Alaska Tribal Health System

Oregon Chapter ACP Meeting
Nov 13, 2021
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Objectives

• Understand how the Alaska Tribal Health System (ATHS) works
  • Southcentral Foundation (SCF) Primary Care Example
    ▪ Two-time winner of the Malcolm Baldrige Quality Award
  • Consider Case Examples demonstrating this work
    ▪ Note that team approach is key

• Consider whether the ATHS might serve as a model system for the US
  • Primary Care right in home community
    ▪ Team Structure provides supervision & clinical judgement
    ▪ Evaluation at progressive levels, specialists etc, as directed by team leader
Alaska Health System

Facts
- 224 Federally Recognized Villages
- Over 300 Villages in the Foodsharing/Health Corporation
- Alaska Native Health Board: Statewide health advocate voice
- Alaska Native Tribal Health Consortium: statewide specialty and tertiary health care services
- Regional health care board is governance

Regional Native Corporations and Health Centers

591,000 Square Miles
1,530,682 Square Kilometers

Alaska Is Larger Than Texas, California And Montana Combined
Alaska Native people chose to assume responsibility.

We Changed Everything.
Medical Culture Replaced by Relationship, Shared Responsibility, Customer-Ownership, Story, & Complex Adaptive System based on Alaska Native culture and values

Rural Communities
Life in the Village

- Accessibility to urban communities is limited
- High cost of living
- Harsh weather conditions
- Lack of infrastructure
- Clean water - “Washeterias”

How do you get to work?

- Car
- Train
- Bicycle
Community Health Aide Program

New Problem or Complaint

During the COVID-19 Pandemic

- For patient who calls the clinic: Ask patient/parent. Why they need to come to the clinic today. Then do telephone screening: Go to "Begin Here for Telephone Screening for Possible COVID-19".
- For patient who comes to clinic: Ask patient/parent. Why have you come to the clinic today?

Note: Everyone who enters clinic needs to be screened for COVID-19. Try to limit number of people that come with patient to ONE, if possible. Put a procedure (surgical) mask on EVERYONE over age 2 who comes to the clinic, if tolerated.

- **For Emergency:** Go to Emergency. During COVID-19 pandemic wear PPE and follow PPE Protocols.
- **For Sick Child Younger than 5 Years:** Go to "Child Younger Than 5 Years Who May Be Very Sick. Wear a mask (or follow your regional guidelines for PPE).
- If known COVID-19 positive patient and coming in with a new emergency or new complaint begin the Launch Page at "Chief Complaint" and continue visit in usual way.
- If negative to ALL COVID-19 telephone screening questions TODAY and a complaint begin the Launch Page at "Chief Complaint" and continue visit in usual way.
- For ALL other patients who come to clinic: Go to COVID-19 Clinic Visit. Wear a mask (or follow your regional guidelines for PPE).

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Review the Release Notes to see what is new in the CHAM.
Clinician Village Coverage

- SCF primary care clinicians cover villages and support our Rural Alaska Service Unit
- Different needs
  - All villages with clinics require minimum of 2 clinician trips per year
  - Villages that have Community Health Aide Practitioners work with medical clinicians in Anchorage

SCF Community Health Centers

- McGrath Health Center
- Iliamna
- St Paul Health Center
- C'eylits' Hwnax Life House Community Health Center
- Indian Creek Clinic
- Sutton
- Tyonek
- Port Alsworth Clinic
- Nilavena Subregional Clinic
- Ilimna
591,000 Square Miles
1,530,682 Square Kilometers

Alaska Is Larger Than Texas, California And Montana Combined

Provider Village Trips

- Scheduling
- Services
  - Provider referral
- CHAP working relationship
- Team approach for rural care
Integrated Care Teams

Working Together to Provide Care

PCT

Customer Owner

Specialist

Rural Clinician
Cultural Considerations

- Strength Based
- Varying Native cultures
- Native hiring preference
- Subsistence lifestyle
- Historical trauma
- Role of Elders
- Using story as a tool
- Relationships differ (aunts/uncles/cousins)
- Honoring customer – meeting them where they are

Case 1

Hyperthyroidism
A Respected Elder in a Village
An Elder in a Village with Hyperthyroidism (pre-pandemic)

- 85+ y-o woman in the Yukon Delta Region
  - Lives in a village of approx 600 people
  - Clinic staffed by community health aide
    - Close contact with Regional Center
  - Labs go by plane to Regional Center (weather permitting)
  - Telemedicine visits available between village clinic and ANMC
- Close family members live in the village and in Anchorage
- Referred to endocrinology because of uncontrolled hyperthyroidism, previously diagnosed during hospitalization for other issues

Initial Endocrine Consultation

- In-Person Visit in Anchorage, while visiting family
- Findings confirm hyperthyroidism due to Graves disease
  - Consistent Hx and Exam
    - Diffuse Goiter
    - Undetectable TSH
    - Elevated Antibody Levels
- Declines I131 and not a good surgical candidate
- Plan: RX methimazole and monitor closely
Follow-Up Endocrine Visits

- Numerous visits required: stabilize TSH, monitor & adjust methimazole
  - Some visits in-person (while visiting family in Anchorage)
    - Labs generally done prior to the visit, arranged by case management team
  - Other visits using telemedicine to clinic in the village
    - Health Aide obtains lab work, sends specimen via plane to Regional Center, obtains results
      - Hopefully all accomplished prior to the visit
      - Frequent challenges: weather, lost specimen, patient missed lab draw, etc
      - VS and some PE done by VHA

Course

- Hyperthyroidism generally controlled at home in village, with frequent telemed visits
- Occasional trips to Anchorage to visit family and see endocrine, in person
- The patient recently passed (not d/t COVID), with family at her side
Case 2

Adrenal Carcinoma
Citizen of an Island Community

- Problems
  - Uncontrolled hypertension
  - Massive edema
  - Electrolyte abnormalities

- Exam: Anasarca & abdominal mass
- Imaging-directed bx: adrenocortical CA, widespread metastases

50 + y-o man referred to Endocrine from an island community in SE Alaska (Pre-pandemic)
Rationale & Management Planning

- Patient understands therapy not likely to be curative
  - Wishes to be home as much as possible

- Has been a leader in the community, mentoring many youth
  - Supportive wife & family

- Phone Consultation with leading expert Dr. William Young at Mayo Clinic
  - Advises on use of ketoconazole and mitotane with lab monitoring

Clinical Course

- Capable and caring PA in home community administers most in-person care

- PA calls or texts endocrinologist weekly
  - Gives clinical and laboratory update

- Plan/Meds adjusted after data assessment by endocrinologist
Community Outpouring of Support

- A potlatch was held, honoring the patient’s life and contributions to the community prior to his passing
  - Note that a potlatch is not just a potluck
  - A traditional ceremony and feast, honoring the life of an important individual

- Patient was able to fully participate and celebrate with his family and community

Case 3

Congenital Disabilities
Young Man Requiring Repeated Hospitalizations
### 20 y-o man with multiple congenital disabilities
**Referred to Endocrine for Wt Loss & Low TSH (during pandemic)**

- Congenital failure of corpus callosum development, Hydrocephalus w VP shunt, Diplegic Cerebral palsy, fetal alcohol effect, developmental delays
- HPI (mainly from adoptive Mom):
  - Resides in Assisted Living Facility
  - Chronic behavioral Issues (head banging, other)
  - Marked recent weight loss
    - Eating poorly….better in hospital
    - Note visitor restrictions during pandemic
  - 15 hospitalizations in past 2.75 years, for intractable constipation
    - Repeated suppositories, enemas, EGDs and colonoscopies
    - Aggressive bowel regimen needed, not always successful

### Additional Details of Hx
**(or as we know: “the devil is in the details”)**

- ROS includes:
  - Lack of interest in usual activities
  - Poor appetite
  - Severe chronic constipation
  - Recent absence of previous frequent masturbation behavior
Objective Data

- PE: Remarkable for emaciation & pale complexion; Wt 40 kg (nadir 39.3); BMI 15
  - Language development minimal
  - Wheelchair-bound: Generalized U & L extremity spasticity present
  - Listless, not communicative
  - AL Staff friendly, seem supportive
  - Mom extremely concerned, dissatisfied with progress

Weight Graph
(a FABULOUS feature of EHRs!)

![Weight Graph](image-url)
# Lab Data

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# Additional Lab Data

**12/2020**

ACTH Stimulation Test: wnl

Testosterone total: 246 (low, nl 264-916)
FSH 14.6 (high, nl 2-12) LH 4.7 (nl)

Prolactin: 10 wnl

IGF-1 83: wnl
### Imaging Studies

- CT neck & submandibular regions: c/w “plunging ranula”  
  (pseudo cyst associated with sublingual glands and ducts, extending into neck)

- MRI Pituitary:
  - Pituitary enhances homogeneously
  - Pituitary stalk distortion, uncertain clinical significance
  - Corpus callosum absent
  - Shunt catheter extends from R parietal region into R ventricle; ventricles are decompressed
  - Right subdural effusion present (up to 5 mm thick)
  - Cephalic appearance of skull

### Clinical Thinking

- Disabled man: developmental midline brain abnormalities
- Declining during pandemic, losing wt, severe chronic constipation, acute depression, nearly moribund
- History suggests social isolation may be a factor
- Labs, imaging and clinical picture suggest:
  - Central hypothyroidism
  - Recent onset hypogonadism of uncertain type
  - Adequate adrenal function
  - Plunging ranula present, unclear whether causing problems
    - Mom wishes for prompt surgical repair by ENT
Management Plan after Team Discussion

- Hold off on surgical procedure for now
- Feeding tube
- RX levothyroxine: monitor FT4 & clinical status
- RX IM testosterone: monitor lab & clinical status
- Move to new living facility ASAP
  - Younger male residents for camaraderie & increased ease of visits by Mom
- Weekly in-person visits with primary physician who knows him best
- Ongoing close team collaboration

Clinical Course

- Likes the new living facility: interacts with young men there!
- Med doses have been appropriately adjusted
- Constipation less severe: no hospitalizations in 9 months
- Tube feeds being tapered gradually
- Jokes with primary physician who now sees him less often
- Ranula not currently a clinical problem
Recent Weight Graph

BMI now 20!

Our Conclusions

- Strong Team Collaboration, including Patient/Mom, FP, Endocrine & ENT has resulted in
  - Improved outcome
  - Enhanced patient well-being
  - Decreased hospitalizations
- Big financial and personal WIN for ALL!
- Ongoing team collaboration will be needed
  - Not all questions have been answered, challenges remain
Teamwork Makes the Difference!

Primary Care Team

Patient & Family Front & Center

ENT Team

Endocrine Team

Could This Model Work Nationwide? Something to Consider...

Relative Size of Alaska and the Contiguous United States
Thank You!

Qaґaasakung
Aleut

Mahsi'
Gwich’in Athabascan

Quyanaa
Inupiaq

AwA'ahdah
Eyak

Quyanaq
Siberian Yupik

Háw’aa
Haida

T’oyaxsm
Tsimshian

Gunalchéesh
Tlingit

Tsinqala
Ahtna Athabascan

Chin’an
Dena’ina Athabascan