



Southcentral Foundation's Nuka System of Care

scfnuka.com

4501 Diplomacy Drive
Anchorage, AK 99508

Target population: Alaska Native and American Indian people in Alaska's Cook Inlet region

Mission: Working with the Native Community to achieve wellness through health and related services.

Context

Southcentral Foundation (SCF) is an Alaska Native customer-owned health care system responsible for providing health care and related services to approximately 65,000 Alaska Native and American Indian people in Alaska's Cook Inlet region. Prior to 1998, health care for Alaska Native people was provided by the United States Indian Health Services department; however in 1998, Alaska Native people chose to take full responsibility for their own health care, with SCF taking responsibility for primary care and related services.

Today, SCF has grown from fewer than 100 to over 2,200 employees, with an operating budget of over \$300 million U.S. SCF operates the Nuka System of Care, which is a customer-driven, relationship-based health care system. In the Nuka System, the Alaska Native and American Indian people SCF serves are not patients, but "customer-owners," working in relationship with providers to achieve overall wellness. Nuka has distinguished itself as one of the world's leading health care systems, and SCF regularly hosts visitors from around the world who come to learn about Nuka and seek help in reforming their own health care systems.



Governance & management

SCF operates under the tribal authority of Cook Inlet Region, Inc., which appoints SCF's seven-member Board of Directors. The Board makes policy for SCF and exercises overall control and management of the organization's affairs. All members of SCF's Board of Directors are customer-owners, as is the President/CEO and over 60 percent of management/leadership.

Funding

SCF has a diverse funding stream, with funding coming from a variety of sources including but not limited to: United States Indian Health Services, private insurance, Medicare, Medicaid, private and public grants, and other third-party payers.

What this initiative is about

Our history

When Alaska Native people chose to assume responsibility for their own health care, they chose not to continue the practices of the past. Although the government personnel who had been running the system previously were well-intentioned, the care provided was ineffective, did not address whole-person wellness, and was not culturally appropriate for the people being served. Alaska Native leaders and community members saw the need for change.

Customer ownership model

Upon taking responsibility for primary care, SCF spent a year collecting feedback from the Native community and transformed the health care system based on what they wanted, establishing the Nuka System of Care. The system was completely overhauled to focus on two major elements: customer-ownership and relationships. SCF does not refer to the Alaska Native and American Indian people it serves as "patients;" this term sounds passive and does not reflect the level of engagement for which SCF strives. Rather, since the people SCF serves are both SCF's customers and the owners of the health care system, as well as of their personal health journeys, they are "customer-owners."

SCF strives to engage the entire Native community in the health care system. On the individual level, SCF recognizes that each person has more control over his or her own health outcomes than providers do, and that when providers build strong, long-term relationships with customer-owners, it helps providers understand customer-owners and the health issues they may be facing. It also builds trust, which allows providers to more effectively support customer-owners in achieving wellness.



SCF hosts the Annual Gathering, a free event that community members can attend to learn more about services available at SCF and enjoy live entertainment, with activities for children and Alaska Native art available for purchase. SCF also maintains close relationships with organizations in the community such as the Alaska Federation of Natives and the Alaska Native Health Board.

Another method of community engagement SCF uses is the Health Education department. Through this collaboration, events and services for customer-owners such as group classes, gatherings, workshops, special events, health fairs, individualized counseling, cooking classes, and educational demonstrations are provided.

Impact

- SCF's efforts to engage customer-owners and the community have had positive impacts. Since establishing the Nuka System of Care, Emergency Department visits for customer-owners have decreased by 40 percent, and hospital stays by 36 percent.
- SCF is in the 90th percentile nationwide for health measures such as cervical cancer screening, diabetes control, and CVD control < 100mg/dL, and in the 75th percentile nationwide for many other measures.
- 97% of customer-owners are satisfied with the care provided by SCF, 96% agree they have a say in care decisions, and 94% agree that their culture and traditions are respected at SCF. SCF has also achieved 95 percent employee satisfaction.



Insights (Key learnings)

- Through establishing and operating the Nuka System of Care, SCF has learned that listening to the community and building the health care system around what they want leads to a more engaged community that is more invested in their own health care.
- Continual engagement efforts and involving the people the system serves in decisions about how that system operates, improve health outcomes and customer satisfaction rates.
- By letting customer-owners take the lead in their own health care, and being unafraid to make bold, sweeping changes, a high-quality, sustainable system can be built and tailored to the needs of the community.
- The Village Services Management Team serves as an advisory committee and liaison between SCF and Alaska Native representatives from the 55 rural villages SCF serves.
- The Elder Council advises SCF on the Elder Program and other areas which impact Elder health.

Context

- Health and social issues are mutually reinforcing each other.
- Social challenges are often unaddressed in medical care, while community organizations struggles to address healthcare issues.
- Experienced patients and engaged citizens are experts in navigating across the healthcare system and their community, but their role is rarely recognized nor integrated within existing structures.
- Caring Community started as a small-scale experiment within a primary care practice in Montreal (Canada). The project co-leaders started caring together for patients in situations perceived as “clinical gridlocks” by professionals.

Mission & Target population

Mission

Partnering with patients, citizens, clinicians and decision- makers to bridge community and professional care.

Target population

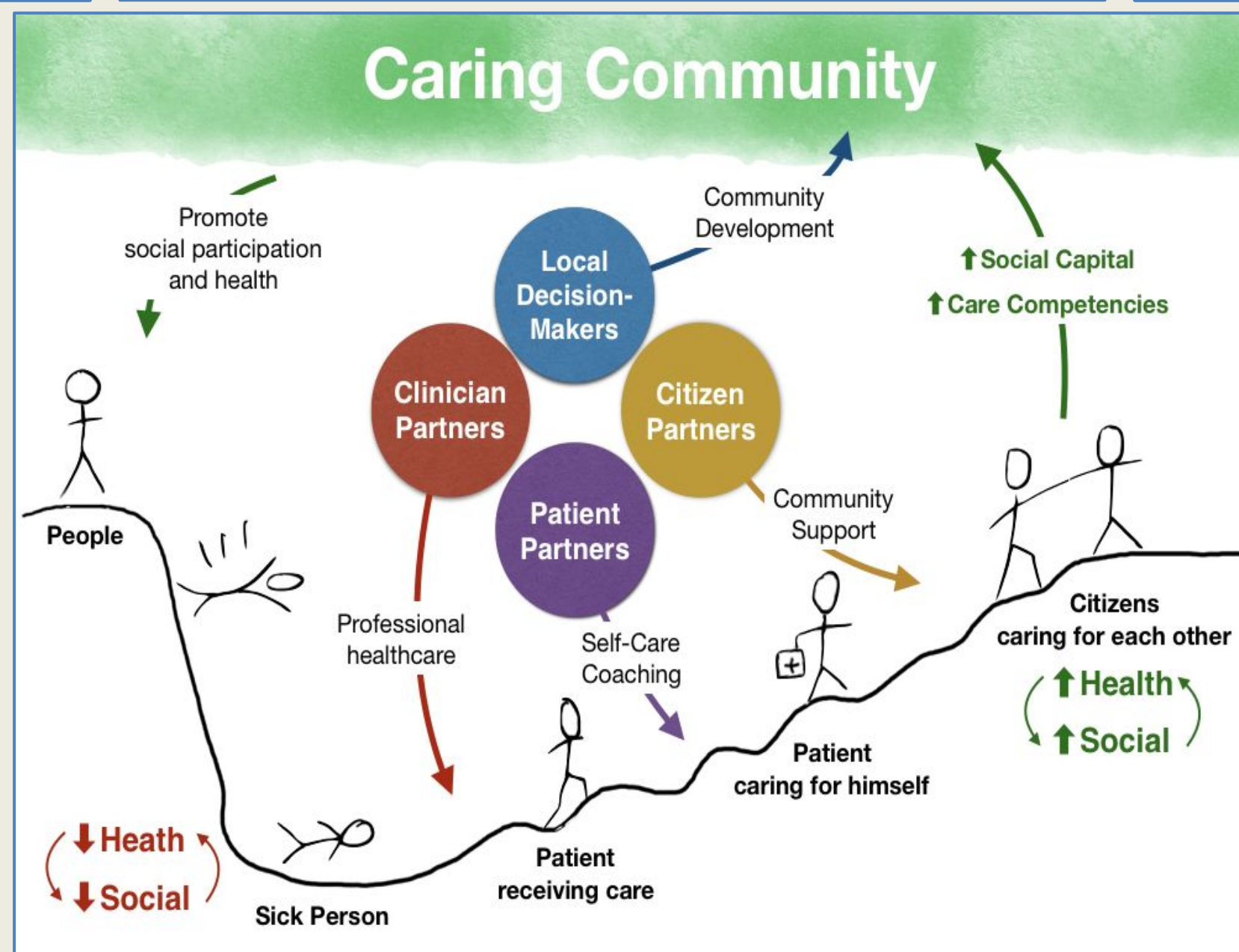
Community members with complex medical and social needs. This is a generic community-focused intervention rather than a disease or population-specific initiative.

Impact

- This initiative is embedded in an ongoing action-research project. Anticipated impacts include:
1. Builds patients’ self-care capacity, social capital, and community connection;
 2. Recognizes patients and citizens partners as full members of community-based primary care teams;
 3. Promotes social participation and full citizenship;
 4. Connects health professionals and community resources for integrated medical and social care;
 5. Builds community capacity through collaboration across healthcare, community and local governments.

Intervention & Governance Model

- **Patient partners** with significant lived experience, integrated in primary care teams, coach other patients in developing their self-care capacity, understand their life goals and needs, and facilitate collaboration with clinicians and community members;
- **Citizen partners** with community engagement experience, facilitate navigation across community resources, support patients’ (re-)integration in their community, and encourage social participation and recovery as full citizens;
- **Clinician partners** identify patients with complex social and medical needs, facilitate trustful relationships with patient and citizen partners, and integration of extended community-based primary care teams beyond the clinic’s wall;
- **Local Decision-Makers** from the community, healthcare, and municipal government levels foster supportive environment for integration of care, mutual support and community development through co-governance, co-funding, collaborative arrangements, and policy change.



What this initiative is about

Caring Community promotes collaboration between different members of the community, capitalizing on the ability of patients and citizens to create social connections and take care of each other. Patient and citizen partners meet with patients on a regular basis to discuss issues related to their illness, social situation, life project, and find ways to reduce the impact of obstacles on their daily life as citizens, by collaborating with other members of the community (eg. patient's family, clinician, community worker). A patient partner can guide the patient to better communicate his symptoms, pain, and objectives regarding his treatment, to improve the quality of his relationships with his care team, as well as with his family, and promote the support he receives. As experts of the community, citizen partner can invite patients to take part in activities or use services available in the neighborhood (eg. art therapy sessions, support groups, food banks), to better meet their needs (eg. to break out of their social isolation).

Key learnings

- It is feasible to integrate patient and citizens as members of extended community-based primary care teams. However, it takes time, mutual trust, structured recruitment, role clarification, and sensitivity to professional and institutional barriers.
- Improvements in care outcomes (eg. reduced hospitalization and emergency room visits) and social well-being (eg. improved connections with family members and community resources) have been noted, particularly for individuals with most complex needs;
- Stabilizing the co-governance and co-funding of the initiative are key issues to address for the scaling-up and sustainability of the intervention.

Partners & Funding

The project is co-led by the local municipal government, healthcare institution, community organisations and a research organization, with shared funding from research, government and philanthropic resources (≈75-100k / year).

Caring Community received external support to strengthen its co-governance and sustainability plan, with secured seed money for implementing the model in other communities.

Target population: People requiring palliative and end of life care, grieving and their carers

Mission: To build compassionate communities where everyone assumes responsibility to care for each other during times of crisis and loss.

Context

Prof. Allan Kellehear was the first to develop a contemporary public health approach to palliative and end-of-life care. To help support champions in cities and communities around the world, he released the Compassionate City Charter (CCC) in 2015, as a guide to achieve community wide engagement around issues of caregiving, serious illness, dying, and grieving. The charter is at the centre of the Compassionate Communities (CC) movement and countries around the world have since adopted this theory of practice.

Recently, with a growing senior population, high incidence of chronic diseases, and an overburdened health care system, quality palliative care has enjoyed a renewed focus. Beyond considering only people for whom death is imminent (end of life care), palliative care also includes individuals whose death from a chronic illness may take years. Six in ten Canadians suffer from a chronic illness or have a sufferer in their immediate family, and chronic illness accounts for 89% of deaths, thus generating considerable palliative care needs. Yet only 16% to

30% of dying Canadians have access to, or receive, palliative and end-of-life care services.

Compassionate Ottawa recognizes that care for one another at times of crisis and loss is everyone's responsibility



Governance & management

Every CC in Canada is different as each is rooted in the community and grow organically based on local resources/strengths and the vision of the local champion. As the CC gains traction in the community, often a leadership team or steering committee, comprised of experienced leaders from the community, is created to further grow the initiative. Some CCs have incorporated as their funding support grows.

Funding

Funding support for CC initiatives comes from a variety of sources. Often during the inform and consultation phase, resource needs can be met by volunteers and in-kind supports or small seed/micro grants. As the CC grows resources for professional coordination, events, etc. may be provided by local charities, donors, hospices, community foundations, and provincial bodies. In more established CCs, funding sources have included research grants, private foundations, and provincial health authorities.

What this initiative is about

Compassionate Communities is a social model of palliative care, rooted in community development processes. It is a theory of practice for Health Promoting Palliative Care, developed to form policy and practice coalitions of support for everyone affected by end-of-life events. This is achieved through the empowerment of community members and stakeholders, increase in death literacy, and the focus on quality of life while dealing with a death journey. To ensure sustainability, there is a focus on top-down initiatives such as policy changes and, critically, bottom-up initiatives (such as increasing death literacy through art galleries) that leverage existing community strengths/assets.

All-natural cycles of sickness and health, birth and death, and love and loss occur every day within the orbits of its institutions and regular activities - Prof. Allan Kellehear

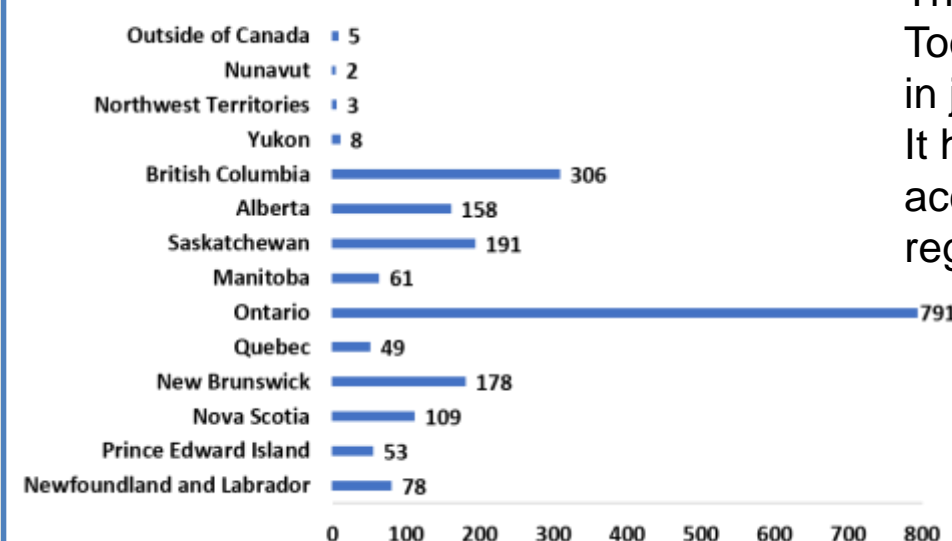
In a CC it is everyone's responsibility to care for each other during times of crisis and loss, and not simply the task of health professionals. The Compassionate City Charter, then, is a tool used to build CCs which includes thirteen areas (e.g., schools, faith groups, institutions) in which social change is fostered.



Pallium Canada is helping communities across the country understand and adopt the CC model, through knowledge translation, project support, connectivity, and leadership. This palliative care approach includes early, compassionate and effective palliative care for all to better support their quality of life. Moreover, it focuses on physical, cultural, psychological, social, and spiritual needs for patients, families (caregivers), and those who grieve, regardless of age or disease trajectory.

CC Startup Toolkit Downloads

Total = 1994



The CC Startup Toolkit downloads in just over a year. It has been accessed in every region in Canada.

Impact

- Evaluating volunteer-led projects operating within the CC model has been a challenge because many initiatives are not-for-profit and volunteer based, and resources allocated to develop evaluation tools has been limited.
- However, having an evaluation is key when CCs are applying to many funding streams. Pallium is partnering with CC initiatives and provincial agencies across the country, to develop common, flexible evaluation tools, which will allow CCs to more easily assess their project impact and contribute to a common understanding of their impact across the country.
- The Compassionate Communities movement in Canada has seen a steady increase in engagement since 2015. Pallium's Compassionate Communities Startup toolkit has now been downloaded in every province and territory with almost 2000 downloads in just over a year.
- At the end of August, Health Canada released the Action Plan on Palliative Care which acknowledges Compassionate Communities as a way to achieve their goal of building greater care capacity in communities.
- More recently, the Federal government has launched initiatives through the Public Health Agency of Canada and New Horizon for Seniors Program that align well with CCs, but there is still a need for a more reliable, sustained network of funders to help the movement grow.

Insights (Key learnings)

To support the palliative care approach, medical professionals, caregivers and community members need to be included in the continuum of care. The addition of community members helps to create a wraparound effect to better support the patient and family dealing with a diagnosis pertaining to a life-limiting and/or life-threatening illness.

Focusing on areas needed to ensure these volunteer led initiatives are sustainable is key. Some of the best practices for community development that we have found to be essential include:

- Finding and supporting passionate community champions.
- Ensuring the champions understand and apply the principles of community development.
- Creating opportunities for connection and mentorship.
- Creating free supportive resources for the volunteer champions.
- Making available appropriate and flexible funding and resource supports as CC initiatives launch and grow.

Instances where countries have tried to mobilize the CC concept but have seen low participation is often due to limited use of best practices in community development such as those listed above.