Kodiak Area Native Association: Many Tools for Change

Nobody likes to get a colonoscopy. But, what if getting a colonoscopy required a several-day journey from your remote village by boat, air, and car to a large city? There, in a hotel room or the home of a friend of a friend, you do the colon prep. Afterwards, you reverse the journey and arrive home a few days later.

It's easy to imagine putting that off.

That was the case of an older patient in Larsen Bay, Alaska, on Kodiak Island. The Island is part of a long archipelago in the Gulf of Alaska. The main settlement on the island is the City of Kodiak, located 250 miles south of Anchorage. The city has a population of about 13,000, of whom about 2,000 are members of federally recognized American Indian or Alaska Native tribes. Another 1,500 people live in remote villages that can only be accessed by boat or small plane. Larsen Bay, for example, is 64 air miles from the City of Kodiak.

The Alutiiq people have lived in Larsen Bay, population 96, for hundreds of years. For people who have lived here all their lives, leaving the village is difficult—logistically, financially, and emotionally.

One Alutiiq elder in his 60s had never had a colonoscopy. Based on results from a fecal occult blood test, his doctor strongly recommended the procedure, which would be performed in Anchorage. The patient didn't want to go, and, because he had no overt symptoms, it would have been easy not to do it.

The elder made the journey. Doctors found and removed a large villous adenoma that could have become cancerous within two years. The colonoscopy saved him major surgery and maybe even his life.

"Only through access and continuity were we able to build a relationship with him where he felt trusting enough to get a colonoscopy," says Robert Onders, MD, primary care physician with the Kodiak Area Native Association, which provides care to about 3,500 beneficiaries in the City of Kodiak and five villages, including Larsen Bay. "It was only through effective case management helping him negotiate the health care system that he was able to get it done."

Providing that kind of consistent, accessible, and coordinated care is not easy in this part of the country.

Village of Larsen Bay

"Continuity is a little harder here because we're in and out," says Dr. Onders. Most KANA providers spend several days each month outside of the main clinic traveling to surrounding villages.

Despite these challenges, KANA has succeeded in improving access, continuity, and care over the past few years. The key has been learning to use the tools and the techniques associated with the Improving Patient Care Collaborative and other projects sponsored by the Indian Health Service.

Team and Technology

The first step in the process was to make sure all patients had a health care team coordinating their care. Now, patients in the City of Kodiak are impaneled to a team that includes a nurse case manager who can identify whose concern can be addressed by phone, who needs to come in right away for an appointment, and who can wait until his or her provider has a slot next week.

Members of KANA's IPC team: James Spillane, improvement program analyst; Margaret Roberts, KANA chairperson; Robert Onders, MD, clinical director; and Nicole Webster, nursing director.

"It's difficult when providers are moving around and going to villages, but [with the care teams] there is always someone around who knows the patients personally," says Nicole Webster, RN, director of nursing for KANA.

Continuity of care in the villages comes from both the community health aides and the regular visits from KANA physicians. The community health aide program was developed in the 1950s to address the special health care needs of Alaska's remote villages. The program now has 550 community health aides and practitioners who practice in 170 villages across the vast state. These providers live and work in the rural communities under the supervision of physicians with whom they communicate by telephone, e-mail, radio, or secure Internet. KANA has 11 community health aides and practitioners who hold regular office hours five days a week and are available 24-7 to respond to emergencies. Once every 6–8 weeks, a KANA physician also holds clinic hours in the villages. At one point in KANA's history, physicians rotated this duty. This arrangement might have been good for the doctors, but it provided little continuity for the village residents. Now, each village has an assigned provider, so patients don't have to start with a new provider at each visit.

Both in Kodiak and in the villages, technology extends the reach of the teams. While James Spillane, improvement programs analyst for KANA, readily admits there is more sophisticated technology available, he says KANA is good at getting the most out of the tools it has. That includes its Resource and Patient Management System, Electronic Health Record, population health tool (iCare), and communications systems.

Most of the villages now have Internet access, so the providers are rarely totally out of touch when traveling. "It doesn't matter where I am, a case manager can get a hold of me," says Dr. Onders.

From most locations, he can easily access the patient's chart in the Electronic Health Record (EHR) and authorize a prescription refill or other routine follow-up. This saves another provider from covering Dr. Onders's patient. It can also save the patient a trip to the clinic. Dr. Onders has the background knowledge of the patient to assist them without a visit in many situations. The covering doctor doesn't have that advantage and would probably ask the patient to come in for an exam.

Max Packing on a Village Scale

Technology helps make village visits efficient and comprehensive—kind of like max packing on a population health scale. Before a provider heads out to a village, the care manager runs an iCare

report on the patients there to see who needs immunizations, a Pap smear, or other screenings. The care manager can then call those patients and ask them to come in while the doctor is in the village.

Technology also helps when the patient comes in for acute care at the main clinic. In the past, when a patient came in with a sprained ankle, just the ankle would get treated. Now, the EHR notifies the provider or other staff that the patient is also due for preventive care and screening.

James Spillane and Dr. Onders credit this multipronged approach for KANA's huge progress on Government Performance and Results Act (GPRA) scores and screening rates. KANA was the first site in Alaska to reach GPRA goals in all areas. Screening rates jumped from roughly 20 percent to more than 70 percent on most measures in only two years.

"These clinical information systems—that's where we at KANA have been able to leap frog so quickly," says Spillane. "Our EHR and our clinical reminders really allow us to take care of the people coming through our doors; and, then, with case management and iCare, we can really identify strongly the needs of people who aren't coming through our doors."

Technology has also expanded the role of front desk staff in a way that engages it more closely in the actual delivery of care. Through regular reports, staff identified high blood pressure management for patients with diabetes as an area for improvement. Patients weren't coming back regularly enough to determine if one high reading was an anomaly or the sign of something amiss. Spillane created a notification that popped up at the front desk, alerting them to call patients for a routine recheck. The result? More patients coming in for rechecks and more satisfied front desk staffers who enjoy the new responsibility and the increased patient contact.

When asked to look back and figure out what has made the biggest difference in the quality of care, KANA staff can't decide: "We started using clinical reminders and iCare, and we started empanelment and case management all at the same time," says Dr. Onders. "We have to assume that all of it helped."