

Nuka-style models of primary healthcare

Experiences of introducing systems in three practices in Scotland, drawing from features of the Alaskan Nuka system, have been positive in improving access, patient and staff experience, says Maxine Jones

Maxine Jones
Primary Care
Development Adviser,
International Futures
Forum

The current crisis threatening the future of family doctor services means that primary care individuals and organisations are looking to new ways for a solution. Addressing this requires a change of mindset and investment in primary care workforce and services.

Experiences of introducing systems in three practices in Scotland, drawing from features of the Alaskan Nuka system, have been positive in improving access, patient and staff experience. Establishing Nuka-style systems requires planning, and the main challenges stem from the need to provide adequate numbers of skilled workforce and availability of an extended range of integrated services to support the model.

General practices are under unprecedented strain. The number of primary care consultations resulting from a combination of demographic change, shifting patterns of disease, advances in healthcare and medicines, rising expectations and the transfer of work from hospital to community, rose by 15% in England between 2010/11 and 2014/15

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and 10% in Scotland between 2003/4 and 2012/13.^{1,2} Staffing levels are failing to keep up with the increased workload, and the future of family doctor services is under threat.

This article will outline the experiences of three practices in Scotland designing and delivering new models of general practice informed by the Alaskan Nuka system, widely regarded as the gold standard of primary care internationally.

Alaskan Nuka system

Southcentral Foundation (SCF) delivers its Nuka state-funded healthcare system to a minority Alaskan native population of 65,000 people with high levels of need. This

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multi-specialty community provider offers expanded, integrated primary and community services.³ Based on the premise that health is a product of quality relationships, Nuka recognises health as a human system and not simply a technical service. Adhering to the philosophy, ‘It’s all about relationships’, SCF adopts a generalist way of supporting people to achieve physical, mental, emotional and spiritual wellness.

Its innovative, small integrated team delivery system optimises long-term relationships between patient and provider. Combined with access to extended clinical services, attention to workforce and culture development, and an obsessive focus on placing patients at the forefront of decision-making, SCF has achieved remarkable results in improving access, health and wellness outcomes, use of health services, and patient and staff experience.^{3,4} Nuka has been described by Don Berwick, former Administrator of the US Centers for Medicare and Medicaid Services and adviser to the NHS, as a ‘rara avis in the world of healthcare improvement’.⁴

Model redesign in Scotland

The first step in the redesign was to adopt a ‘three horizons’ approach, recognising that previous activity on improvement had been sustaining a declining system, whereas a refocus on transformative innovation was needed.⁵ Although achieving a far-reaching Nuka system was limited in these relatively small practices, each with fewer than 11,000 patients, the aim was not to do something differently, but to do something different. In collaboration with patients and workforce, the models were geared to putting patients and relationships first (Figure 1).

In the smallest practice, where resource did not allow for a Nuka-style small-team to be set up, a model of case management and holistic assessment was introduced and, in the medium practice, a ‘proof of concept’ pilot involved establishing one small team. In the largest practice, five small teams were introduced located within a central hub to facilitate ‘huddle’ working. Each team comprised a GP, nurse, healthcare assistant and administrator looking after a defined list of patients. GP and nurse-led case management aimed to address the emotional, psychological and social determinants of health, as well as managing

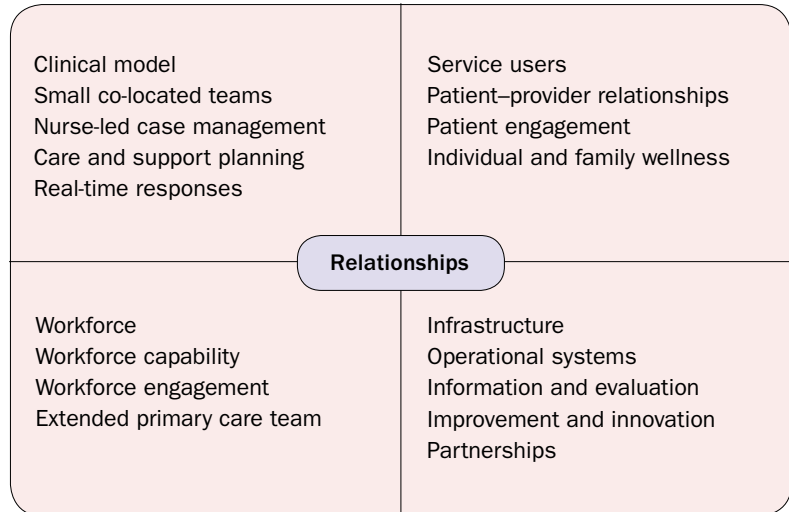


Figure 1. New model framework

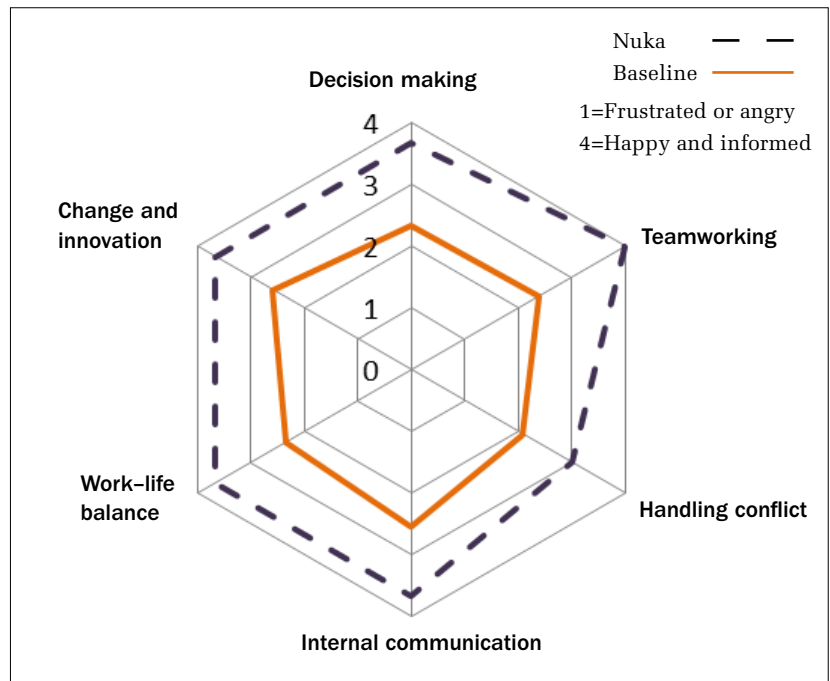


Figure 2. Staff satisfaction before and after small team established

illness. In the ‘proof of concept’ practice a health psychologist fulfilled the Nuka role of behavioural health consultant and in the others, the appointed staff have not yet taken up post but, in one, a community development worker is in place to test social prescribing approaches.

The effect of change

The small practice retained its original team set up and, in the medium practice, the staffing mix allowed its team to be established

Box 1. Key points

- It is possible to adapt features of the Alaskan Nuka system successfully to the local context
- Small co-located team-working can enhance patient and staff experience, improve continuity and care coordination, and achieve same day access
- Workforce capability in case management extending the range of integrated services available locally, could aid implementation if secured in advance
- Team capitation should align as closely to Nuka's 1,400 patient teams as resources allow to provide capacity for proactive and individualised care
- Initiatives may benefit from economies of scale through opportunities offered by larger community and primary care infrastructures

quickly. An inability to replace GP vacancies in the largest practice allowed a review of workforce skill mix and the practice was able to recruit more nurses and healthcare assistants for the teams to be configured more closely to Nuka than was originally possible. Nevertheless, fewer GPs meant that team sizes were larger than originally envisaged.

These initiatives had their challenges and benefits from which useful learning could be derived. In the practices that introduced Nuka-style small teams, patients and workforce quickly reported improved experience of same-day access, quicker response to queries and better continuity with the same team of providers who knew their story well. Where staff satisfaction was formally evaluated, the medium practice saw an improvement in every aspect of satisfaction (*Figure 2*), and the largest saw a moderate improvement.⁶

Anecdotal reports from the smallest showed that staff experience remained satisfactory. It appeared that, where staff felt a sense of control over their working day and enhanced relationships with patients and each

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other, satisfaction levels increased. Likewise, patient experience improved in all cases and formal measurement in the large practice showed an increase from 73% at baseline to 82% six months after implementation.

In the medium practice, nurses were already functioning at an advanced level and could easily adapt to Nuka's case management role. In the other practices, nursing skill varied and opportunities for clinical skills training and consolidation to equip the nurses for case management and generalist care proved challenging and modifications were made to enable this.

In all three practices, telephone consultations increased, and clinical case management meant that many queries could be dealt with more conveniently for the patient by phone, resulting in a sharp fall by about half in booked GP appointments. Better schedule coordination meant that workload planning improved and patients had timely access to the right care providers within their team. Although it was anticipated that improved continuity might lead to decreased demand, the opposite happened in the large practice. This was not unexpected and reflected the experience of Nuka in which demand rose initially and then later declined. Easier access to teams may account for part of this, but larger than planned team sizes limited the capacity to deliver proactive holistic care there, whereas in the medium practice where team size aligned more closely to Nuka, demand felt manageable. In the small practice, where the entire team continued to look after its whole population, demand felt unchanged.

Moving forward, the small practice is consolidating its care and support planning model and, in time, may establish small teams. The large practice is taking steps to expand its range of services and demand management strategies to ensure that resources are matched to need. The medium practice preferred to develop in a different way and, following the pilot, introduced a modified version of team working.

Key lessons learned

The management of change in these three practices has raised multiple issues, but several key points need to be addressed for success (*Box 1*). Whereas all shared a similar vision for a generalist, relationship-based service, differing local contexts meant

that the model evolved in different ways. Nevertheless, the initiatives demonstrated that patient-centred models can enhance patient and staff experience, continuity and care co-ordination, although small team capitation should align as closely as possible to Nuka's 1,400 patient teams to allow for a proactive and individualised approach to care.

Although all achieved same-day access, ideally models should be fully staffed and supported by on-site extended services, available in real time where possible, to ensure that resources match need and patients have timely access to the right care providers. In this respect, Nuka initiatives may benefit from economies of scale in larger community and primary care infrastructures. It is possible to adapt Nuka's features locally, but it is not simply a matter of transplanting the model. The challenges in setting it up should not be underestimated, not least in 'three horizons' terms of redesigning the plane while flying it. Nevertheless, having begun to embed some of Nuka's features in these practices, this has not only alleviated the sense of strain that existed there, but has led to an improvement

in workforce and enhanced the experience of patients. For GPs who are prepared to adapt, they need look no further than Nuka for inspiration in finding ways of alleviating the current crisis and improving quality service delivery and experience. **PM**

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