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Nuka: The “*Customer-Owner*” Model

Ted Ball

There ‘s a story about President **Lyndon Baines Johnson** emerging from the White House onto the lawn in the Rose Garden where there are two helicopters warming up.

“Your helicopter is over here sir”, says the spiffy young uniformed cadet as he snaps to salute his Commander-and-Chief. “Son,” says LBJ with his sun-beaten crinkley face smiling broadly, “They are all my helicopters.”

Like the US President’s helicopters, the people of Ontario own all the component parts of our healthcare delivery system. Patients’ organizations today are saying to the provincial government and to healthcare service providers “we own all the healthcare provider organizations, and we have an expectation that these various component parts of our healthcare services delivery system will collaborate to address our holistic needs.”

Imagine a healthcare delivery system where the patients and clients are treated like they “own” the place. There are in fact such *large-scale change systems* currently under construction.

The *Institute for Innovation & Improvement* defines **Large-Scale Change** (LSC) as “the emergent process of moving a large collection of individuals, groups and organizations toward a vision of a fundamentally new future state, by means of high-leveraged key themes, distributed leadership, massive and active engagement of stakeholders, and mutually-reinforcing changes in multiple systems and processes, leading to deep changes in attitudes, beliefs, and behaviors that sustainability becomes largely inherent.”

Since *Health Links* are Ontario’s attempt at large-scale change, health system leaders will no doubt be interested what a successful health system transformation looks like -- and what can we learn from others who have already gone down this path?

At last June’s AOHC Annual Conference on “***People-Centred Care***”, the CHCs had two presentations from the *Southcentral Foundation* in Alaska on their now world-famous “**Nuka Model**”. (Check out their website – these guys have truly transformed their healthcare delivery system). They have engaged in a large-scale transformation process that has enabled them to move beyond “patient-centred” care and “people-centred” to something much richer, deeper.

When any one of Southcentral’s 150,000 clients come to one of their hospitals or clinics, they are thought about (mental model), treated as (process design), and referred to as “*Customer-Owners*”.

That is a very different healthcare system than our somewhat paternalistic version.

Like the challenge facing each *Health Link*, Southcentral had to redesign the patient journey to become “person-focused”, not “provider-focused”. The *Nuka Model* of healthcare delivery is all about thinking and behaving differently – a fundamental transformation producing excellent balanced scorecard outcomes -- and very satisfied owners.

“In our process redesign, we transferred control of the system to the people who are receiving the services and are using the expertise of our professionals to help them make decisions”, says Southcentral’s **Jana Towne**. “That is a very different mindset than just being a customer or patient. The Nuka system of care transcends the organizational boundaries because it includes our community, our partners, our stakeholders – all those things, all together,” she told conference delegates.

So what could Ontario’s *Health Link* leaders and facilitators learn from the experience of health system re-design teams from the first nations’ peoples in Alaska? I think we could learn how -- through their *Customer-Owner Redesign Process* -- they were able to achieve:

- A 50% reduction in urgent care and ER utilization;
- A 53% drop in hospital admissions;
- A 65% drop in specialist utilization; and,
- Customer and staff satisfaction rates over 90%.

Why did Southcentral’s integrated healthcare delivery system achieve such dramatic performance improvements as a result of their large-scale change learning journey? *Health Link* early adapters ought to reflect on the **NUKA SYSTEM’S OPERATING PRINCIPLES** that include:

- **The hub of the system is the family;**
- **The interests of the *Customer-Owner* drive the system to determine what we do -- and how we do it;**
- **Customer-Owners are “active partners” in their care, and, in decisions about their care;**
- **Relationships between the *Customer-Owner*, the family, and health service providers must be fostered and supported;**
- **Emphasis on wellness of the “whole person”, family, and community including; physical, mental, emotional, and spiritual wellness;**

- **Population-based systems and services;**
- **Intentional whole system design to maximize coordination and minimize duplication;**
- **Outcome and process measures to continuously evaluate, learn and improve; and,**
- **Services are financially sustainable and viable.**

So, why does Southcentral succeed? How do they live by these *Operating Principles*? How do they get such great performance results?

There seems to be two main reasons: **1.** The macro *organizational design* of their healthcare service delivery system; and, **2.** The *common language & frameworks* for the staff to talk about, plan for, and implement change to the way they deliver services to their people.

On the design side, I would say that Nuka reflects many of the characteristics of **Chaordic Design** conceived by **Dee Hock**, the founder and CEO Emeritus of VISA International. Dee Hock said: “By *Chaord*, I mean any self-organizing, adaptive, non-linear, complex system, whether physical, biological, or social, the behaviour of which exhibits characteristics of both order and chaos or, loosely translated to business terminology, cooperation and competition.”

In addition to macro design and philosophy, the *Nuka Model* also relies on Southcentral’s 1,500 staff to share a “*common language*” and to use “*common frameworks*” that enable them to think collectively about their future, plan for it, and implement the changes required to achieve their vision.

When I review the smashing successes Quantum has been involved with in the United States and Canada in the organizational and whole system transformation business over the last twenty years, the key to all these successful transform projects was the customized transformation curriculum that was presented by the organization’s own leaders that provided the *common language and frameworks* for talking about, planning for, and implementing change.

Similar to the Quantum’s learning-by-doing model, at Southcentral, all employees come together for 3-Day training workshops led by the CEO and senior team -- who strive to “practice what they are preaching” about being “open-to-learning”. As a *Learning Organization*, they get their people to better understand themselves, and their own individual learning styles -- because they have learned that the more self-aware people are, the more empathic they become. Leaders in organizations undergoing transformation need to be empathic.

Human organizations (where 90% of people would rather die than change) that are undergoing a fundamental transformation, need *common frameworks* to talk about themselves, and about the organization, as everyone undergoes even more unrelenting changes. For the humans, change is often hard, messy work.

If *Health Links* are to succeed in the medium and longer term, they need to invest some time and attention to front-end developmental dialogues that build momentum and trust in the short-term. Nobody is under the gun to succeed quickly, or before the next election occurs. This is not a race. *Health Links* need to “slow down, in order to speed up the transformation process”.

Each *Health Link* now has a plan approved by their LHIN – which the partners will continue to refine and adjust as circumstances evolve and shitstorms happen in their dynamic little complex adaptive human system. The key challenge ahead will be: *Strategy Execution*. How will the *Health Link* partners implement change? How can they become one of the 30% of Links that will succeed? What can we learn from the “lessons learned” in Alaska?

When we listened to the powerful stories about Southcentral’s transformation from **April Kyle** and **Jana Towne** at AOHC’s 2012 Annual Conference, “*People-Centred Care: Are We There Yet?*”, we could understand the galvanizing forces that has enabled their 1,500 staff to build a much better system that is well beyond just “patient-centred”. Indeed, it appears that these mental models are truly embedded in their organizational DNA.

“Among our highest corporate priorities”, says **April Kyle** of Southcentral, “we invest in the development of our people with extensive learning workshops, coaches and mentors.”

While the Alaska Nuka System is way beyond just “patient-centred”, most of the U.S. healthcare system is just now being impacted by their renewed drive for quality and patient-centredness. While Ontario is starting to move, there is a lot emerging in this field in the US where, for example, they have developed some initial models/programs for *Patient Advisory Councils* as well as proven patient-centred design methodologies adapted from Disney’s Imagineering Corporation.

So the patient revolution is now underway.

In his article, “*What ‘Patient-Centered’ Should Mean: Confessions Of An Extremist*”, Don Berwick, the US quality guru, proposes his definition of patient-centred as: “the experience of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one’s person, circumstances, and relationships in health care.”

Berwick says that in the hospital sector his definition would mean:

- Hospitals would have no restrictions on visiting – no restrictions of place, or time, or person – except restrictions chosen by, or under the control of, each individual patient;

- Patients would determine what food they eat, and what clothes they wear in hospitals (to the extent that health status allows);
- Patients and family members would participate in rounds;
- Medical records would belong to patients;
- Shared decision-making technologies would be used universally;
- Operating room schedules would conform to ideal queuing theory designs aimed at minimizing waiting time, rather than to the convenience of clinicians;
- Patients physically capable of self-care would, in all situations, have the option to do it; and,
- Patients and families would participate in the design of healthcare processes and services.

So that's a good place to start – the hospital sector. Building on this initial thinking from Berwick, *Health Links* partners ought to determine what “patient-centred/client-focused” actually means in the homecare sector, the primary care sector (FHTs, CHCs, solo-docs, etc) and in the community care sector (mental health, public health, etc).

Health Links partner teams also need to address both their customers’ “**expressed needs**” -- as well as their “**latent needs**”.

“*Expressed Needs*” are the needs patients/clients/families can articulate because, they (a) know what they are getting now; and, (b) they know what they want instead. Their all-important “*Latent Needs*” are needs patient/families have, but because they don't know about what they need, they can't express it. So they can't ask for it directly, because they simply don't know.

Experience-based design *Storyboarding* techniques is one way to surface these critically important “latent needs” in the co-design process with patients/family/staff.

Health Link leaders and facilitators who are open to doing things differently will find some thought-provoking new ways of looking at and thinking about the “same/old”, “same/old problems” from the insights of thought leaders like **Dee Hock**, **Barry Oshry**, **Margaret Wheatley** and **Peter Senge**, and from the “lessons learned” from such remarkable organizations like the Southcentral Foundation's *Nuka Model*, and from Ontario's own *Children's Treatment Network* in York/Simcoe regions (check my Feb 11th blog post “[Learning From Our Past Successes](#)”).

While no doubt each *Health Link* has the capability within the staff and leadership to successfully achieve the goals that the local partners have committed to, the fact is experience teaches us that there will be a 70% failure rate for large-scale healthcare transformations like re-engineering, mergers, TQM/CQI, program management, etc. That

reality ought to have some people feeling a little bit “at risk” as they begin their learning journey forward.

Many people will be focused on how to be among the 30% of *Health Links* that will succeed. The Southcentral Foundation’s transformation journey suggests that alignment on the basics like vision/values, and the ability to engage the whole workforce in the strategic change process of their large-scale change project, are some of their critical success factors.

To maximize the chances of success, *Health Link* partners should review the literature on what happens in the first two stages of team development: the **Forming Stage** and the -- **Storming Stage**. How will the *Health Link* partners get through the dynamics of the first two stages in order to get to the **Norming Stage**, and ultimately to the **Performing Stage**?

Smart *Health Links* will be engaged in failure prevention strategies at the same time as they are advancing the components of their strategy that will lead to the overall success of their collaborative efforts. There will be no need to worry about **Performing**, if the *Health Link* can’t successfully go through the **Forming & Storming** stages.

So what skills will the *Health Link* require to get through those human dynamics? See next week’s blog: “*Survival Skills For Transformation*”.

FORWARD THIS BLOG TO COLLEAGUES WHO ARE INTERESTED IN THE ‘CUSTOMER-OWNER’ MODEL.

