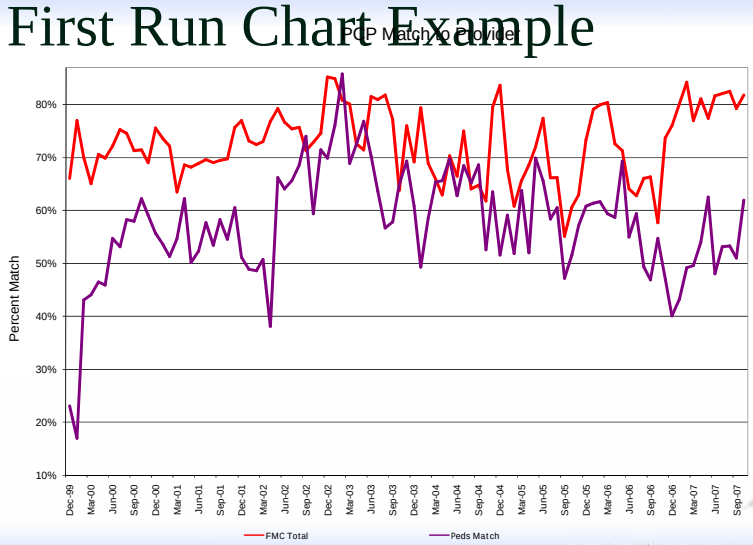
First Run Chart Example



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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.)

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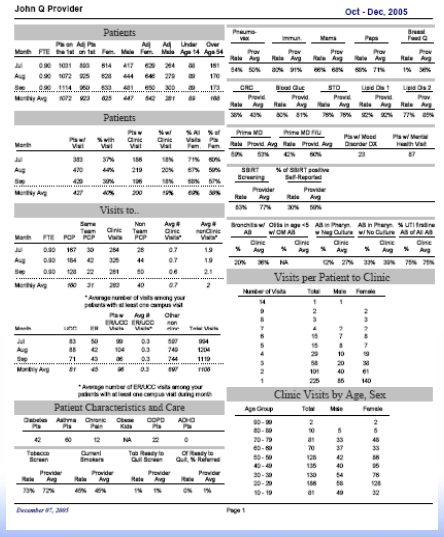
Provider Panel Packet



John Q Provider — Oct - Dec, 2005

Patients

Month	FTE	Pts on the list	Adj Pts on list	Pts Fem.	Pts Male	Adj Pts Fem.	Adj Pts Male	Under Age 14	Over Age 54
Jul	0.90	1031	885	614	417	628	264	88	181
Aug	0.90	1072	925	638	444	646	279	89	170
Sep	0.90	1114	969	653	461	650	300	89	173
Monthly Avg		1072	923	635	447	642	281	89	168

Presumo-vax		Immun.		Mams		Paps		Breast Feed Q
Prov Rate	Prov Avg	Prov Rate	Prov Avg	Prov Rate	Prov Avg	Prov Rate	Prov Avg	Prov Rate	Prov Avg
54%	52%	82%	91%	66%	68%	80%	71%	1%	38%

CRC		Blood Glue		STD		Lipid Dis 1		Lipid Dis 2	
Provid. Rate	Provid. Avg	Provid. Rate	Provid. Avg	Provid. Rate	Provid. Avg	Provid. Rate	Provid. Avg	Prov. Rate	Prov. Avg
36%	43%	80%	81%	78%	78%	92%	92%	77%	85%

Patients

Month	Pts w/ Visit	% with Visit	Pts w Clinic Visit	% w/ Clinic Visit	% All Visits Fem.	% of Pts Fem.
Jul	383	37%	188	18%	71%	60%
Aug	470	44%	219	20%	67%	59%
Sep	439	39%	196	18%	65%	57%
Monthly Avg	427	40%	200	19%	69%	59%

Prime MD		Prime MD FIU		Pts w/ Mood Disorder DX	Pts w/ Mental Health Visit
Rate	Provid. Avg	Rate	Provid. Avg		
59%	63%	42%	80%	23	87

SBIRT Screening		% of SBIRT positive Self-Reported	
Provider Rate	Provider Avg	Rate	Provider Avg
83%	77%	30%	59%

Visits to..

Month	FTE	PCP	Same Team PCP	Clinic Visits	Non Team PCP	Avg # Clinic Visits*	Avg # non-Clinic Visits*
Jul	0.90	167	39	264	28	0.7	1.9
Aug	0.90	164	42	326	44	0.7	1.9
Sep	0.90	128	22	281	50	0.6	2.1
Monthly Avg		160	37	290	40	0.7	2

* Average number of visits among your patients with at least one campus visit

Month	UCC	ER	Pts w ER/UCC Visits	Avg # ER/UCC Visits*	Other non -ER/UC	Total Visits
Jul	83	50	99	0.3	597	994
Aug	88	42	104	0.3	749	1204
Sep	71	43	96	0.3	744	1119
Monthly Avg	81	45	96	0.3	697	1106

* Average number of ER/UCC visits among your patients with at least one campus visit during month

Bronchitis w/ Abx		Otitis in age <5 w/ OM Abx		Abx in Pharyn. w neg Culture		Abx in Pharyn. w/ No Culture		% UTI fosfine Abx of All Abx	
%	Clinic Avg	%	Clinic Avg	%	Clinic Avg	%	Clinic Avg	%	Clinic Avg
20%	36%	NA		12%	27%	33%	39%	75%	75%

Visits per Patient to Clinic

Number of Visits	Total	Male	Female
14	1	1	
9	2	2	
8	3	3	
7	4	?	?
6	15	7	8
5	15	8	7
4	29	10	19
3	58	20	38
2	101	40	61
1	225	85	140

Patient Characteristics and Care

Diabetes Pts	Asthma Pts	Chronic Pain	Obese Kids	COPD Pts	ADHD Pts
42	60	12	NA	22	0

Tobacco Screen		Current Smokers		Tob Ready to Quit Screen		Of Ready to Quit, % Referred	
Provider Rate	Provider Avg	Rate	Provider Avg	Provider Rate	Provider Avg	Rate	Provider Avg
73%	72%	46%	46%	1%	1%	0%	1%

Clinic Visits by Age, Sex

Age Group	Total	Male	Female
60 - 69	2		2
80 - 89	10	5	5
70 - 79	81	33	48
60 - 69	70	37	33
50 - 59	128	42	86
40 - 49	135	40	95
30 - 39	130	54	76
20 - 29	166	58	108
10 - 19	81	49	32

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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

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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

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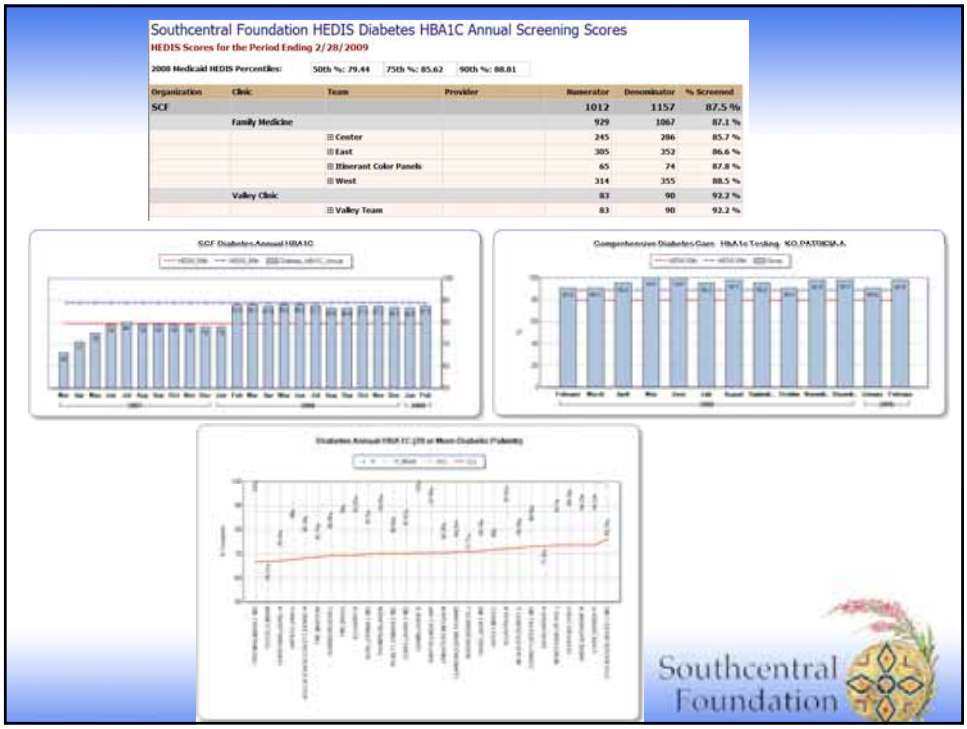

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Phase 5 of Data Management

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

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Data Mall

- Sources of data
  - RPMS
  - Signature
  - Kronos
- How does the Data Mall work?
- Demonstration of the Data Mall

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Roll Out of Data Mall

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

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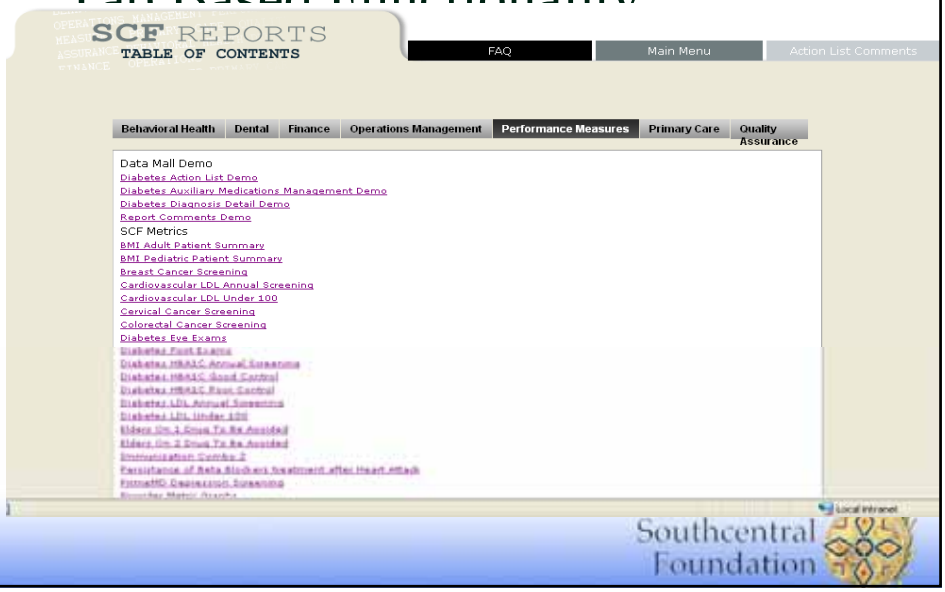
Tab Based Functionality



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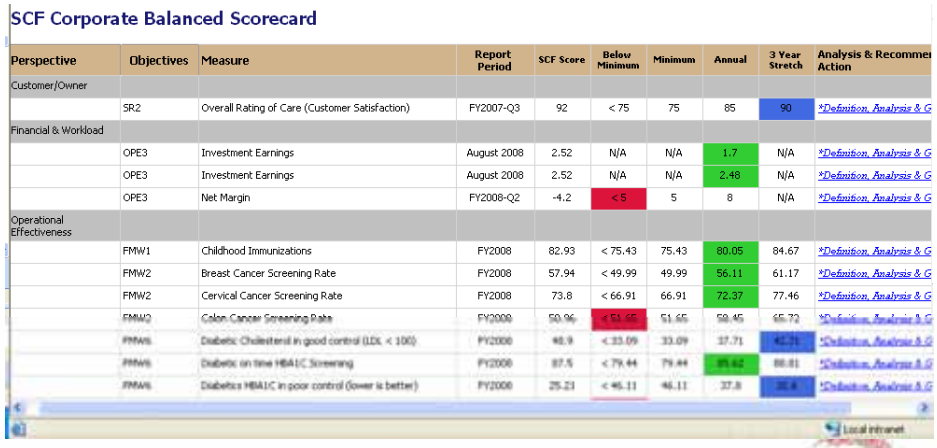
SCF Balanced Scorecard



SCF Corporate Balanced Scorecard

Perspective	Objectives	Measure	Report Period	SCF Score	Below Minimum	Minimum	Annual	3 Year Stretch	Analysis & Recommer Action
Customer/Owner									
	SR2	Overall Rating of Care (Customer Satisfaction)	FY2007-Q3	92	< 75	75	85	90	*Definition, Analysis & G
Financial & Workload									
	OPE3	Investment Earnings	August 2008	2.52	N/A	N/A	1.7	N/A	*Definition, Analysis & G
	OPE3	Investment Earnings	August 2008	2.52	N/A	N/A	2.48	N/A	*Definition, Analysis & G
	OPE3	Net Margin	FY2008-Q2	-4.2	< 5	5	8	N/A	*Definition, Analysis & G
Operational Effectiveness									
	FMW1	Childhood Immunizations	FY2008	82.93	< 75.43	75.43	80.05	84.67	*Definition, Analysis & G
	FMW2	Breast Cancer Screening Rate	FY2008	57.94	< 49.99	49.99	56.11	61.17	*Definition, Analysis & G
	FMW2	Cervical Cancer Screening Rate	FY2008	73.8	< 66.91	66.91	72.37	77.46	*Definition, Analysis & G
	FMW2	Colon Cancer Screening Rate	FY2008	50.96	< 51.65	51.65	59.45	65.72	*Definition, Analysis & G
	FMW6	Diabetic Cholesterol in good control (LDL < 100)	FY2008	48.9	< 33.09	33.09	37.71	42.31	*Definition, Analysis & G
	FMW6	Diabetic on time HBA1C Screening	FY2008	87.5	< 79.44	79.44	85.62	88.81	*Definition, Analysis & G
	FMW6	Diabetics HBA1C in poor control (lower is better)	FY2008	25.23	< 46.11	46.11	37.8	32.4	*Definition, Analysis & G

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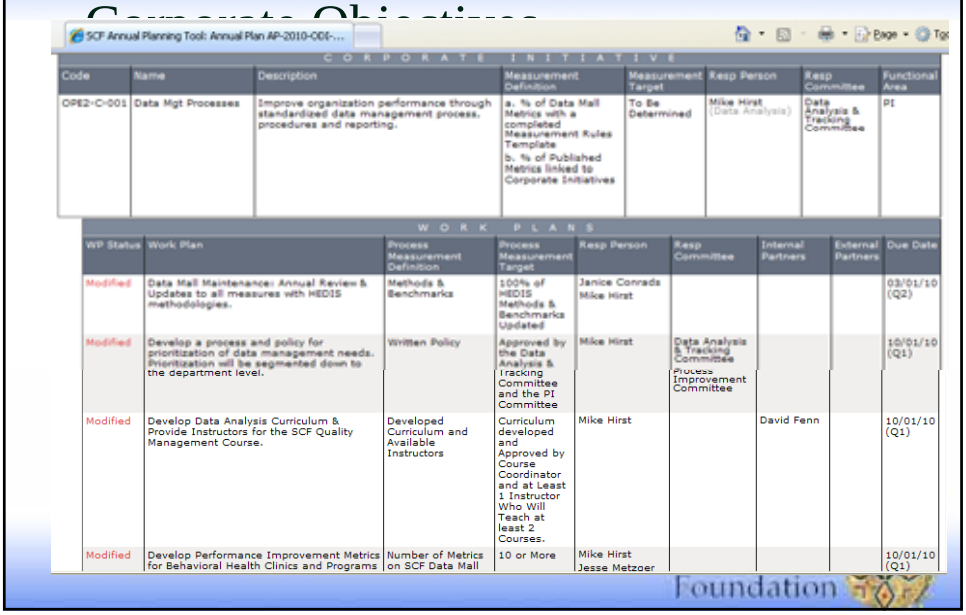
Work Plan Alignment with Corporate Objectives



SCF Annual Planning Tool: Annual Plan AP-2010-ODF-...

CORPORATE INITIATIVE

Code	Name	Description	Measurement Definition	Measurement Target	Resp Person	Resp Committee	Functional Area
OPE2-C-001	Data Mgt Processes	Improve organization performance through standardized data management process, procedures and reporting.	a. % of Data Mall Metrics with a completed Measurement Rules Template b. % of Published Metrics linked to Corporate Initiatives	To Be Determined	Mike Hirst (Data Analysis)	Data Analysis & Tracking Committee	PI

WORK PLANS

WP Status	Work Plan	Process Measurement Definition	Process Measurement Target	Resp Person	Resp Committee	Internal Partners	External Partners	Due Date
Modified	Data Mall Maintenance: Annual Review & Updates to all measures with HEDIS methodologies.	Methods & Benchmarks	100% of HEDIS Methods & Benchmarks Updated	Janice Conrads Mike Hirst				03/01/10 (Q2)
Modified	Develop a process and policy for prioritization of data management needs. Prioritization will be segmented down to the department level.	Written Policy	Approved by the Data Analysis & Tracking Committee and the PI Committee	Mike Hirst	Data Analysis & Tracking Committee Process Improvement Committee			10/01/10 (Q1)
Modified	Develop Data Analysis Curriculum & Provide Instructors for the SCF Quality Management Course.	Developed Curriculum and Available Instructors	Curriculum developed and Approved by Course Coordinator and at Least 1 Instructor Who Will Teach at least 2 Courses.	Mike Hirst		David Fenn		10/01/10 (Q1)
Modified	Develop Performance Improvement Metrics for Behavioral Health Clinics and Programs	Number of Metrics on SCF Data Mall	10 or More	Mike Hirst Jesse Metzger				10/01/10 (Q1)

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Segmentation of Data

Southcentral Foundation HEDIS Diabetes Eye Exam Scores

HEDIS Scores for the Period Ending 5/30/2009

2008 HEDIS Medicaid Percentiles: 50th %: 53.28 | 75th %: 62.46 | 90th %: 67.07

Organization	Clinic	Team	Provider	Numerator	Denominator	% Screened
SCF				589	1053	55.9 %
	Family Medicine			542	970	55.9 %
		⊞ Center		145	287	50.5 %
		⊞ East		170	299	56.9 %
		⊞ Itinerant Color Panels		35	56	62.5 %
		⊟ West		192	328	58.5 %
			CORBETT,VERLYN L MD	31	42	73.8 %
			KO,PATRICIA A	31	39	79.5 %
			LEMASTERS,MEGAN K	15	31	48.4 %
			LOHSE,SHANDA R	28	49	57.1 %
			MCALISTER,ROBERT L	24	44	54.5 %
			NORRIS,KENNETH J	12	35	34.3 %
			OLNES,LAURIE E MD	14	28	50.0 %
			PICKETT,TAMARA E MD	15	30	50.0 %

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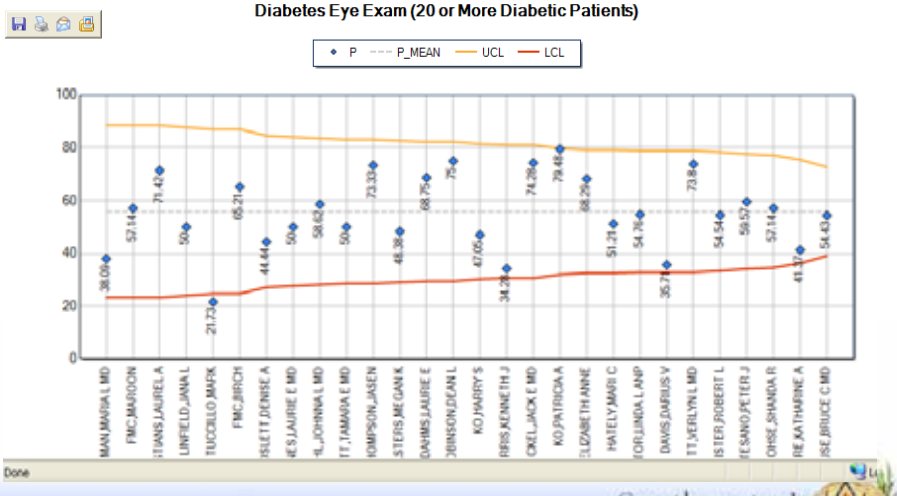
Comparison Charts to Identify Best Practices



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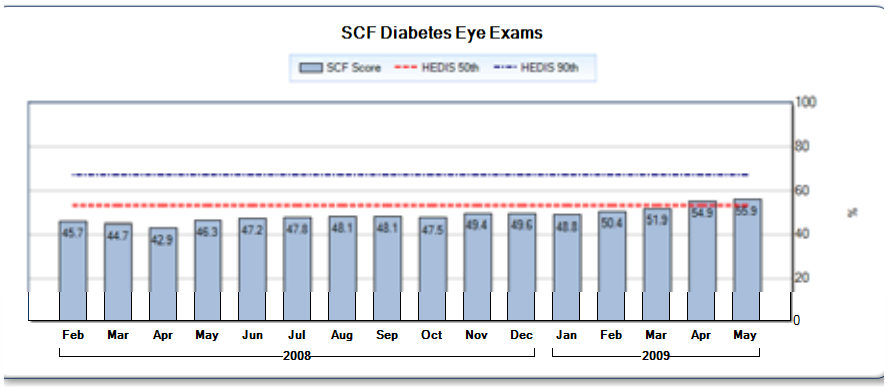
Corporate Data Aggregated Over Time



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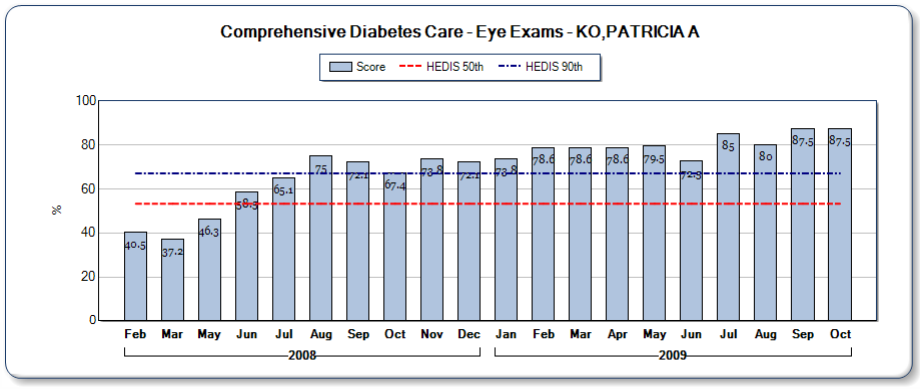
Provider Performance Over Time



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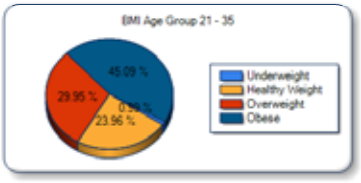
Corporate Data Segmented by Age Groups

SCF Patient BMI Prevalence - Adults over 20

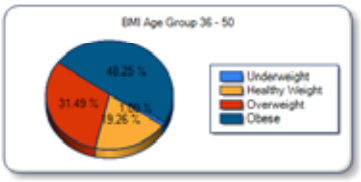
Age Group 21 - 35

Age Group	BMI status	Total	Percent
21 - 35			
	Underweight	72	0.99%
	Healthy Weight	1740	23.96%
	Overweight	2175	29.95%
	Obese	3274	45.09%
		7261	



Age Group 36 - 50

Age Group	BMI status	Total	Percent
36 - 50			
	Underweight	65	1%
	Healthy Weight	1247	19.26%
	Overweight	2039	31.49%
	Obese	3124	48.25%
		6475	



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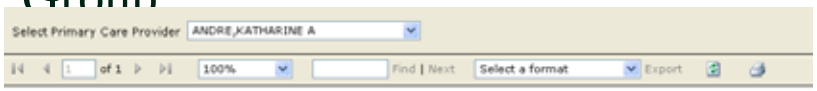
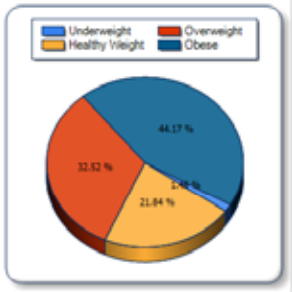
Provider Data Segmented by Age Group



BMI Summaries by Age Group

Totals for Age Group 21 - 35

Age Group	BMI Status	Total	% of Patients
21 - 35			
	Underweight	3	145.6
	Healthy Weight	45	2184.5
	Overweight	67	3252.4
	Obese	91	4417.5
		206	



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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

HRCN	Patient	New Diabetic (<< 90 Days) *Click Link to see Diagnosis Details!*	Sex	Age	HBA1C Result	HBA1C Date	Most Recent LDL Result	LDL Date
Ko, Patricia A		Total Diabetic Patients: 47						
72048	Abbasi, Darren	No	M	71	5.8	2009/01/13	67	2009/01/13
42457	Abell, Frederick	No	M	67	6.3	2009/03/06	86	2009/03/06
12916	Allen, Marcus	No	M	82	6.4	2008/06/03	129	2008/06/03
72098	Armston, George	No	M	81	5.3	2008/12/01	90	2008/12/01
1192	Bark, Samuel	No	M	85	6.9	2009/01/22	110	2009/01/22
45979	Bevis, Michael	No	M	76	5.7	2009/03/09	79	2009/03/09
32158	Black, Lewis	No	M	36	6.3	2009/03/03	116	2008/11/15
19202	Caldwell, Charlotte	No	F	80	5.8	2009/02/23	93	2009/02/23
84893	Evarza, Wallace	No	M	40	5.7	2008/06/24	113	2008/06/24
61328	Ferris, Adam	No	M	40	6.8	2009/02/12	86	2009/02/12
19492	Gafford, Joseph	No	M	41	6.3	2008/03/31	64	2008/03/31

Fictitious Patient Info

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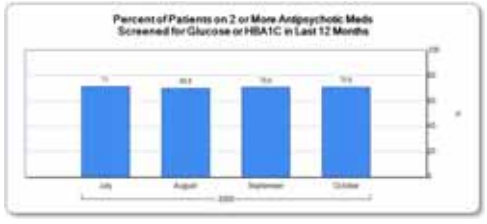
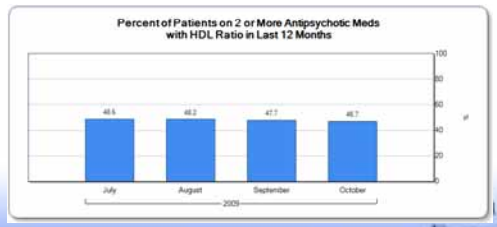
Evid

Antipsychotic Metric for Glucose/HBA1C and HDL Ratio

Report Current as of: 10/10/2009 *Click Here for Methodology!

Glucose/HBA1C Count	HDL Count	Denominator	% Screened for Glucose or HBA1C	% of Patients with HDL Ratio
288	190	407	70.8 %	46.7 %





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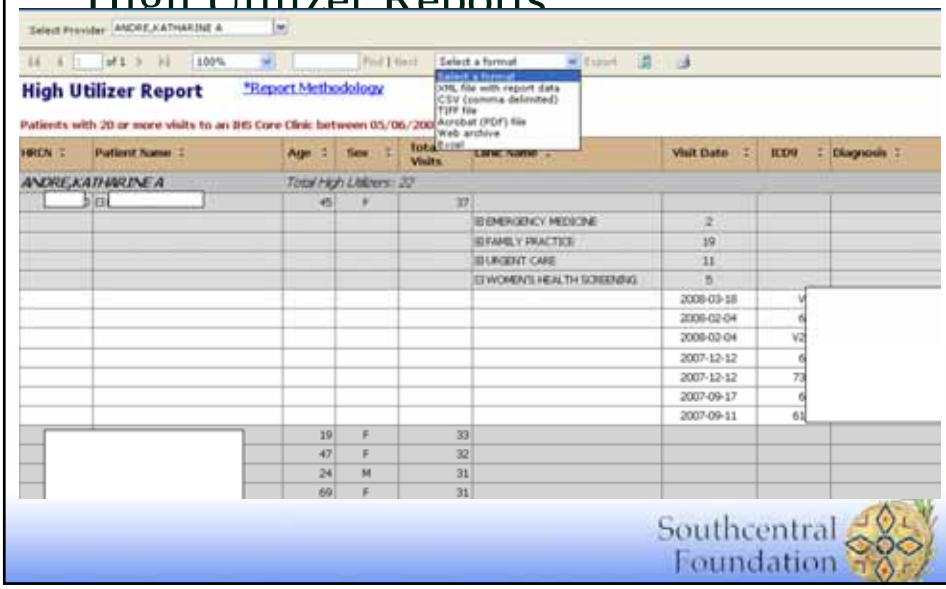
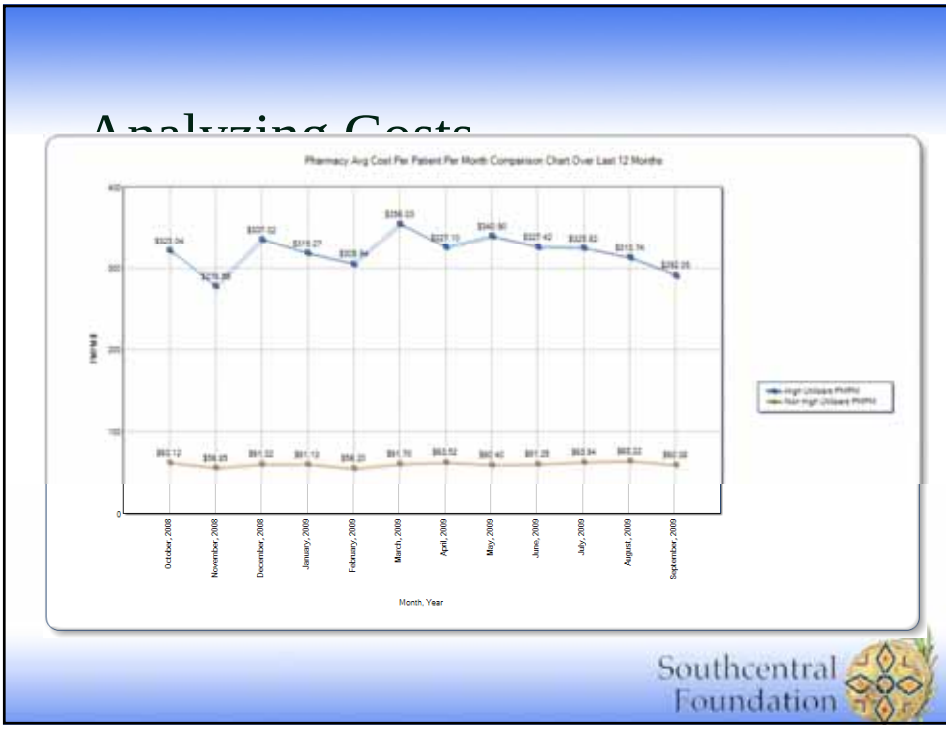
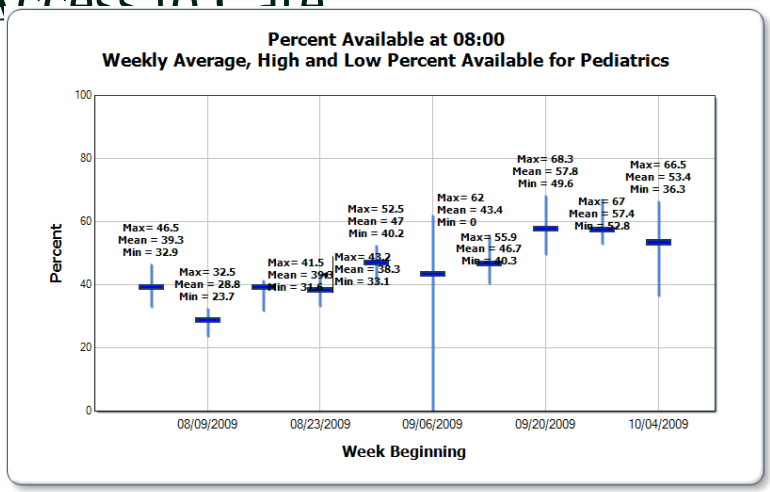
High Utilizer Reports



Analyzing Costs



Access to Care



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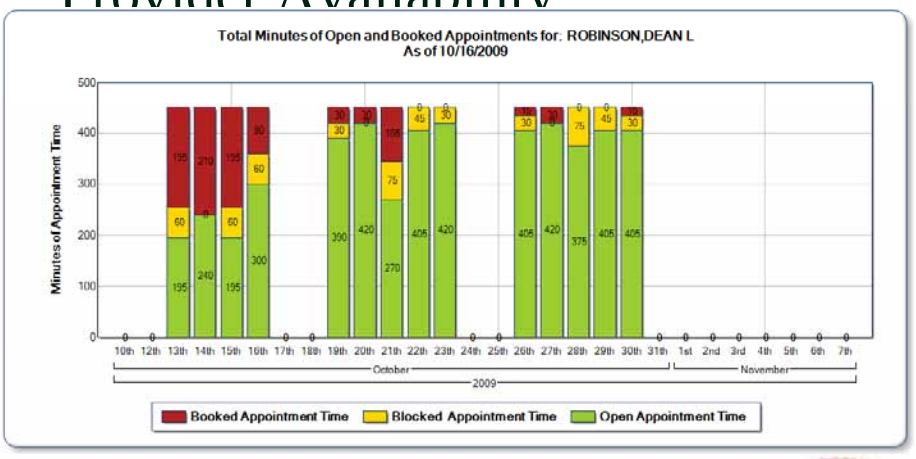
Provider Availability



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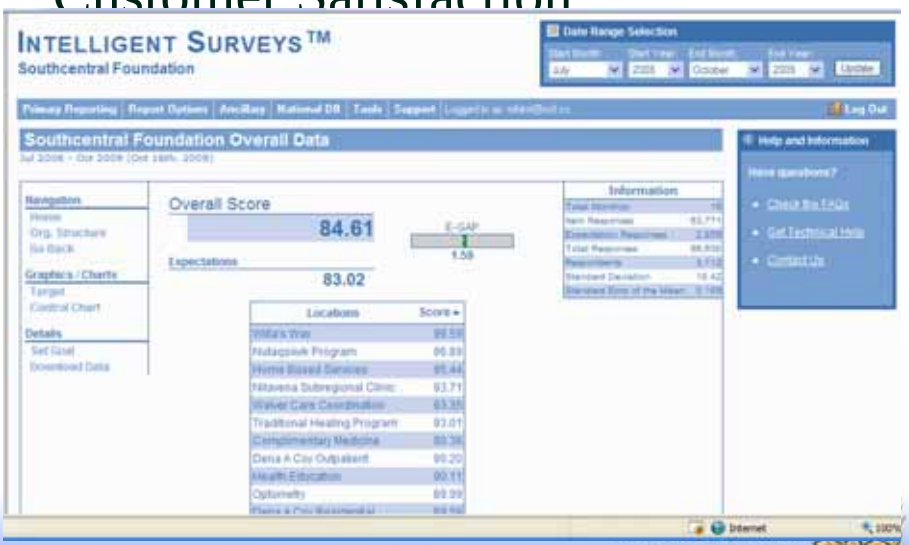
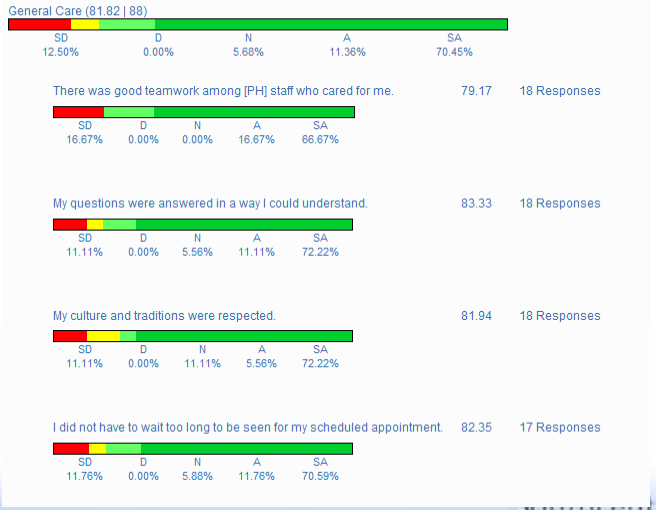
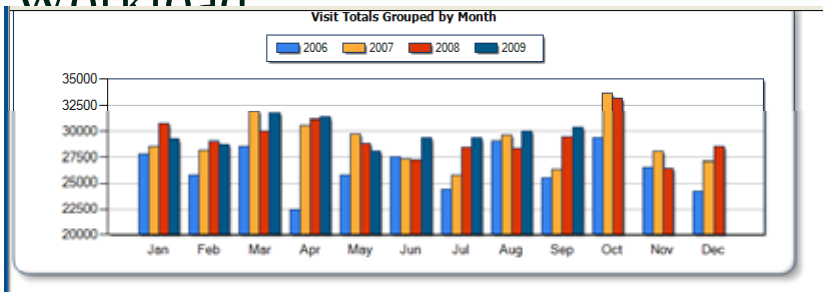
Customer Satisfaction



Customer Satisfaction Specifics



Workload



Clinic Visit Details by Calendar Year and Month

Visit Year/Month Total		Audiology	CompMed	DENT	DM	ED	ENT	ER	FMC
2006	TOTAL	3801	13119	7	43	7127	9893	15543	91533
2007	TOTAL	2487	13718	5	404	12985	9608	16979	114222
2008	TOTAL	3814	12542	12	1257	10140	9035	19098	118063
2009	TOTAL	3023	11703	5	886	4823	7286	15836	92959

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Qua

Quality Assurance Categories Metric

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

Category	% Yes	Denominator
Environment of Care	70.1	107
Improving Organizational Performance	65.0	103
Infection Control	91.4	70
Management of Human Resources	71.4	105
Management of Information	90.0	02
Medication Management	84.6	169
National Patient Safety Goals	86.5	178
Provision of Care, Treatment and Services	77.4	527

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Quality Assurance

Quality Assurance Category Questions Metric

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

Category	#	Question	% Yes	Denominator
National Patient Safety Goals				
	1	How do you identity a customer when providing care, treatment, or services?	81.0	42
	2	What is your process for receiving verbal orders or critical test results?	50.0	6
	3	If you receive critical test results, and can you show me when they were received?	75.0	4
	4	Do you have a list of Do Not Use Abbreviations and where is it located?	92.9	42
	5	Do you have a process to handle "hand-off" communication?	90.5	42
	6	How does your program reconcile medications throughout the continuum of care?	88.1	42
Provision of Care, Treatment and Services				
	7	Did an assessment of learning needs occur?	75.6	41
	8	Was the customer screened for suicide risk?	88.0	25
	9	Was a physical health assessment performed within specified time frames? (24 hours after admission to inpatient or crisis stabilization or within one week after admission to residental program)	90.0	10
	10	Was a bio-psycho-social assessment completed as specified by the program/department?	90.9	22
	11	Was the addictive behavior assessment completed within time frame specified by the organization?	95.8	24

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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

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Next Steps

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

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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

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Operational Principles Scoring

Applying the Operational Principles to System Design Ideas 5.11.06 PC CBG

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.

Issue	**Alignment Score** Score this issue overall with a 1-10 scale 1=low alignment 10 =high alignment	This issue **Supports** the following Operational Principles (Check the box for all that apply)	This issue **Opposes** (Is a barrier to) the following Operational Principles (Check the box for all that apply)
	Low Alignment 1 2 3 4 5 6 7 8 9 10 High Alignment	☐ **R**elationships… ☐ **E**mphasis… ☐ **L**ocations… ☐ **A**ccess… ☐ **T**ogether… ☐ **I**ntegration… ☐ **O**ne seamless… ☐ **N**o duplication… ☐ **S**imple… ☐ **H**ub… ☐ **I**nterests… ☐ **P**opulation… ☐ **S**ervices…	☐ **R**elationships… ☐ **E**mphasis… ☐ **L**ocations… ☐ **A**ccess… ☐ **T**ogether… ☐ **I**ntegration… ☐ **O**ne seamless… ☐ **N**o duplication… ☐ **S**imple… ☐ **H**ub… ☐ **I**nterests… ☐ **P**opulation… ☐ **S**ervices…

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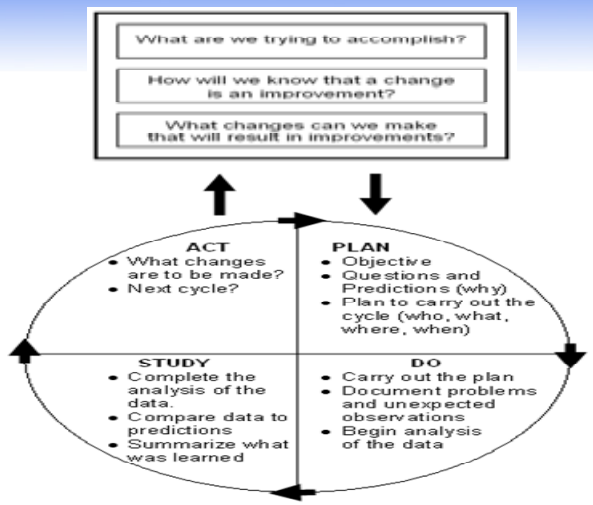
Improvement Model:



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

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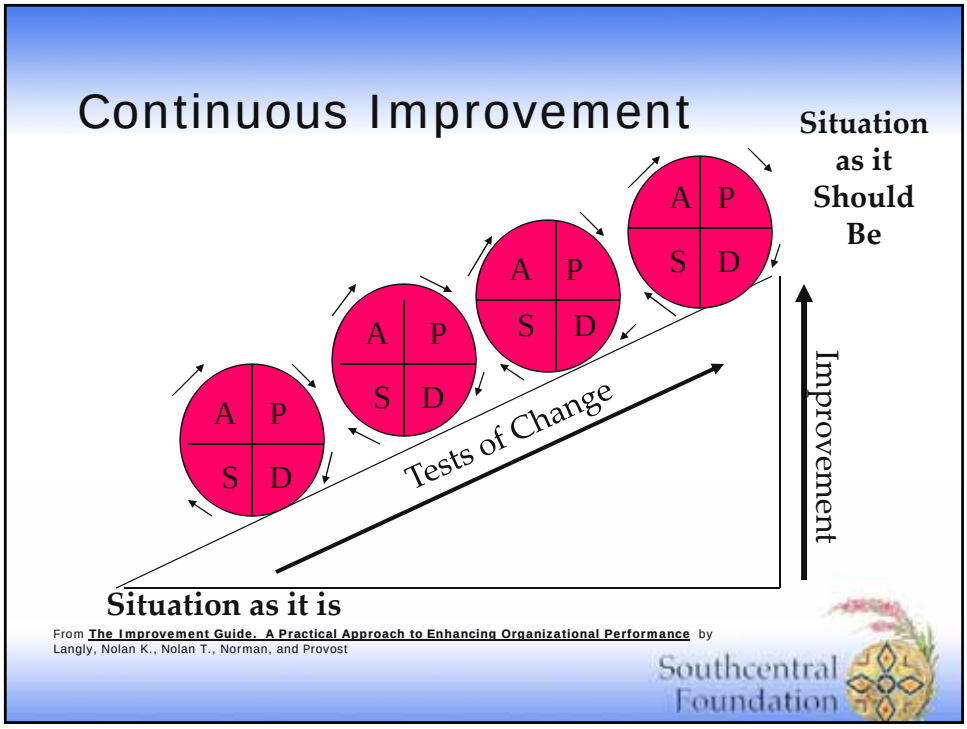
Continuous Improvement
Situation as it Should Be
A P S D
Tests of Change
Improvement
Situation as it is
From The Improvement Guide. A Practical Approach to Enhancing Organizational Performance by Langly, Nolan K., Nolan T., Norman, and Provost
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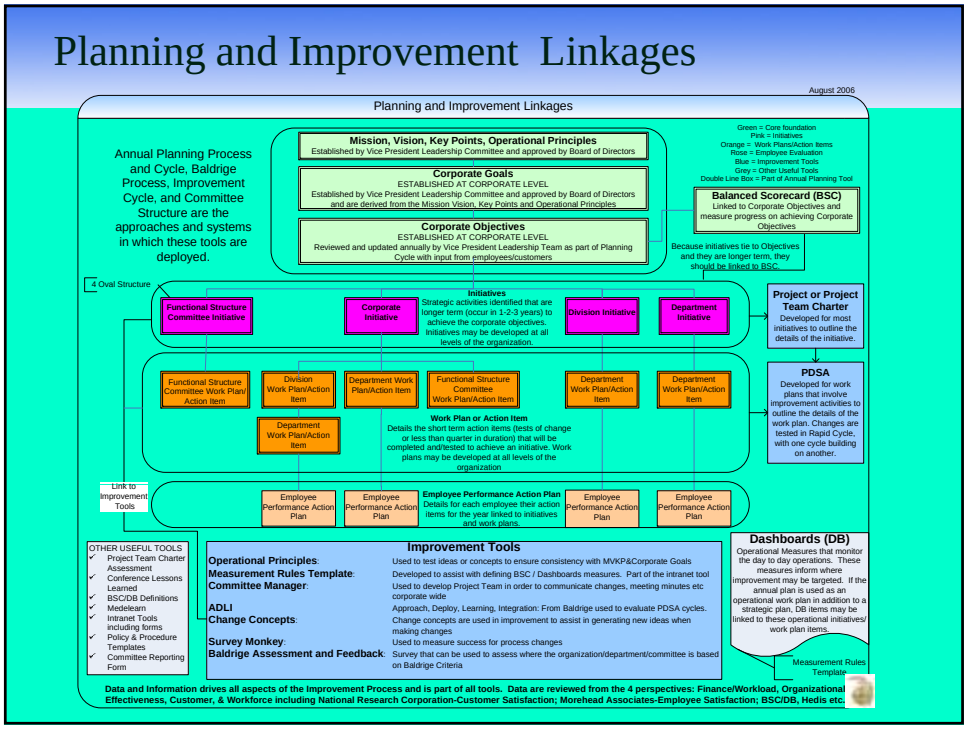
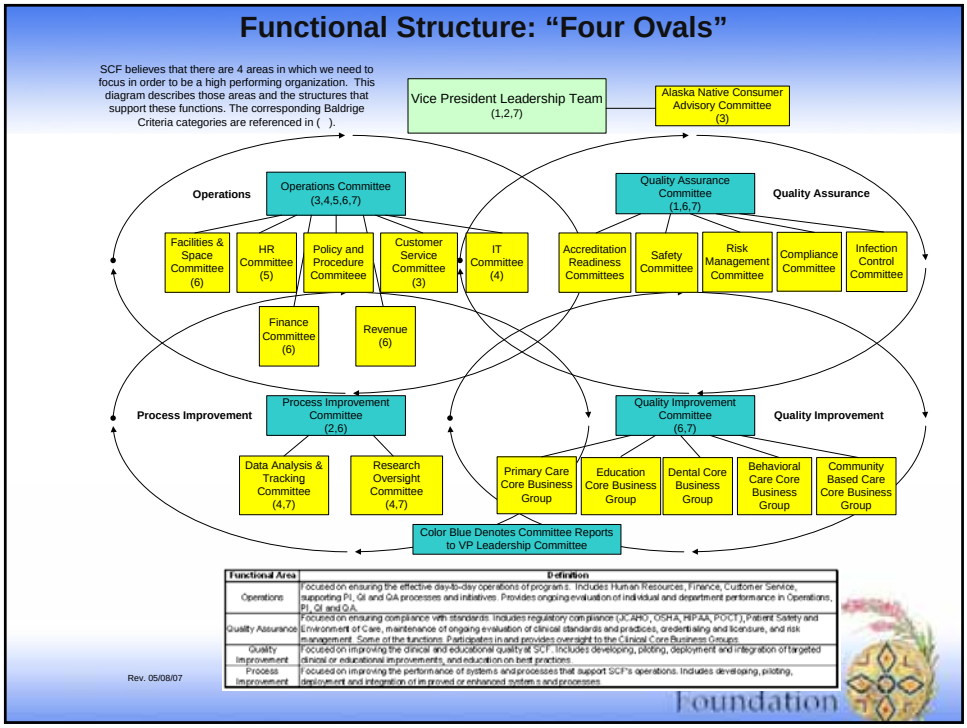
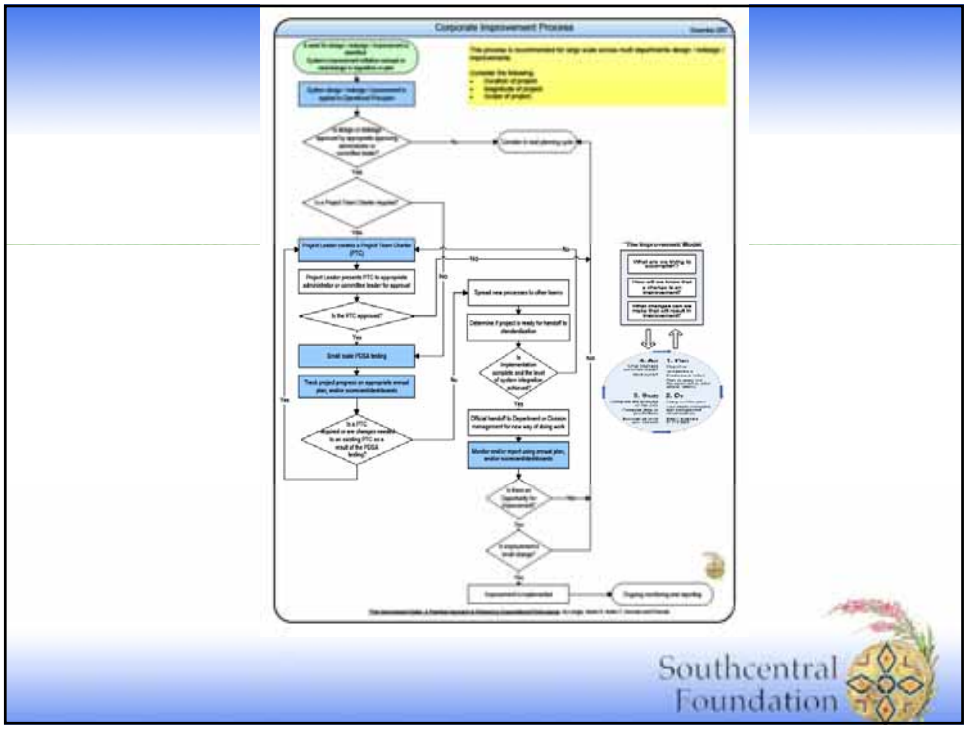

Planning and Improvement Linkages
August 2006
Planning and Improvement Linkages
Annual Planning Process and Cycle, Baldrige Process, Improvement Cycle, and Committee Structure are the approaches and systems in which these tools are deployed.
Mission, Vision, Key Points, Operational Principles
Established by Vice President Leadership Committee and approved by Board of Directors
Corporate Goals
ESTABLISHED AT CORPORATE LEVEL
Established by Vice President Leadership Committee and approved by Board of Directors and are derived from the Mission Vision, Key Points and Operational Principles
Corporate Objectives
ESTABLISHED AT CORPORATE LEVEL
Reviewed and updated annually by Vice President Leadership Team as part of Planning Cycle with input from employees/customers
Green = Core foundation
Pink = Initiatives
Orange = Work Plans/Action Items
Rose = Employee Evaluation
Blue = Improvement Tools
Grey = Other Useful Tools
Double Line Box = Part of Annual Planning Tool
Balanced Scorecard (BSC)
Linked to Corporate Objectives and measure progress on achieving Corporate Objectives
Because initiatives tie to Objectives and they are longer term, they should be linked to BSC.
4 Oval Structure
Functional Structure Committee Initiative
Corporate Initiative
Division Initiative
Department Initiative
Initiatives
Strategic activities identified that are longer term (occur in 1-2-3 years) to achieve the corporate objectives. Initiatives may be developed at all levels of the organization.
Project or Project Team Charter
Developed for most initiatives to outline the details of the initiative.
Functional Structure Committee Work Plan/ Action Item
Division Work Plan/Action Item
Department Work Plan/Action Item
Functional Structure Committee Work Plan/Action Item
Department Work Plan/Action Item
Department Work Plan/Action Item
Department Work Plan/Action Item
Work Plan or Action Item
Details the short term action items (tests of change or less than quarter in duration) that will be completed and/tested to achieve an initiative. Work plans may be developed at all levels of the organization
PDSA
Developed for work plans that involve improvement activities to outline the details of the work plan. Changes are tested in Rapid Cycle, with one cycle building on another.
Link to Improvement Tools
Employee Performance Action Plan
Employee Performance Action Plan
Employee Performance Action Plan
Employee Performance Action Plan
Employee Performance Action Plan
Details for each employee their action items for the year linked to initiatives and work plans.
OTHER USEFUL TOOLS
Project Team Charter Assessment
Conference Lessons Learned
BSC/DB Definitions
Medelearn
Intranet Tools including forms
Policy & Procedure Templates
Committee Reporting Form
Improvement Tools
Operational Principles: Used to test ideas or concepts to ensure consistency with MVKP&Corporate Goals
Measurement Rules Template: Developed to assist with defining BSC / Dashboards measures. Part of the intranet tool
Committee Manager: Used to develop Project Team in order to communicate changes, meeting minutes etc corporate wide
ADLI: Approach, Deploy, Learning, Integration: From Baldrige used to evaluate PDSA cycles.
Change Concepts: Change concepts are used in improvement to assist in generating new ideas when making changes
Survey Monkey: Used to measure success for process changes
Baldrige Assessment and Feedback: Survey that can be used to assess where the organization/department/committee is based on Baldrige Criteria
Dashboards (DB)
Operational Measures that monitor the day to day operations. These measures inform where improvement may be targeted. If the annual plan is used as an operational work plan in addition to a strategic plan, DB items may be linked to these operational initiatives/ work plan items.
Measurement Rules Template
Data and Information drives all aspects of the Improvement Process and is part of all tools. Data are reviewed from the 4 perspectives: Finance/Workload, Organizational Effectiveness, Customer, & Workforce including National Research Corporation-Customer Satisfaction; Morehead Associates-Employee Satisfaction; BSC/DB, Hedis etc.


Functional Structure: "Four Ovals"
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 ( ).
Vice President Leadership Team (1,2,7)
Alaska Native Consumer Advisory Committee (3)
Operations
Operations Committee (3,4,5,6,7)
Facilities & Space Committee (6)
HR Committee (5)
Policy and Procedure Commiteee
Customer Service Committee (3)
IT Committee (4)
Finance Committee (6)
Revenue (6)
Quality Assurance
Quality Assurance Committee (1,6,7)
Accreditation Readiness Committees
Safety Committee
Risk Management Committee
Compliance Committee
Infection Control Committee
Process Improvement
Process Improvement Committee (2,6)
Data Analysis & Tracking Committee (4,7)
Research Oversight Committee (4,7)
Quality Improvement
Quality Improvement Committee (6,7)
Primary Care Core Business Group
Education Core Business Group
Dental Core Business Group
Behavioral Care Core Business Group
Community Based Care Core Business Group
Color Blue Denotes Committee Reports to VP Leadership Committee
Functional Area
Definition
Operations
Focused on ensuring the effective day-to-day operations of programs. Includes Human Resources, Finance, Customer Service, supporting PI, QI and QA processes and initiatives. Provides ongoing evaluation of individual and department performance in Operations, PI, QI and QA.
Quality Assurance
Focused on ensuring compliance with standards. Includes regulatory compliance (JCAHO, OSHA, HIPAA, POCT), Patient Safety and Environment of Care, maintenance of ongoing evaluation of clinical standards and practices, credentialing and licensure, and risk management. Some of the functions Participates in and provides oversight to the Clinical Core Business Groups
Quality Improvement
Focused on improving the clinical and educational quality at SCF. Includes developing, piloting, deployment and integration of targeted clinical or educational improvements, and education on best practices
Process Improvement
Focused on improving the performance of systems and processes that support SCF's operations. Includes developing, piloting, deployment and integration of improved or enhanced systems and processes
Rev. 05/08/07
Foundation


Corporate Improvement Process
Southcentral Foundation

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

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Improvement Tools

(Under Construction)

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

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Annual Planning Tool

Demonstration

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Committee Manager

Demonstration

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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….

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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.

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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*

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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

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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

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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

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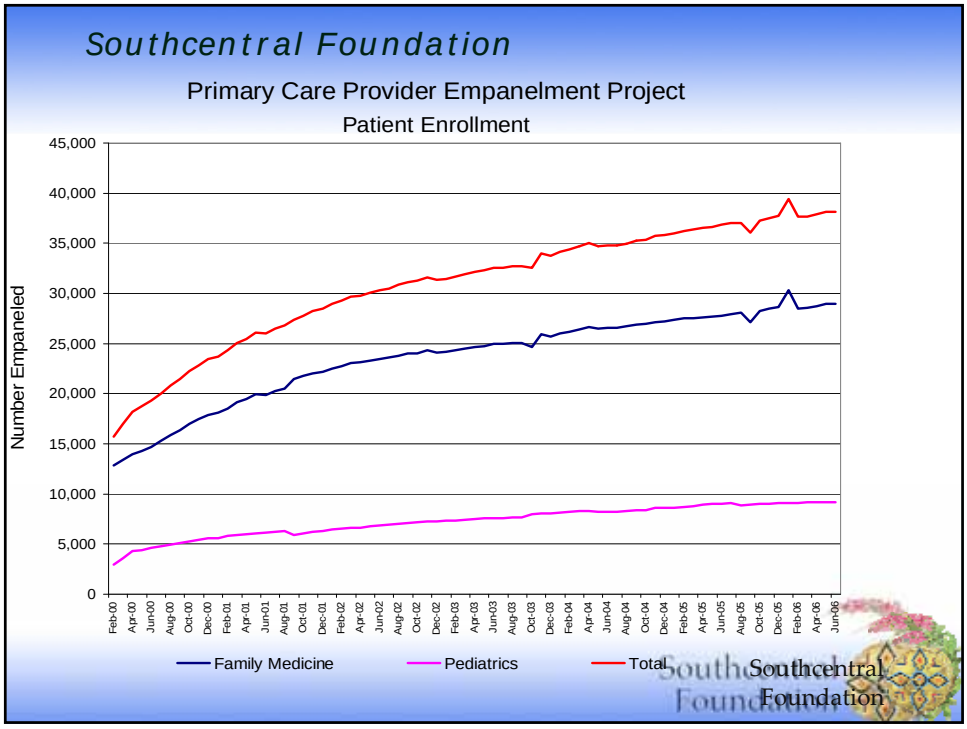
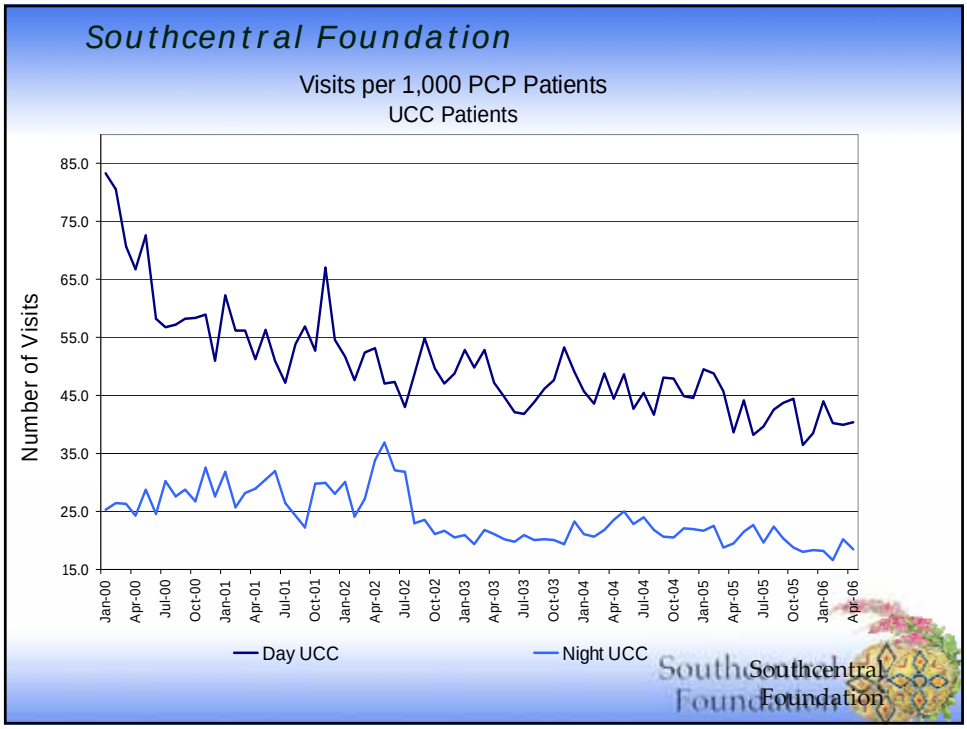
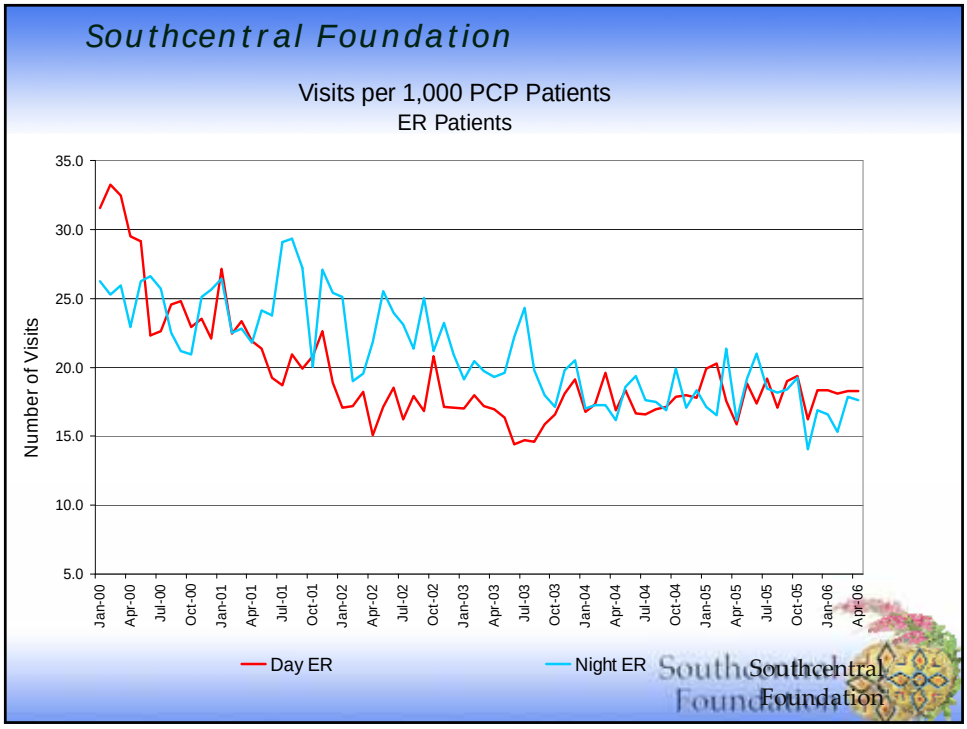

Southcentral Foundation
Primary Care Provider Empanelment Project
Patient Enrollment
Number Empaneled
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
Family Medicine
Pediatrics
Total
Southcentral Foundation


Southcentral Foundation
Visits per 1,000 PCP Patients
UCC Patients
Number of Visits
85.0
75.0
65.0
55.0
45.0
35.0
25.0
15.0
Day UCC
Night UCC
Southcentral Foundation


Southcentral Foundation
Visits per 1,000 PCP Patients
ER Patients
Number of Visits
35.0
30.0
25.0
20.0
15.0
10.0
5.0
Jan-00 Apr-00 Jul-00 Oct-00 Jan-01 Apr-01 Jul-01 Oct-01 Jan-02 Apr-02 Jul-02 Oct-02 Jan-03 Apr-03 Jul-03 Oct-03 Jan-04 Apr-04 Jul-04 Oct-04 Jan-05 Apr-05 Jul-05 Oct-05 Jan-06 Apr-06
Day ER
Night ER
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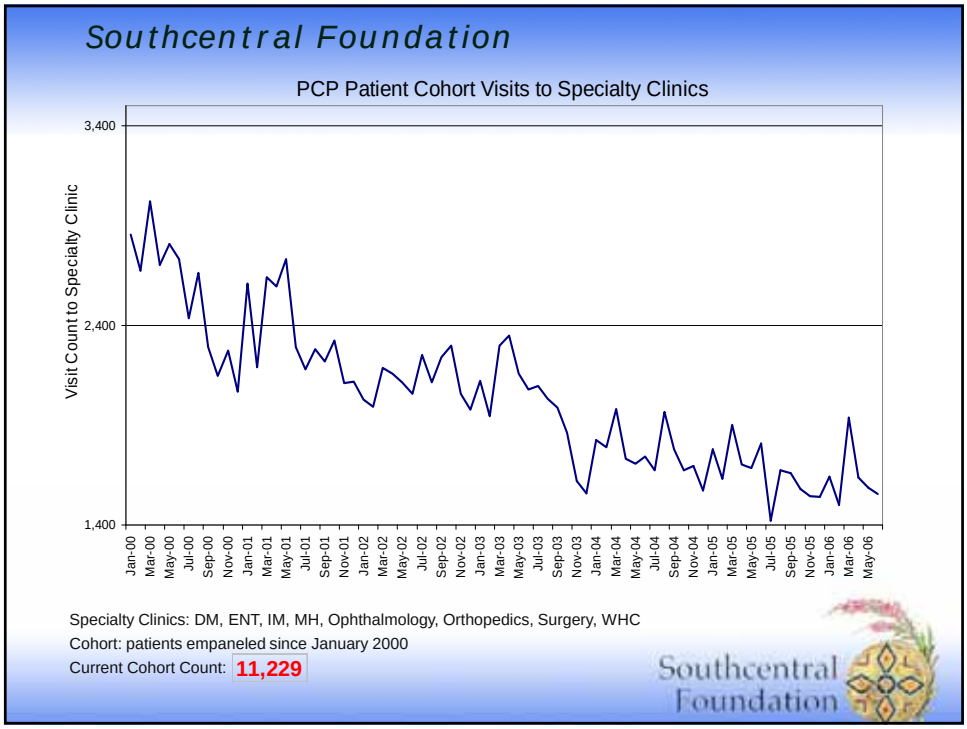
Southcentral Foundation
PCP Patient Cohort Visits to Specialty Clinics
Visit Count to Specialty Clinic
3,400
2,400
1,400
Jan-00 Mar-00 May-00 Jul-00 Sep-00 Nov-00 Jan-01 Mar-01 May-01 Jul-01 Sep-01 Nov-01 Jan-02 Mar-02 May-02 Jul-02 Sep-02 Nov-02 Jan-03 Mar-03 May-03 Jul-03 Sep-03 Nov-03 Jan-04 Mar-04 May-04 Jul-04 Sep-04 Nov-04 Jan-05 Mar-05 May-05 Jul-05 Sep-05 Nov-05 Jan-06 Mar-06 May-06
Specialty Clinics: DM, ENT, IM, MH, Ophthalmology, Orthopedics, Surgery, WHC
Cohort: patients empaneled since January 2000
Current Cohort Count: 11,229
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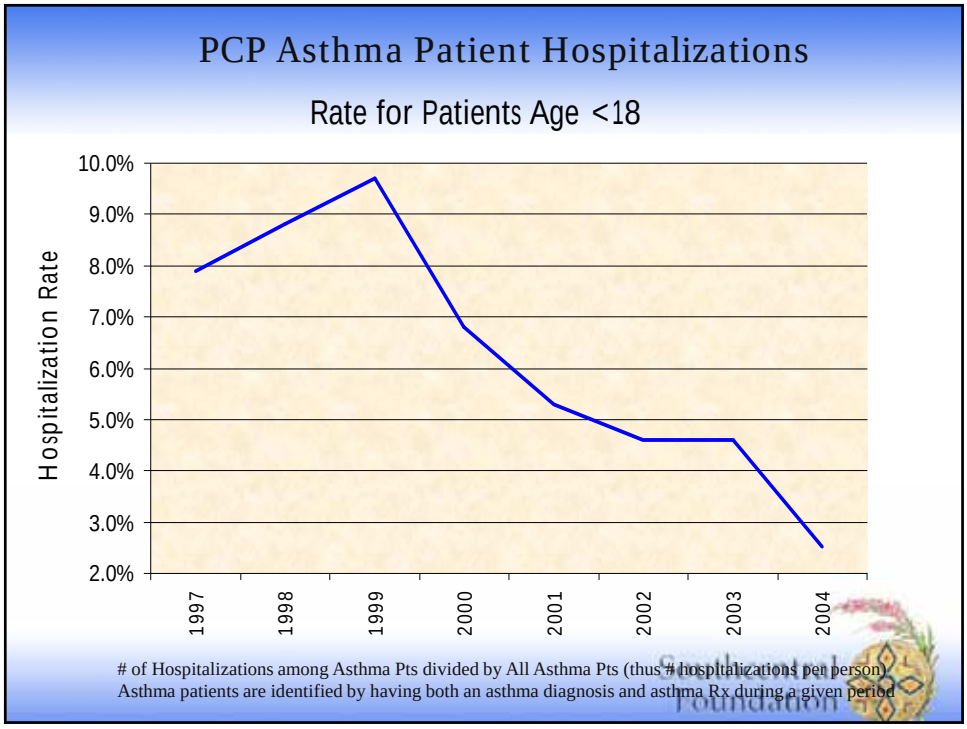
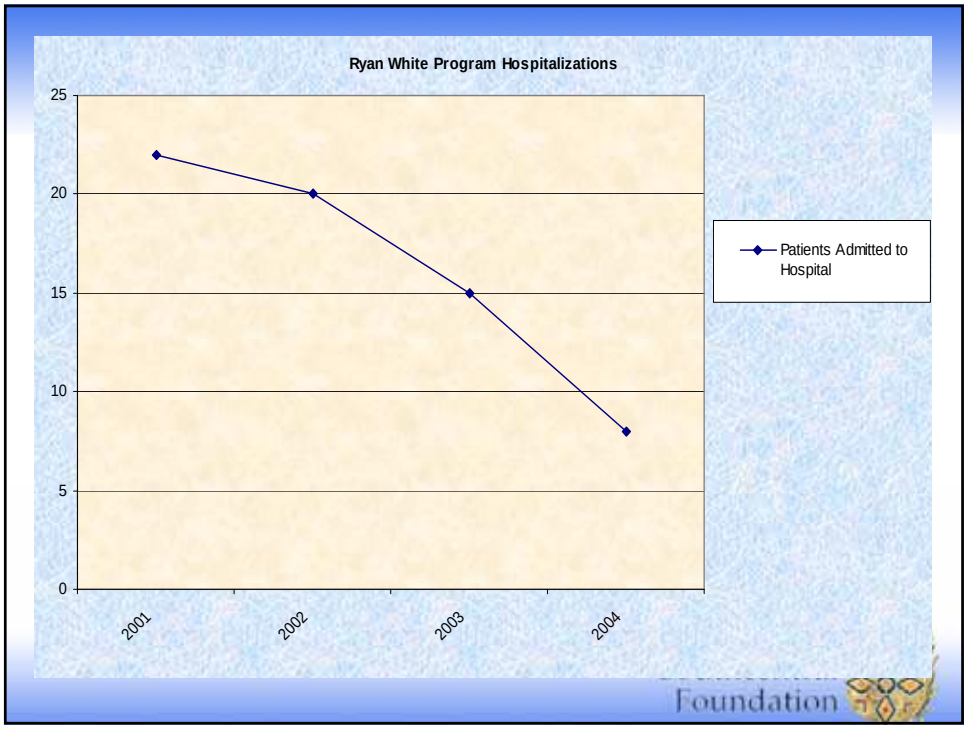

PCP Asthma Patient Hospitalizations
Rate for Patients Age <18
Hospitalization Rate
10.0%
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1997
1998
1999
2000
2001
2002
2003
2004
# of Hospitalizations among Asthma Pts divided by All Asthma Pts (thus # hospitalizations per person)
Asthma patients are identified by having both an asthma diagnosis and asthma Rx during a given period


Ryan White Program Hospitalizations
25
20
15
10
5
0
2001
2002
2003
2004
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…

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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.

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Frank's Diagnosis

- COPD
- CHF
- Diabetes

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

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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

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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

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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.

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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

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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*

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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

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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-inn 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-care

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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

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What is the Big Deal about Southcentral Foundation's Nuka Model of Care?

Katherine Gottlieb
President/ CEO

Southcentral Foundation

Why is it important to tell our story?

Why is it important that Alaska Native people know it is "our" story?

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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.

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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.

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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.

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VERSUS

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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%.

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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%).

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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.

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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.

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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

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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.

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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.

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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

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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

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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

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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.

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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…

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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

Southcentral Foundation

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*

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Thank You!

Southcentral Foundation