Southcentral Foundation—Nuka Model of Care Provides Career Growth for Frontline Staff

by Lisel Blash, Catherine Dower, and Susan Chapman, Center for the Health Professions at UCSF
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ABSTRACT

Southcentral Foundation (SCF) assumed management of a primary care system with low patient satisfaction and high staff turnover. This led SCF to create extensive employee development programs and to support a human resources policy in which frontline staff, including medical assistants, can work their way up to the highest ranks of the organization. SCF has developed a uniquely community-centered, team-based model of care that incorporates the people receiving health care as customer-owners of their own care. These initiatives have resulted in excellent health outcomes and high staff retention.

Background & Inspiration

Southcentral Foundation's CEO, Katherine Gottlieb, leads by example. She started her career at Southcentral Foundation in 1987 as an administrative assistant and worked her way up. This background gives her an intimate understanding of the experience of frontline employees and career advancement. To this day she personally leads monthly employee trainings and has supported the creation of an extensive workforce development system and programs at Southcentral Foundation's campus in Anchorage, Alaska. Workforce development is a central tenet of this organization, which sees for itself a dual role in promoting community wellness *and* career development for Alaska Native people.

Southcentral Foundation (SCF) is an Alaska Native-owned health care organization providing integrated primary care and behavioral health services, as well as dentistry, complementary medicine, traditional healing, and home-based services, and education. It jointly owns and manages the Alaska Native Medical Center (ANMC) with the Alaska Tribal Health Consortium. The ANMC includes an 150-bed hospital and provides acute, inpatient, and specialty care.

SCF was formed in 1982 by Cook Inlet Region, Inc. (CIRI), an Alaska Native regional corporation, to

Practice Profile

Name: Southcentral Foundation

Type: Alaska Native-Owned Health Care Organization

Location: Anchorage, Alaska

Staffing: App. 1,400 staff, including

- 40 leadership staff
- 240 providers (MDs, NPs, PAs)
- 230 other health care staff, including:
  - 100 CMAs/LPNs
- 20 clinical, and 117 non-clinical, managerial staff
- 360 clerical staff

Number of Customer-owners: 55,000,

Annual Customer-owner Visits: 400,000 +

Customer-owners: Nearly all those receiving health care at SCF are Alaska Native and American Indian people of Southcentral Alaska (the Cook Inlet Region), although the organization has recently begun offering care to employees who are not Alaska Native people.   Approximately 10,000 of these customer-owners live in remote villages.

improve the health and social conditions of Alaska Native People. This was the result of the Indian Self Determination and Education Assistance Act of 1975, which authorized the federal government to enter into contracts with and make grants to federally recognized Alaska Native / American Indian groups. Because of this law, tribes can determine for themselves what services and infrastructure they need, negotiate contracts and apply for grants from the federal government, and then administer their own programs and deliver their own services. [i]

Prior to that time, the health facility was run by the federal Indian Health Service. Employees, many of whom were patients of the prior organization, described it as "health care of the last resort", remembering long waits, uncoordinated and impersonal service, and a general feeling of not being known or valued. The facility was run down; patients, providers, and staff were unhappy; and employee turnover was high. Patients had no consistent physician.

The Nuka Model of Care

When the organization became Alaska Native-owned, administrators wanted to formulate a new model of care that would be not only patient and community centered, but owned by the people it served. SCF moved to calling those receiving services at SCF "customer-owners". Senior administrators noted that customers demand and receive respect; whereas the patient / provider relationship is characterized by inequality. This is more than a simple language shift: Alaska Native people *are* shareholders in the Alaska Native Regional Corporation of which Southcentral Foundation is a part. The transition to a customer-owned system was completed in 1999.

Many of SCF's customer-owners are experiencing the types of chronic diseases that have become all too common place in the United States, especially in disenfranchised communities, including diabetes, hypertension, chronic obstructive pulmonary disease, obesity and others. SCF realized customer-owners had more control over the outcomes for these conditions than the health care system, and that only by enhancing customer-owner empowerment could SCF even begin to address these conditions. Customer-owners are partners in the wellness process and their feedback is solicited, appreciated, and acted upon.

Because customer-owners are facing many challenges that may impact their ability to stay well, SCF has adopted a comprehensive range of integrated services to address multi-dimensional definition of wellness that includes social, physical, and emotional well-being.

Over time, SCF developed a philosophy it calls "the Nuka model of care". This philosophy governs all aspects of the organization and is based on the notion of relationship—getting to know and recognize the uniqueness of the individual customer-owner, employee, or provider in order to develop flexible strategies that fit individual needs. As one staff member noted, "Everything is a conversation; our policies are guidelines."

> *"The name came from my children. They heard the name as they grew up. It is a name given to strong, giant structures and living things, mountains and polar bears. I have an association with this name that relates to SCF – it is about Love – it is an association with a deep, long relationship with a living, breathing thing that has life."*
>
> *-Katherine Gottlieb, President and CEO-*

Training Needs

As the organization tried to transition, it found that the high turnover rate among frontline employees (around 40%) impeded its ability to implement the new model. A series of surveys and exit interviews revealed that many employees had little training in customer service skills or team-based work. Staff felt they were just being put on the floor with little or no orientation. As one staff member remembered, it was "sink or swim".

SCF had initial experience in developing training programs for dental assistants. It was difficult to find trained dental assistants in Alaska. SCF recognized a need to grow their own dental assisting workforce, and so began a job training program to prepare high school graduates to become dental assistants.

In 2001, SCF developed an employee training initiative for frontline clerical staff. The ASTP, or Administrative Support Training Program, was inspired by a Baldrige Award-winning employee training program implemented at Pal's Sudden Service.[ii] The Baldrige Performance Excellence Program of the National Institute of Science and Technology awards and profiles high-performing private sector companies that are willing to share their quality improvement strategies with others to inspire replication.

Pal's Sudden Service was a fast food chain with high employee retention rates and high customer service ratings. This organization had invested significantly in quality improvement and staff training, development, and advancement. SCF adapted parts of this initiative to fit the health care environment. From this model, it developed a six to eight week training and on-boarding session for new clerical staff. The ASTP was very successful at improving quality and retention.

At the same time, SCF created the Development Center, which provides employee on-boarding and training. As a result of its success, the Development Center has grown from a staff of three in 2002 to a staff of almost twenty today.

SCF also found that it needed to make some structural changes to clinical staffing in order to afford the type of high-quality, comprehensive, preventive, and chronic care its customer-owner's required. Staff were trained to work at the top of their license in small teams, and all but the most critical tasks were delegated to non-providers. The role of the registered nurses (RNs) was shifted to panel management and chronic disease management. Many of the RN's day-to-day clerical tasks were delegated to advanced administrative staff, or case management support (CMS) staff. Nearly all of their day-to-day clinical tasks were delegated to certified medical assistants, or CMAs.

While it began to depend more on its CMAs, SCF still experienced retention and performance issues with this group of employees. Clinical managers realized that the ASTP training model could be beneficial for entry-level clinical staff as well. The CMA/LPN Clinical Training Program (CCTP), which started in 2005, was intentionally modeled after the ASTP. This one-week on-boarding and training program was developed by a nurse who worked with high performing CMAs to develop it.

CMA Training

Medical assistants are required to be nationally certified prior to hire and are hence certified medical assistants, or CMAs. CMAs, like all employees, undergo a three and one half day new hire orientation. After this orientation period, they attend the five- to six-day CMA/LPN Clinical Training Program with a learning and development specialist and adjunct staff. Trainees attend courses in a simulated clinic in the Development Center. Initially, ASTP and CCTP sessions had up to 25 participants. Due to increased retention, they now often include no more than four participants, so trainees receive individualized attention.

CMAs and LPNs have already received training through their pre-employment medical assisting or nursing programs. For these workers, SCF training involves a review of clinical skills and competencies with a new focus on how these relate to the Nuka model of care, customer-ownership, wellness, and cultural appreciation.

> "When medical assistants go through their MA training, no one is talking to them about what to do when someone needs comfort or shares their story-- how do you cope with that? They are just learning technical skills in their schools. Our organizational culture is about creating relationships with each other and the customer-owners; this is what you have to be good at here."
>
> *-Michelle Tierney, Vice President of Organizational Development and Innovation-*

Other topics covered include understanding expectations, working in teams, integrated care, quality improvement measures, and PDSAs or the Plan-Do-Study-Act Cycle method of testing a change for quality improvement. New hires are also given information about what would be required to advance in the organization.

Clinical topics are covered via role play, simulation and didactic instruction in the mock exam room. Trainers review the equipment used at SCF, how to do blood draws, and dosage calculation. There is a competency test for clinical skills. However, as one staff member noted, "Competencies are not the core; competencies reinforce philosophical values."

A unique aspect of the training is the use of peer instructors, or subject matter experts (SMEs) for many of the sessions. Experienced CMAs, behavioral health consultants, physicians and others are given time off from their jobs to teach from their experience. The Development Center can assign instructional designers to work with the SME to develop a curriculum that the SME can then deliver.

> "We operate now with the SME (subject matter expert) model; that's nearly 100 SCF employees who are not Development Center employees serving as adjunct faculty through formal learning courses and programs. It is an unwritten expectation that employees give of their own expertise through teaching their peers. It's not just the job of employees with the word Trainer in their title."
>
> *-Kristi Brenock-Leduc,*
> *Director of Learning & Development-*

However, CMA / LPN training does not stop after new hires leave the Development Center to enter their departments. After they go through on-boarding at the Development Center, they go through a structured departmental orientation, which lasts two to six weeks, depending on the department. Employees are mentored by a senior CMA until they are ready to work on their own.

Finally, there is mandatory 3-day workshop lead by the president and CEO that is offered once a month. This workshop reviews key tenets of the organizational philosophy and model of care, and the fact that it is led by top leadership demonstrates the organization's commitment to employee training and the Nuka model of care.

Due to the commitment to a relationship-based model, most of the training the Center conducts is in-person. However, they have recently moved to conducting some trainings online via an online learning management system. For instance, CMAs are required to do an annual refresher course, which was previously conducted via a skills fair. The Center is experimenting with conducting this course via MediLearn.

Educational Assistance

The Development Center also administers an educational assistance and scholarship program. All employees can receive at least some funding for the time they need to take off to attend college or advanced health care training.

Alaska Native and American Indian employees can apply to receive funds to cover the cost of tuition and other educational expenses. Currently, at least two CMAs are studying to become physician assistants utilizing these resources. As several interviewees noted, there is great need for more Alaska Native providers and the organization is eager hire staff into these positions once they graduate.

The Development Center works with the Human Resources Department to achieve SCF's broader organizational goals around workforce development, which include increasing the number of Alaska Native employees and strengthening the development of Alaska Native leaders by providing education, development and promotional opportunities. The SCF workforce is currently approximately 53% Alaska Native / American Indian, so many of the staff are customer-owners.

Maximizing Human Resources

The Human Resources Department has enacted some innovative models of recruitment, hiring and deploying staff. SCF Human Resources employees participated in the Institute for Healthcare Improvement's workforce collaborative and tested two initiatives—team based hiring and the behavioral approach to interviewing.

Because of the organizational goals of hiring more Alaska Native staff, developing Alaska Native leaders, and emphasizing integrated relationship-based care, SCF has focused more on recruiting and screening based on attitude and potential rather

than strictly on credentials and experience for front line staff. This is especially true for administrative support staff, who receive extensive training at SCF after hire.

There is a behavioral-based interview committee for each applicant that includes seven individuals from different parts of the organization.

The organization has moved to a non-vacancy based model for positions that have multiple openings across the system. Departments are asked to try to predict their hiring needs for the next month. Due to the trainings, a long lead time is needed before an employee can be put out on the floor. SCF over-hires by about 20% to avoid being short-staffed and to cover during the training period. This strategy also allows the organization flexibility for large scale training, such as training for the upcoming transition to electronic records, because it has additional staff to cover operations while some staff participate in these sessions.

Departments used to advertise individually for new hires and screen their own applicants. Now the organization posts one job description for categories that commonly have openings across the organization. All screening, interview, and selection is done by the interview committee. Committee members take into account overall organizational needs in determining whether the interviewee would be a good fit for SCF in general, and then whether he or she would be a good fit for a particular department. If the candidate is a good fit for the organization, but there are no openings, the candidate is placed on a wait list so he or she can be hired and trained faster once a position opens up. Departments do not get to know which candidate was hired for them until the trainee shows up for their departmental orientation. This has required building a strong, respectful and trusting relationship between the departments and the HR Department.

Because the organization hosts externships for MAs, promising externs can be interviewed in the last segment of their externship. While there is a preference for Alaska Native and American Indian trainees in externships, there are not enough of these candidates to fill all of the open positions at SCF.

The organization has developed a career ladder as part of a "grow-your-own" strategy to promote from within and develop leaders. Once hired, each

employee has an individual performance development plan agreed between the employee and his or her supervisor.

For CMAs, the initial career steps are CMA I, CMA II, and CMA supervisor. Supervisors do the same work as the people they manage along with their supervisory responsibilities. Frontline staff could, also, move up to Manager I--managing a small program, Manager II—managing a primary care clinic, and Administrator I and II, which entail managing multiple departments. As noted earlier, the CEO of the organization started out as an administrative assistant. While most CMAs follow the supervisory track, some CMAs and other frontline employees might follow a process improvement track going from supervisor to program coordinator, to improvement specialist, to improvement advisor.

The Nuka Model of Care in Practice

Facility Design: SCF was able to better realize some of its principals when it rebuilt its primary care center in 2009.

The three story building contains six primary care clinics, two per floor, including a pediatric clinic and a women's clinic. Each clinic operates independently, but each is similar in design and each dyad of two clinics on a floor shares some meeting, procedure, and break rooms. Decor throughout the building incorporates Alaska Native themes and artwork.

Waiting areas have outside facing windows and comfortable seating arrangements meant to encourage gathering. Waiting areas include a television screening health education videos relevant to the Alaska Native community. There are computer terminals available for customer-owners to research health information.

In the back office, the hallways are carpeted and walls are painted in warm colors. Many rooms have outside facing windows for natural light. The overall atmosphere is warm and welcoming. One of the most striking features of the back office area is the number of "talking rooms". There is one talking room and two exam rooms per provider. Each room has a computer so that providers and staff can access customer-owner education material and records. The talking rooms provide a place where providers can meet with customer-owners for health education, and where customer-owners can meet

with behavioral health providers and/or dieticians as necessary. This frees up exam rooms for clinical purposes, although talking rooms also contain basic tools, such as blood pressure cuffs, for taking vital signs. There are some extra large exam rooms with extra chairs and wider doors that allow for family members to attend an exam.

Each of the six clinics has six clinical teams. Each team has one provider, one RN case manager, 1.5-2 CMA/LPNs and 0.5 case management support (CMS) staff. Each CMS works for two teams. Each team has a panel of approximately 1300 customer-owners. Customer-owners can choose their own team, and often an entire family will see the same team for care.

The seating arrangement in the clinical office is meant to enhance team-building and identity. There are no provider offices. All members of each of the six teams sit in a long room with windows and a high ceiling. The team members sit in a four-square plus-one pattern made up of facing desks with the provider and RN on one side facing the two CMAs in the team. The CMS sits directly behind the RN he or she supports. There are groupings of two teams, then a room divider, then two teams. At either end of the room sits a behavioral health consultant. This seating arrangement facilitates collegiality and communication between team members, and mitigates some of the hierarchical nature of the practice environment. This encourages staff and providers to see themselves as peers.

Another benefit of this particular mode of co-location is that it allows for close supervision of non-licensed staff. This made it possible to delegate more tasks to CMAs, LPNs and CMSs rather than relying solely on RNs.

Aside from the clinical teams, there is also one clinic manager, a CMA supervisor, a dietician, and one CMA who is assigned to do blood draws in the "Support Clinic"—a room set up specifically for this purpose. A front-office staff, including a call center, supports the clinical staff.

Staff can use the talking rooms for private conversations or phone calls, and computer privacy screens prevent anyone except the person sitting directly in front of the computer from seeing confidential information.

New Roles

Clinic Manager: The clinic manager sits just outside the clinical team room in an alcove in the hallway. This places the clinic manager in the middle of clinic operations so he or she can see what is going on with patient flow and be available for team members. The clinic manager directs the overall operations of the clinic.

RN Case Managers: RNs usually do not have direct customer-owner interaction as they work behind the scenes as case managers on prevention and chronic disease management. RNs manage the panel and referrals, take patient calls, and do triage.

Case Management Support: Case management support staff, or CMSs, provide administrative support to the team, particularly to the RN case manager.

Medical Assistants: SCF utilizes CMAs almost exclusively in back office clinical roles.

CMAs do the daily clinical work, and they are the staff members that connect with and build a relationship with the customer-owners. Because families often choose the same team for every member, the CMA will get to know the entire family over time and understand how the health of each member is impacted by that of the others. The ability to retain CMA staff over time is vital to building trust with customer-owners. As one executive noted, the tasks that MAs do at SCF are not that different from traditional MA tasks, but the context in which they do those tasks, and their ownership of the process, *is* very different.

CMAs work from paper charts and schedules, although the organization is in the process of adopting an electronic health record (EHR) system. At the start of the visit, CMAs greet customer-owners, room them, take vitals, and administer a number of screening questionnaires for issues such as depression, and alcohol, drug and tobacco use. They may take part in quality improvement initiatives with their teams, including the PDSA testing of possible improvements. There is a great deal of documentation as the organization is transitioning between paper charts and a new EHR.

CMAs also do blood draws, blood cultures, throat swabs, wound culturing, EKGs, and assist with minor surgical procedures such as colposcopies;

toenail, cyst and skin tag removal; IUD insertion and removal; and scheduling of mammograms and radiology exams. They deliver nebulizers, administer medications, immunizations and antibiotic injections. They may also collect specimens, label them and send them to the lab. They conduct lead testing on children, as needed, and apply fluoride treatments to children's teeth.

CMA Supervisor: The CMA supervisors are responsible for assigning to CMAs the monthly duty rotation, which includes quality control for various tests, making sure emergency equipment is functional, maintaining hygienic conditions in labs and test rooms, and ordering supplies. The supervisors also have disciplinary responsibility over other CMAs and collect and review timesheets. The CMA supervisor is the person other CMAs can go to with clinical questions and may serve as the CMA mentor for new CMAs. He or she may serve as a float and can cover for other CMAs. Finally, the CMA supervisor may serve as adjunct faculty for the Organizational Development Center.

Information Technology

SCF is moving to implement electronic health records. It uses paper charts while records are being scanned and transitioned over to the EHR. Despite the lack of an EHR, SCF is very data-driven. It currently uses a number of systems to track outcomes and compiles them in what it calls a data mall. Each clinic has a staff member assigned to the front office to track operational and clinical outcomes. This employee compiles and mails periodic outcomes reports to staff. These reports are shared at the monthly all-staff meetings, and at CMA-only meetings and used for quality improvement. At one clinic, the CMA supervisor incentivizes other CMAs to improve their screening rates by offering prizes, like a ½ hour massage, for high achievement.

Resources

Operations: SCF has an annual budget of $210 million. The organization receives approximately 44 percent of its funding from the Indian Health Service, 49 percent from third party reimbursement (including Medicare, Medicaid, and other), and 7 percent from grants and investments.

Development Center: Funding for the Development Center comes out of the general operating budget. As part of the annual budget

process, leadership makes the difficult decisions about what to fund. SCF, as part of its strategic plan, is committed to developing and retaining its work force. Therefore, leadership has decided to provide funding for training and development.

The Center is housed in its own two-story building. It has close to 20 employees, a computer learning center, and a number of classrooms and conference rooms for trainings and meetings. In addition to the regular Development Center Staff, the center relies on the support of leaders and employees across the organization that serve as SMEs (Subject Matter Experts). For the CMA training program, one physician and an RN Case Manager provide this support.

Scholarship Fund: The funds for the scholarship to grow leaders in Alaska Native organizations come out of general operation funds. The fund has averaged about $100,000 per year.

Challenges

Scope of Practice: Moving to a team-based model entailed some discomfort. Because staff are asked to work at the top of their license, some nurses initially resented the greater reliance on CMAs for hands-on clinical care. RNs are now employed as case managers, with administrative support from CMS staff, which entails a higher level of skill from the RN and has reportedly resulted in greater satisfaction. However, nurses who prefer hands-on clinical work are unlikely to be happy with this role.

Complaints from nurses and others that CMAs were not well-enough trained to cover a range of clinical tasks were answered by forming multidisciplinary teams and co-locating the members so CMAs get constant feedback and supervision. The SCF has confirmed through legal review of the scope of practice issues that the delegation of tasks to CMAs is appropriate.

Provider Resistance: While providers are reportedly happy with the current model, a few have found it difficult to delegate tasks and work with a team. Because SCF practices open access scheduling, providers cannot afford to hang onto tasks that others could do in their stead. SCF has worked to enhance providers' trust in their teams by carefully screening and placing employees, intensive training and on-boarding of employees, and through co-location of team members.

Time Required for Training: The on-boarding and training of new employees takes a long time. Many departments would prefer to get their staff faster. However, Development Center staff believes that making the investing upfront in training will pay off in the long run.

Departmental Resistance: Initially the individual departments were apprehensive about giving up control about who they were hiring into their departments. The Human Resources department was able to show that they could save them time and energy by taking on that component for them. The Human Resources Department invested a lot of time and energy meeting with departmental heads to build a positive relationship. Proving that they could make good choices for departments was key to building that trust.

Supervisory Skills: One challenge has to do with the grow-your-own career ladder. Staff move up the ladder to the level of supervisor because they are good at their job, but they may not have any background in supervising others. This has led some to suggest greater investment in supervisor/mentor training programs to prepare staff to take on managerial roles.

Marketing Educational Advancement: The Development Center has had $100,000 per year on average available for scholarships. Because of poor take-up, several years went by without the full allocation being used. In 2009, the Development Center started a marketing campaign called DEAL (developing employees as academic leaders) and started working with universities to recruit staff into academic programs. Due to this campaign, they were able to use the entire allocation in the last fiscal year. The program has now become quite competitive and the Center is fielding high quality applicants.

Outcomes

Because SCF is invested in evidence-based practices, it maintains extensive data to measure its progress over time in a number of realms.

Employee Satisfaction: SCF administers Morehead Associates' Workforce Commitment Survey annually. This survey utilizes a five point scale to measure employee response to a number of questions about the workplace. From 2005 to 2009, the organization has made

improvements in satisfaction scores, including satisfaction with benefits (from 3.69 to 3.89), agreement that SCF helps in balancing work life and personal life (from 3.67 to 3.87), agreement that SCF is interested in health/wellness (from 3.68 to 4.02), and agreement that SCF cares about employee safety (from 3.88 to 4.30). Overall, employees generally highly agree that they understand SCF's mission and core values (4.43).[iii]

Retention: Overall staff retention is now 83%. This figure has improved steadily since 2008, when it was approximately 70%, and the early part of the decade, when it was around 60%.

Retention has many benefits for the organization and the customer-owners. CMAs report that they build a relationship and familiarity with customer-owners that is important for enhancing care. Retention also means that CMAs get to know and work with their teams better and learn more skills, which again, enhance care.

> "The retention rate keeps your familiarity with customer owners and your team. You get more comfortable; they are more comfortable with you assisting with the procedures, and you feel better because you are learning more."
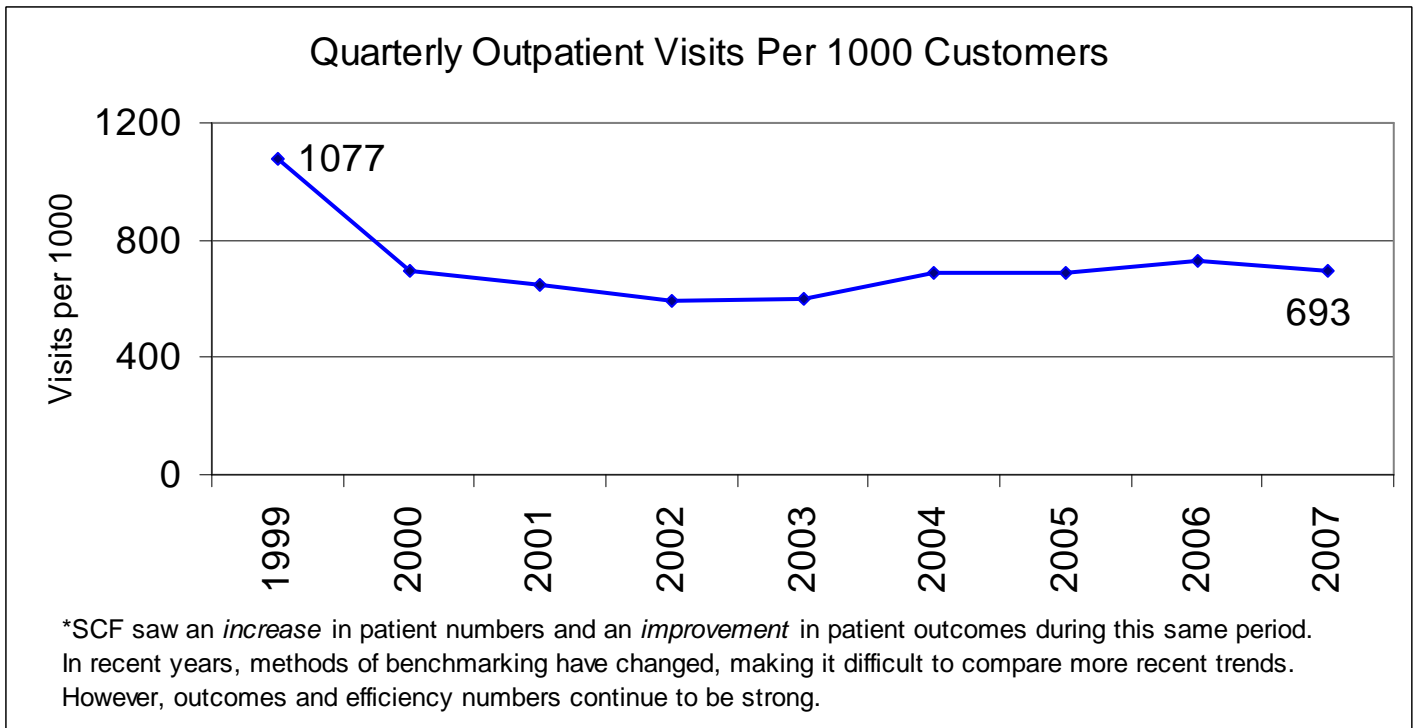>
> –Jolene Torsen, CMA Supervisor-

Patient Satisfaction: In a 2010 survey, SCF received an overall customer satisfaction score of approximately 91%.[iv]
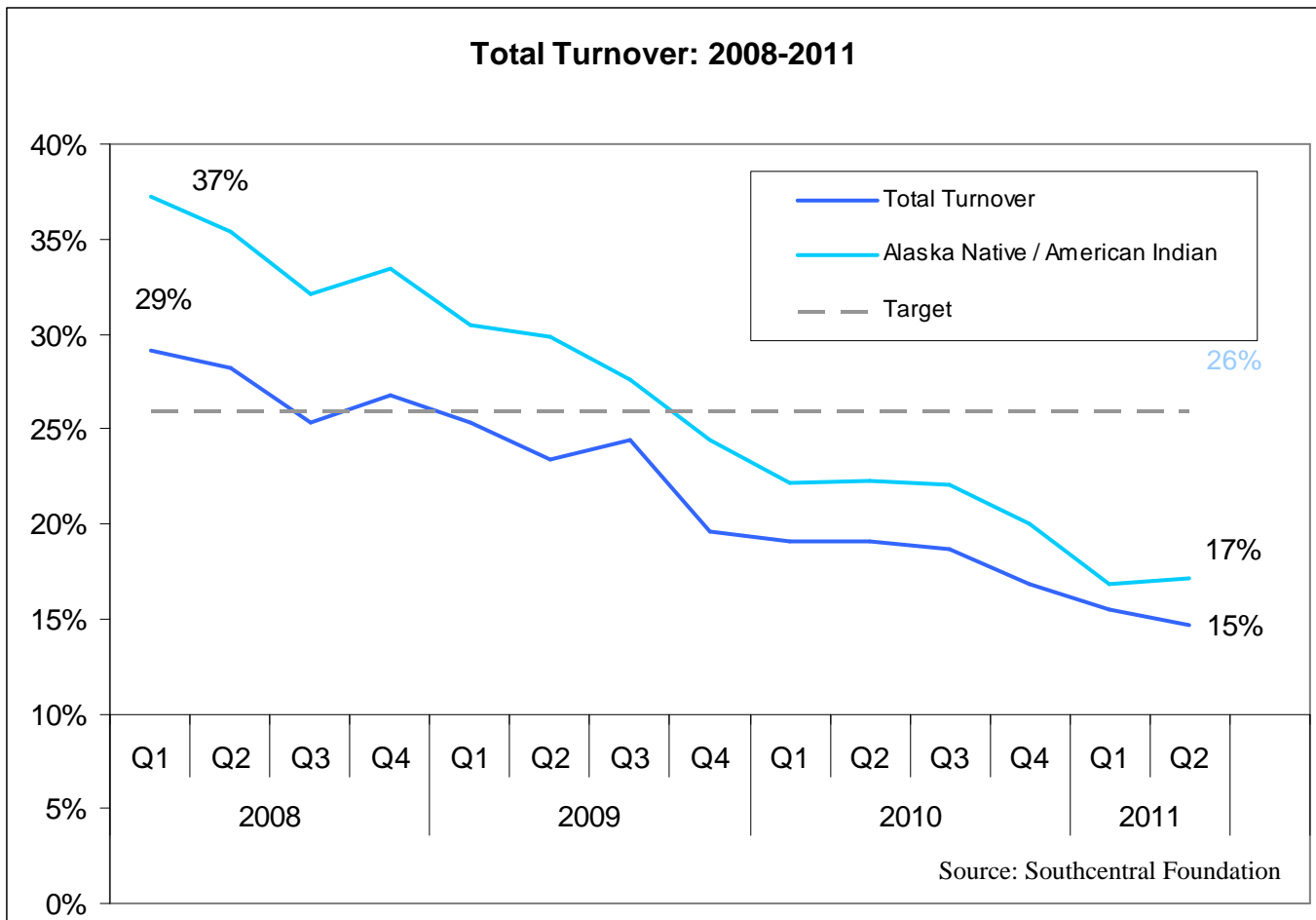
Clinical Outcomes: SCF has achieved good clinical outcomes and continues to improve. For example, in December of 2007, 78% of diabetic patients at SCF had received their annual HBA1C screening, but by December 2009, 91.9% of diabetic patients had been screened, exceeding HEDIS 90th percentile (88.1%).[v] SCF has also made considerable improvement in childhood immunization rates (from 80% in 1998 to 93% in 2006),[vi] and colorectal screening rates (for those over 50) have increased from 48.9% in 2008 to 58.6% in late 2009.[vii]

Figure 1. Decline in Quarterly Outpatient Visits, 1999-2007*

Quarterly Outpatient Visits Per 1000 Customers

*SCF saw an *increase* in patient numbers and an *improvement* in patient outcomes during this same period. In recent years, methods of benchmarking have changed, making it difficult to compare more recent trends. However, outcomes and efficiency numbers continue to be strong.

Figure 2. Decline in Employee Turnover Rates, 2008-2011

Total Turnover: 2008-2011

Source: Southcentral Foundation

Utilization and Cost Savings: Because the Southcentral Foundation's Primary Care Center is integrated with the Alaska Native Medical Center, it is able to track outcomes across the system. Some clinical outcomes include the following:

- Same-day access to care; which has led to a 50% decrease in Emergency Room and Urgent Care visits;

- A decrease in specialty care visits by about 65%;

- A decrease in primary care visits by 36%; and

- A decrease in hospital admissions and days by 53%.[viii]

SCF has *increased* the number of patients it serves while improving health outcomes and decreasing unnecessary utilization.

MA Career Impacts

SCF has become an employer of choice for MAs and other staff because of its work environment and staff development policies.

Benefits: Employees who work over 32 hours per week are eligible for benefits, which include medical, dental, and vision benefits as well as life, disability, and accidental death and dismemberment insurance. Employees may participate in a 401(k) retirement plan. There is also an onsite daycare center. Staff at SCF are not a part of any union.

Educational Opportunities: As noted previously, the SCF Educational Assistance Program offers scholarships, academic leave, and career counseling to employees seeking higher education. All employees can receive up to 50 paid hours per year for time spent in educational programs. Some supervisors flex employee hours to allow them to attend classes. Alaska Native and American Indian employees can receive scholarships to cover tuition and other educational expenses.

Promotional Opportunities: Overall, as of 2008, almost 13% of the current workforce had been promoted. [ix] As noted previously, CMAs can and have moved up the ranks in the organization both as CMAs and in other capacities.

To move up to the CMA II level, CMAs have to have been employed for at least six months, train an extern, finish their competency checklist, and then answer a number of questions in writing to demonstrate their knowledge of working in their clinic. Those that are successful receive a promotion and 5% pay raise.

CMAs can apply for CMA supervisor positions when openings occur. Once selected, the CMA supervisor receives a promotional pay increase, and can enter the management track at SCF.

CMAs have found many paths for promotion at SCF. For instance, one CMA became a program manager, and eventually an improvement specialist. Others were hired back into the organization in new roles after pursuing additional education. One CMA was hired back as a physician assistant, and another as a registered nurse. Finally, one former SCF CMA trained as a physician assistant and went to work in that capacity for a rural Native Health Organization.

> *"I love my job—it is so comfortable working here, everybody is just really generous and helpful; you learn a lot."*
>
> *-Maria Bellova, CMA-*

Satisfaction & Aspirations: CMAs report that they like working in the SCF environment. Because there are extra staff or CMA "floats", there is someone there to cover if staff need time off to tend a sick child or attend or teach classes at the Development Center. They noted a level of collegiality and support from other team members and encouragement to socialize with other staff members via a number of organization-sponsored social events.

CMAs are aware of scholarship programs for further education in health care, which they see as an incentive to return and work for SCF after graduation. Two are in training to become physician assistants at the neighboring University of Alaska, Anchorage. Another is currently training to become a registered nurse.

Future Plans

The Development Center has explored many potential training and development options. EHR implementation is scheduled to roll out in fall of 2011. SCF is preparing for a major staff training initiative in using the new system.

The Center has also developed a proposal to open its own medical assisting school. Such a program would allow SCF to recruit Alaskan Native and Native American Indian students out of high school and train them from the start in the Nuka model of care. This proposal is currently on hold as the organization has just invested in building its new primary care center and in introducing the EHR, but may hold promise for the future. The Center currently works closely with several local private schools to recruit MA externs and CMA employees.

Smaller training initiatives include a possible IV competency training for CMAs and supervisor / mentor training for supervisory staff are under exploration.

> "The approach is no longer just about retention. It's about true long-term development and continuous career growth. That's very different. Now if you have a CMA who is a high performer and doing a great job, especially if they are Alaska Native or American Indian, why have them stop at CMA? Why not have them train to become a doctor, an NP, or a PA? I think we have a responsibility to encourage that and integrate that into the curriculum…Maybe we should make that an expectation of the job—this is where it stops; when you become a doctor."
>
> *-Kristi Brenock-Leduc,*
> *Director of Learning & Development-*

Finally, because of rising interest in staff development scholarship funds, there has been discussion of targeting these funds better rather than distributing them through open application. Making the scholarship more competitive might encourage the "best and the brightest" to apply, and encourage a higher level of academic achievement, which would benefit the organization and the community in the long run.

Replication and Lessons Learned

Organizations from around the world visit Southcentral Foundation every year to learn from what they are doing. Southcentral has organized a formal program to host site visits and teach others about how to implement its model. Visitors generally use those components of this model that work best for their unique situations.

The two most common challenges cited by would-be replicators are the staffing costs of the multidisciplinary team approach, and scope of practice concerns. The team-based approach with a provider, RN case manager, 1.5 CMAs and ½ of an administrative support person for each team appears too expensive to some visitors. SCF utilizes MAs to conduct many of the clinical tasks formerly performed by nurses, which does save money. However, some health care organizations (and/or state laws) will not allow MAs do blood draws, injections, or administer medications. Nonetheless, Southcentral continues to attract attention from around the world because of its success.

Overall, key elements for this success include:

- Relationship-building, between the caregiver team and the customer-owner (and his or her family), among members of the caregiver team, and between departments within the organization, is the key to the success of this model.

- Attention to individual needs and preferences is important. One size does not fit all for customer-owners staff, or departments—hence policies are flexible guidelines.

- Evidence-based medicine and relationship-based care are complementary, not contradictory.

- Co-location of staff and providers and strategic architectural design can enhance team-building and improve supervision, allowing greater delegation of tasks.

- Staff selection is very important to implementing a relationship-based system. For frontline jobs, attitudes and behaviors may be more important than technical skills, which can be taught.

- Systematic training and on-boarding of staff improve both retention and continuity of care. These measures also enhance provider buy-in to a team-based model of care.

- Consistent and ongoing communication of advancement opportunities and educational options are important to ensuring uptake.

- Visible leadership commitment to, and involvement in, staff development has been essential to building the infrastructure for training and in ensuring staff and provider acceptance.

- Investing in staff training and development takes time and money, but the investment pays off in the long run.

- In addressing the wellness needs of a community, health care organizations can serve as vehicles for community development. Workforce development for frontline workers improves the health of the entire community by providing skill-building and economic opportunities to community members, by offering continuity of care, and by retaining staff that reflect the cultural and linguistic background of the customer-owners.

Notes

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v. Ibid iii

vi. Ibid iv

vii. Ibid iii

viii. Ibid iv

ix. Ibid iii

See also: Gottlieb, K., Sylvester, I. and Eby, D. (2008). "Transforming Your Practice: What Matters Most". *Family Practice Management.* 2008 Jan; 15(1): 32-38.

Acknowledgements

Center for the Health Professions
University of California, San Francisco
3333 California Street, Suite 410
San Francisco, CA 94118
http://futurehealth.ucsf.edu