



PCMH: SOUTH DAKOTA URBAN INDIAN HEALTH CENTER



CASE STUDY:

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About Ms. Tami Hogie-Lorenzen

In this interview, we talk with Ms. Tami Hogie-Lorenzen at South Dakota Urban Indian Health Center about how they operate as a Patient-Centered Medical Home. SD Urban Indian Health is a Federally Qualified Health Center with locations in Sioux Falls and Pierre. SD Urban Indian Health provides primary care services primarily for the Native American population, the uninsured and the underinsured.

Thank you to Tami Hogie-Lorenzen for sharing this story.

What is your role?

Tami Hogie-Lorenzen is the Lead Medical Provider at SD Urban Indian Health. Tami has been involved in the process of implementing the PCMH model from the beginning, where she led the committee responsible for implementation.

What population(s) do you serve?

SD Urban Indian Health is a Federally Qualified Health Center serving the Native American population, uninsured, and under-insured. SD Urban Indian Health is part of Indian Health Service (IHS) and receives funding from IHS and bills Medicare and Medicaid.

How did your facility start implementing PCMH?

Beginning in 2008, SD Urban Indian Health began looking into different ways to improve patient care. They attended trainings, did an Improve Patient Care program through the Institute for Healthcare Improvement (IHI), and through that program got to take a tour of the South Central Foundation in Anchorage who is very progressive and advanced in their PCMH model. Over the course of about three years, SD Urban Indian Health explored different models, weighing the pros and cons, and in 2011 began working toward certification for the PCMH model. They put together the PCMH Executive Team and worked toward certification, which they first received in 2013. It took two years to fully implement PCMH, but the team had been thinking about it for five years.

Tami shares, “One strength to the program getting up and running is that we’ve had the same six core members of our original team remain throughout that whole process so that was really a strength that we could keep that consistency building.”

What stakeholders were involved in making decisions about team-based care?

SD Urban Indian Health created a PCMH Executive Team to guide the process and involve all of the staff in some way. The PCMH Executive Team is made up of the Executive Director, Finance Manager, Behavioral Health Lead, Medical Lead (Tami), Lab Manager, Nurse Representative, Risk Manager, Quality Assurance Officer, and the IT Manager. The PCMH Executive Team oversees how PCMH is done at the facility and the Executive Team determines the mission and goals and provides general oversight for the Patient-Centered Medical Home model within the clinic. The Executive Team assigns tasks to different teams which are called “busses.” “We don’t want everything to come from the top down, but rather build PCMH from the ground up in involving all staff,” says Tami.

What are these “busses” you mentioned?

There are 34 employees between the two clinics (Sioux Falls and Pierre) and the staff are divided into groups, or “busses.” Tami explains, “We divide the staff between both clinics into what we call ‘busses,’ after the [Jon Gordan](#) Get On the Bus model. Each bus then takes part of our aims statement that is related to being a patient-centered medical home and focuses their efforts on that aims statement.” There are busses for patient self-management, coordinated care, comprehensive care, and so on.

For example, the bus for patient-self management sends out emails to staff for “Motivational Monday” or “Trivia Tuesday” to keep them self-motivated and encourage them. The patient-self management bus also holds events for patients around monthly awareness topics such as colorectal cancer awareness month, diabetes awareness month, and National Native American HIV Awareness Day.

Another bus works on the aim of vaccination. They do something each month involving vaccines with children and adults. Another bus set up text message reminders for patients, since a lot of patients have pay-per-month phones that sometimes get shut off and they weren’t receiving appointment reminder phone calls. Another bus set up a Facebook page with social media campaigns. This bus makes sure content is posted on the page 3-4 times per week and encourages patients to “like” the page and share posts to get the word out.

Do you have a policy in place specific to providing team-based care?

“We have a lot of policies and we review those annually through the team. We also send out general memos to all staff so they’re made aware of any policy changes so they stay up to date on all of those policies and procedures we have in place,” explains Tami.

What have you seen as benefits of this model?

Tami shares some of the benefits: “Patients know when they come in they’re going to see the same person repeatedly unless that person is out on vacation or traveling. It’s really helped to coordinate their care and make it more comprehensive.” Furthermore, Tami explains, “Staff really get to know patients and their families.”

“I think the patient-centered medical home model has definitely helped us get to where we are today because it’s very patient-focused, patient-centered, giving the patients that voice in their health system.”

What has been challenging about this model?

“I would say a challenge to maintaining the model and keeping it up is when we have staff turnover - retraining staff and making sure we get everyone on board with the model, making sure they know what is going on,” explains Tami.

“Another challenge, which is becoming less of a challenge with this model, has been patient engagement. When I first started practicing 15 years ago, the patients would come in and pretty much say, ‘fix me,’ ‘give me something to make me better,’ and weren’t super engaged in their care. But through patient self-management and being more patient-centered and patient-focused, I think it’s evolving more into conversations with patients on ‘what would you like to do?’ or ‘what do you think is best for you?’ ‘If I put you on a drug regiment 4 times a day, are you going to be able to be successful with that? If not let’s come up with a different plan that’s going to work for you.’ And I think those conversations are happening a lot more and that patient engagement is really evolving and happening, [whereas] it probably wasn’t when I first started.”

What advice would you give other facilities considering a team-based care approach?

Tami says, “I would say just do it. It is a lot of work and it seems daunting at times but in the end it’s so worth it. You just see how it improves workflow and overall care given to your patients,” says Tami. “I would also say to find a mentor program. The South Central Foundation, as I talked about before, really was what spurred our interest. And then we found other agencies who were also going through the same process. Work smarter not harder and find that champion program that’s willing to mentor you and help you through.”

To learn more about how South Dakota Urban Indian Health Clinic operates as a patient-centered medical home, you can contact Tami Hogie-Lorenzen at Tami.Hogie-Lorenzen@sduih.org.



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- **What is your role?**
- **What population(s) do you serve in your clinic?**
- **Who is part of the care team?**
- **How do team members communicate with one another?**
- **What does this look like from a patient perspective?**
- **What are some challenges?**
- **What are some benefits?**
- **How long has your facility been a Patient-Centered Medical Home?**
- **How did the clinic start implementing this model?**
- **What challenges did you face in implementing this model?**
- **What stakeholders were involved in making decisions about this model?**
- **What advice do you have for other facilities considering a team-based approach?**



About Mrs. Erin Hartig, Ms. Katie Wick and Falls Community Health

In this interview, we talk with Mrs. Erin Hartig and Ms. Katie Wick at Falls Community Health (FCH) about how they operate as a Patient-Centered Medical Home (PCMH). Falls Community Health is a robust primary care clinic with its main location in downtown Sioux Falls and three school-based sites throughout the city.

Thank you to Erin Hartig and Katie Wick for sharing this story.

What is your role?

Erin Hartig is the Clinic Quality Coordinator. Her primary responsibilities include managing the quality measures for the clinic as well as managing the PCMH requirements.

Katie Wick is a Clinical Services Manager who oversees nursing staff, provider schedules, and manages day-to-day clinical operations.

What population(s) do you serve in your clinic?

Mrs. Hartig and Ms. Wick explain that the clinic is a Federally Qualified Health Center (FQHC) which is a safety net provider serving primarily underserved, uninsured patients. In 2017, the total patient population was 12,780. Of this population, 49% are uninsured, 30% have Medicaid coverage, 15% have private insurance and a small percentage have Medicare coverage. Approximately 300 newly arriving refugees to Sioux Falls are being seen in the clinic for their basic healthcare needs. Approximately 21% of patients are best served in a language other than English, and last year the clinic documented the use of 33 different languages. To ensure appropriate communication, FCH contracts with interpreter services, utilizes language phone line services, and has staff and providers that speak more than one language.

Who is part of the care team?

The basic care team consists of a provider (MD, DO, CNP, or PA), a licensed practical nurse (LPN), and a registered nurse (RN) who is shared between two providers. Depending on the patient's needs, other staff can be pulled into the team such as a dietitian, RN-nurse case manager, social worker, counselor, or clinical pharmacist. The clinic has four different care teams that are designated by color (red, purple, blue, and green).

How do team members communicate with one another?

“In addition to daily huddles, each care team meets monthly to review dashboards of the clinical quality measures.”

The reports on these dashboards are broken out by the overall clinic, care teams, and then by each individual provider. This gives an opportunity for providers to benchmark with each other. During care team meetings, providers and staff discuss patients that are in need of more complex care. The teams also utilize the functions of the EMR, including patient flags and patient messages.

What does this look like from a patient perspective?

The intent of PCMH is to provide an enhanced coordination of care for patients. Patients have the opportunity to choose who their primary care provider (PCP) will be, which will determine the rest of their care team. When a patient calls for an appointment, the scheduling staff will make an appointment with the patient's PCP; if this provider is unavailable, every effort will be made to schedule with another provider on their care team. Any necessary follow up on the patient visit, such as referrals, labs, or imaging, will be communicated to the patient by a member of their care team.

What are some challenges?

Continuity of care can be a challenge because of multiple locations and the partnership with a residency program, where residents are only available 4-8 hours per week.

Additionally, the patient population faces many challenges, including transportation, financial barriers and limited resources. For example, if a patient on the blue team can only get a ride to the clinic that afternoon, but a blue team provider is not available until the next morning, that patient will be seen by a provider that may not be a member of the blue team, breaking the continuity of care.

Language barriers can also pose a challenge with this population. Interpretation services are utilized, but information can still be lost in translation; patients don't always understand the health care system, proper use of medications, side effects, etc. and there may be cultural barriers.

What are some benefits?

Benefits to PCMH include increased continuity of care, a more proactive approach to patients' healthcare needs, identification of patients who are at an increased risk of poor health outcomes, and an enhanced team approach.

How long has your facility been a Patient-Centered Medical Home?

The clinic was first recognized in 2014 as a level 3 Patient Centered Medical Home. In 2017 the clinic reached level 3 recognition for the second time.

How did the clinic start implementing this model?

Key management and staff attended trainings to gain an understanding of the basic principles and requirements of PCMH. Weekly meetings included discussion of the standards, and needed changes to the workflow, and required enhancements. The clinic completed small tests of change and refined workflows over an 18 month time frame before submission.

What challenges did you face in implementing this model?

Demonstrating the value to providers and staff was a challenge. Along with the multiple workflow changes and documentation required to produce needed reporting, time limitations for necessary rollout created some confusion. The residents' limited time at FCH created difficulties in consistency of implementation.

A valuable lesson learned was the importance of involving front line staff throughout the process. There was some involvement during implementation, however there could have been more. It also became evident that hiring the Clinical Quality Manager to keep everything on track, including documentation, has been very beneficial.

What stakeholders were involved in making decisions about this model?

Executive leadership was very involved and very supportive. The management team was instrumental in implementing this model. The clinic board was informed and asked for their input, and continues to be informed on the process. Over 50% of the board is made up of patients, so patients were able to provide feedback as well.

What advice do you have for other facilities considering a team-based care approach?

“It’s not easy but it’s worth it,” says Mrs. Hartig. “Lessons learned include that you need a team with front line staff that can provide insight, and you need leadership on board, too. Front line staff and providers give credibility to the program and more buy-in.”

Mrs. Hartig and Ms. Wick recommend trying small tests of changes to workflow before jumping in and changing all at once. Having front line staff try those changes to see if they work before rolling it out to everybody can be very helpful.

Ms. Wick states, “It seems like a lot of work up front, but it pays dividends in the end.”

To learn more about how Falls Community Health operates as a Patient-Centered Medical Home, you can contact Erin Hartig or Katie Wick at ehartig@siouxfalls.org and kwick@siouxfalls.org.