# Primary Care Cures
# Episode 143: Dr. Steve Tierney

Ron Barshop:

Welcome to the only show dedicated to a new way of delivering healthcare. This new model has no name, but let's go ahead and call it direct contracting or digital first care. The new way centers on opting out of the games bigs play with their rigged dice, their crooked game board and their purchased referees. And if you're looking for a future where everyone wins, that's the doc, the consumer, the employer, and with assured amazing outcomes and measurably lower costs that are ranging up to 60%, you're in the right place. I'm Ron Barshop, your host. I'm glad you're here. Welcome to the new healthcare economy.

Ron Barshop:

Today, we're going to talk about a hidden gem in primary care that nobody knows about, probably, and it's called the Southcentral Foundation's Nuka System of Care. What can we learn from the only healthcare entity to win the Malcolm Baldridge award, and it's a national quality award, twice healthcare, and it's won it in the last 10 years. Today's show has a lot of gold nuggets, so you get to pay attention and everybody's going to learn something. It's a very exciting story, and it has a lot in common with the digital first direct contracted care that we celebrate on this show. Nuka Alaska is what I'll call it going forward, and it's the community-owned uber profitable medical system, despite a relatively low spend, and has an employee and customer satisfaction rate at 95 and 97%. Their outcomes are consistently in the top quartile and top decile of HEDIS measures.

Ron Barshop:

Let's call this what it is. It's a world class advanced primary care system offering, but for half of what it would cost in the lower 49 states, if you will. The Alaskan Native Health System is, in fact, a globally admired system delivering primary care and, by extension, greater healthcare overall in a unique model divorced from the tyranny of premiums, deductibles, and copays. It's financially frictionless. Sounds familiar, I'll bet. Here's what Don Berwick, who ran CMS for Obama said, "I think it's the leading example of healthcare redesign in the nation, probably in the world." The whole person, physical, mental, emotional, and spiritual wellness is the context for 65,000 Alaskan and Native American Indian customer owners. I didn't say patients and you'll know why in a minute. Casinos on Indian reservations are for profit. Casinos on reservations for profit and the gambling addiction that goes with that phooey and all that for profit model.

Ron Barshop:

How about instead, a healthcare system that really works for profit? Free clinics versus slots, you decide what makes more sense. Now, nuka, so you understand what it means, is an Alaskan Native term that means strong, giant structures and living things, which you'll understand by the

end of today is a perfect name for it. While we're on language, let's talk about the language that the Nuka system uses. Everybody is a customer owner, not a patient, applies more active, less paternalistic titles and entitlements. Instead of having exam rooms, again, doctor centric, they're talking rooms, which is exactly what are an exam room should be. There's 17 community health centers. Don't talk about compliant and non-compliant patients, because those are derogatory patient centric, doctor centric terms. Leadership calls those words out as physician centric arrogance. There's a lot more words, but that's just giving a taste of how these folks think.

Ron Barshop:

You're getting the idea of customer centricity versus physician centricity, frictionless care versus transaction care prevalent in the lower 49, and Nuka Alaska adopted virtual primary care before was cool, at a much higher than 1% adoption rate, but they had to pre pandemic and we'll explain why in a minute. Been virtual for a long time, because let's do a quick geography lesson. Everybody knows how big Alaska is. Well, everybody also knows I'm from Texas. If Alaska was laid over Texas, it's two and a half times the size of Texas, to give it a context. If you took Alaska, put it on Texas and flipped it left or flipped it right, you'd hit both oceans by hundreds of miles, you'd be deep into the oceans. If you flipped it north, you're deep into Canada, and if you flip Alaska south, you're past the Southern Mexico border. I don't mean the Mexican-Texas border. I mean south of Mexico, you're now into central America, closer to Panama.

Ron Barshop:

It's a giant state and you could throw, in fact, Texas, California, Montana, plus a bunch of the baby states to round it all out, and you're still not the square mileage of Alaska. Imagine you laid Alaska in Western Europe, it covers, pretty much blots out all of Western Europe, except for Scandinavia. It's big. You've got to do virtual care when you have 65,000 members, owners in that giant space. It's pretty spread out. Here's the cool thing is their spend is about 2/3 per person at the US average, but if you look at the chronic conditions that this population has, it's really 1/2. It's $7,500. It's not what it should be, which is $15,000 to cost for this higher at risk population. It's half. Very cool.

Ron Barshop:

Again, a lot of hypertension, a lot of diabetes, a lot of addiction, et cetera, but it's all about team with this approach, and we're going to learn all about that, how that works today. What declines when you have a team approach to taking care of customer members instead of patients is you have a ChenMed. It's a team approach focused on real relationships. We've had them on the show before, so you're going to have lower labs, you're going to have lower specialty visits, you're going to have lower imaging. We need all that volume, all that over testing and all that over labs. All that overage, over utilization we call it, and with hospital admissions, they go way down, in fact by 40%. ER visits, almost the same, 36%. It drops when you have an intense focus on primary care and a team approach.

Ron Barshop:

This is all going to sound very familiar to direct contracting that we talk about on the show a lot, because it predates direct contracting. When they started this redo of primary care and healthcare, by extension, starting in 1995 when our guests joined the team.

Ron Barshop:

Let's talk about no more middle men. That's exactly what's going on here. We have the tyranny of financial friction gone. Again, as I said, no copays, no deductibles, no premium. You have a financial architecture of shared skins in the game. Let's restate that. Let's talk about the tyranny of financial friction with no copays and no deductibles. We were told back in the '80s that you've got to have some skin in the game, so there's got to be these copays, and deductibles, and patients, they've got to have some skin in the game. The truth is that's been proven untrue, not only with direct primary care models, but it's also been proven true with the Nuka system.

Ron Barshop:

It's not skin in the game, it's more like your liver's in the game today because most people cannot achieve and reach the deductibles that they have with their company plan. They have insurance, they just can't use it. That's not insurance, that's not healthcare, for sure. If you're functionally uninsured, and that's well over half of all working Americans. Well over half make under $15 an hour, and the bulk may enter $20 an hour. Functional uninsurance is a number one or two problem in America with healthcare. You got it, you can't use it. There's a rich system and a poor system. That, as I said, is a big problem.

Ron Barshop:

Let's describe the integrated care team, and I really want to hear from our guests today what that really looks like, but here's their primary care and behavioral and integrated team at the 17 clinics that I know about. We'll learn more. Imagine in a big room and you have a specialist, you have a PCP, you have an RN case manager, case management support. Then you have a dietician, a midwife, certified medical assistant, maybe a nurse midwife. You have mid-levels, you have a colorectal screener, you have behavioral health specialists and a pharmacist all working cooperatively. Not in their individual offices, but in a big room with a team approach. Again, every member not only knows the name of their pharmacist, their NP, their midwife, they know each other for generations sometimes. Hold on.

Ron Barshop:

The customer knows the team. There's this beautiful way they think about each encounter. The way they think about each encounter is what is the story behind the customer owner's eyes? Pretty refreshing, right? I can't wait to welcome to the show and introduce you to Steve Tierney, who's a family practice doctor who's been with them since this transformation began in 1995. Steve, welcome to the show.

Steve Tierney:

Thank you so much for having us and thank you for the lovely intro.

Ron Barshop:

I watched so many hours of video to get this intro down because I don't want to waste time explaining how the model lights up. I want to talk about the softer skills. Can we talk about the soft stuff and then maybe get into the hard stuff later?

Steve Tierney:

Sure. Yeah. What we realized is healthcare had over-engineered itself to say that no matter what, every encounter will be built exactly the same, because just case it could be a tumor or something quite serious. They would build the whole process as if you had to do a medical school level history and physical the time that you show up. Now, the reality is most people are much more straightforward than this. They need simple things in a medical home, refills of medications, have questions about a medication they took several years ago that maybe they want to try again for their allergies or their skin rash. It's very, very straightforward things. If you add to that all of the things that are required, we realized about 85% of all the prescriptions and lab orders were all repeats or refills.

Steve Tierney:

We realized we were spending a tremendous amount of energy to do what we already knew was going to be done and the time it was going to need to be done. We said, "Well, what if we just made only the full court press heavy handed full on evaluation only required when it was absolutely necessary, and then smoothed all of the rest of them by removing referrals, removing process times, and making things quite simple. Those were the things that we had to work with physicians, to say if you know the person's on this med, if you know they're successful with it and you know their labs are up to date and in control, then evaluating them doesn't add to your base of knowledge or value for that encounter. You just want to proceed. You can even do so through a surrogate, but we had to train them to say work via a team through another person like your case manager or your case manager support, as opposed to doing this as a solo act yourself during each and every individual encounter.

Ron Barshop:

The Native American in America have the highest uninsured rate in America by far, much more than any other minority group due to probably a lot of factors, but you don't have any of that problem in Alaska because of how you designed this. Is that correct?

Steve Tierney:

Yes. What we did was we coached our workforce to say it's irrelevant for what you do for this customer owner, what payer they have. We're going to treat them all the same, and if they do have a payer, we'll manage whatever we can recover on the backend. If they don't, it still doesn't matter, but it means our approach, the workflow, and the team integration efforts and work sharing will be the same. It just leaned up our entire operational approach. It took a lot of reorienting for a workforce to say if somebody has a positive depression screen and your medical assistant knows that you typically would always ask the behaviorist to step in and just check in with them, then they can do so directly without waiting for an order or specific instructions by their primary care provider. Since they had already done the screener and since they had already found it to be positive, they could just proceed to the next logical step without specific instructions.

Ron Barshop:

I've watched videos of your medical assistants do their screening. It is so much more thorough than any screening that I've ever seen in America. It's not a patient history, it's a spiritual history, it's a lifestyle history. I mean, it is psychographic, it's demographic, it's sociographic, it's deep

and wide. It seems like you've deputized them to... I'm not going to say diagnose the problem, but to really give the doctor a crystal clear insight about what's going on here.

Steve Tierney:

What we found when the same team works with the same number of customer owners over time, everyone on the team begins to know them is if they were extended family members. It's not like you need to do a specific screener to know somebody's a little off their game. You know them well enough to be able to say, "Hey, you doing okay? What's going on for you? What are you worried about?" Since every member of the team already has a pre-established relationship with each customer owner, it's easy to cross that gulf of normally they might not feel comfortable taking that sort of a risk, but what we've done is empower the team to say if you already know exactly what the answer is, please proceed and inform the rest of the team. If it is leaned up from the normal business as usual, that's actually better.

Ron Barshop:

I love the way you relatively talk to your members. We are all about shaming in the rest of North America. Get your eyesight fixed, or you're going to get in a wreck and hurt somebody. Get your diabetes handled or you're going to lose your foot. Stop eating so much bad processed food. What y'all talk about is things like, "Do you want to continue doing the hunt with your grandson because this is how you're going to stay healthy and be able to do it longer." It's a beautiful way that you've transformed shame into, basically, reward.

Steve Tierney:

One of the things we've worked hard on is regaining time to have a person to person, more humanistic encounter. Instead of banging through 30 appointments a day just to keep your access, doing them all one size fits all, we actually do longer visits. Since we know them and we've seen them before, it's easier to fast forward to say, "Hey, did you get a chance to go fishing? It's fish camp season, but normally you're not here in August. What's happening for you?" You can't get to know that in a transactional, move through as many interactions as possible and do so with process. What we try to do is do it more with relationship, to be able to say, Listen, I know you would do the right thing for your diabetes. I know pretty much everybody would, but you're not. Tell me what it is that's happening for you that's making that a challenge. Maybe we can help."

Steve Tierney:

What we're realizing is the exact same goals that the healthcare system and the healthcare workforce has, customer owners have the exact same goals. If we make it easy for them, they will actually just simply do it. When they don't, we know, ah, there must be something that's creating a barrier for you. Tell me more about that. Tell me how we could help or tell me how we can make adjustments because we know you don't want to be unhealthy. We know you want to join us and our goals, and when you're not, there must be something we're missing. Share with us what that could be like and share with us how we could help you."

Ron Barshop:

Your foundational supposition is that every consumer is smart and wants to be better. Whereas I think... It's not fair to do broad swipes, but I think a lot of physicians in the rest of America are thinking these patients are dumb, they don't do anything I tell them to do. They're not complying with their meds, they're not complying with their exercise, they're not eating differently. They gained three pounds since I saw him a year ago. Dumb guy, dumb consumer, dumb patient. That's not y'all's attitude. Y'all's attitude is really they're smart. They just need to know what to do next. Is that a good summary?

Steve Tierney:

Yeah. One of the most interesting moments that I had as a medical director is when I noticed that staff, when a customer wouldn't get the referral to the specialist in a timely fashion, wouldn't get something else. They would get mad, because they were invested personally in the outcome of this individual. I'm like, okay, so this is no longer you are just punching buttons and processing widgets. This matters to you. When it does matter to you, you begin to feel more comfortable saying, "Listen, I know you do well with your diabetes, and I know now you're not. What's happening, are you.." That's how we get to the deeper issues that truly drive healthcare when it goes off the rails. "Well, I'm going through a divorce and I'm trying to cook for myself, but the only thing I do is go to the carry outs and normally I used to have dinner with my spouse, but now that's not the case anymore."

Steve Tierney:

Or "Oh man, your diabetes is the least of our worries. We got to deal with this. How is this affecting your life?" It helps you gain perspective into what makes people tick. With that perspective, you can actually find out how could we actually redirect this instead of doing the almost insulting behavior. "Well, I'm going to refer you to the diabetic education specialist so they can school you on this diabetes that you've had for 15 years, that you have already demonstrated the ability to do well with, and now you're not." That's the normal default setting. Poor control of diabetes, have the health educator check in. We would actually say poor control by diabetes. What's going on? This is not the case. This is not how it's been, but it is now. What do we need to do? You need the space and you need the relationship to say, "Wait a minute. You know how to take care of this. You know what your insulin is. Something's going wonky. What's going on for you?" That's not something you can do with somebody who you just met and you never will meet again.

Ron Barshop:

We're obsessed in America with digital solutions to things like diabetes, when it's what you're proving, what Vera Health is proving with their model that seems to be extremely successful, is you can maintain and reverse diabetes with a team approach, not an app. A digital app's not going to say what's going on.

Steve Tierney:

It's enticing to believe we can fix things by throwing more money at it. Tech is always sort of a default. If we just get the fancy machine, if we get you the fancy glucose monitor and we..." But what we learn is you actually do not need to monitor your diabetes with regular finger sticks if you have a stable controlled environment that is supportive for you. You can get in the zone and

people do things pretty much the same way most days, unless they can't. When they can't, that's why we got to find out why can't you, what changed up for you, and adding a glucometer to you and telling you to take more finger sticks when we know you're likely just going to put this on the shelf and not use it, but I'll feel comforted that I've given you some tech. Now if you want the tech, that's fine.

Ron Barshop:

Get you off my back.

Steve Tierney:

Yeah. Right. Yeah. This is I need to check a box to make this seem like I did something, even if it may be a disingenuous something.

Ron Barshop:

Let's get into some of the hard numbers because I want to understand the model a little better. It seems like if I take 65,000 Native Americans from Alaska, we're talking about in 17 clinics, that's about 3,850 or roughly 4,000 per clinic. I assume you're geographically distributed where your members are. Is that about right, so you have two or three providers at each clinic, at least, that are primary care. It's really a panel size, it's not 4,000, it's more like 2,000 or 1,500. Is that about right?

Steve Tierney:

That's about right. Some of our clinics have more providers because they're larger, so there will be five or six. Some of our clinics are in more remote locations where there'll only be two or three. I would say a good average is maybe four per clinic with a panel size of about 12 to 1,400 people.

Ron Barshop:

Okay. I get that there's about 2 or 300, I'm going to call them providers and support staff, that are immediately in the clinics, but y'all have 2,500 employees. What are the other 2,300 doing? Help me understand your system because I know it's not simply clinical. There's some backup to support that clinic.

Steve Tierney:

We spend a tremendous amount of time on data extraction. We have an entire, 12 person data team. We have a research team that actually has 12 PhD researchers, all of whom are Native tribal members. We have a very robust tech system because there's a lot of tech that we need to connect as we virtually interact with a small village of 25 people on the Yukon–Kuskokwim River 300 miles away as the supervising provider. Of course we put way more than your average healthcare company into training. We realized that one of the things that you didn't show up with with your normal doctor, nurse, behaviorist degree was the ability to work on a team. You were indoctrinated to think of yourself as a solo act, independent of everyone else. We said, Wow. This is not intuitive and we can't leave it to chance, so we're going to put a tremendous amount of hours per clinician per year." We have a very robust, we call it development center, where we have all of our training staff, where we do all of our trainings in house.

Ron Barshop:

I'm going to assume that it's a no brainer. Let's talk about specialists and specialist referrals. It's a no-brainer that you have your own surgeons for routine surgery. You have your own cardiologists and their endocrinologists, but there's 120 specialties. You don't need 120 specialties in Nuka, you can refer to the larger Alaskan system, I'm assuming with a lot of the unusual stuff. How y'all interact with the larger Alaskan health system that's North American traditional health?

Steve Tierney:

The larger health system actually serves the entire state, of which we are one of the 12 tribal health organizations. We're the largest of the tribal health organizations, but there are people in Bethel, and Katzebue, and in Juneau that are also referring in to our cardiologist. Our cardiology department's not massive, it has six cardiologists for the entire state. We would use that amongst the other tribal health organizations. The way we interact with the specialist, like the surgeon, like the neurologist, like the endocrinologist is we say, "We're going to send you things that it's clear that you have the special skills for." If you're a cardiologist, I'm going to send you to send someone to see you if you need a cath, a stint, a treadmill, an echo, a stress echo.

Steve Tierney:

Once you determine what the diagnosis is, once you come up with a plan, then I will take back over the refill of the Simvastatin, of the Carvedilol, of the Digoxin, and monitoring the labs to absolve you of doing this more grunt refill work, and also open up your access, so the next time I call you, you can see somebody quickly. Our cardiologists, as an example, a result of this, have a routine referral wait time of about four business days. For routine. If it's a little bit more pressing, we can get same day, but it means we had to clear their plate by taking back a lot of this sort of once you're Dig, once you're on Lasix, once you're on Carvedilol, those are refills we can manage. If you tell us what labs we got to keep an eye on, no problem. We'll take care of that too.

Ron Barshop:

You also own your own surgery center, so you have a da Vinci and you can do more complex surgeries that are beyond labor and delivery, right?

Steve Tierney:

Yes. Yeah.

Ron Barshop:

When you're baffled by a rare condition... I know there's not a single burn unit in all of Alaska and cancer care is very rare too, if nonexistent in Alaska. Are there some cases where you have to send them down to the lower 48 to get treated?

Steve Tierney:

Yeah. We have cooperative relationships with Seattle Children's or Fred Hutch. We do have a cancer specialist, but if there are things outside the normal scope of our workforce and capacity,

we'll send them away. We have business agreements with some places in Seattle or some other places.

Ron Barshop:

Okay. All right. Well, so when you're raffled by a rare condition, do you have others you consult with in a larger health system that can help y'all solve the crime scene of what's going on there?

Steve Tierney:

Yes, we do. It depends upon what the condition is and what the age. If it's a more pediatric population, then we have a relationship with Seattle Children's Hospital, but we have... I would call it the primary tier, and then the secondary tier with the majority of the subspecialist. Then we would have tertiary tiers to say, "Well, you need a valve replacement, which is a unique specialist thing that not a tremendous amount of people in this state of Alaska do. We're going to send you to Providence Hospital where they will do valve surgeries with, supporting the cardiothoracic surgeon."

Ron Barshop:

Okay.

Steve Tierney:

Which we don't have on staff.

Ron Barshop:

All right. I'm going to assume that Nuka is one of the largest employers, if not the largest employer in the tribe. Hiring family can be a privilege, could be a pain in the butt too. Does that pose a challenge for you guys?

Steve Tierney:

Not necessarily. We actually have, in some cases, people that are the fourth generation that are working in the healthcare system. They have come in, sometimes very often, at age 18 after their grandparents worked here and have worked and now are with the company 20 years before the age of 40.

Ron Barshop:

That's neat. What are your big challenges you have to face every day as a quality control position for... You got to make sure the medical economics work, but you also got to make sure the outcomes work. What are your biggest challenges you have to face?

Steve Tierney:

The biggest single challenge is, I would say the extremely process centric mental model of the joint commission, CMS, and the insurance agencies. Where they will say, "You need to do this very significant amount of documentation for every interaction that you have, irregardless of, I just need to refill my Hydrocortisone, to I'm having new headaches that are leading me to have blindness in one eye." The problem is that the EHR that we have is one of the very few high tech

certified EHR platforms that's meaningful use compliant. I will say as software, it is poor in quality. It takes a tremendous amount of training, tremendous amount of work, and it operates quite slowly. It is chock full of mandatory process steps, which in most cases are completely unnecessary, but absolutely necessary if you want to be able to bill for your services. We're stuck with them. What we found is, in most cases, you really don't need to do a full on H&P history to refill somebody's Lisinopril. You don't, but CMS, if you want to bill for that encounter, makes you do so.

Ron Barshop:

You work with Medicare, obviously, and getting paid by Medicare for your older population.

Steve Tierney:

We do. We have... Probably about 40% of our population is Medicare or Medicaid eligible, with another, maybe 15 to 20% who have private insurance, Aetna, State Farm, whatever. About 40% has no insurance payer at all, but our teams still have to do the same workflow as if we're going to build, even when we're not going to, because we're coaching them to say, "Pretend like it doesn't matter to you, and you don't even know if they have a payer. Just do the same workflow." We're married to during this very labor intensive workflow, just to make sure that we get paid even for the very simplest of interactions.

Ron Barshop:

Again, just to sum up, I think you have extremely high, high 90s customer satisfaction, physician satisfaction. You have extremely low cost compared to North American customers of this ilk. You're in the top quartile or 10% of most of the HEDIS metrics. I think you're done it for half the cost, so the beautiful thing about this is you're being studied around the world by other countries, aren't you?

Steve Tierney:

I would say we have probably over... What is it Ms. Tanya, 4,000 different interactions over the past 15 years or so? All across the world, from Singapore to Western Europe, to Southeast Asia, to Canada, pretty much everywhere in between.

Ron Barshop:

Right. Did the pandemic prove that your model is not only resilient, but really the model of the future? I know your virtual care percentages are way higher than the 1% we had pre pandemic.

Steve Tierney:

What was easy for us is since we already had a clear established relationship with a clearly listed number of people, then shifting to the phone, shifting to video was actually quite comfortable because these were people that already knew us. We already knew them. We didn't have to really depend on a very labor intensive let me get to know you for the very first time sort of interaction. We could say, "Yeah, yeah. We're keeping everybody safe. We're working from home, in some cases. We're on our video, but we already know each other well. What do you need?" It was easy for us to do that and then back again, as we needed to bring you back in the building, because

there is some things, like, cervical cancer screening or colorectal cancer screening that you do need to do in person. It was easy for us to flip back and forth as COVID cases went up or down.

Ron Barshop:

If folks want to reach out to you to learn more, how is the best way to find you?

Steve Tierney:

We have an entire Institute called the Nuka Institute. It is online. We have regular conferences that are both in person or virtual. We actually will do consults, either to have you attend our site or we do offsite consults all the time. I think I'm doing one in California the week of the 13th of September for a couple days who an organization said, "Come down, take a look at us and give us some review of our workflow, our process, our staffing package." Because they're thinking about making some change.

Ron Barshop:

There's a 97% chance that you love your job, so I'm not even asking that question, but if you could fly a banner over the rest of America with one single message, what would that message be for all healthcare to see?

Steve Tierney:

Make it about the people, not the process. We have fallen in love with mandatory process steps and assumed that that will make us get to know people and what's happening for them more. What we've learned is if you skip the process steps and spend time getting to know somebody well, you don't need the process steps. The process steps were something we fell in love with because we thought that by not knowing them, we could fix that gap by just doing huge, huge amounts of process. What we learned is knowledge of a person's life, of a person's struggle, of a person's change, of their story was vastly superior in performance clinically with operational outcomes and cost outcomes than any list of processes that you could do.

Ron Barshop:

Dr. Tierney, thank you for time. Tanya, thank you for setting this up and we'll check in with you again soon, because you are a fun story to follow.

Steve Tierney:

Thank you again.

Ron Barshop:

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