Integrating specialty care into primary care: The Nuka approach

An overview of the Southcentral Foundation's gradual approach to integrating specialty services with primary care.

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In October 2018, I attended the Southcentral Foundation's (SCF) 3-day course called Behavioral Health Integration in Anchorage, Alaska, which was designed to present their Nuka System of Care (https://scfnuka.com), an approach to integrating fully collaborative psychiatric consultation liaisons into primary care. I also took the course hoping it would be an opportunity to learn how the SCF integrates some secondary and even tertiary health care into their primary care. I wondered where and how they draw the boundary between specialty care and primary care.

The word *nuka* is like the Coast Salish word *skookum*, meaning "strong" or "big." The Nuka System of Care is a comprehensive service mostly for Indigenous people, who are the foundation's customer-owners (i.e., patients). It is important to understand how the Southcentral Foundation does this because, based on their metrics, they are a highly rated primary care health delivery system when compared with any other (as reported by Don Berwick from the Institute for Healthcare Improvement). SCF reports these changes from 2000 to 2017: 40% drop in ER visits, 36% drop in hospital admissions, 97% customer-owner satisfaction, 95% employee satisfaction, 75th to 90th percentile on many Healthcare Effectiveness Data and Information Set outcomes (www.ncqa.org/hedis). They have won the Malcolm Baldrige National Quality Award twice in the last 7 years. The award, established by the US Congress, recognizes US organizations in the manufacturing, services, small business, education, health care, and not-for-profit sectors for performance excellence. Given this commendation, we should be interested in how they do things. Their practices could be of interest and application as British Columbia moves toward patient care networks, also an example of team-based health care.

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Perhaps their most significant project was reassigning the tasks in a family doctor's office. Even the most traditional office divvies up tasks—who answers the phone, who brings the patient to the exam room, who gets the chart out, who makes the first appointment, and who makes the next appointment. The SCF went much further. They slowly and incrementally brought on team members to do more and more tasks that were formerly assigned to a family physician or nurse practitioner, and this changed the relationship between primary and specialty care. They show the changes using two graphics **[Figures 1A and 1B]**.

Today, the SCF's core team centres on the customer-owner and their family [Figure 1B]. This arrangement originated with the decision to shape Nuka based on the cultural values of the Indigenous Alaskan people who own the SCF. Other examples of important Nuka values are "sharing story" (focused listening and telling) and their mantra, "it's all about relationship." The members of an integrated primary care team are the case management support (CMS), registered nurse case manager (RN CM), certified medical assistant (CMA), and primary care provider (PCP, who may be a physician or nurse practitioner). There are seven of these core integrated primary care teams. A team's members sit together in an open area with immediate access to one another and flexibility in who will respond to any customer-owner who walks in. Customer-owners can schedule appointments, but each primary care team keeps approximately half of their appointments open each day for customer-owners who need immediate access to care.

The SCF made changes to the traditional work flow model very gradually starting 20 years ago. The changes were guided by a commitment to:

- Seek feedback from customer-owners through regular surveys.
- Focus on whole person health care.
- Remain up to date on scientific literature (assigned to certain team members).
- Reassess work flow demands.
- Try new things by starting small and then assessing.
- Figure out how to figure things out.

The SCF gradually added support services external to the integrated primary care team but immediately available to the customer-owner. The support services now include the certified nurse midwife (CNM); community resource

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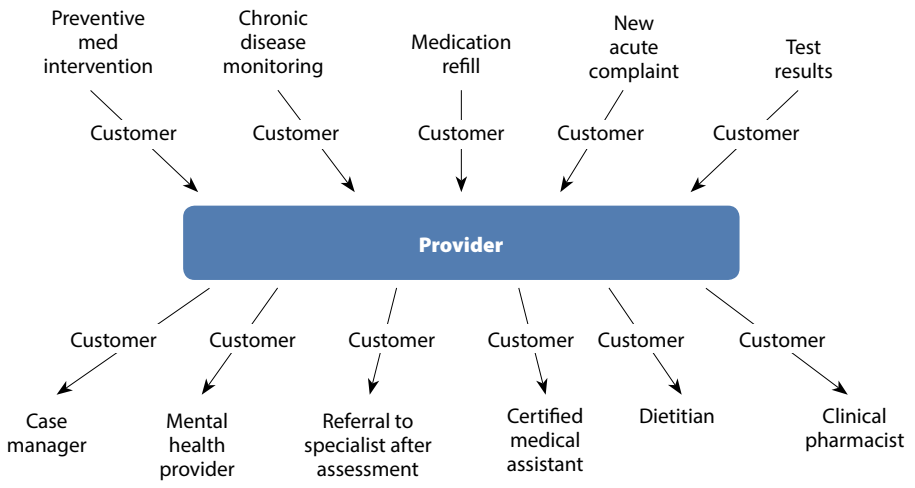

FIGURE 1A. Traditional work flow relationship between patient (customer) and primary and specialty care.

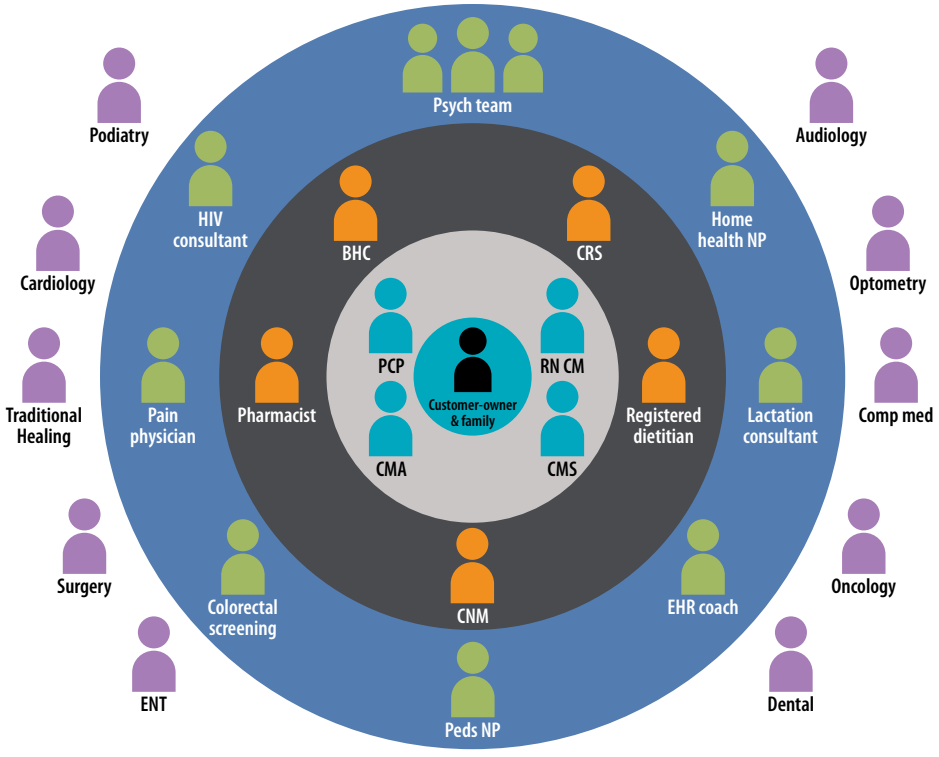

FIGURE 1B. The Nuka System of Care's revised work flow relationship between customer-owner (patient) and primary and specialty care.

Light gray ring: Integrated primary care team—primary care provider (PCP), who may be an MD or nurse practitioner; certified medical assistant (CMA); case management support (CMS); and registered nurse case manager (RN CM).

Dark gray ring: Support services—behavioral health consultant (BHC); pharmacist; community resource specialist (CRS); registered dietitian; and certified nurse midwife (CNM).

Dark blue ring: Shared services—available to customer-owners in all their various distributed teams.

Purple figures: Specialty resources.

Source: Figures 1A and 1B come from the Behavior Health Integration, Participant Guide, provided in the Behavior Health Integration course.

specialist (CRS), who is a little like a social worker; registered dietitian; pharmacist; and behavioral health consultant (BHC).

The SCF hired two behavioral consultants 14 years ago and now has 40 sprinkled around their organization, not only located in core teams. This spread has been gradual, based on the commitments listed above, and tested for effectiveness. The behavioral health consultant's original focus was anxiety and depression, but their effectiveness has led to additional applications. Now they act like consultation liaison specialists, filling a role on the primary health team that was once performed variably by the primary care provider. They contribute to a broad range of clinical situations from advising about flossing teeth to responding to adversity or struggles with illnesses like diabetes or cancer. Their clinical orientation starts with motivational interviewing and brief solution-focused intervention, but they are ready for anything because they are supported by (and provide support to) the whole team, including the in-house psychiatry team and external specialty resources.

All BHCs have master's degrees, but there is no comprehensive university preparation for the job of behavioral health consultant, so the SCF adopted the practice of "growing their own" through constant learning, an intense onboarding process to welcome new employees, and collaboration with local universities through practicums. Clearly, the job is not for everyone. New employees are selected based on their likely fit, determined through behavioral-based recruitment interviews, which focus less on knowledge and more on personal style.

In Figure 1B, the positions shown in the dark blue ring are still within the purview of primary care, having been integrated in response to a demonstrated need and usefulness to the SCF's customer-owners. This includes on-site home health, a lactation consultant, an electronic health record coach, a pediatric nurse practitioner, colorectal screening, a pain physician, an HIV consultant, and an in-house psychiatry team. All of these professionals are readily available to the seven integrated primary care teams and the customer-owners they serve.

Specialty resources are outside the SCF primary care organization but are available through

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established and agreed-upon referral patterns. The SCF reports large reductions in referrals outside their Nuka System of Care. The specialties closest to the SCF are shown on Figure 1B: podiatry, traditional healing, surgery, ENT, audiology, optometry, complementary services (acupuncture, chiropractic, oncology, and massage), dental, and cardiology. Cardiology provides its own referral resource of consultations for patients they have not seen. The SCF asserts that emergency room visits and hospital stays do not contribute to long-term health and are preferably avoided by continuous primary care.

Migrating what were formerly specialist roles into primary care has paid for itself.

Lessons learned

The following are my main takeaways from learning about the SCF's gradual development of the Nuka approach (SCF's gradual approach to integrating specialty services with primary care):

1. The SCF innovated slowly, with careful measurement. Rushing to incorporate expensive innovations for theoretical reasons is not the Nuka way.
2. Choosing which services to integrate was guided primarily by asking customer-owners what worked best for them and keeping track of outcomes (e.g., reductions in specialist visits and ER or hospital stays).
3. Migrating what were formerly specialist roles into primary care has paid for itself by saving costs associated with emergency room visits, specialist office visits, hospital stays, and an overall healthier population. ■

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were referred directly to First Link by health care professionals (direct referrals) received services 11 months sooner than clients who accessed the services themselves (through self-directed referrals). Early intervention helps individuals with dementia plan their own care while they can do so. The referral form is a fillable PDF document (except in the Firefox web browser).

Further information on First Link, referral documents, and helpline information is available on the First Link website [see box on page 24]. ■

—Hetesh Ranchod, MD

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If you have questions or would like more information, contact gpsc.billing@doctorsofbc.ca or download the physician FAQ document posted at http://gpscbc.ca/what-we-do/longitudinal-care/incentive-program/community-longitudinal-family-physician-payment. ■

—Shelley Ross, MD
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