

# Transforming Your Practice: What Matters Most



WHEN CUSTOMERS DRIVE THE SYSTEM,  
IT CHANGES EVERYTHING – FOR THE BETTER.

Alaska Native people, the indigenous people of Alaska, have long and rich traditions. Storytelling is one of these traditions. When someone tells his or her story and invites others to tell theirs, knowledge and understanding are gained. Sharing stories can teach, motivate, admonish, inspire and create personal relationships.

Southcentral Foundation (SCF), the Alaska Native-owned nonprofit health care system located in Anchorage, Alaska, has a story to tell. Ten years ago, SCF was a typical, inefficient health care system. Patients had to wait weeks to get an appointment and had to wait again when coming into the office. Care was impersonal. Patients often saw a different provider at each appointment. Patients weren't happy, staff weren't happy and doctors weren't happy.

In the Indian Self-Determination and Education Assistance Act of 1975, Congress found that "prolonged federal domination of Indian service programs has served to retard rather than enhance the progress of Indian people and their communities." (25 USC §450) The government recognized that if the people receiving services were involved in the decision-making process or owned the entities that delivered the services, there would be a greater potential for improving their health statistics.

SCF began contracting services from the federal government in 1987 and completed the transition to a customer-owned system in 1999. Alaska Native leadership saw this as an opportunity to examine what was being done and to completely redesign the system to better meet the needs, values and priorities of the Alaska Native community. Today, SCF is achieving some world-class health outcomes and high levels of satisfaction. This article explains our journey and some of the principles that have led to where we are today.

### Rethinking our business: understanding our core product

The first step in the redesign process was for Alaska Native leadership to define what our business was really about. It is about human beings. Alaska Native people are not just patients; they are customers and owners of the business. As such, we refer to them as "customer-owners."

Prior to our redesign, the SCF medical system suffered from one of the key problems in health care today: The system misunderstood the core product as being tests,

### ABOUT SOUTHCENTRAL FOUNDATION

Southcentral Foundation (SCF) is the Alaska Native-owned nonprofit health care system located in Anchorage, Alaska, under the tribal authority of Cook Inlet Region Inc. The geographical service area covers 150,000 square miles in Alaska, spanning from the Kenai Peninsula to the Aleutian and Pribilof Islands in the Bering Sea to the interior of Alaska in McGrath to Anchorage and the Matanuska-Susitna Valley. SCF employs more than 1,350 individuals and has an operating budget in excess of \$153 million annually. SCF provides a broad spectrum of health care and related services including primary medical care, dentistry, behavioral health (including residential and day treatment programs), complementary medicine, traditional healing, home-based services and education. With the Alaska Tribal Health Consortium, SCF also jointly owns and manages the Alaska Native Medical Center, which includes a 150-bed hospital providing inpatient, specialty and tertiary medical services.

This article describes the whole-system transformation of this health care system when it moved from the Indian Health Service to the customer-owned and managed Alaska Native Health Corporation. Taking nothing for granted and rethinking everything in the system so that it would be built on the values, wants and needs of Alaska Native people and the community, SCF has achieved dramatic improvements in system performance, health outcomes, per capita costs, individual experience of care and staff satisfaction.

diagnoses, pills and procedures. When individuals sought health care services, providers would take their signs and symptoms, perform a physical examination, and produce a differential diagnosis. Then, providers would do what health care does really well: order a bunch of tests. That would lead to a definitive diagnosis, which would then result in pills being prescribed, procedures and tests being ordered, and perhaps some advice being delivered. When the visit was done, providers thought the work was done. An additional problem was that our many departments and programs acted independently, with all of them doing what they thought best within their particular boundaries – a common situation in health care under any payment or organizational model. ►

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# In many organizations, staff are tired of change and don't know which way the organization is headed.

But while this linear, standardized, nonintegrated, provider-driven model may effectively influence outcomes for the small percentage of health care that involves short-term and high-acuity problems, it isn't the best model for the majority of health care, which involves chronic illnesses, long-term conditions, prevention and wellness. In these cases, the customer – not the provider or health system – has the most control over the outcome. (See “Who really controls outcomes?” on page 35.) The customer decides whether to pick up the medicine the provider prescribes, whether to take it as prescribed, whether to share it with a neighbor, whether to split it in half so it lasts longer, whether to stop taking it in a few days, whether to exercise, what to eat, whether to drink too much, whether to smoke, etc. All of these things are determined by the customer and not always in the provider's presence. These decisions drive outcomes related to chronic care, long-term care, prevention and wellness, which account for 75 percent to 85 percent of health care expenditures.<sup>1</sup>

Alaska Native leadership recognized that the core product is something bigger than just tests, diagnoses, pills and procedures. It is about human beings and *relationships* – messy, human, longitudinal, personal, trusting, informing, respecting and accountable relationships.

Focused on that core product, SCF developed a clear vision, mission, key points and operating principles that now drive the structure of our strategic and annual plans. All levels of management are expected to reinforce these concepts. Our vision, mission, key points and operating principles keep our focus, hold people accountable and offer staff real direction. In many organizations, staff are tired of change and don't know which way the organization is headed. Often, the problem is too many projects without an integrated strategy. But when everything done is aligned with the single intent of the vision that drives the mission that drives key points that drive opera-

tional principles, staff will feel more energized and purposeful. Decisions will also come easier.

## Now, change everything you do

If a practice or organization really believes that the core product is relationship – that is, partnering to make a difference over time – a fundamental change is required. Where money and time are spent, what work staff members do, who is hired and how staff are trained – every action is intentionally designed to optimize relationships.

While this article can't describe every detail of every change we made, it does describe four of the key ideas that now drive our organization:

### 1. The customer drives everything.

There's a lot of talk in health care today about being “patient centered.” Unfortunately, what that usually means is that the patient is put in the middle and then all the “really smart, professional people” stand around and try to decide what's best for that person.

In our organization, we use the term “customer driven.” This means that everything our customer-owners define as needs, goals and values become the system's focus. The doctor and clinical team provide expertise, keep track of preventive matters, explain options and make recommendations. But the customer-owner is in control and makes decisions, rather than the provider trying to decide what's best.

It turns out that when given this kind of control and partnership over time, customers make knowledgeable, informed decisions about their health care treatment and generally choose less aggressive treatments than medical professionals would choose for them.<sup>2</sup>

SCF has at least 10 different strategies that we use to listen to our customer-owners. These strategies include surveys, focus groups, mystery shoppers, project teams and advisory councils.

It's been well documented that our country's health care system does not work particularly well for *any* human being, but it

■ Southcentral Foundation embarked on a whole-system transformation when it transitioned to customer ownership in 1999.

■ Its customer-driven approach has led to improved outcomes and satisfaction.

■ In the SCF system, the core product is relationships.

works less well for those who are in the minority.<sup>3</sup> The way to be culturally competent and to narrow health disparities is to put services into culture rather than culture into services. This means to integrate services, functions and advice into individuals' lives on their terms in personal partnership over time. For example, Alaska Native people are inclusive when addressing illness and health, so primary care is delivered with integrated care teams that fully incorporate tribal doctors or traditional healers as well as chiropractors, massage therapists and acupuncturists. A system owned by the customers will at its core be culturally competent because they are the decision makers.

**2. All customers deserve to have a health care team they know and trust.** In the SCF system, the team's job is to work with the customer-owner to establish a trusting, accountable, long-term relationship, provide primary health care services and coordinate all other health care needs. When describing the health care team, the customer-owner should be able to say: "I work with my team and have determined what I need and when, where and how I want it. I know the team, and the team knows and cares about me. The team listens, provides advice and supports my health journey. My questions and concerns

are answered. Care is coordinated. My values and goals drive care plans." That is the crux of ideal health care.

Small, integrated primary care teams (or "medical homes") have been established to provide this type of service. Customer-owners choose their own doctor (family physician, pediatrician or internist) and may choose a different one if they are dissatisfied. Each team has a doctor with one or two medical assistants, a full-time nurse who focuses on care coordination and an administrative assistant who provides case management support.

One of the more transformative steps we've taken is to recognize that behavioral issues are an important component of health. SCF is attempting to put the mind and body back together by incorporating behaviorists into the primary care team.

All care in the clinic occurs in exam rooms using all or selected members of the integrated care team, depending on the customer-owner's needs. All members of the team must work at the top of their license, with doctors giving work to nurses, nurses giving work to administrative support, and so on. Behaviorists become primary for those for whom it is appropriate.

An objective of our system is to have customer-owners and their families seeing the

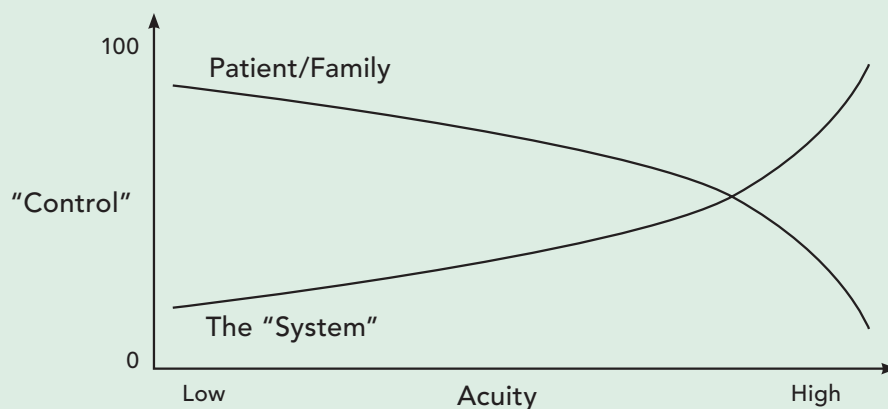
■ Small, integrated, primary care teams not only deliver care to customers but also seek to know them and develop relationships with them.

■ Each team includes a primary care physician, one or two medical assistants, a nurse who focuses on care coordination, an administrative assistant and, often, a behaviorist.

■ All members of the team are encouraged to work at the top of their skill level.

### WHO REALLY CONTROLS OUTCOMES?

The majority of health care occurs at the low-acuity end of the scale, where outcomes are controlled not by physicians or "the system" but by the everyday choices of individuals and families, which are strongly influenced by their values, culture and communities. The largest opportunity clinical staff have to influence health outcomes is to influence choices by partnering over time.



same team every time, and to have teams seeing only their panel, which is equally important. This allows teams to be responsible and accountable. A team that doesn't manage its schedule efficiently will suffer the consequences, and a team that *does* manage its schedule efficiently won't be penalized by having to absorb another team's overflow. In other words, each team reaps all the positive and negative benefits of how it interacts with its panel. If doctors insist on separate visits for every little problem, schedule follow-up visits even when it doesn't make good clinical sense, don't manage minor issues on the phone or by e-mail and don't hand work off to their case managers, then those doctors stay late. Attention is paid to each integrated team's panel size, which averages about 1,200. Panels are opened and closed to keep them equivalent, and we adjust by age and gender. (We don't adjust by severity. When you allow individuals to choose their physician, a fairly random distribution of complexity occurs.)

The vast majority of health care needs can be met within the integrated care team in primary care, but high-risk, complex or fragile

portions of our population may occasionally be sent outside of the medical home for care. In these situations, care coordination is happening within the medical home. The handoff is immediate so the crisis can be taken care of promptly and the customer-owner can be returned to the medical home.

The team concept has been extended by assigning specialists and ancillary providers to each primary care team. For example, Dr. A's team may be assigned to work with nutritionist B, midwife C and pharmacist D, so they are all familiar with one another. This helps reinforce the importance of relationships – even among team members. When team members are in relationship with one another, they are more effective.

A side note to physicians in solo or small group practice: From a customer's perspective, health care is best delivered as a system. That system need not be under the same organizational roof. It can be a voluntary alliance of individuals or practices that have gotten together and decided to work as a system.

**3. Customers should face no barriers when seeking care.** To build relationships,

■ Teams see only their panel; they do not have to absorb overflow from another team.

■ Panels are managed so they maintain a standard size of approximately 1,200 individuals.

■ When care is needed outside of the medical home, the handoff is immediate and the customer is returned promptly.

## MEASURES OF SUCCESS

Each year, Southcentral Foundation's customer-owner population grows by about 7 percent, and the organization receives a funding increase of approximately 2 percent from the Indian Health Service. Despite being underfunded, we have dramatically improved our performance since we began our transformation efforts in 1999. The following are just a few examples:

**Utilization.** We've seen a drop of more than 40 percent in urgent care and emergency department utilization, 50 percent in specialist utilization and 30 percent in hospital days. We attribute this to our relationship-based approach, same-day access and better management of chronic conditions.

**Clinical quality.** Looking at state-produced Medicaid data on children with asthma, our "perfect care" went from 35 percent to 85 percent and hospital admissions dropped from almost 10 percent to less than 3 percent. The number of HIV-positive individuals admitted to the hospital went from 22 percent to 8 percent. Our childhood immunization rate went from about 85 percent (which was good) to 94 percent.

**Access.** By implementing same-day access, we reduced the number of individuals on our behavioral health wait list (backlog) from about 1,300 to nearly zero in one year.

**Customer-owner satisfaction.** Our latest survey of customer-owners found that 91 percent rate their overall care favorably.

**Staff satisfaction.** Every two years, we do a thorough review of every clinical team in our organization conducted by an outside consultant. The latest review found that 80 percent of our teams think they're the best team in the organization, which we believe is a strong indicator that we're doing something right.

## Each team reaps all the positive and negative benefits of how it interacts with its panel.

all barriers must be removed, including the barriers of space, attitude, language and time.

To address time, our primary care system has been offering same-day access for about eight years with 70 percent to 80 percent of our appointment slots open on any given day when that day starts. Every doctor has a schedule composed of 15-minute appointment slots; how those slots are filled is decided almost entirely by those calling, in communication with the team. About two-thirds of teams give out their direct phone lines, so customer-owners have easy access. Teams handle what they can over the phone, and if someone needs to be seen, he or she can be scheduled today with the doctor or can meet with the case manager, behaviorist, medical assistant or other members of the team, depending on the nature of the problem. The expectation that everything needs to go through the doctor, who then disbursts the work to everyone else, is gone. To eliminate the doctor as a rate-limiting step, or bottleneck, processes are performed in parallel, shifting the work to where it's most appropriately and cheaply done. For example, the case manager could be seeing someone who needs chronic disease monitoring, the medical assistant could be performing a point-of-care test, and the doctor could be working with someone who has new health issues. This improves access and reduces waiting times because more people can move through the clinic in the same amount of time.

Office visits are not the only way to relate. Teams also use phone and e-mail as needed. Although there is no payment in our system for interactions that are not face to face, they are beneficial, as these often replace low-level office visits, which lose money in our environment.

If a customer-owner needs or wants the advice of a specialist outside the primary care team, we try to take care of that on the same day. Ideally, specialist access should take only minutes (e.g., the doctor sees someone who

needs another provider's assistance, the specialist is called, and either the information is obtained or the individual is sent to the specialist's office right away). For example, in our system, the cardiologists tend to know most of the fragile cardiology cases and the pulmonologists tend to know most of the fragile pulmonology cases, so if these specialists are accessible by phone during the primary care visit, issues usually can be taken care of immediately. If an issue can't be resolved over the phone, the customer-owner can walk over to the specialist's office that day. This goal has not yet been achieved for all specialists in our system.

Another area where SCF has worked hard to remove barriers is in the design of our physical spaces. The importance of intentional facility design has resulted in top awards nationally and internationally for our outpatient facility design, which was inspired, designed and built by Alaska Native people based on how they said they wanted our facility to look, feel and function (see <http://www.southcentralfoundation.com/images/pccnight.jpg>). Besides offering functionality, beauty and inspiration, our facility design also promotes dignity, pride and self-confidence, which influence health status.

**4. Staff members and supporting infrastructure are vital to success.** Staff members, particularly front-line staff members, are critical in building relationships in health care. Therefore, who is hired, how they are trained, and how they are managed is important.

A lot of time, energy and resources are devoted to helping employees understand their roles, and a variety of protocols and best practices have been developed to help employees work effectively. Regular huddles and team meetings are held so that information is shared. Regular feedback is given, including monthly provider packets that show how each team is performing on dozens of different clinical measures, including comparisons to the clinic average and clinic best. Specific listings show which individuals are overdue

■ To remove barriers to care, primary care teams offer same-day appointments and are accessible by phone and e-mail.

■ The system is working toward same-day access for specialty care as well.

■ Because staff members are important in building relationships in health care, SCF devotes significant resources to hiring and training.

# Good principles, intentional whole-system design and a clear, defined purpose can work in any setting.

Physicians' salaries aren't based on the volume of their visits but on their team's overall performance.

Staffing strategies include group interviewing, same-day hiring and extensive employee orientation.

To encourage ongoing improvement throughout the system, every staff member is expected to understand and apply basic quality improvement methods.

for services, have been hospitalized in the last month, are high utilizers of particular services or medications, etc. Teams discuss how things are going and how they can move closer to the high performers. In our system, physicians' salaries aren't determined by the size of their panel or how many visits they provide per day; they are driven by the team's performance, how well they manage their panel and how much responsibility they take on. All physicians are reviewed annually and are eligible to receive a merit increase based on performance. In addition, a career progression is being developed so that as physicians gain expertise and accept additional responsibilities in the system, they are compensated with additional money. Doctors have to earn their way into the next level.

Our hiring process involves group interviewing of the candidates, which gives more input and better matching on the final decision, and behavioral-based interviewing, which is more probing than traditional interviewing. Instead of asking candidates simply to "tell us a little bit about yourself," they are asked to "Tell about a time when you encountered an angry customer." Personal stories are illuminating.

Same-day hiring occurs as much as possible, meaning individuals drop off their applications, interviews are conducted and a decision to make a job offer is made within 24 hours. This is consistent with SCF improvement philosophy, which suggests that any delay in the hiring process that does not add value is waste and ought to be eliminated. Same-day hiring also gives us a competitive advantage, particularly in an environment with shortages in health care professionals such as nurses, behaviorists and primary care physicians.

Every new hire goes through a week-long orientation to learn about SCF processes, philosophy and Alaska Native people and cultures. Our front-desk employees receive two additional weeks of training before ever sitting behind the front desk. The front-desk opera-

tions are extremely important to the success of our system, so an investment is made to provide the appropriate up-front training. After up-front training, a six-month mentoring system follows. This has significantly improved performance at the front desk, and turnover in this position is one quarter what it used to be. A similar training process is in place for our medical assistants, and we're looking to add programs for every new member of the clinical care teams.

Every employee is required to be familiar with basic quality improvement methods and to apply those methods in their work. Concentrating quality improvement efforts with a few people will not bring about whole system transformation. It takes commitment and attention to improvement at all levels.

## Impressive progress

Ten years ago, the SCF system was a typical medical nonsystem with good people working under the well-intentioned Indian Health Service. Alaska Native leadership set about changing the system and everything in it. Now, SCF has a great story to tell – a story of real transformation focused on what matters most: our customer-owners.

The lessons SCF has learned along the way can be useful to other health care systems. Each practice, organization and environment has its own set of advantages and disadvantages. But good principles, intentional whole-system design and a clear, defined purpose can work in any setting. **FPM**

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1. Lynn J, Straube BM, Bell KM, Jencks SF, Kambic RT. Using population segmentation to provide better health care for all: the "Bridges to Health" model. *The Milbank Quarterly* 2007;85(2):185-208.
2. Deyo RA. Patients as partners in medical decision making. *J Gen Intern Med*. 2000;15(10):752-754.
3. Moy E, Dayton E, Clancy CM. Compiling the evidence: the national healthcare disparities reports. *Health Affairs*. 2005;24(2):376-387.