2025 PCMH Learning Network In-Person Statewide Session

June 25, 2025

Pittsburgh Regional Health Initiative

Robert Ferguson, MPH, Chief Policy Officer, Pittsburgh Regional Health Initiative

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Learning Objectives

- ✓ Describe the evolution of the HealthChoices PCMH and PCMH-PNC Programs from the perspectives of the PA DHS, MCOs, and PCMHs
- ✓ Describe what leads to success in the HealthChoices PCMH and PCMH-PNC Programs
- ✓ Describe examples of how PCMHs are implementing key interventions during the PCMH Learning Network's 2025 Sprints

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Learning Objectives

- ✓ Describe preliminary findings and progress from the mid-year sprint surveys
- ✓ Receive advice on how to breakthrough a current challenge with implementing a key intervention in one of the Sprints
- ✓ Describe examples of how PCMHs are using data to drive improvements
- ✓ List next steps and tactics to take back to your team to inform your quality improvement work in the HealthChoices PCMH and PCMH-PNC Programs

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Welcome and Highlights from the Mid-Year PCMH Sprint Surveys

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HealthChoices PCMH Program

One of the Physical HealthChoices value-based payment models

The PH-MCOs:

- Contract with high volume providers in their network who meet the requirements of a PCMH
- Make payments to their contracted PCMHs
- Collect quality related data from the PCMHs
- Reward PCMHs with quality-based enhanced payments
- Develop a **learning network** that includes PCMHs and other PH-MCOs
- Report annually on the clinical and financial outcomes of their PCMH program.

Also includes a specialized Pediatric Nursing Care PCMH Program for providers who serve at least 20 children who are receiving shift care nursing services

See Exhibit DDD

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Physical Health MCOs

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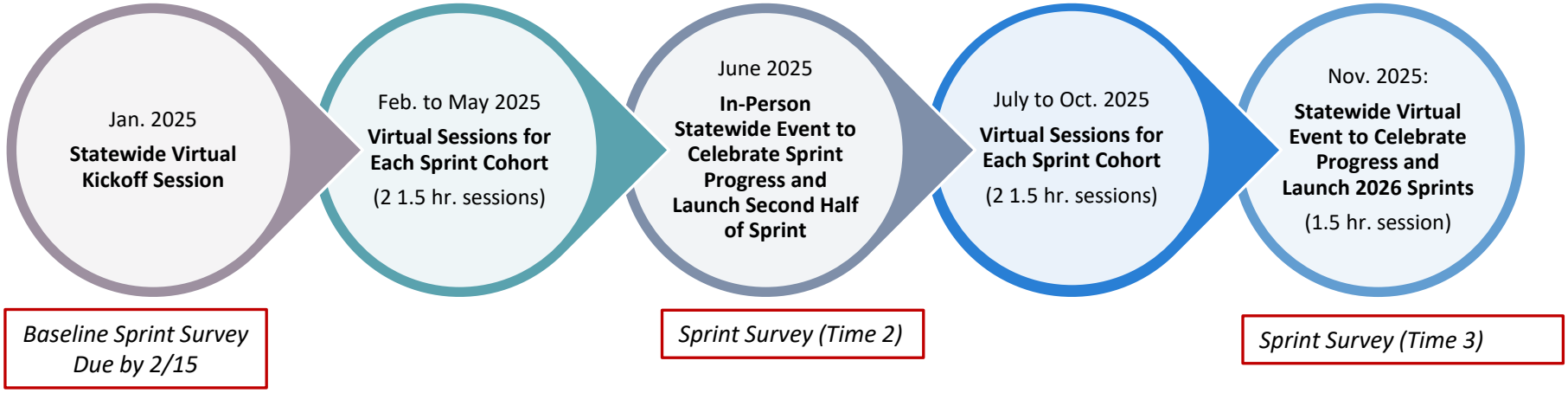
2025 PCMH Learning Network



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Review of Mid-Year Sprint Surveys

- Reflects what PCMHs are working on and changing within sprints

- Included data from PCMHs that completed a baseline AND mid-year survey
  - Post Hospital Follow-Up and Readmission Prevention – 9
  - Blood Pressure Control & Asthma Medication Ratio – 5
  - SDOH Interventions – 6
  - Well-Child and Well-Care Visits – 5
  - Pediatric Nursing Care Program – 2

**Full version of baseline vs. mid-year results are available online*

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Blood Pressure Control

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	Baseline	Midyear
Implement processes and team roles for consistent, accurate in-office BP screening: Trained Staff	Fully in Place: 80% In Progress: 20% Have not Started: 0%	Fully in Place: 100% In Progress: 0% Have not Started: 0%
Use Self-Monitoring Blood Pressure, including validated cuffs, sending average BP in electronically for review and action by clinical teams	Fully in Place: 60% In Progress: 20% Have not Started: 20%	Fully in Place: 80% In Progress: 0% Have not Started: 20%
Develop a multi-disciplinary team with disciplines, such as pharmacists, nurses, health educators, and community health workers (CHWs)	Fully in Place: 80% In Progress: 20% Have not Started: 0%	Fully in Place 100% In Progress: 0% Have not Started: 0%
Address disparities in the BP measure by race, ethnicity, gender, age, language, and/or geography	Fully in Place: 20% In Progress: 80% Have not Started: 0%	Fully in Place: 40% In Progress: 40% Have not Started: 20%

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Asthma Medication Ratio

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	Baseline	Midyear
Implement processes for routine vaccinations	Fully in Place: 60% In Progress: 20% Have not Started: 20%	Fully in Place: 80% In Progress: 20% Have not Started: 0%
Develop and implement a medication algorithm, defining ideal prescribing behavior for specific circumstances and incorporating Medicaid formulary restrictions	Fully in Place: 20% In Progress: 20% Have not Started: 60%	Fully in Place: 40% In Progress: 20% Have not Started: 40%
Ensure correct diagnoses	Fully in Place: 20% In Progress: 80% Have not Started: 0%	Fully in Place 40% In Progress: 40% Have not Started: 20%

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Post-Hospital Follow-Up and Readmission Prevention

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	Baseline	Midyear
Develop a multi-disciplinary team with roles, such as care coordinators, pharmacists, nurses, social workers, and community health workers (CHWs)	Fully in Place: 44.44% In Progress: 33.33% Have not Started: 22.22%	Fully in Place: 66.67% In Progress: 11.11% Have not Started: 22.22%
Implement telehealth programs for follow-ups, including team members going out to the home to "room" the patient for the provider	Fully in Place: 33.33% In Progress: 33.33% Have not Started: 33.33%	Fully in Place: 55.56 In Progress: 22.22% Have not Started: 22.22%
Stratify the needs of the patient population, including SDOH and comorbidities to prioritize follow-up and outreach	Fully in Place: 44.44% In Progress: 44.44% Have not Started: 11.11%	Fully in Place: 66.67% In Progress: 22.22% Have not Started: 11.11%
Share and access timely information across care settings, including both Admission, Discharge, and Transfer (ADT) notifications and more in-depth clinical information, such as medication lists, using health information exchanges	Fully in Place: 33.33% In Progress: 66.67% Have not Started: 0%	Fully in Place 66.67% In Progress: 33.33% Have not Started: 0%
Use systems for appointment completion reminders and follow-up	Fully in Place: 66.67% In Progress: 33.33% Have not Started: 0%	Fully in Place: 88.89% In Progress: 11.11% Have not Started: 0%
Implement team roles and workflows for making follow-up phone calls within 24-72 hours post-discharge to review and reconcile medications, review instructions, and set up follow-up appointment	Fully in Place: 55.56% In Progress: 33.33% Have not Started: 11.11%	Fully in Place: 88.89% In Progress: 11.11% Have not Started:0%

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SDOH Interventions

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	Baseline	Midyear
Frame questions as part of routine care and provide linguistically and culturally appropriate messaging and materials, including use of translation services, to facilitate patient sharing of information	Fully in Place: 66.67% In Progress: 33.33% Have not Started: 0%	Fully in Place 83.33% In Progress: 16.67% Have not Started: 0%
Deploy a community-based care management team (including community health workers)	Fully in Place: 16.67% In Progress: 66.67% Have not Started: 16.67%	Fully in Place 16.67% In Progress: 83.33% Have not Started: 0%
Implement tools within electronic health records (EHR) or integrated platforms (e.g., PA Navigate) to facilitate referral outcomes reporting	Fully in Place: 16.67% In Progress: 16.67% Have not Started: 66.67%	Fully in Place: 0% In Progress: 66.67% Have not Started: 33.33%
Evaluate whether the services addressed the patient's needs effectively and review outcomes data for any differences related to health disparities	Fully in Place: 0% In Progress: 33.33% Have not Started: 66.67%	Fully in Place: 0% In Progress: 66.67% Have not Started: 33.33%

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Well-Child and Well-Care Visits

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	Baseline	Midyear
Develop text, email, or app-based reminder systems and messaging for consistent well-child and well-care visits	Fully in Place: 60% In Progress: 20% Have not Started: 20%	Fully in Place: 40% In Progress: 60% Have not Started: 0%
Develop adolescent engagement strategies for consistent well-care visits up to age 21	Fully in Place: 20% In Progress: 40% Have not Started: 40%	Fully in Place: 0% In Progress: 80% Have not Started: 20%
Provide anticipatory guidance based on the child's developmental stage	Fully in Place: 80% In Progress: 20% Have not Started: 0%	Fully in Place: 100% In Progress: 0% Have not Started: 0%
Provide caregivers with guidance on reducing children's exposure to lead hazards, including practical steps for minimizing risks from household sources and environmental factors.	Fully in Place: 20% In Progress: 80% Have not Started: 40%	Fully in Place 60% In Progress: 40% Have not Started: 0%
Follow the Recommended Schedule for Obtaining a Confirmatory Venous Sample established by the CDC if capillary samples are used for blood lead testing	Fully in Place: 60% In Progress: 20% Have not Started: 20%	Fully in Place: 80% In Progress: 20% Have not Started: 0%
Screen all sexually active women 24 years or younger for chlamydia and gonorrhea at least once a year based on national guidelines, and consider universal screening to reduce stigma.	Fully in Place: 20% In Progress: 60% Have not Started: 20%	Fully in Place: 20% In Progress: 80% Have not Started: 0%

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Pediatric Nursing Care

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	Baseline	Midyear
Establish goals, team roles, and standard work for convening team meetings with the PNC Care Team at least quarterly	Fully in Place: 0% In Progress: 100% Have not Started: 0%	Fully in Place 50% In Progress: 50% Have not Started: 0%
Create team roles and processes for maintaining medical orders and initiating and maintaining the necessary and authorized services.	Fully in Place: 50% In Progress: 50% Have not Started: 0%	Fully in Place 100% In Progress: 0% Have not Started: 0%
Establish processes for coordinating additional case management services, including those related to a PH-MCO case management or Special Needs Unit, Home Health Agency services, DME, Early Intervention, BH, and education.	Fully in Place: 50% In Progress: 50% Have not Started: 0%	Fully in Place 100% In Progress: 0% Have not Started: 0%

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HealthChoices PCMH and PCMH-PNC Programs: History, Evolution, and Future Directions

Gwendolyn B. Zander, Esq., Director, Bureau of Managed Care Operations, PA Department of Human Services' Office of Medical Assistance Programs (PA DHS OMAP)

David Kelley, MD, MPA, Chief Medical Officer, PA DHS OMAP

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Patient Centered Medical Homes and Pediatric Nursing Care

Dr. David Kelley, Chief Medical Officer

Gwendolyn Zander, Director of Managed Care Operations

Office of Medical Assistance Programs

History of PCMHs

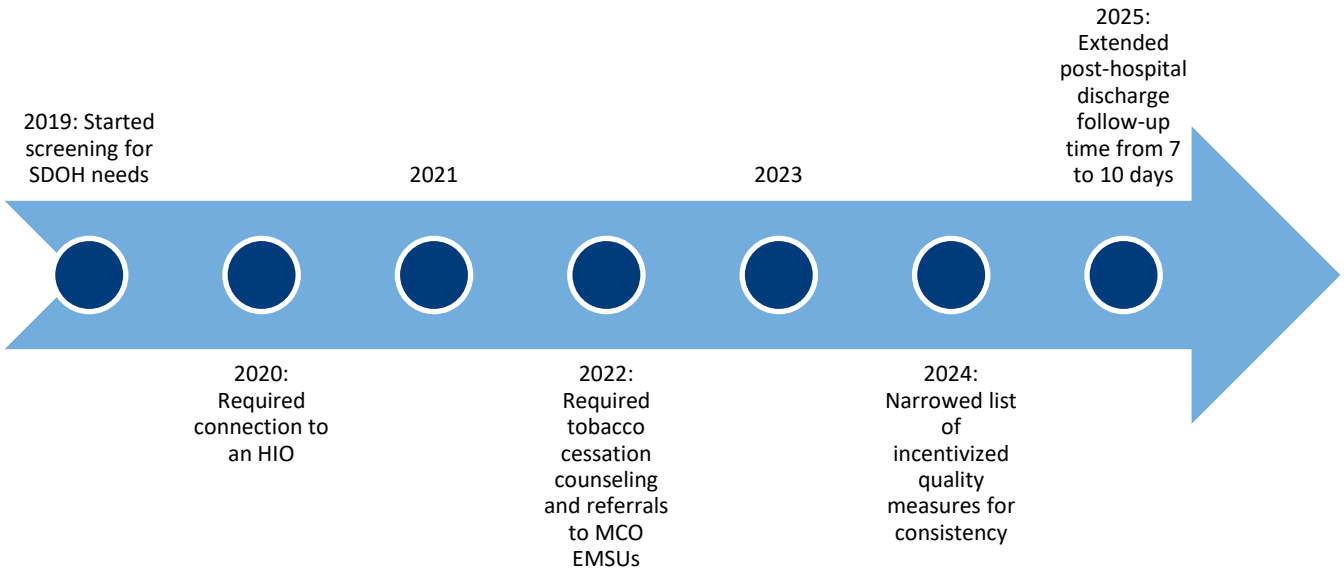
- **Planning began in 2016 under the Wolf Administration, and requirements were added to the 2017 HealthChoices Agreement**
  - Elected not to use ACA health home or NCQA accreditation due to reporting requirements and instead developed a unique Pennsylvania model through iterative, intensive stakeholder input over a year or so
    - Legislatively-mandated Advisory Council was convened and issued a report in 2019
      - Act 198 of 2014
  - Added $1.00 PMPM to rates, has increased to $1.50 PMPM

History of PCMH-PNCs

- **Convened MCOs, home health agencies, and family representatives over 18 months to develop a White Paper of strategies to improve pediatric shift care in Pennsylvania**
  - One set of recommendations centered around service coordination, including the option to provide medical homes for children with medical complexities that would take the lead for coordinating all of the children's care and meeting family's needs
- **ARPA Funding was provided by the federal government, and CMS approved DHS's proposal to use some of these funds to create PCMH-PNCs in at the end of 2021**
  - Added to the 2023 HealthChoices Agreement
  - Will continue after ARPA funding expires in 2026

Evolution of PCMHs

Pennsylvania
Department of Human Services



PCMHs by the Numbers

Pennsylvania
Department of Human Services

	2024	2023	2022	2021	2020	2019	2018
Number of PCMHs	1,428	1,700	1,744	2,229	1,835	1,939	1,058
Number of PNCs	154	6					
Number of Members in PCMH	826,923	931,815	994,084	1,040,164	898,730	778,430	697,063
Number of Members with SPMI	104,445	123,979	129,116	123,809	106,162	96,300	83,574

PCMH Quality Outcomes

Pennsylvania
Department of Human Services

P4P Quality Metrics	2024 Average	2023 vs 2024	2023 Average	2022 vs 2023	2022 Average
Annual Dental Visit	55.19%	↓	61.63%	↓	65.50%
Asthma Medication Ratio	68.41%	↓	71.87%	↑	68.89%
Child and Adolescent Well Care Visits	62.68%	↑	54.24%	↓	55.22%
Comprehensive Diabetes Care: HbA1c Poorly Controlled (>9%)	41.67%	↓	43.74%	↓	50.11%
Controlling High Blood Pressure	63.67%	↑	55.65%	↑	54.99%
Developmental Screening in the First Three (3) years of Life	54.46%	↓	54.70%	↑	46.44%
Lead Screening for Children	78.36%	↑	71.87%	↓	72.62%
Plan All Cause Readmissions	1.25/1000	↓↓	2.33/1000	↑↑	1.03/1000
Postpartum Care	79.12%	↑↑	73.81%	↑	62.30%
Prenatal Care in the First Trimester	81.88%	↑	80.79%	↑	73.51%
Well-Child Visits in the first 30 Months of Life	72.04%	↑	64.51%	↓	71.15%

KEY
P4P Quality Metrics Required as of 2024
↑ or ↓ = Change of less than 10%
↑↑ or ↓↓ = Change of 10% or more

PCMH Quality Outcomes

- **Other non-P4P measures vary by MCO/PCMH and include:**
  - Well child visits
  - Potentially preventable ER visits/ED utilization
  - Rate of follow-up within 7 days of hospital discharge
  - SDOH screening rates
  - Immunizations
  - Breast, cervical and colorectal cancer screenings
  - HBA1c testing
  - Pharmaceutical utilization measures
  - Chlamydia screenings
  - Eye exams and kidney health evaluations for people with diabetes
  - Weight assessments/counseling for nutrition/physical activity in children and adolescents

PCMH-PNC Quality Measures

Pennsylvania
Department of Human Services

- **2023 was the implementation year, and 2024 will be the first year we receive full reporting for. Therefore, there is no trend yet.**
- **Measures that MCOs and PCMH-PNCs will be evaluating include:**
  - Appropriate shift care coverage
  - Well child visits
  - Emergency department utilization

The Future of PCMHs

- **Advancing DHS's VBP Strategic Plan**
  - Whole-person, whole-family, whole-community care
  - Prioritizing pediatric preventive care and management of adult chronic conditions
  - Coordinating care for special populations, including those with heightened health-related social needs, such as those being served by the Keystones of Health 1115 waiver
  - Integrating care for those with serious, persistent mental illness and/or substance use disorders
- **Advancing the Commonwealth's Maternal Health Strategic Plan**
  - Ameliorating maternity care deserts
  - Improving birth outcomes
  - Addressing maternal mortality

The Future of PCMH-PNCs

- **Continuing to expand in numbers and staffing**
  - MCOs will continue to fund after ARPA funding expires in 2026
  - MCOs can count members together to identify PCMHs who jointly serve more than 20 children receiving shift care services so more PCMHs are eligible for the funding
- **Coordinating with regional Pediatric Complex Care Resource Centers and Family Facilitators**
  - PCCRCs help coordinate care for children receiving shift care
  - Family facilitators help bring children back home or to community-based settings from residential facilities or hospitalizations
- **VBP arrangements that incentivize:**
  - Decreased missed shifts
  - Higher patient/family satisfaction
  - More complete care plans being shared and used by the whole care team
  - Better health outcomes, including decreased ED and hospital utilization

Break

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MCO Panel: Effective Examples of MCO-PCMH Collaborations

Highmark Wholecare; Geisinger Health Plan; Jefferson Health Plans; AmeriHealth Caritas & Keystone First; United Healthcare Community Plan; and UPMC for You

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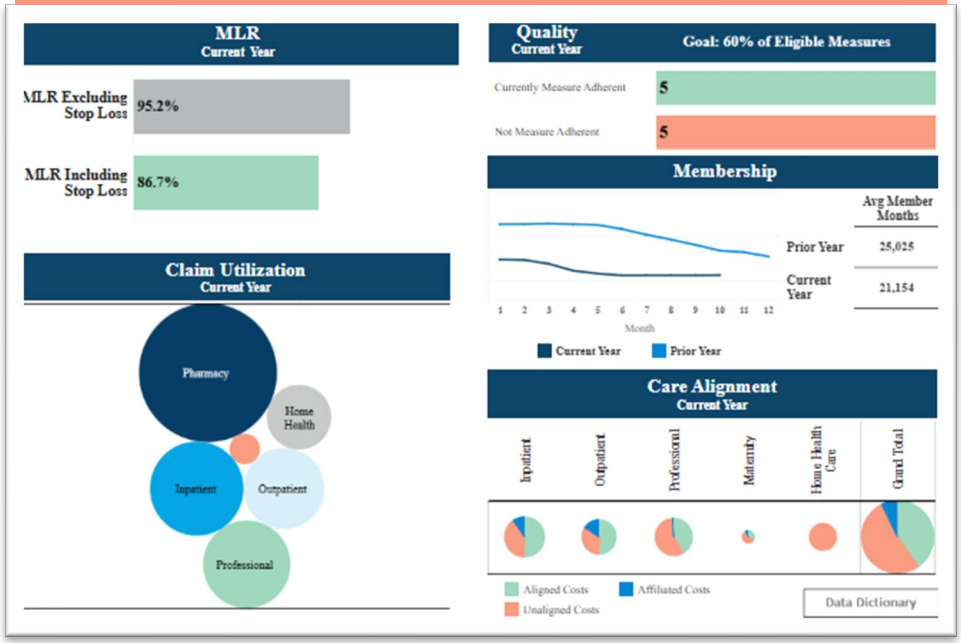
Highmark Wholecare PCMH Program Data

All PCMH providers have access to a robust Tableau dashboard that includes MLR, Cost, Utilization, Quality, Member Roster, and other relevant information.

Highlights of PCMH Program

- Majority of our PCMH providers are also enrolled in Shared-Savings and/or Maternity Episodes of Care programs
- Each provider has access to a Tableau Dashboard (example on right), accessible directly from provider portal
- Dashboard contains summary-level information on cost and utilization trends, and detailed information on quality and member rosters.
- Member roster includes chronic condition indicators, risk score, claim spend, and ED utilization.
- Currently focused on Pharmacy trends and new dashboard developed and released for all providers.

Example of Tableau Dashboard Home Screen



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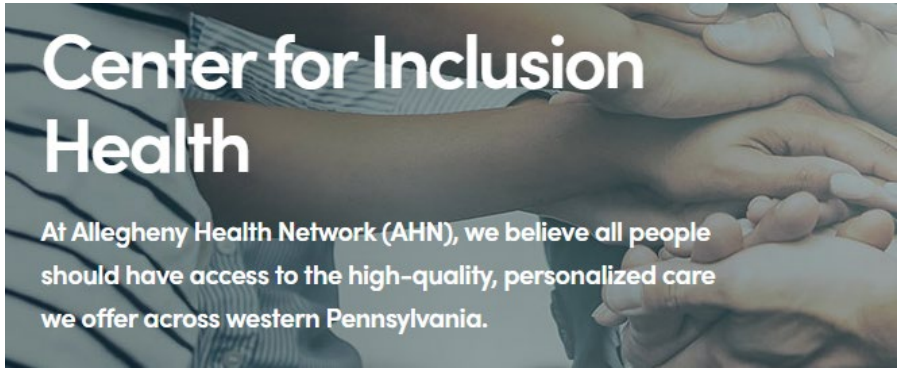
PCMH Provider: AHN Center for Inclusion Health

Partnership and Collaboration with Highmark

Partnership Spotlight: Kristin Lazzara, Director Strategic Operations at AHN Center for Inclusion Health



AHN Center for Inclusion Health (CIH) aims to transform health care through the **development of innovative clinical care models, advocacy, training and research** to **better serve all people, including those experiencing social and health exclusion**. CIH's many unique programs are rooted in a **harm-reduction model**, designed for and with people experiencing exclusion, to meet them where they are, both physically and psychologically.
The center provides **low-barrier services** in traditional and non-traditional settings, including in **medical clinics and hospitals, on the streets, in the jail, on mobile units and via telehealth**. CIH programs address health issues related to **addiction, food insecurity, HIV/AIDS, homelessness, gender diversity, incarceration, intimate partner violence, transgender health, and immigrant and refugee health.**

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One Center for Inclusion Health

Population Characteristics

- Marginalized
- Disconnected from Health Systems
- Complex Medical, Behavioral and SDOH needs

Target Populations

- Addiction
- Homeless
- Post Incarceration
- Immigrants/Refugees
- HIV
- Transgender
- DSNP
- Food Insecure
- Intimate Partner Violence

Multidisciplinary Teams

- Clinicians
- Social Workers
- Community Health Workers
- Peers

Supportive Services

- Transportation
- Meds for under-uninsured
- Healthy food for food insecure
- Support groups and advocacy
- Outreach
- Care navigation

Low barrier Access

- Co-located Clinical/supportive services
- Inpatient/ED
- Mobile services
- Street Rounds
- CBO Partners
- Allegheny County Jail

Treatment

- HIV Care
- Addiction/MOUD
- Primary Care

Patient and Care Model Advocacy

- Formed PA Community Health Worker Collaborative (PACHW), a statewide coalition and 501c3
- Working with PA DHS to recognize CHW services under Medicaid

Community and Government Partnerships

- Humane Animal Rescue
- FQHCS's
- Domestic Violence Orgs
- City of Pittsburgh
- Allegheny County DHS
- PA DHS

Medical Respite

Addiction Medicine

Community Health Worker

Healthy Food Centers

Intimate Partner Violence

Humane Health Coalition

Immigrant & Refugee Health

CIH Ambulatory Care

Urban Health Outreach

LGBTQ+ Health

Post Incarceration Clinic

Positive Health Clinic

AHN
Center for Inclusion Health

Geisinger

HEALTH PLAN

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Health Partners Plans
part of Jefferson

PCMH Learning Network

MCO Panel Presentation

June 25, 2025

Offering High Quality and Affordable Health Plans

- Health Partners Plans, Inc. is:
  - Serving members for more than 40 years
  - Headquartered in Philadelphia
  - Solely owned by Jefferson since 2021 (previously owned in most recent past by Jefferson, Einstein and Temple)
- We provide health care for all stages of life through our health plans.
  - Under the Health Partners Plans brand, we offer Medicaid and CHIP (Children's Health Insurance Program) plans statewide in Pennsylvania
  - Jefferson Health Plans Medicare Advantage plans, including PPO, HMO, and DSNP options, are offered in 15 counties in Pennsylvania and seven counties in New Jersey
  - Jefferson Health Plans Individual and Family Plans (IFP) are offered in six counties in Pennsylvania

Meeting Members Where They Are

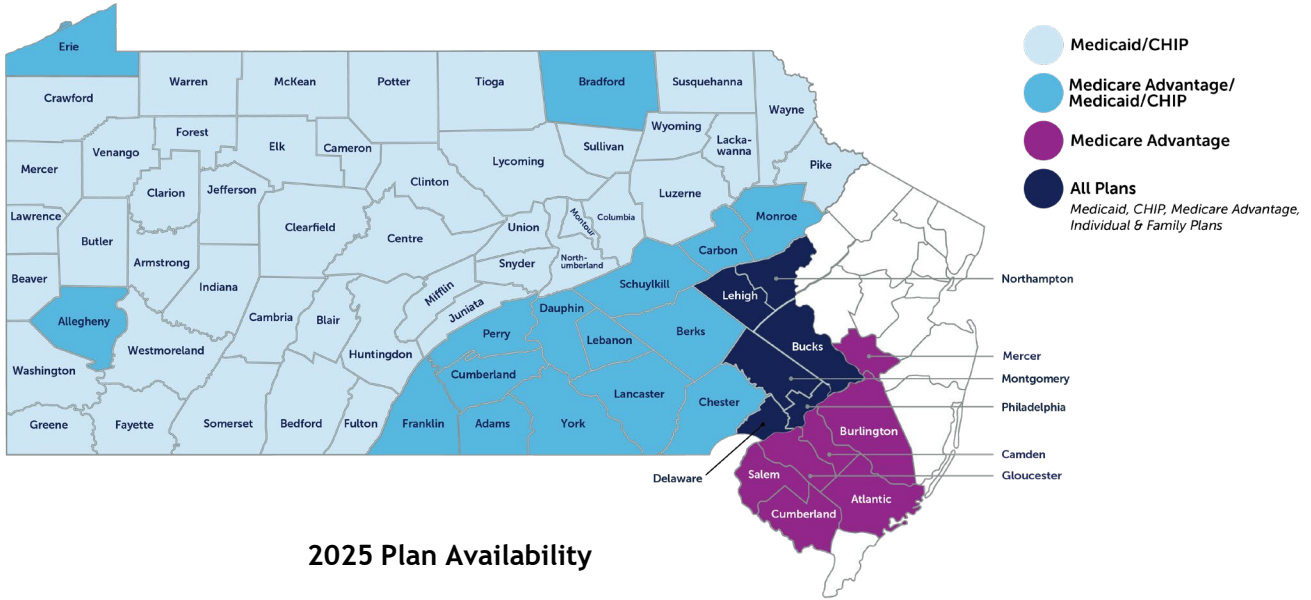
- A leader in innovative managed care, our health plans go beyond the basics of insurance with enhanced health and wellness benefits and a passionate commitment to building healthier lives and stronger communities.

- We are nationally recognized for our innovations in managed care, including NCQA accreditation for health equity and quality standards.

- We support accessible care that extends past the doctor's office, through community partnerships that connect our members with essential resources like housing, food, fitness, transportation, and more.

Caring for Members in Pennsylvania and New Jersey

- We offer some of the most affordable and high-quality health plans in the region, built by our team of insurance experts to improve health outcomes through a whole-person approach to health.



2025 Plan Availability

Committed to the Communities We Serve

We support accessible care that extends past the doctor’s office, through community partnerships that connect our members with essential resources like housing, food, fitness, transportation, and more.

- Health Partners Plans has partnered with MANNA since 2015 to provide medically tailored meals for members with complex health care needs, including those managing high-risk pregnancies. As MANNA's first contracted partner, we delivered our one millionth medically tailored meal in 2021.
- We hold an annual Night at the Zoo event at the Philadelphia Zoo, which draws several thousand health plan and community members. After Medicaid expansion statewide in 2022, we expanded the event to the Lehigh Valley Zoo.
- Our Community Wellness Center hosts in-person and online classes and programs related to job readiness, fitness, and nutrition.
- We began partnering with Fabric Health, an organization dedicated to educating low-income families about healthcare options while they’re at local laundromats, in 2022.

JHP's PCMH Network Overview

- Large health systems, FQHCs and independent physician practices
- Many practices have participated since program inception in July 2017
- PCMH members account for 37% of total Medicaid membership and 39% of members in the top 5% of medical costs.
- PCMH practices continue to demonstrate **higher quality scores, lower admission rates and higher PCP visit rates than our non-PCMH practices.**

Care Management Collaboration with PCMH Providers

- Monthly high-risk and PNC member lists shared with the PCMHs
  - Collaboration on members lost to care
- Workflow improvements designed to reduce administrative burden for both JHP and PCMH practices
- PCMH funds used to staff designated PCMH population health resources
  - 111 clinical resources and 69 non-clinical resources hired across all PCMH practices
- Care management-focused webinars to align on goal and share resources/best practices
- MCO-led trainings on integrated care plans (ICPs) and ICP completion incentive
- Facilitation of PNC case rounds to foster full care team engagement

Leveraging PCMH Partnerships

- Regular collaboration on initiatives tied to quality measures (e.g., HEDIS, care gap closure)
  - Block scheduling events, diabetes days, Room2Breathe, RPM program
  - Quality reporting feedback/enhancements
- PCMH practices participate in joint pilot programs outside of the scope of the PCMH program
  - Referral process implemented for in-home vendor to complete care gap closure for noncompliant members.
- Trusted feedback loop strengthens long-term alignment on these efforts
- PCMH partners provide valuable insights for JHP's network-wide decisions and priorities
  - Tobacco cessation counseling, EMSU referrals, SDoH/HRSN screening and referral process, patient satisfaction assessment/surveys
- Best practices learned from PCMH providers can be shared with JHP's network
  - Provider best practice webinar series, provider communications

Member Stories

- A social worker at an ECHA practice worked with a teen patient and her mother on numerous issues. The patient reported experiencing anxiety and depression, and the social worker was able to connect the patient to integrated behavioral health resources located within the practice. Additionally, the patient's mother reported experiencing discrimination at work due to her dyslexia. The social worker was able to connect the patient's mother to a physician who could properly diagnose her dyslexia and was also able to connect the mother to the Medical-Legal Community Partnership located on-site to discuss issues related to the employment discrimination she is navigating.

- A Community Health Worker at a DVCH practice met with a pregnant patient who was concerned about not having clothing and other needs for her baby. The CHW connected the mother to a nearby clothing resource and informed the mother about the Philly Families CAN program, which provides additional material support to pregnant women and families with kids. The mother reported she had thought about connecting with Philly Families CAN, but expressed appreciation for the CHW facilitating the connection.

Health Partners Plans

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HealthChoices PCMH Learning Network

Effective Examples of MCO-PCMH Collaborations

6/25/2025

United Healthcare®

Patient Centered Medical Home Program Overview

- PCMH Program rolled out in 2017
- UHCCP of PA has 4 active PCMH agreements in 2025 (3 started in 2017 and 1 started in 2024)
- PCMH's receive a monthly PMPM payment to support care management activities and have an annual quality performance incentive opportunity
- Bimonthly or quarterly JOC meetings with the UHC Core Team (CMO, Clinical Transformation Manager, Account Manager, and Clinical Practice Consultant)
- Meetings have evolved to include a variety of teams and topics (e.g. ICP, Shift Care Nursing, Diabetes Prevention, Asthma Medication Adherence and Education, Pharmacy, Enhanced Member Support Unit, SDOH, Community Based Organizations, Smoking Cessation)
- PCMH Program serves as a bridge to develop additional value-based partnerships with these provider groups (e.g. ACO Shared Savings, PC-AICC, Pediatric PC-AICC/ PNC, Hospital MOUD Program, State Maternity Episodes of Care Programs, and various other Episodes of Care Programs)

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PCMH Program Focus Areas

1 **Collaboration**

Data sharing and access to electronic medical records, building relationships with the Care Management and Population Health teams

2 **Improving Outcomes**

Focus on reducing readmissions, 10-day follow-up for ambulatory sensitive conditions, review IP and ER utilization trends, focus on high-risk members through care management

3 **Quality**

Preventative care focusing on contracted quality measures and the additional P4P measures, SDOH screenings and referrals to CBO's, focus on member satisfaction

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PCMH Program Highlights

Improving Outcomes & Utilization

- In total, PCMH's have demonstrated the following results when comparing CY 2022 versus CY 2024 on a risk adjusted basis:
  - 8.3% reduction of IP admissions/ 1000
  - 20.2% reduction of IP days/ 1000
  - 7.6% reduction of ER visits/ 1000
- Absolute Care PC-AICC Program reduced average PMPM costs in 2023 by 19% comparing costs prior to enrollment to post enrollment costs. Additionally, during this timeframe:
  - 7-day hospital follow-up rate increased from 6% to 43% (600% increase)
  - IP admissions/ 1000 decreased 16%
  - PCP visits/ 1000 increased over 100%
  - Medication adherence increased over 20%
- CHOP Pediatric PC-AICC Program reduced average PMPM costs by 30% comparing costs prior to enrollment to post enrollment costs

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PCMH Program Highlights

Improving Quality

- PCMH groups are performing approximately 9% better than the non-PCMH groups at closings gaps in care when comparing the 8 aggregate quality measures across all PCMH agreements
- PCMH reporting of SDOH screening activities, based solely on claims, has improved by over 100% between 2022 to 2024
- CHOP has met all 6 PC-AICC performance measure targets for CY 2024
  - Social Determinants of Health (“SDOH”) Assessment, SDOH Referral for Program Customers with Positive Result, Program Customer/Family Survey, Shared Plan of Care Completion, Continuity of Care: PCP, Care Manager, or Specialist Engagement at least every 3 months, 7-Day Follow-up
- Absolute Care has met all 6 PC-AICC quality targets for CY 2024
  - Diabetic Eye Exam, Breast Cancer Screening, HBA1c testing, Adult Access to Preventative Care, Controlling High Blood Pressure, and Diabetes HbA1c Poor Control

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UPMC
LIFE CHANGING MEDICINE

UPMC PCMH Highlights

June 25th, 2025

Successes

Collaboration with Providers

- Transparent and Regular Communication
- Bi-directional Data Sharing
- Alignment with other VBP programs, including Premier Partners and Provider P4P

Engaged Provider Partner

- Utilization of Resources Offered by HP (i.e. PBCM, Resource Navigator)
- Review Variances

Reimbursement and Analytics

- Utilization Targets and Results
- Quality

2025 Premier Partners Program

2025 Program Structure Key Components:

Attribution / Membership

- Care Coordination Fees Unchanged from 2024
- **Medical Home Attribution Update to Emphasize Preventive Visits**

Quality

- **Overall Star Rating Quality Bonus with 3 Tiers of Opportunity**
- 4 Quality Bonus Measures with 3 Tiers of Opportunity

Risk Adjustment

- CDPS Medicaid Risk-Adjustment Incentive

Utilization

- **Added Medicaid Preventive Visit Incentive**
- **Added Medicaid MER Based Enhancement**
- ED Utilization Metric for all Adult Lines of Business

Key Clinical, Social & Experience Focus Areas

- Social Determinants of Health Incentive
- Depression Screening Incentive
- **Added Member Experience Initiative Based around Access**

Describe an example of how the MCO and PCMH developed an effective working relationship through the HealthChoices PCMH Program, where the MCO and PCMH are now sharing data to collaboratively identifying/driving improvements

Monthly Data Sharing

- Financial Reporting:
  - Income Statement
  - P&L Summary
  - Leakage reports
  - KPI's (PMPM and Utilization)
- Clinical and Quality Reporting:
  - Quality Gap lists (site level by measure)
  - Key Driver Unplanned Care Metrics: By PCMH group and individual office sites with comparisons to all other groups for ER visits, inpatient admits, observations, and urgent care visits
  - Member level reporting: Unplanned care visit, quality gaps in care, PCP visits, specialist visits, predictive risk score, required CDPS diagnoses, and an indicator if a member has a diagnosis of SPMI

Bi-Directional Data Feeds: Providers have access to a Care Management Gap Tool that provides Quality open gap information that is refreshed monthly. This tool provides an opportunity for providers to upload documentation to close additional gaps

Highlights the major changes/improvements that they have observed as a result of the HealthChoices PCMH

- Comparison of CY2018 (initial baseline period for groups with longest participation in PCMH) to CY 2024

ER Utilization/1,000

Pediatric Groups	2018	2024	% Change
Group 1	536.0	391.4	-36.9%
Group 2	746.3	542.5	-37.6%
Group 3	426.0	292.0	-45.9%

Adult Groups	2018	2024	% Change
Group 1	841.9	745.3	-13.0%
Group 2	1,107.0	727.2	-52.2%
Group 3	583.2	402.8	-44.8%
Group 4	1,139.2	926.9	-22.9%

IP Utilization/1,000

Pediatric	2018	2024	% Change
Group 1	35.0	26.8	-30.6%
Group 2	46.4	54.5	14.9%
Group 3	33.6	26.5	-26.8%

Adult	2018	2024	% Change
Group 1	103.1	86.5	-19.2%
Group 2	131.0	84.2	-55.6%
Group 3	78.1	63.9	-22.3%
Group 4	108.1	92.7	-16.6%

Highlights the major changes/improvements that they have observed as a result of the HealthChoices PCMH

Pediatric Quality

W15	2018	2024	% Change
Group 1	80.1%	81%	1.1%
Group 2	54.4%	66%	17.6%
Group 3	79.8%	84%	5.0%

Child and Adolescent Well- Care	2022*	2024	% Change
Group 1	66.0%	72.0%	8.3%
Group 2	58.0%	65.0%	10.8%
Group 3	74.0%	75.0%	1.3%

**Measure specifications significantly change in CY 2022.*

Adult Quality

A1c Good Control (<8%)*	2018	2024	% Change
Group 1	54.9%	66%	16.8%
Group 2	64.7%	66%	2.0%
Group 3	65.4%	62%	-5.5%
Group 4	59.5%	60%	0.8%

**Specification changes occurred between the two time periods.*

Controlling High Blood Pressure	2021*	2024	% Change
Group 1	60.6%	76%	20.3%
Group 2	54.9%	75%	26.8%
Group 3	69.8%	74%	5.6%
Group 4	65.4%	75%	12.8%

**2021 was the first year CBP was a measure in the Premier Partners Program.*

MCO and PCMH Appreciative Interviews: HealthChoices PCMH Accomplishments

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MCO and PCMH Appreciative Interviews

- Stand up, find someone you don't know, ask the following questions of each other. You will each have 4 minutes for each person to talk
  - Name, Title, and Organization
  - Share one success within the PCMH program
  - Describe what was essential to that success
- When the facilitator notes 8 minutes have passed, find a new person to talk to and repeat the above questions

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Breakout: Troika Consulting in PCMH Sprints

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Troika Consulting

1. Take a minute to reflect on your consulting question (your challenge and the help needed), which you will share when you are the client.
2. Get in a group of three - these should be people who are NOT from your organization. A variety of perspectives is helpful.
3. Decide who is going to be “the client” first (the other two people will be “consultants” for the first round)
4. When the moderator says to start, the “client” has 1-2 minutes to explain their question/issue - the “consultants” listen without interrupting or asking questions.
5. Consultants then ask the client clarifying questions for 1-2 min.
6. The Client then turns around with their back facing the consultants
7. Together, the consultants generate ideas, suggestions, and coaching advice for 4-5 min. The Client listens quietly.
8. Then, the Client turns around and shares what was most valuable about the experience. 1-2 min.
9. Then, one of the Consultants becomes the Client and the group repeats all steps

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Lunch

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PCMH Sprint Knowledge Café Breakouts: Learning Across Sprints

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Knowledge Café Breakouts: Learning Across Sprints

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Break

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Report Outs from the PCMH Sprint Knowledge Café Breakouts

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PCMH Spotlights: Using Data to Identify and Drive QI Work

Kathleen Barry, MS, Deputy Chief Operating Officer, Alex Lillis, LPN and Melissa Calachino, LPN, The Wright Center for Community Health

Maryann Salib, DO, MPH, Associate Medical Director of Community Health and Wellness, Population Health and Clinical Quality Assurance, Esperanza Health Center

Laura Stack, DNP, MBA, RN, NE-BC, Ambulatory Nurse Executive, Tower Health

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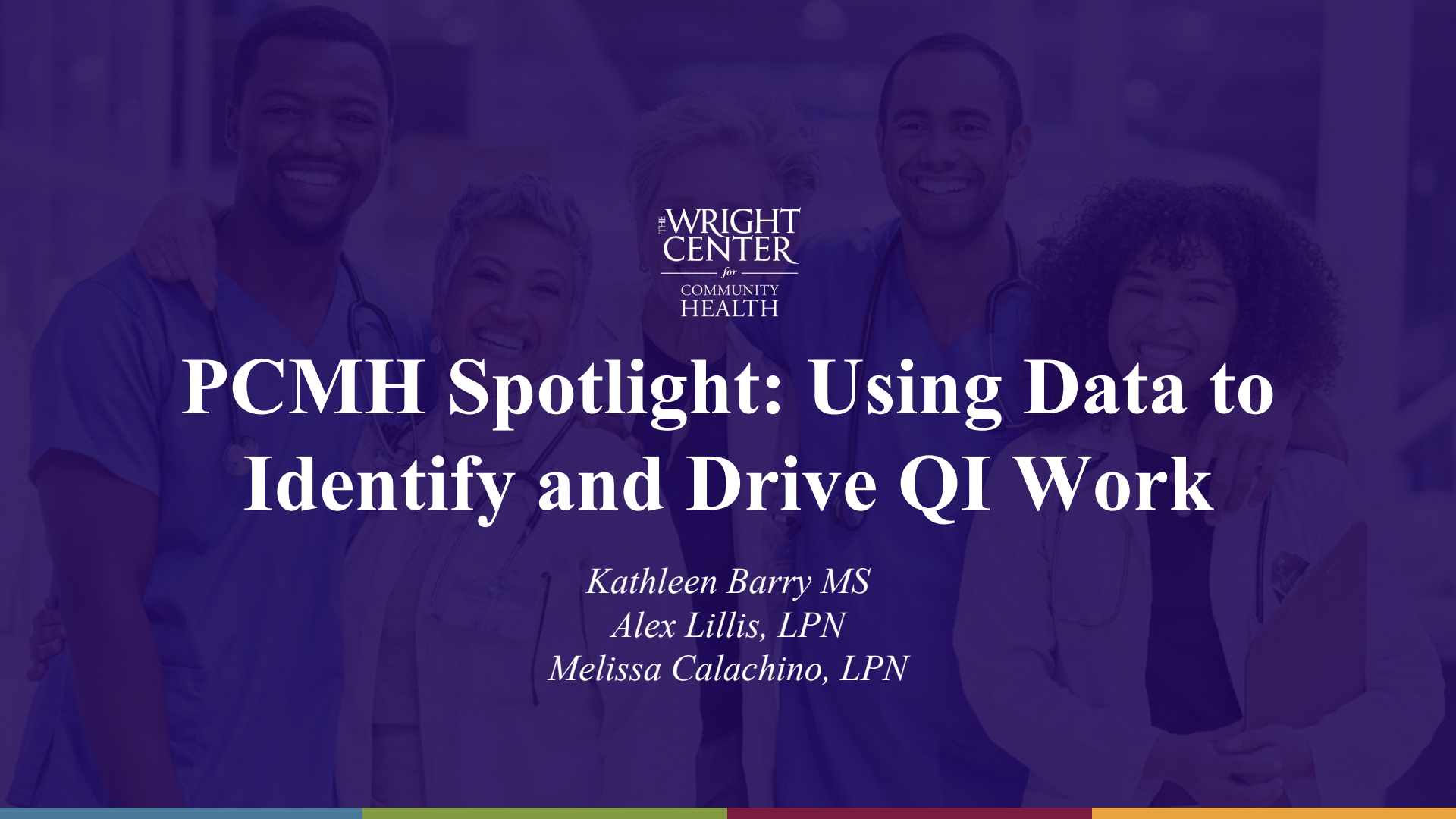

THE WRIGHT CENTER for COMMUNITY HEALTH

PCMH Spotlight: Using Data to Identify and Drive QI Work

Kathleen Barry MS
Alex Lillis, LPN
Melissa Calachino, LPN

Who We Are

Our Mission:
To improve the health and welfare of our communities through responsive, whole-person health services for all and the sustainable renewal of an inspired, competent workforce that is privileged to serve

Our Vision:
For our Graduate Medical Education Safety-Net Consortium framework that integrates patient care delivery, workforce development, innovation, and empowered voice of communities to be the leading model of primary health care in America

Our Values:
Do the Wright thing
Be privileged to serve
Be an exceptional team member
Be driven for excellent results
Be trustworthy and accountable
Spread optimism

10-year Vision:
Graduate Medical Education Safety-Net Consortiums are recognized by the President of the United States as THE Health and Human Services gold standard community-based model for comprehensive primary health care with integrated workforce development by June 30, 2027.

Our Niche:
World-Class, innovative, responsive, whole-person primary health services for all through community-centric, incumbent and future workforce renewal

When thinking of the HealthChoices PCMH expectations, what internal measures does your team use to define success in this program?

- Reduce unnecessary admission and prevent readmission
- Scheduling the patient with Primary Care within 3-5 days of discharge
  - Tracking internally with the care manager for the follow up in the office and outcome of the visit
- Focus on team based care with consistent regular communication from ***inpatient team*** and ***outpatient team***
  - Team members include:
    - Hospitalists
    - Resident Physicians
    - Primary Care Clinicians
    - Care Management Nurse
    - Community Health Worker
    - Social Worker

THE WRIGHT CENTER for COMMUNITY HEALTH

For these measures, what current results would you like to share?

- **Monitoring the trends of the readmission rates through**
  - ACO partnerships
  - Internal reports and metrics
  - Patient feedback and improvements of outcomes
    - Patient engagement with Chronic Care Management and satisfaction
  - Outcomes of patients from admission and overall health management

- **Deepened network within the hospital setting for regular communication**
  - New partnerships or contacts to help with the coordination transition of care plan *BEFORE* patient leaves the hospital
  - Starting the discharge plan of care at admission to help with the overall well-being of patient

What are the results ?

- **Defining the Problem**
  - Decrease readmission post-hospitalization
  - Increase the adherences to post hospital follow ups (TOC) appointments with primary care clinician
    - *Targeting the most vulnerable patients proactively (i.e .TOC patients) to help prevent readmissions*

- **What is at the root of the problem?**
  - Talking with the team and getting patient feedback
  - Care team spoke with the patient through the process to help find out their needs to design the care plan that would be most successful for the patient but also to help improve their health literacy
  - Educating all internal team members about the importance of communication and why transitions of care are so critical for patients

Overall Takeaways

- Continuous communication is key with all team members
- Planning for next steps is key to help focus patients on plan and overall goal
    - Having scheduled appointments proactively
    - Actively communicating with patient about plan
- Leveraging network of outside partnerships to help manage overall communications and help with goal

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Thank You!

Questions?

Esperanza Health Center
Compassionate Care For Everyone

Quality Improvement in Diabetes at Esperanza Health Center

HealthChoices PCMH Learning Network
Statewide Session
6/25/25

Maryann Salib, DO MPH
Associate Medical Director for Community Health and Wellness, Population Health, and Clinical Quality Assurance

Esperanza Health Center

"Compelled by the love of God in Christ Jesus, in cooperation with the Church and others, Esperanza Health Center is a multi-cultural ministry providing holistic healthcare to the Latino and underserved communities of Philadelphia."

Overview of our population

Esperanza Health Center
Compassionate Care For Everyone

- 14,848 patients served last year
- 62% (9,168 patients) best served in a language other than English
- 86% identify as Hispanic/Latino
- 60% insured by Medicaid, 23% uninsured, 9% Medicare
- 58% living below 200% of the Federal Poverty Level

Our Services

Esperanza Health Center
Compassionate Care For Everyone

- Primary Medical Care
  - Including Adult Care, Pediatrics & OB-GYN services (including CenteringPregnancy)
- Dental Care
- HIV Care
- Behavioral Health (integrated within primary care)
- Medication Assisted Treatment for Opioid Use Disorder (group model)
- Nutritional Counseling
- Spiritual Care
- Social Services
- Community Health and Wellness Programs supporting families, and residents, addressing Social Drivers of Health
- Other- Medical Legal Partnership, partnership with Everence (credit union)

Strategic focus: Diabetes

Esperanza Health Center
Compassionate Care For Everyone

- Significant source of morbidity and mortality for our patient population.
  - 1,717 patients in total with diabetes at EHC
  - 363 patients with A1C > 9
  - 987 with pre-diabetes
- Focus on chronic disease mitigation at EHC this year
- A1C control is also a priority state measure selected by DHS, and therefore also monitored by MCOs
- Our work is done in mostly a payer-agnostic manner (caring for both insured and uninsured patients)
- Particular projects with MCOs (Diabetes screening event with JHP)
- Data source is population health management system – Azara DRVS

Diabetes Outreach Team at EHC

Esperanza Health Center
Compassionate Care For Everyone

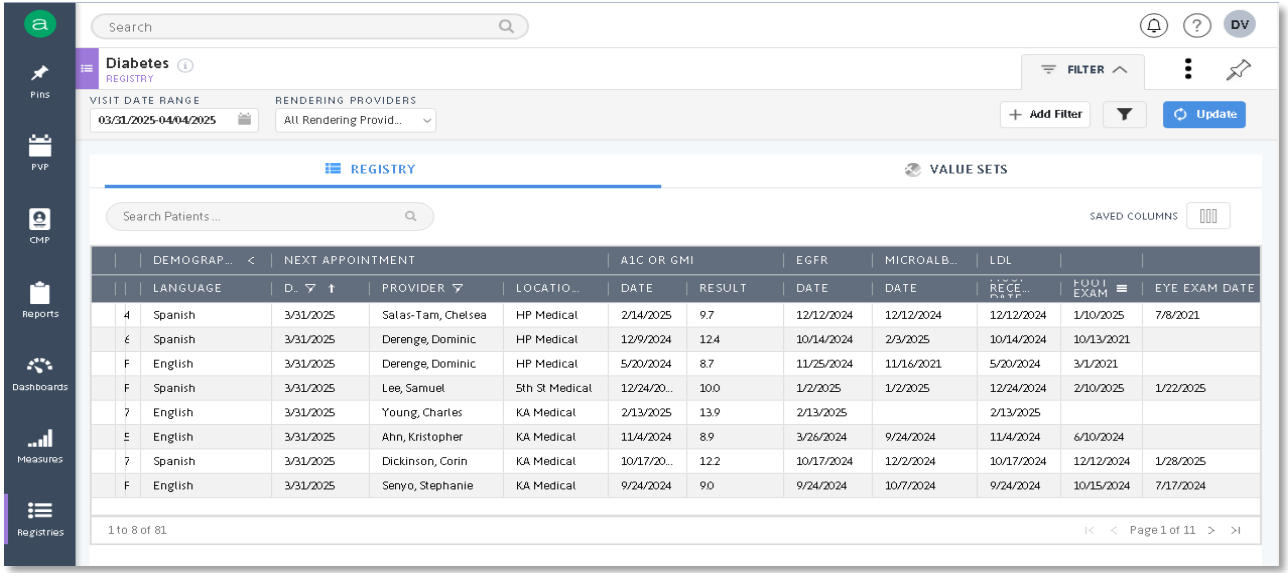
- Through the generous support and partnership with the Health Federation of Philadelphia, we have been able to significantly expand our diabetes outreach work.
- Currently, EHC is a sub-grantee on a 5-year, multi-component collaborative project funded by the CDC to improve care and outcomes for people with or at risk of diabetes
  - Team members:
    - Diabetes Care Coordinator and two part time Diabetes Navigators
    - All new positions as part of HFP grant (apart from supervisor)

  Activities:
    - Reports pulled monthly of patients with uncontrolled A1C.
    - Reports pulled for those seen in office 2 weeks ago.
    - Report for in office visits (for team to attend visits in office)
    - Recruit pre-diabetics for DPP classes

Monthly “Care Gap” Outreach Calls

Esperanza Health Center
Compassionate Care For Everyone

Reports pulled monthly of patients with uncontrolled A1C. Outreach calls conducted to close care gaps



- Remind patients of labs due, and retinopathy screening.
- Conduct SDOH screening and schedule appointments as needed.

Office Visit Follow Up Calls

Esperanza Health Center
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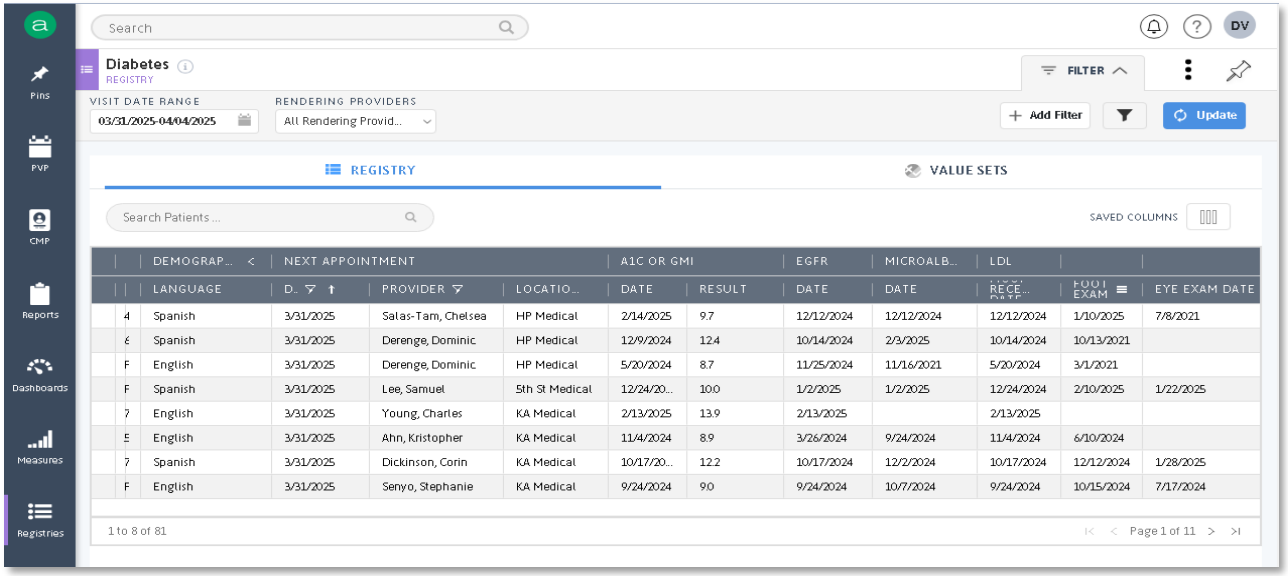
Reports pulled for those seen in office 2 weeks ago. Calls are made to follow up on adherence to provider's instructions given during that visit.



Team troubleshoots any barriers and links to other members of the care team as needed.

Diabetes care provided by all EHC staff

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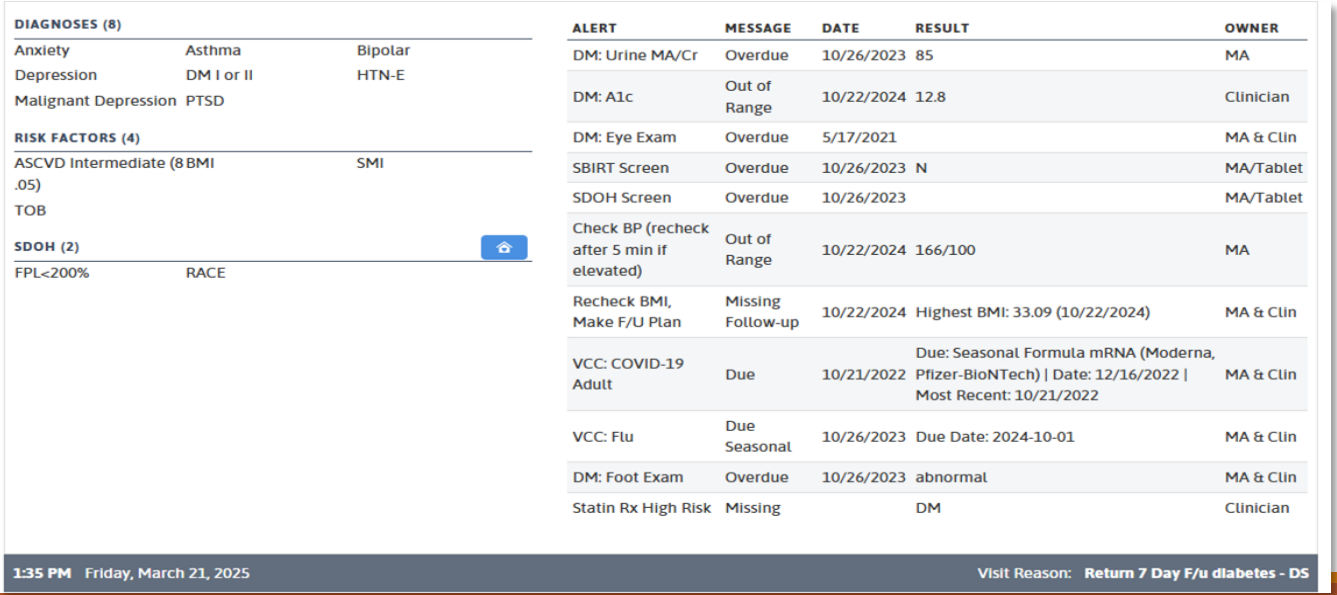
DM team supports the existing care provided by the rest of the care team members (providers, RNs, MA's) during clinic visits.
PVP used during team huddles.



DIAGNOSES (8)

Anxiety	Asthma	Bipolar
Depression	DM I or II	HTN-E
Malignant Depression	PTSD	

RISK FACTORS (4)

ASCVD Intermediate (8 .05)	BMI	SMI
TOB		

SDOH (2)

FPL<200%	RACE

ALERT	MESSAGE	DATE	RESULT	OWNER
DM: Urine MA/Cr	Overdue	10/26/2023	85	MA
DM: A1c	Out of Range	10/22/2024	12.8	Clinician
DM: Eye Exam	Overdue	5/17/2021		MA & Clin
SBIRT Screen	Overdue	10/26/2023	N	MA/Tablet
SDOH Screen	Overdue	10/26/2023		MA/Tablet
Check BP (recheck after 5 min if elevated)	Out of Range	10/22/2024	166/100	MA
Recheck BMI, Make F/U Plan	Missing Follow-up	10/22/2024	Highest BMI: 33.09 (10/22/2024)	MA & Clin
VCC: COVID-19 Adult	Due	10/21/2022	Due: Seasonal Formula mRNA (Moderna, Pfizer-BioNTech) | Date: 12/16/2022 | Most Recent: 10/21/2022	MA & Clin
VCC: Flu	Due Seasonal	10/26/2023	Due Date: 2024-10-01	MA & Clin
DM: Foot Exam	Overdue	10/26/2023	abnormal	MA & Clin
Statin Rx High Risk	Missing		DM	Clinician

1:35 PM Friday, March 21, 2025 Visit Reason: Return 7 Day F/u diabetes - DS

Diabetes QI Plans

Esperanza Health Center
Compassionate Care For Everyone

QI Project Plan

Root Cause to be Addressed: Knowledge and education gaps regarding retinopathy screening for diabetic patients

Intervention: Implement outreach calls by diabetes team to patients overdue on screening

Aim: To increase retinopathy screening for diabetic patients

Questions to Consider:

1. What is the idea we will test?
    a. Several of these factors are ameliorated by the diabetes outreach calls, whether in regards to education, advising of locations for screening or emphasizing screening as priority. We will test the overall impact of diabetes outreach calls on retinopathy screening rates.

2. What resources do we need to test this idea?
    a. Diabetes team

3. Who needs to be involved?
    a. Diabetes team
    b. Supervisors

4. What steps will be taken?
    a. Diabetes team trained on importance of retinopathy screening
    b. Standing order updated so that team may be able to sign off on referrals for screening
    c. Workflow created for the processing of retinopathy screening referrals
    d. Team trained on discussing retinopathy screening with patients who are overdue (including updating charts on patients who have completed screening)

5. Where will we implement this plan?
    a. Across all three health centers

QI Project Plan

Root Cause to be Addressed: Patients not being able to provide urine at visits.

Intervention:

- MA will provide all patients who are unable to urinate with a cup to collect at home, then return with a sample.
- During DM navigation calls, DCC/DCN will remind about bringing specimen back.

Aim: to improve rates in diabetic nephropathy.

Questions to Consider:

1. What is the idea we will test?

MA will provide all patients who are unable to urinate with a cup to collect at home, then return with a sample.
During DM navigation calls, DCC/DCN will remind about bringing specimen back.

2. What resources do we need to test this idea?
   Staff

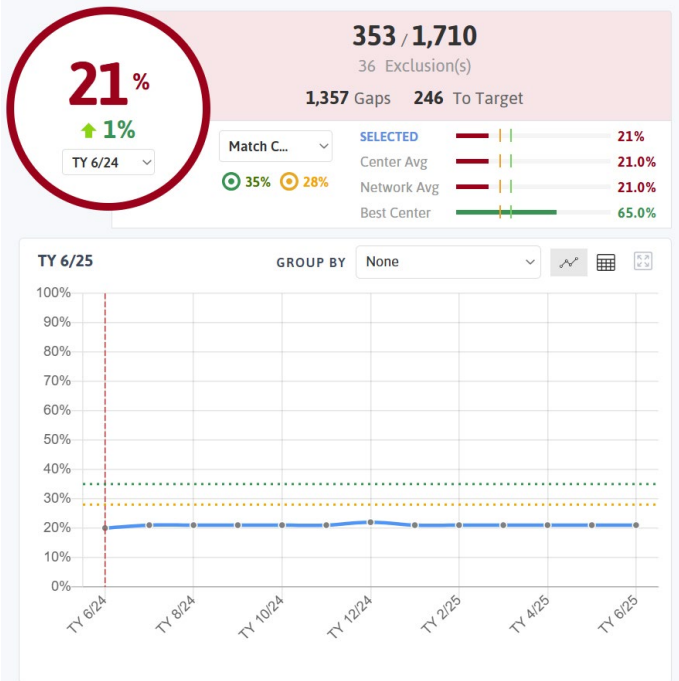
3. Who needs to be involved?
   Director of Clinical Services, Clinical Supervisors, Medical Assistants, Clinicians, Diabetes Team

4. What steps will be taken?

- Clinical Supervisors will review with MAs protocol to provide patients urine cups to return with specimens.
- Clinician and MA will identify pts due for urine MA via the PVP Huddle.
- MA will provide cup for urine specimen for patient during visit.
- If patient unable to provide urine, clinician will let MA know.
- MA will provide cup and instructions for returning with sample.
- If cup provided for patient, MA will place care alert in EHR chart.
- DCC/DCN will follow up on this during navigation calls after appointments, reminding

Progress - Diabetic Retinopathy Screening

Esperanza Health Center
Compassionate Care For Everyone



QI Strategies:

- Outreach calls
- Referrals sent by mail
- ROI's obtained
- PVP used during huddle to advise team that patient is due for screening

Successes:

- Improved workflows with referrals (standing orders)
- DCC connecting with optometry practices to identify more locations for uninsured pts

Challenges:

- Receiving reports
- Offices taking uninsured patients

Progress - Diabetic Nephropathy Screening

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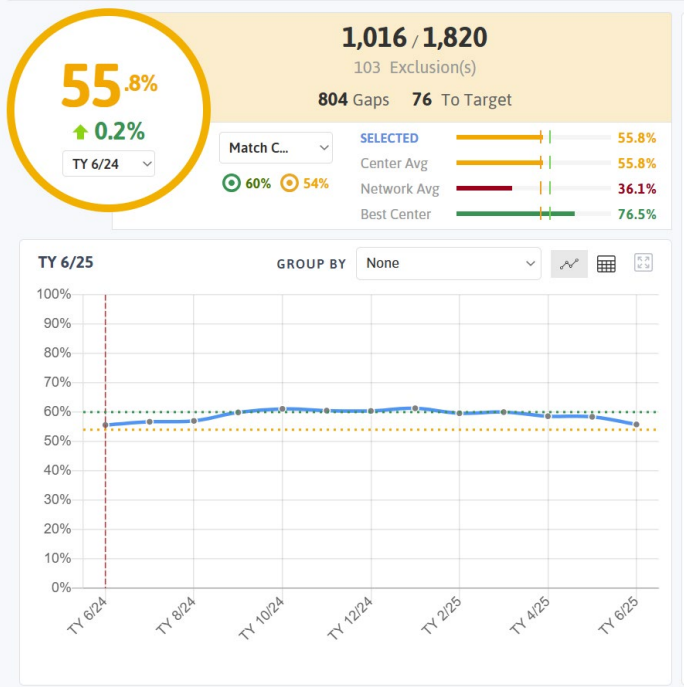


QI Strategies:

- Outreach calls
- MA's collecting urine samples during visits
- PVP used during huddle to advise team that patient is due for screening

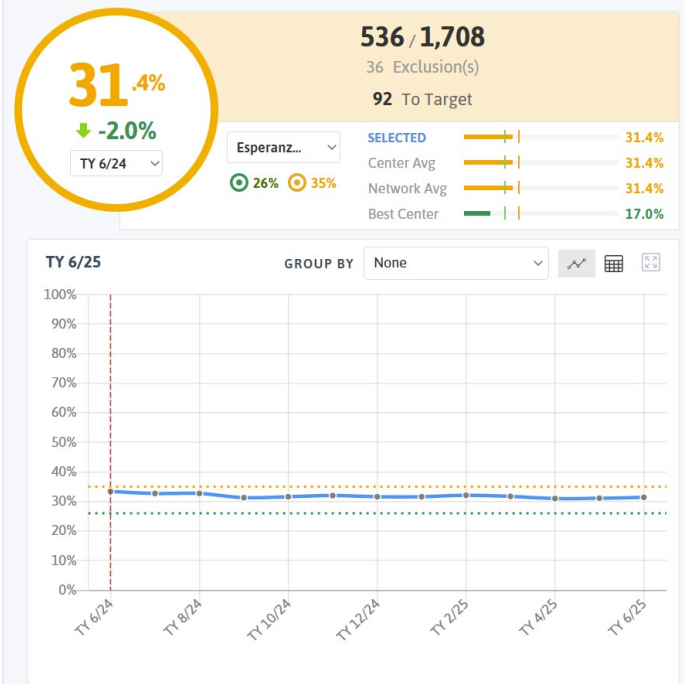
Successes:

- Increased screening

Challenges:

- Patients not being able to give sample during visit and not returning cup later

Progress – A1C >9 or untested



QI Strategies:

- Outreach calls
- PVP used during huddle to advise team of DM metrics

Successes:

- Increased screening

Challenges:

- Patients being lost to care, not getting labwork as recommended

Progress - Missing A1cs

Esperanza Health Center
Compassionate Care For Everyone

QI Strategies

- Outreach calls by DM team
- Increasing phlebotomy hours
- Availability of POC A1C machines at all three sites

Successes:

- More patients are up to date on their A1C's.

Challenges:

- Patient hesitancy. Fears of their results.

Diabetes Project Next Steps

Esperanza Health Center
Compassionate Care For Everyone

- Continue to track progress on QI plans and impact on quality measures
- Identify process measures to drive improvement
- Implement referral module to facilitate follow-up on obtaining retinopathy results
- Build relationships with ophthalmology practices to facilitate warm hand-offs
- Explore options for uninsured patients to access specialist services
- Expand outreach to patients due for A1Cs with more care team members
- Looking to plan diabetes screening events with MCO partners
- Exploring support from MCOs for on-site retinal screeners

Tower Health Medical Group: Data to Drive Quality Improvement

Laura Stack, DNP, MBA, RN, NE-BC
Associate Vice President – Ambulatory Nursing

Tower Health Medical Group
TOWER HEALTH
Advancing Health. Transforming Lives.

Health Choices Expectations at Tower

- Framework for Improvement
  - Early successes
    - Problem, Data Analysis, Root Cause
  - Managing complex change through continuous improvement
    - Many small A3s
  - Sustaining change via monitoring
  - Team based approach
- Outcomes Examples

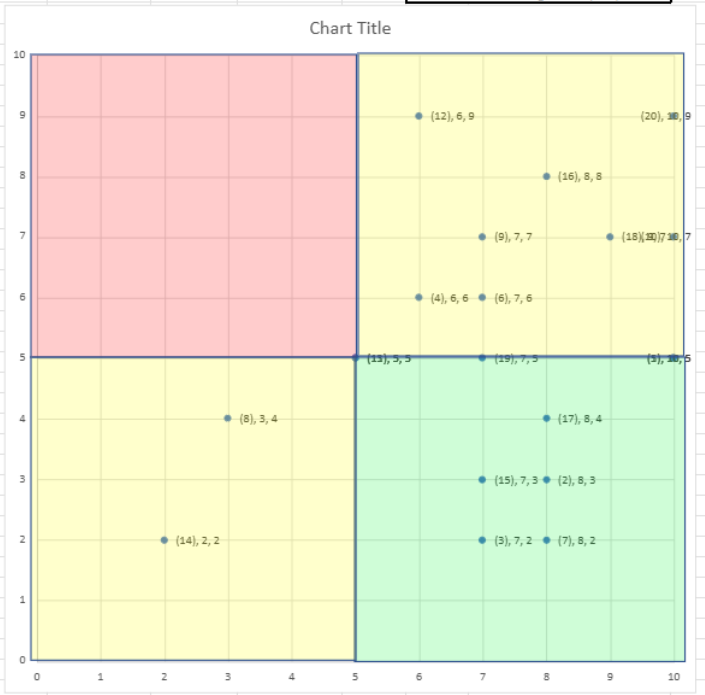
Process Improvement & Problem-Solving Approach

1. Pre phase visioning and prioritization
   - Brainstorming
   - Alignment to strategic alignment and resource availability
   - Review of data availability
   - Impact and Effort matrix
2. Launch Work
   - Problem statement formation
   - Assigning of resources
   - Report/ Data validation
3. A3 Problem Solving
   - Frontline engagement
   - Map current process, root cause identification, counter measures
   - Identify bottlenecks & areas for improvement

Impact and Effort: Example Phase Planning

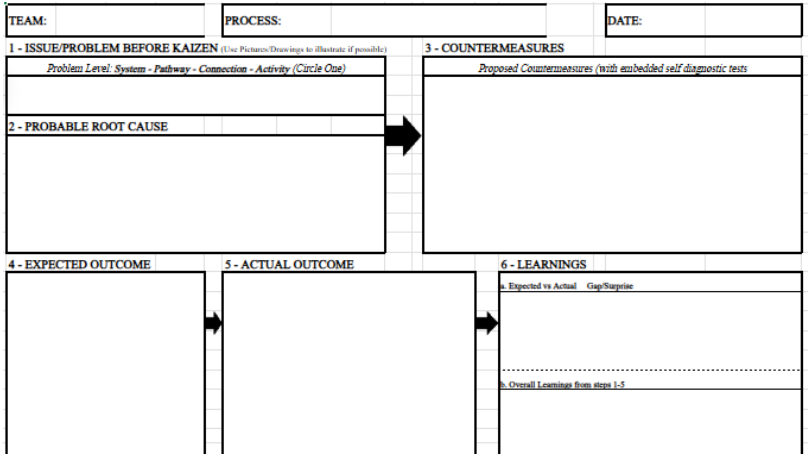
	Initiative	Impa	Effo
7	Update Rooming Standards	(7)	8	2
3	TNT TOC appt availability	(3)	7	2
14	Policy Approval Process	(14)	2	2
2	Lost Revenue Oppt. Nurse Visits	(2)	8	3
15	TOC Cancellations STD	(15)	7	3
17	STD for Medication Prior Auth	(17)	8	4
8	MA Scope of Practice	(8)	3	4
1	SPCA High Level Disinfection	(1)	10	5
5	OSHA Standards	(5)	10	5
19	RN Coverage for Exeter OBGYN/GYN	(19)	7	5
11	External Discharge Summaries	(11)	5	5
13	Autoclave Microbe Testing	(13)	5	5
6	My Tower E-Check In	(6)	7	6
4	Commerical Vaccines RH Pharmacy	(4)	6	6
10	Knowledge Deficit w/ Current OSHA STD	(10)	10	7
18	Quantify Work for Anyalsis Tool	(18)	9	7
9	CDE Team Competing Resources	(9)	7	7
16	STD for Sharing MA Staff	(16)	8	8
12	Onboarding Orientation STD	(12)	6	9
20	POCT Annual Policy Review	(20)	10	9

Note: 1 is the lowest impact/effort
10 is the highest impact/effort



Tower Health Medical Group
TOWER HEALTH
Advancing Health. Transforming Lives.

A3



Item No.	Problem to be Resolved	Action Needed	Responsibility	Due Date	% Complete	Results
1					25% 75% 50% 100%	
2					25% 75% 50% 100%	
3					25% 75% 50% 100%	
4					25% 75% 50% 100%	
5					25% 75% 50% 100%	
6					25% 75% 50% 100%	
7					25% 75% 50% 100%	
8					25% 75% 50% 100%	
9					25% 75% 50% 100%	
10					25% 75% 50% 100%	
11					25% 75% 50% 100%	
12					25% 75% 50% 100%	
13					25% 75% 50% 100%	
14					25% 75% 50% 100%	
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17					25% 75% 50% 100%	
18					25% 75% 50% 100%	
19					25% 75% 50% 100%	
20					25% 75% 50% 100%	

Leveraging Data to Drive Outcomes with Multifaceted Benefits

- Transition of care optimization to improve outcomes
  - Standard, cancellation, availability and external discharge summaries
- Maternal Child Health Navigator responsibility integration to ensure management of venerable populations
- Offering of telemedicine, flip from system to patient centric by integrating into call center decision tree
- E-Check in Utilization
- Vaccine storage and handling
- Patient Entered Questionnaires
- Blood Pressure Re-Check
- SDOH Optimization

A3 Overview Example

- Each individual practice has unique A3 and coach
- Blood pressure (BP) compliance rates range from 62% to 70%.
- A global compliance rate of 80% would have resulted in significant additional incentive earnings based on current scoring projections following standard CMS/HEIDIS definitions
  - If internal % of high BP values ***were*** rechecked 50.5% of rechecked values became compliant.
  - If 50.5% of patients not rechecked became compliant, overall compliance rate would rise to >82%, meeting benchmark

Learnings A3 and Specifically Urgent Care integration

- Last Recorded Value Analysis
  - Attributed patients (200k +) (our THMG PCP patients 18 years and older with an urgent care visit)
  - 9.4% had their last value taken in Urgent Care
    - Next two largest practices are at 6.4% and 4.8%
- Takeaways knowing where your visit and values are coming from matters.
  - This changed the mindset to appreciate UC locations as a singular largest impact
- DATA is power to evoke change to overcome huddles and barrier to recheck in a variety of settings

Tower Health System
Blood Pressure Recheck Rate Analysis

Intervention Impact Assessment • CY24 Baseline vs CY25 Performance

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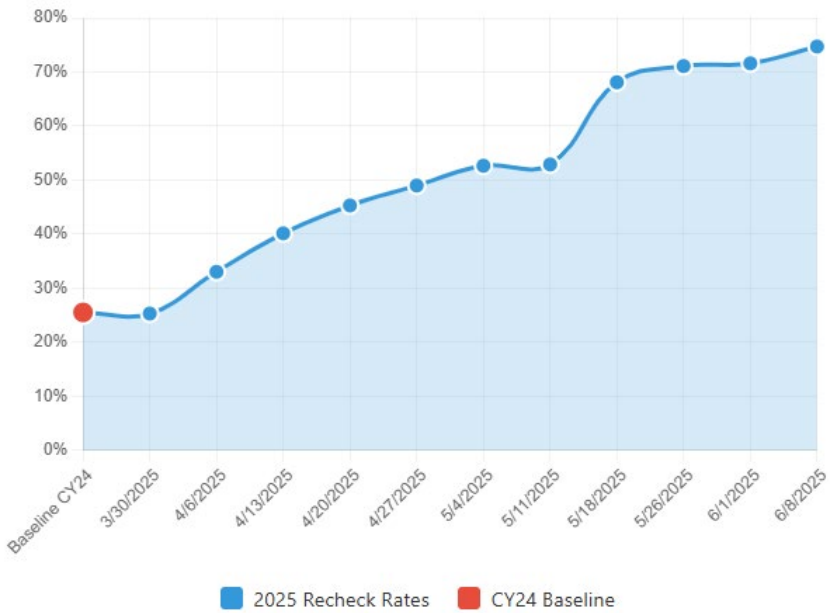
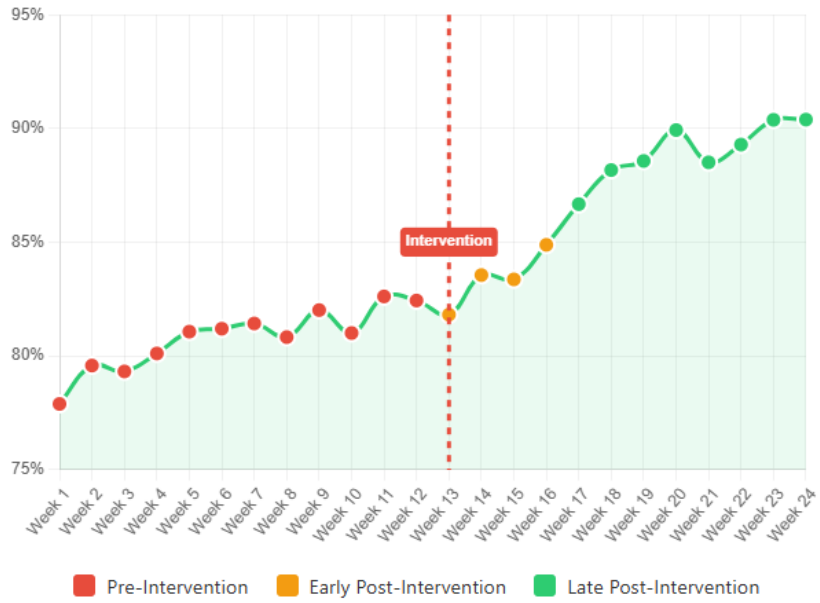
BP Recheck Rate Progression



BP Compliance Rate Trends (2025)



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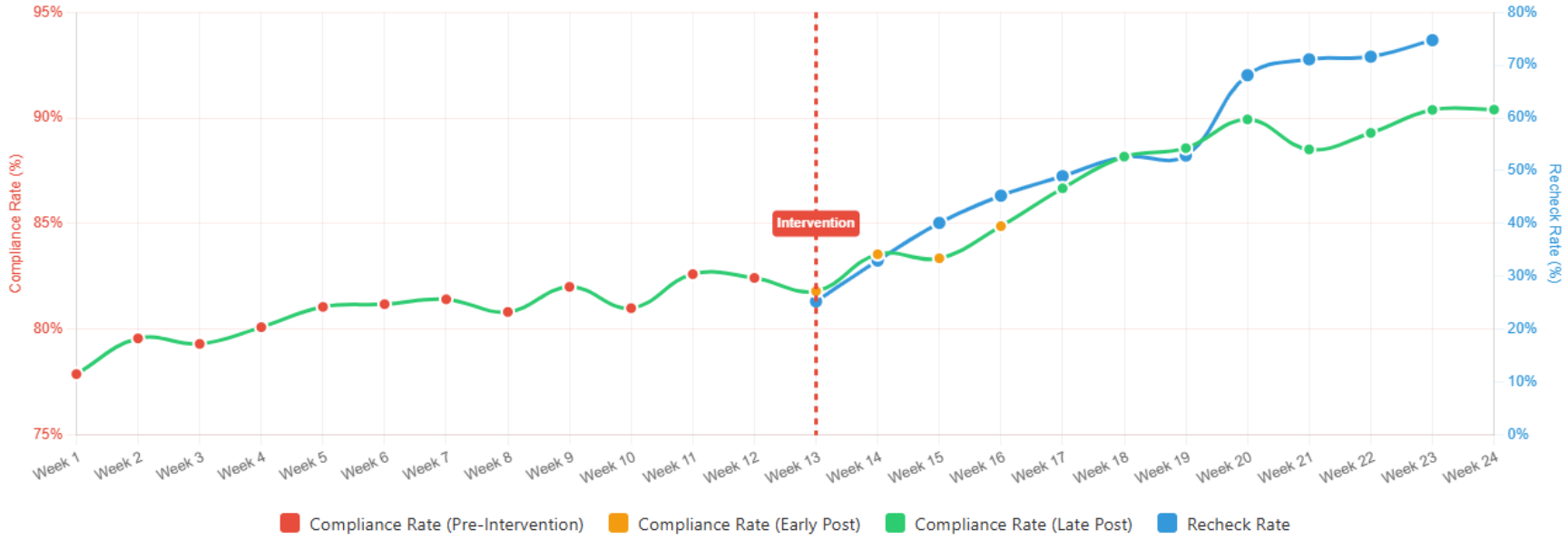
Combined Intervention Impact Analysis



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BASELINE CY24	CURRENT CY25	LATEST RECHECK RATE	INTERVENTION START
25.50%	86.44%	74.71%	Week 13
Recheck Rate	Most Recent BP Compliance Rate	+193% vs Baseline	March 30, 2025
			INTERVENTION LAUNCHED

BP Compliance Rate Summary by Period

Pre-Intervention	Early Post-Intervention	Late Post-Intervention
80.99%	83.40%	88.50%
Weeks 1-12 Average	Weeks 13-16 Average	Weeks 17-24 Average
	+2.41% vs Pre	+7.51% vs Pre

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SDOH Project

- Extension of ongoing improvement
- Current SDOH Project Optimizations
  - Alignment across markets and service line
  - Expansion to pediatrics
  - Alignment to EMR foundation build
    - Update provider BPA to improve flow and connection to CHW
    - Expansion to safety domain and alignment of domestic violence screening
  - Flip from Wellsky to Findhelp contact for aligned community support
  - View from Continuum of Care (inpatient and ambulatory collaboration)
  - Dashboard launch, improve data transparency

Lessons Learned

- Good at implementation, we get lost in follow up
  - Inspect what you expect
  - Standard work from frontline
- Keys to success:
  - Leverage external ideas, apply to internal analysis (increases ownership, our data)
  - Weekly access to data
  - Transparency
  - United vision
  - Patient centric
  - Access to resources (data and IT)
  - Follow up- 30/60/90

Thank you

Questions?

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Huddles and Report Outs

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Wrap Up & Session Evaluation

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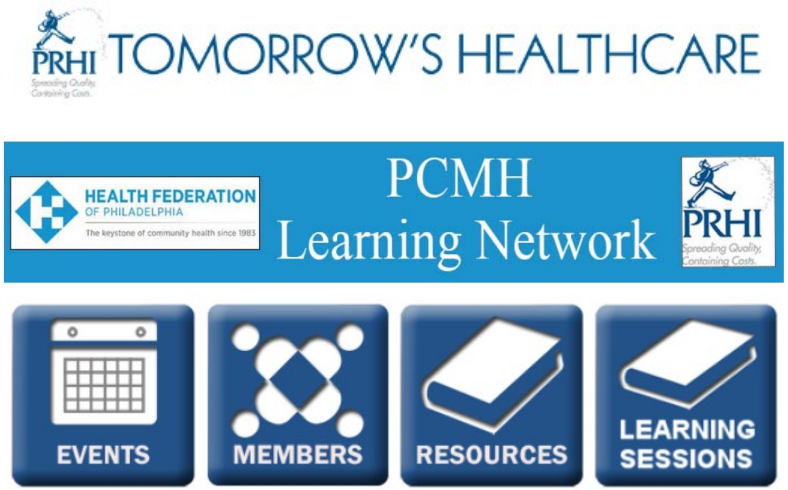
PCMH Online Community

https://www.tomorrowshealthcare.org/

Members of your PCMH's multi-disciplinary learning team will receive log-ins. Email Boyd@jhf.org with questions.



- Access the session materials in "Learning Sessions"
- Look for guides and tools in "Resources"

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CEU Process

You will receive a follow up email with links to:

Complete the survey at: https://www.surveymonkey.com/r/NHT9SHD
by July 2nd

1. Please be sure to designate which CEU credits you are requesting **CME, CNE, Social Worker or Certificate of Attendance**. If you already have an account with the UPMC Center for Continuing Education, please be sure the email you enter on the survey matches the UPMC CCE account email that you create.

2. The UPMC Center for Continuing Education will follow up with you via email after **July 2nd** with instructions on how to claim your credits.
   - ❑ To prepare, we recommend you create an account with UPMC CCE via this website https://cce.upmc.com.

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Thank You!

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