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SPEAKERS

Madge Kaplan, Paul Batalden, April Kyle, Doug Eby, Tony Bovaird, Elke Loeffler

Madge Kaplan 00:00
Welcome to “The Power of Coproduction,” a podcast series that explores the lived experiences of patients and professionals who are redesigning healthcare service to achieve better health through mutual respect, collaboration and science informed practices. Your host and guide is Paul Batalden, Professor Emeritus of the Dartmouth Institute for Health Policy and Clinical Practice and a guest Professor at Jönköping Academy. The Power of Coproduction is produced in partnership with the International Coproduction of Health Network (ICoHN), the Dartmouth Institute, Jönköping Academy and the Health Assessment Lab. On Episode 12, “Coproduction For All,” Southcentral Foundation and the Alaska Native Medical Center have our attention. First April Kyle and Doug Eby describe how coproduction at the macro level centers the health and well being of a broad and diverse community. Then Tony Bovaird and Elke Loeffler, global experts on coproduction, join Paul for the key takeaways. Here's Paul,

Paul Batalden 01:07
Welcome. Today's theme is related to coproducing health care services as a whole system. We want to open the journey from traditional methods for a system to make healthcare service for people who are sometimes known as beneficiaries, to a system that works actively to coproduce health care service with people known as “customer-owners.” Our guests are April Kyle, who is the CEO, and Doug Eby who is the Chief Medical Officer of the Southcentral Foundation, which leads the Nuka System of Care in the Alaska Native Medical Center in Anchorage, Alaska. Thank you for joining us. And welcome April and Doug.

April Kyle 01:52
Hi, Paul. Good to see you.

Doug Eby
Pleasure to be here.

Paul Batalden 01:54
So you folks made a big change several years ago when the Alaska Natives went from beneficiaries of a government health program to customer owners of the system. What was involved? How did that happen?

April Kyle 02:12
I'll share a little bit and then maybe Doug can add to it. And just for reference, I am Alaskan Native Athabaskan descent. So when I was a kid, I went to our Indian Health Service government-operated hospital. And in my lifetime, the ownership of the tribal healthcare system has shifted from being operated by the government to being operated by Alaska Native people through self determination. So Southcentral foundation is part of that journey. We are a regional native healthcare organization in the southcentral region of the state as part of the larger tribal healthcare system. And for about 40 years, we've been on this journey of transitioning from government operations to tribal operations. And it's been sort of this grand experiment of what it can look like, if we give ownership of healthcare, really give the power, to the people and community whose wellness that healthcare system is about. It's been an exciting journey to be part of.

Doug Eby 03:15
So there's many places that the health system is consumer owned. So across tribal lands, there's quite a bit. Also every community health center in the US is supposedly governed by people who use this system and many community hospitals are, but often what happens is the local owners, the customer owners take control of the corporate office and the business management, but they leave the practice of medicine to the medical professionals. And so the envelope around the system changes, but the core function of how modern medicine is delivered doesn't fundamentally change. And what happened here is that the customer owner voice became the way in which we questioned all the paradigms and assumptions of modern medicine, and ended up changing the fundamental platform on which medicine and healthcare is delivered. Customer ownership gives the opportunity but doesn't necessarily result in massive change. But it provides the opportunity for massive change. It's not present if you don't have customer ownership.

Paul Batalden 04:12
So is there a story that would sort of take that big conceptual change and make it understandable for people that aren't necessarily familiar with these concepts? Like, what was it like for someone to be involved in this change?

April Kyle 04:30
I'll say, Paul, that early on, I think our leadership at the time was really forward thinking in pausing and asking (the) community what they wanted out of their healthcare system. And we did that in a bunch of ways. They had surveys and focus groups, they sat in lobbies, they talked to elders, they talked to employees who were working in the system that wasn't keeping up with community need, and listened and heard from (the) community what mattered to them in healthcare. And that idea of listening and

allowing the voice of community to be the driver in how we're going to design the healthcare system has become sort of a fundamental competency of what we do.

Doug Eby 05:14
Yeah, the people who had been through such transitions previously advised us to not rock the boat. Employees are going to feel insecure, you're going from the safety of government, unionized employees to tribal employees; make it a non disruptive transition so that people aren't scared and bail. We thought about that for a few minutes and said, “Nope, not that.” Instead, we're going to do it (as) April just said, which is we're going to listen deeply and intently to the community and to the frontline employees, and then we're going to blow the sucker up (the current system) and do something different. So we took the moment in history to do something dramatically different and reset the fundamental assumptions that we would be customer owner driven in just the way that April said.

Paul Batalden 05:54
So you started after you did this listening, which is such a powerful way to begin, it seems to me, and your leadership took what was heard, and developed a series of general principles or policies that would sort of put what they wanted to become in some kind of a framework.

Doug Eby 06:17
Yes, Paul, we took 10s of 1000s of opinions that we got and distilled them down to, at the time, what we called “the ideal elements of a perfect healthcare system.” And within months, those became what we call our operational principles. And here we are, you know, over 20 years later, and still have essentially exactly the same operational principles. And then we actively use them all day, every day. They are what determine how we're going to be organized. So someone has an idea, “Hey, we should do things this way,” the first thing we do is score it up against those operational principles. If it aligns, we probably want to figure out how to do it. And if it doesn't align, we probably don't want to do it, even if everyone in healthcare is doing it. And that's been powerful, because then it's not what April wants, or Doug wants or the board wants, it's what the community as a whole and all the workforce said was necessary in order to create a system that actually works. And that's been tremendously powerful. And it keeps the control over the system in the hands of the community and the frontline staff.

Paul Batalden 07:19
I mean, it seems like what you've done here is to move way beyond getting advice from people that we sometimes know as patients. And that journey, as you suggested, Doug, of the design of the service itself, and the driving of the process by the customer owners is very different than just asking for advice from those who are served. Did everybody like that?

April Kyle 07:50
We did. Very honestly, I think we landed on this philosophy of customer ownership, which is really challenging the hierarchy in healthcare, right?here you have the healthcare system, and the doctors and the professionals with all these initials behind their name, who sort of know what's best, and often, at best, have a “check-the-box listen to patients,” right? And it's resetting that to say, what if we break that hierarchy and instead create partnership between the system that's owned by its community, and we ask the healthcare system and the health care professionals to bring all of that expertise with them,

but to sit in relationship with community who also has expertise, right, who has experience and wisdom. And to put those things together. It's a nice philosophy, right?

But what we've done is implemented that idea of working in relationship as how we do our business, and that happens at a macro level between system and community in a whole bunch of ways. We can give some examples. And it happens at a micro level between care teams, people and families every day. And we often say that the primary output of this healthcare system, the thing that we're working to create, is not diagnosis or treatment plans or revenue. It's the quality of relationship that we can sit in between the healthcare system and the community that owns it. And that is our fundamental competency that allows us to imagine ourselves continually redesigning what we do, because the needs of our community will change over time.

Doug Eby 09:29
You know, we were like kind of most medical systems. We had a lot of nurse managers running clinics. In primary care, we had nurses that were focused on diabetes and nurses that were focused on HIV and nurses that were focused on immunizations. And so we had kind of disease specific concentrated expertise in our primary care system, and increasingly primary care people who are kind of emphasizing specific disease states and so forth and a lot of medical people providing the day to day management.

After this process of listening and creating principles that all went away, we eliminated disease specific approaches, we eliminated clinicians in management. And we put all those people to work as whole persons, whole family care, coordinating immediate access for people. So, for over 20 years, we've guaranteed same day access to people who know you, and who are capable of helping coordinate and address all the different dimensions of who you are. So we moved away from centers of excellence and moved away from disease specific approaches. Instead, its mind and body and spirit back together in the context of the whole family. That was painful and I remember the person who was most angry was the nurse who headed up the immunization efforts, and all of a sudden her empire was gone. And she became a whole person case manager. She, by the way, did a fabulous job, but she had this painful loss of her puddle that she could control. We only have enough money for one approach. And often in healthcare, there's multiple parallel competing approaches. And we listened deeply as April's described and used all those principles and said all our eggs in the basket of whole person, same day access to people who know them, mind and body back together, walking with them in shared responsibility over time, and no more diabetes Mondays and HIV Thursdays and focused people on individual disease states.

Paul Batalden 11:24
So life was different for a health professional, or a person we sometimes know as a health professional. And how was life different for a person who was trying to get health care?

April Kyle 11:35
So in the old system, Doug remembers it from working there, I remember it from going there as a patient the native hospital, the native healthcare system was really the second class place to go. I went

there as a kid, when my dad didn't have insurance;you largely entered the system through the emergency department. They say there was primary care. I guess that's true; I never got there.

And in our system, now, as a mom, I have a primary care team. And those are the people whose names I know, whose numbers are in my cell phone. I never call a front desk and talk to a stranger. I call the case management support (person) who sits with that primary care team and I say, “Hey, I'm struggling, my kiddo's temperature is this.” They're sitting physically right next to the RN, case manager and the physician. I can hear them say, “Hey, let me just ask the nurse” and just chat about my question. I'm accessing that team by email, by messaging my phone far more often than I'm coming in for a clinical visit. And they have sitting with them this integrated care team, so that they can pull experts into my care delivery, as they need to, without breaking sort of that value of relationships. So we want that primary care team to be expert at the relationship with the 11,12, 1300 people, made up of families, who are on their panel. And we want to minimize how we break that relationship and send folks to someone new. For example, we have an integrated behavioral health person, a dietitian and midwife who are doing fully integrated pediatric care, psychiatry–all right there, sitting in primary care to maximize care delivery through what we think is the most important competency, which is sitting in longitudinal relationship with a family.

Doug Eby 13:26
From a clinical perspective, the consequence of the relationship is influence. So if someone comes to see us, and they don't do something different after encountering us, we have not added value. So, just giving someone a diagnosis, a treatment plan and some pills, is not the end of the conversation. It's what do they do with those things? Because they're in control, they hold all the control of all the variables? Do they take the pills? Do they exercise? What's their relationship to alcohol, tobacco, and drugs? What do they eat? How do they handle frustrations in life? All those things are under their control.

Modern medicine thinks if we give them a diagnosis, a treatment plan and pills we’re finished, and then we judge them compliant or non compliant in our most arrogant, condemning way, which we're doing harm when we do that. And instead, the question is, how do we brew those trusting relationships as April described? How do we end up with different activity on the other end of the encounter? So that means our staff have to not just be good at diagnosis and treatment planning and prescribing, they have to be good at partnering, listening, respecting and influencing, which means we’ve got to move our goals and aspirations to align with their values and goals and aspirations or we're going to get nowhere.

Most medical professionals are not trained in the art of coaching and influencing and mentoring and cheerleading, but yet that's the most important skill set that we need in all of our clinical staff. So we invest in that. Every single person that works for us goes through a three-day core concepts training that April Kyle, as our CEO, personally leads every single time. And it sets in place deep knowledge and understanding of yourself, of your team, and how to enter into healthy communication patterns, problem solving, how to be fabulous team members, and most importantly of all, how to give and receive story. And in fact, we're doing a little bit of COVID-catch-up right now. So half of April's job this

month and next month, is running these core concepts trainings for all of our staff, as the CEO of the company.

Paul Batalden 15:32
So it's through relationship that you've really changed the agency, who actually is the agent. This must have also changed the lives of leaders, people who are used to doing their work as leaders of a system. Is there a story that comes to mind about that?

April Kyle 15:51
One of the ways that we have created the work of being in relationship at a macro level between system and community is through the time that leaders spend interacting with tribal leaders, with families, with advisory councils. So I'll share with you an example I can remember pre-COVID. We were planning to meet with a health council in one of our hubs, and that health council is made up of various families from the community. And we as leaders fly to their community and spend the day, and in that day we're eating, we're hugging, we're meeting children, we're having a business meeting where we talk about the budget and the needs of the community. That business meeting starts with the community sharing with us what's happening in their world and in their lives and what they're concerned about.

And I remember one time we fly into this village, and we walk into the school, and we can hear over the intercom, “Southcentral Foundation is here, everybody go to the gym, you need to tell them all of your concerns about healthcare, bring your complaints.” And the whole community showed up and we're in the back, like cutting all the sandwiches in half and getting all the fruit out because it's going to be this big meal. And so we're sitting around this table. And we began with introductions and community members who are saying, “Here's my name, my uncle is going to speak for me.” “My name is this, also same uncle is going to speak for me.” And the community had two or three concerns they wanted to tell us while they had the Southcentral Foundation leadership team there. And I remember the concern being something like the medications we’re flying to the community on the airline that had the contract with the Postal Service/ And it (the concern) was only if there was a bad weather day when the flight was canceled. And that flight only went once a week. But if we could change to our cousin's airline that flies three times a week we will be more likely to get those deliveries in. The point is that the community not only knew the impact of the problem, but was best suited to think about potential solutions. And we're all sitting there thinking, okay, these are medications, we can't just give them to your cousin and have him fly them on his plane. But we probably need to take that back and then use our expertise around what's logistically possible. And then at the next community meeting a quarter later, be ready to say, here's what we heard from you. Here's the work we did. And here's the idea that we think we want to try, how does that sound to you? And that's just one of many real life examples of how that kind of planning plays out between system leadership and community leadership,

Doug Eby 18:25
The top 10 most powerful people in SCF (Southcentral Foundation), if you look at our schedules for any given month, somewhere between 10 and 40% of the hours we work are in listening mode in the community. So there's not one advisory council that meets, you know, once a month for one hour., And, as April said, these are half day or full day meetings, and they're completely oriented around them, their

agenda, their priorities, and our reporting to them is secondary. We travel and speak, interact with lots of systems. I've never seen another healthcare system that comes even close to the amount of hours and commitment and formatting that we use, so that we are actually consumer driven, not patient-centered. So patient-centered usually means the (Patient Family) Advisory Council meets once a month for an hour, and they come into our holy temples and our institutions and follow our rules and give us some advice. That's not what we do. This is a whole different thing, continual, obsessive, responsive interaction. And then we also don't just say, hey, what do you want? We say, like April said, here's the problem you raised. Here's the solution you suggested, here's other thoughts we have, here's what we tried. How'd that work for you? What do you think? What can we try differently? So it's not a blank slate, hey, what's on your mind only? It's a continual interaction that builds on previous conversations over the long term that's deeply committed to intentional problem solving and understanding the lived experience and their frustrations rather than just, you know, here's what I feel at the moment.

Paul Batalden 19:52
I mean, this is such a powerful example. And a lot of people have heard about what you've done and they've sort of been sitting there, listening (and thinking: "So I wonder how in the world where I work, we could start something like this?" If they asked you that, what do you tell them?

April Kyle 20:08
It's a big decision to choose to give away control and power. It's easy to say on a podcast, it's actually really hard to decide the way that you want to operate. It really pushes against how professionals in healthcare, in lots of industries, think about the work that they do. And so for us, when we work with other organizations who are on a journey like ours, it's about deciding that that's your intention. And deciding that at a governance level and at a leadership level, and being sure enough, that that's what's going to drive your change, that you're going to lean into all of the resistance that's naturally going to come from that sort of change in orientation. And, Paul, I just want to say, we have a lot of people look at our system, and I love the way you're asking these questions, because a lot of people want to hear about our service delivery model. We launched advanced access in the 90s. We've been doing behavioral health integration for 18 years. We have this continuum of behavioral health services; that's where I grew up, is in the behavioral health side. And they want to learn about things like, "H are you delivering care?" What I love about your question is that it's really about the philosophy that comes before that. And knowing that our care delivery today, while we're doing some cool things, it is only the right-now model, and that the future model will be created because of the relationship we'll have with community to evolve to meet their needs. And so I just want to stop and appreciate, kind of, the framing that you've created for the conversation.

Doug Eby 21:40
Of course, everybody wants to know, "What should I do next Tuesday?" that's a simple, straightforward thing to do? And that's not our story. Our story is, it's what I said at the very beginning, that rather than the customer owner voice just taking over the corporate office. In our system, the customer owner voice came into the conversation about how is medicine delivered, what are the beliefs of modern medicine, and let's talk about those because that then fundamentally changes absolutely everything about the assumptions of the professionals and the structures that we use, and so forth. As April said, the

fundamental conversation here is about customer ownership, relationship, influence and continual commitment to never ever, ever letting up on customer owner driving, not patient-centered, customer owner-driven philosophy, design structure, and all of that, and this is very hard. This is going against the grain, all the medical professionals are trained in almost exactly the opposite way.

So for example, just two things to add to this. That not only listening to the community when we go out and sit in the community, but the other commitment is, if you're in the business of influencing people through relationship, the best people to do that are people from the same lived experience as the people that you're trying to influence. Which means you must commit to hiring and developing from within the community that you're trying to impact, no matter where you live in the world. That is a true fundamental principle. So often, especially in these kinds of safety net places, it's people who live in the rich suburbs who drive into the challenged areas, and then are there to fix people. And that's the opposite of what's needed. You need to hire from within the community you want to influence, so we spend 10 times the usual amount on workforce development. We've committed to in house training at all sorts of levels, we've committed to retraining the clinical professionals. As a result, we've moved from 15% Alaska Native hires to over 50, pushing on 60% Alaska Native hires, and about 75% Alaska Native hires in management and leadership positions. Because the people with the lived experience in the community need to not only advise but actually own, govern and staff the service or you're not going to achieve what we're trying to achieve.

And then the other thing to say as you do this and deeply listen, you end up realizing that immediate access to these professionals is what people want and need. So if they drive across town, take off of work, take a whole half day to have an appointment, by the time they see me they want labs and X rays and pharmaceuticals because they've made this massive investment. But if instead I'm continually available to them all day, every day, what happens eventually even pre COVID, about 70% of our touches per day were virtual, some synchronous, some asynchronous, but like a primary care team would have 50 to 70 connections per day with people on their panel, but only 9,10,11,12 of them would be in person - and nd what that does is you have this continual web of connectivity, a whole team of people available as April described in her personal experience. But it also means when you need a longer, more in depth conversation, you have the time and the ability to do that because you're not forcing everything through an institution professional-centric office visit paradigm.

Paul Batalden 24:55
Thank you for your compliment and thank you also for your answer. I mean, it's a really concise guide. But Doug, I bet people pull you aside and say, “All right, I get it, I'm a doc. So what should I do?”

Doug Eby 25:07
One more paradigm thing as April mentioned earlier. So often, populations with the biggest healthcare challenges are put in the safety net category. And then they're told, you know, that kind of crappy place over there, that's for you, and you should be thankful because you get to have that, rather than getting nothing. And that's just horrible, that's destructive to that population, and to those people, whoever they are, whatever category they are. So for us, it turns out, if you look at the research, the number one determinant of health outcomes at an individual level is the amount of self confidence people have. So in addition to influence, a core part of our job is raising pride, honor, dignity and self esteem. And you

do that by empowering, by connecting to them on their journey, their values, their priorities, but you also do it by creating beautiful buildings and marvelous spaces and bringing community pride along with medical service provision. So there's a whole other conversation here about pride, honor, dignity, self determination, and how that plays out in terms of facilities, spaces, and the continual business of raising self confidence. If you do to life, life goes better; if life does to you, life doesn't go so well. And in modern medicine, we're so institution and professional-centric and paternalistic, we actually are doing harm to that conversation with the people who most need us to do the opposite and build them up.

April Kyle 26:36
So Doug, I'd like to just add, I agree with everything you've said, I was thinking your word “beautiful,” and what that might mean to different listeners. And I'll share with you, what beautiful to me means is that it is the first class place to be, that I see things about Alaska Native culture that I want my children to know. I see art, I see materials, I see textures, I see places from within our community, our culture represented in physically how that space design works. And Paul, you asked us a question: if you're a system, how do you make this change? Right? And I think that's an important question. And we can imagine that right, we can imagine choosing an organizational culture, and building through core concepts, trainings, and mentoring and retraining, how we move a system. I'm gonna say, it's actually harder to do that consistently enough over time, so that a community starts to internalize a different relationship with healthcare. And so what I see is this very hard 5,10,15 year transition that requires this consistency and focus on values and leadership playing out. But from the community perspective, I think it's really generational change. So my grandmother took down the word of her doctor as gospel, was nervous to ask questions. My children arrive at a primary care visit, knowing that this is their time. And if they want to talk to the behavioral health person on the team, my kids have been doing that their entire life. They know nothing other than this system and how it is reoriented to be driven by their needs. And so I think that generational change in how community experiences healthcare is something that you really have to put in time (for), for the long run.

Paul Batalden 28:24
What a spectacular gift you have given us. Thank you so much for taking this time and for sharing your insights into this. Thanks again.

April Kyle 28:33
Thank you, Paul. Great to be here.

Doug Eby 28:35
Thanks for your commitment to this conversation. It's so wonderful.

Paul Batalden 28:42
It's a privilege for me to welcome Tony Bovaird and Elke Loeffler, in joining on this reflection of the Alaska Native community’s story that we've heard from April and Doug. You two have worked in many communities to foster the coproduction of public services. Tony, are there any general impressions that you have of this Alaskan experience?

Tony Bovaird 29:11

We are very impressed by many aspects of the case study. We also put a very strong focus on listening as part of our work, as our Alaskan case study has illustrated. We particularly love in the Alaskan case study the emphasis on customer owners, that's unusual. The word customer wouldn't go down so well in Europe, but the idea of the citizens who are involved as owning the services is quite brilliant. We also love the fact that the customer owners are driving the service. It's not just a patient-centric approach. It's driven by the customer owners. We love the fact that relationships are central as we believe they are in our work too. Same day access to someone who knows you–what a magnificent offer to citizens, only 1200 customer owners for each medical team; in the UK it would be 1000s. Lots of listening going on. Very resource intensive it would appear, but very outcome oriented, outcome intensive, also. Perhaps in the longer term, a much better way of saving money because the outcomes are so much better. It's a practical approach. Even before COVID, 70% of the contacts, the interactions were virtual, those are wonderful things.

And we can only replicate some of those in the UK context. There are some things that we would do slightly differently, or perhaps bring out slightly differently from the case study. We'd emphasize coproduction, not only through citizen voice, but through citizen action. We'd emphasize the value of capability assessments for all patients and members of the community who are keen to help so that we know what their capabilities are. We'd emphasize the value of community action, as well as medical interventions. Peer group support, in particular, building on those relationships that we heard about, and especially looking at peer group support for the lonely and the isolated people with mental health issues, people with disabilities. And a social prescribing type of approach to get the medical teams actually prescribing activities in society, which will improve health even though they're not medical interventions. And we think coproduction is not a purpose in itself. Obviously, it's about continuous assessment of improved outcomes. Many of those were illustrated in what we heard from the Alaskan case study, some of them are perhaps things that we would emphasize slightly more in our work.

Paul Batalden 31:19
Thank you very much. So Elke, how do you start if you want to develop a community-led coproduction effort?

Elke Loeffler 31:29
Well, we actually think this isn't rocket science, we recommend that you ask people around you what they are doing already in coproduction, and what else they might like to do to help others and simply build on what is already working. And in our experience, building on each other's good practice is a great way to learn.

Paul Batalden 31:51
So you've written extensively about this in both recent publications and in historic contributions. And you find this four "co" frame helpful: co-commissioning, co-design, co-delivery and co-assessment. How do you find that most useful?

Elke Loeffler 32:12
We have made the experience both in our practical work, but also in our research, that coproduction offers citizens, but also professionals, a variety of roles. And it does not only include citizen voice, but

also citizen action and this is where co-delivery comes in. And I think it's important that we also see coproduction as a dynamic relationship, you know, one “co” can lead to another “co.” So if people are co-assessing outcomes, co-assessing services, ideally, that could lead to the co-design of a new service. And that's also the experience of many coproduction initiatives we have been involved in.

Paul Batalden 32:55
So not everybody uses the term co-commissioning or commissioning. Can you help us understand what commissioning means?

Tony Bovaird 33:05
When we talk about co-commissioning, Paul, we're really talking about the planning function at the very beginning of the service or the project cycle. You know, when we talk about commissioning, what we mean is the decisions about what services should be paid for by public monies, what priorities between those services should be established, and for whom those services should be provided? Who are the priority target groups? And those big questions: Which outcomes do we seek? Whose outcomes are we trying to further? Which services are likely to get to those outcomes? We call that “the commissioning process.” I guess in most of the world, it would still be called the planning process. And (for us) co-commissioning is bringing citizens, the service users and members of the community into those commissioning decisions, the planning of which outcomes matter, which target groups are we trying to bring those outcomes for, and which services from which providers are likely to produce those outcomes for those target groups? That's what we mean by co-commissioning.

Paul Batalden 34:03
I think that General Eisenhower would be deeply proud of what you have laid out as he said: “Plans are useless, planning is essential.” And I would add co-commissioning is essential for co-producing.

Tony Bovaird 34:21
We would agree with you Paul, because planning has done so badly, co planning or CO commissioning makes it just a little bit less unreliable.

Paul Batalden 34:30
That's wonderful. Thank you so much for your thoughts about this.

Tony Bovaird 34:34
Our thanks to you.

Elke Loeffler
Thank you.

Paul Batalden 34:37
The story behind the macro system coproduction that has become the Nuka System of Health Care in Alaska, describes a huge transformation the Alaska Native community has made. People we sometimes know as health professionals and patient persons are both responsible for the planning and

making of the changes. It began with the possibility of self determination envisioned in the Indian Self Determination and Education Assistance Act of 1975.

The first thing leaders did was embark on an aggressive listening campaign. They listened in community meetings, in one to one sessions, and through surveys. These leaders moved beyond the typical mode of receiving advice to sharing a sense of agency with the community. They wanted to help the community move from being beneficiaries of government provided health care to customer owners who could drive their own health care services. As a result of all the listening, a new set of operating principles was developed to define what became and was named the Nuka System of Health Care. These principles envisioned the creation of a system in which the Native community could enjoy physical, mental, emotional, and spiritual wellness. Partnerships with others in health care and related services would help fulfill this mission. Key points of the operating philosophy were shared responsibility among people, sometimes known as patients, sometimes known as families, sometimes known as community members, and sometimes known as health professionals. Second, a commitment to quality and fully qualified staff by way of recruitment and development of native staff and organizational structures that optimized the skills and contributions of all. And third, family wellness as the cornerstone of the Native community. This meant going beyond the absence of illness and prevention of disease to a focus on the physical, mental, social, spiritual and economic wellness of the family in the context of community, broadly defined.

Those behind the Nuka system didn't see it as a project or an event. They saw it as a way forward, requiring a deep commitment to continued listening to never ending staff and community development. This meant creating new practices to address situations as they arose and making sure that the practices of one's values evolved to match the new situations they required.

As Tony Bovaird and Elke Loeffler noted, when coproduction of public service involves an entire community, it may begin in different ways, but usually involves persons in multiple roles, agreeing to form a new way, and often building on what has already emerged as possible. As Tony and Elke have explored the diversity of community wide efforts and public services, they have found it helpful to think more deeply about four enabling coproduction modes: co-commissioning, co-designing, co-delivering, and co-assessing.

April Kyle and Doug Eby and their colleagues in the Southcentral Foundation, recognize that the proper locus of responsibility for someone's health is the person whose health it is. They recognize, as a practical matter, that this requires transformative change for every person involved, and it must be grounded in a deep set of values which have to be lived, not only spoken about. The measured outcomes and the multiple awards Nuka has garnered speak volumes about the effects of these pioneering efforts. Thanks to April and Doug in Alaska, and to Tony and Elke in the UK. I am Paul Batalden.

Madge Kaplan 39:15
Thank you for listening to Episode 12 of the podcast series, “The Power of Coproduction” with Paul Batalden. On Episode 13, “Safer Together,” Charles Vincent and Maren Batalden make the case for enabling patients and families to be a real part of an organization’s safety agenda. All podcasts in the

series, including an overview of coproduction, are available at ICoHN.org/podcasts. The website is where you'll find supplementary materials, guest bios and brief profiles of the production team. You can subscribe to the podcast series wherever you get your podcasts. Thanks for Listening.