Housekeeping Reminders

Please submit questions via the Zoom chat during the presentation.

For attendance, please type in your name and organization in the chat.

Attendees are muted upon entry. Click “Unmute” when you would like to speak. Please mute yourself after speaking.

The presentations are posted on Tomorrow’s HealthCare www.tomorrowshealthcare.org

2025 PCMH Learning Network Pediatric Nursing Care Sprint Session #3

August 5, 2025

Robert Ferguson, MPH, Chief Policy Officer

Pittsburgh Regional Health Initiative

Continuing Education Information

In support of improving patient care, this activity has been planned and implemented by the University of Pittsburgh and The Jewish Healthcare Foundation. The University of Pittsburgh is jointly accredited by the **Accreditation Council for Continuing Medical Education (ACCME)** and the **American Nurses Credentialing Center (ANCC)**, to provide continuing education for the healthcare team. **1.5 hours are approved for this course.**

As a Jointly Accredited Organization, University of Pittsburgh is approved to offer social work continuing education by the **Association of Social Work Boards (ASWB)** Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. University of Pittsburgh maintains responsibility for this course. Social workers completing this course receive **1.5 continuing education credits**.

Disclosures

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Learning Objectives

- ✓ Describe preliminary findings and progress from the mid-year sprint surveys
- ✓ Describe examples of how PCMH-PNCs are structuring team roles and workflows

Agenda

1. 1:00 p.m. to 1:10 p.m. – Welcome & Review of Midyear Sprint Survey Results – Robert Ferguson, MPH, Chief Policy Officer, Pittsburgh Regional Health Initiative (PRHI)
2. 1:10 to 1:20 p.m. – Debrief from Statewide Session – Carol Frazer, MEd, LPC, Behavioral Health Specialist, PRHI
3. 1:20 p.m. to 2:00 p.m. – CHOP's PCMH-PNC Model, Team Roles, and Workflows –The Children's Hospital of Philadelphia
4. 2:00 p.m. to 2:25 p.m. – PCMH Peer-to-Peer Learning Discussion – Facilitated by Carol Frazer
5. 2:25 p.m. to 2:30 p.m. – Next Steps & Wrap Up – Lisa Boyd, Program Specialist, PRHI

Welcome & Review of Midyear Sprint Survey Results

Robert Ferguson, MPH, Chief Policy Officer, PRHI

HealthChoices PCMH Pediatric Nursing Care Program

1. PH-MCOs recognize HealthChoices PCMHs that serve at least 20 children receiving shift care nursing services to participate in the PCMH-PNC Program.

2. PCMH-PNCs:

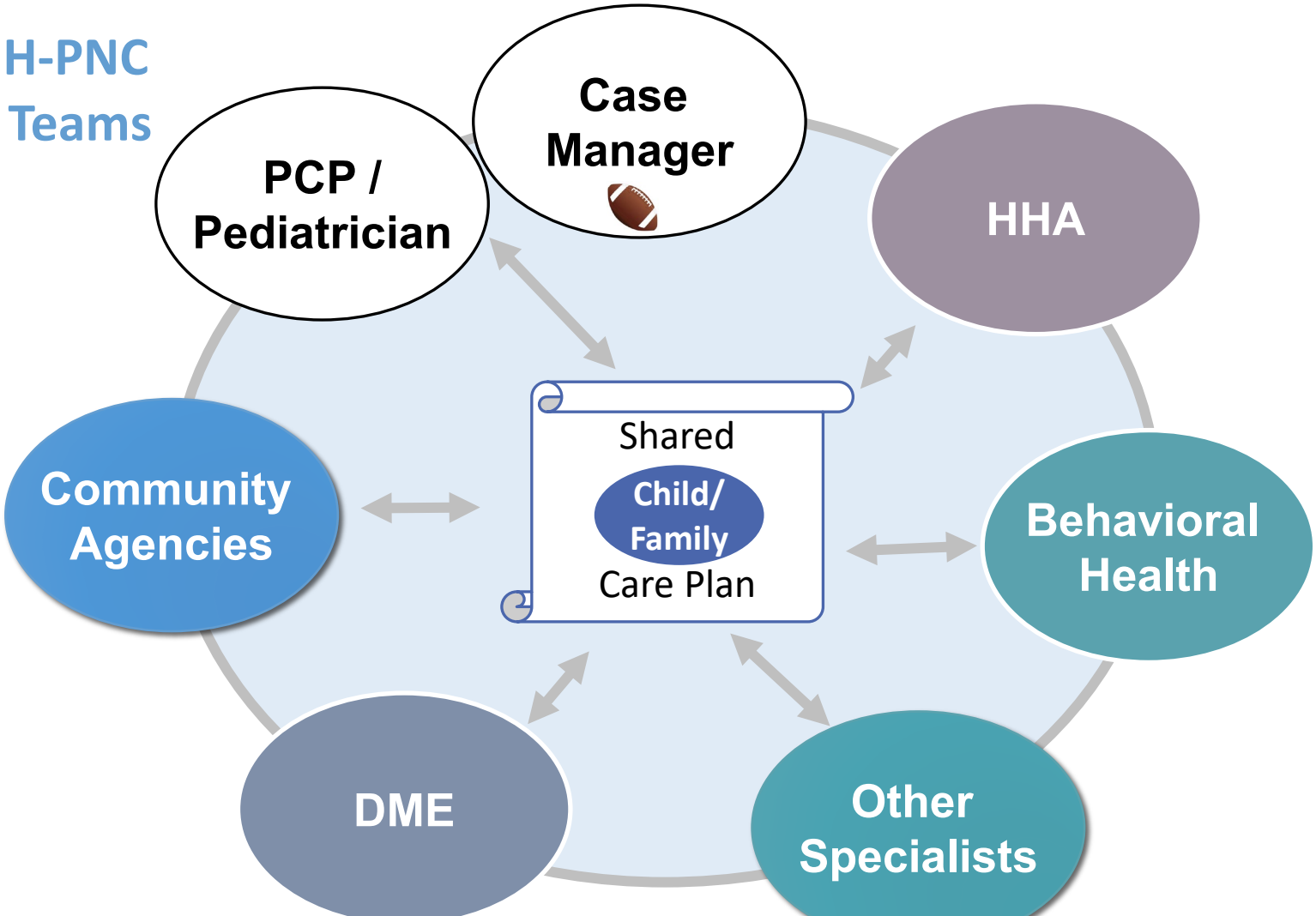
- ✓Complete comprehensive screenings
- ✓Provide case management services to convene care team meetings, maintain a family-centered plan of care, make warm hand off referrals, coordinate all case management services
- ✓Assessable a care team to:
  - ✓Maintain medical orders and initiate and maintain necessary and authorized services
  - ✓Ensure that all members are working from the most current version of the Family-Centered Plan of Care
  - ✓Assist the HHA(s) with scheduling of shifts by identifying appropriate skills needed by nurse/ home health aide
- ✓Works collaboratively with the Pediatric Complex Care Resource Centers (PCCRCs)

See Exhibit DDD

PCMH-PNCs

Children’s Hospital of Philadelphia (CHOP)
UPMC Children's Community Pediatrics
Evangelical
Geisinger Health System
Keystone Rural Health Center
Pediatrics of Kingston
Penn State Health Community Medical Group, LLC
Scranton Primary Health Care Center Inc
The Wright Center For Community Health
Tower Health - St. Christopher's Hospital for Children
Valley Health Partners Community Health Center

PCMH-PNC Care Teams



Learning Network Resource Reminder:

Examples of PCMH-PNC Case Managers, Teams, and Care Plans

Valley Health

3/5/25 Session

Keystone Health

3/5/25 Session

St. Christopher's

11/15/23 Session

11/4/24 Session

Pediatric Nursing Care – Midyear Survey Results

Pediatric Nursing Care Program – 2 practices completed baseline and midyear surveys

- **Full version of baseline vs. mid-year results are available in Tomorrow's Health Care*

	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%

Debrief from Statewide Session

Carol Frazer, MEd, LPC, Behavioral Health Specialist, PRHI

CHOP's PCMH-PNC Model, Team Roles, and Workflows

Faith V. Dague, MSN, RN, CPN, Regional Care Coordinator, Primary Care, CHOP

Jennifer DeJesus, BSN, RN, Regional Care Coordinator, Primary Care, CHOP

Andrea McInerney, BSN, RN, CCM, Nurse Care Coordinator, Primary Care, CHOP

Linda Vu Van, MSN, RN, VA-BC, Regional Care Coordinator, Primary Care, CHOP

Value Based Care Management Program (VBCM)

August 5, 2025

Faith Dague, Jennifer DeJesus, Andrea McInerney, Linda Vu Van

Children's Hospital of Philadelphia®

Objectives

- VBCM program overview: background and growth
- Offices covered and geographic reach in PA
- Enrollment: patient types and referral process
- Remote program benefits and unique communication
- Patient services: care plans, scheduling, follow-ups
- VBCM role with assisting families with shift care needs
- SDOH calls and social worker need
- Impact summary: metrics and outcomes

Overview of VBCM Program

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VBCM Program Timeline – Where We Started

July 2022

- Initial agreement between the CHOP Value-Based Care Department and one PA Medicaid payor to begin a remote care coordination program

January 2023

- Hired two full-time Registered Nurses for remote care coordination
- Focused on patients with mild to moderate medical complexity, including autism & ADHD, across three PA offices
- Developed processes and workflows to deliver remote care coordination to patients and families

Value-Based Care Program Timeline – Where We Are Now

Serving patients from 24 PA CHOP primary care offices

Now accommodating patients with 4 Medicaid payors

Multidisciplinary Team:

Nurse Manager

Medical Director

Outreach Coordinator

Value-Based Care Director

Expanding to 5 full-time nurses and 1 full-time social worker

Additional cohorts:

- Pediatric shift care
- Elevated lead levels
- Language barrier
- Asthma
- Complex care management graduates

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Enrollment Eligibility

Criteria (One or more)

- 2 Chronic Complex Conditions
- 1 CCC with tech dependence
- ADHD diagnosed within the last year
- Autism
- Blood level >20 ug/dl
- Trisomy 21/Down Syndrome
- Social Complexity

PA Primary Care Offices

- Patient in one of the 24 primary care offices in PA

Insurance Based

- Multiple agreement with Medicaid payers

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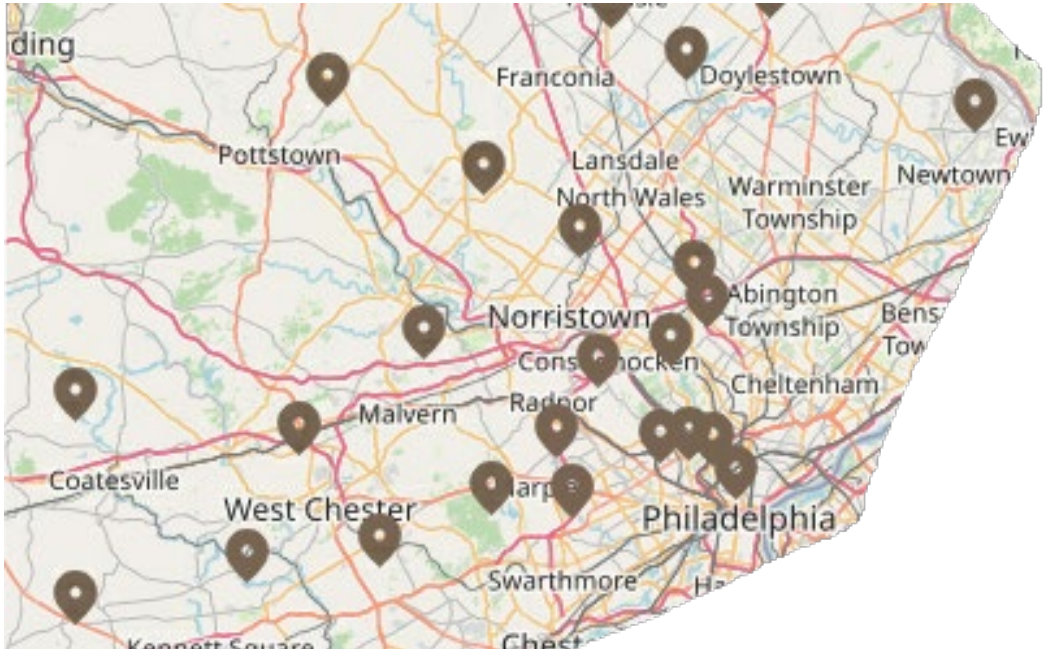
Location of PA Primary Care Offices



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Referral Order Process

1. Referral orders live since 3/2025 Monitored by RN Care Coordinators
2. Order placed by internal providers for RN team to review
3. Decision made by RN Care Coordinators with Medical Director review if necessary
   - Turnaround time for referral 5-7 business days
4. Outreach coordinator reaches out to family for enrollment
5. Family receive callback from RN care coordinator with care plan review if enrolled

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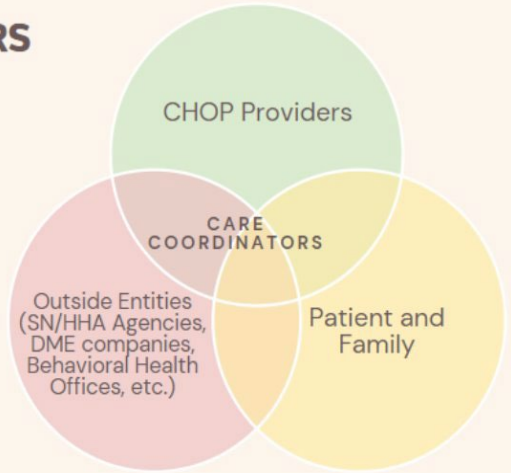
Remote Care Coordination

CARE COORDINATORS

Help Bridge care gaps that exist inside and outside of CHOP.

We help CHOP families feel supported in navigating the healthcare system by taking a partner-approach in tackling questions and concerns.



Interdisciplinary Communication

Within CHOP, Care Coordinators use EPIC (staff messaging & chat), Microsoft Teams, and Outlook to communicate with providers.

- PCPs, Specialists, PSRs, Social Workers, Child Life, CHOP Home Care

Care Coordinators partner with families and outside entities to help address care gaps that exist outside of chop via telephone and email.

- Home Health Aid and Skilled Nursing Agencies, DME companies, Insurance companies, Behavioral Health Organizations, Early Intervention, Schools

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Pediatric Shift Care

Initiation:

- Potential need for shift care is identified
- Confirm PCP is in agreement
- LOMN sent to insurance

Post-Authorization:

- Assist with completing LOMN renewals as needed
- Assist with completing Plan of Care Recertifications as needed
- Collaborate with Insurance Case Manager to address issues with care

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What Do We Do for Our Patients?

Care Plans

- Provides a snapshot of the patient in one document (parental concerns, medications, appointments, ER/Admissions, feeding, therapies, DME, SN/HHA, social concerns)
- Complete a care plan and discussion with family after initial enrollment
- Send care plan to the PCP for review and signature
- Contact the family at least every 3 months for routine check-in calls and update care plans

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What Do We Do for Our Patients?

Pre-visit calls
- Contact the family and review the care plan prior to any well visits
- Care plans are sent to PCP before well visit

Scheduling appointmen
- Ensure no gaps in care between primary care and specialties
- Complex scheduling requests for 3 or more appointments

ED/TCM Follow-up
- Ensure appropriate follow-up after ER/Urgent Care visits and hospital admissions

Assist the PCP office with
- Letter of medical necessity
- Education

SDOH Screenings
- Provide Resources
- Social Work Consult

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Social Determinants of Health

- Conduct screenings at least once per year
- Utilization of WeCare Survey
- Addresses Social Determinants of Health:
  - Transportation
  - Childcare
  - Housing
  - Food insecurity
  - Utilities/shut-off notices
- Collaborate with CHOP Social Work to provide resources for positive screenings and proper follow-up

Success of Program

Metrics Measured

Fluoride application annually

Well Visit Completion

Lead levels checked by 2 years of age

ED/TCM follow up

Outreach minimally every 3 months

Annual SDOH screening

Success Results

Engagement in the program leads to:

- Increased well visit completion rates
- Higher rates of lead screening
- Significantly higher rates of dental varnish application
- Increased influenza vaccination rates
- Higher HPV vaccination rates

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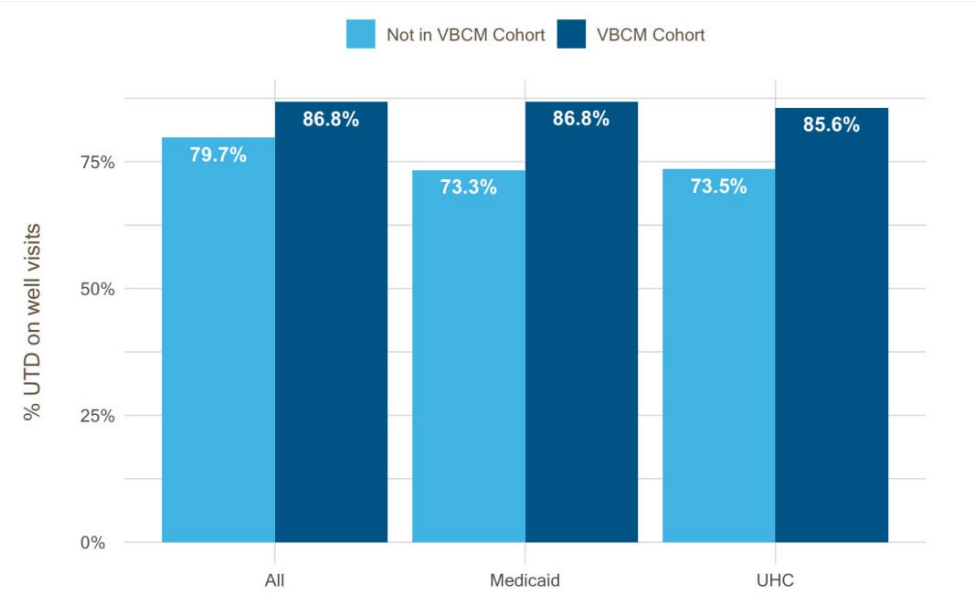
VBCM Impact on Well Visits



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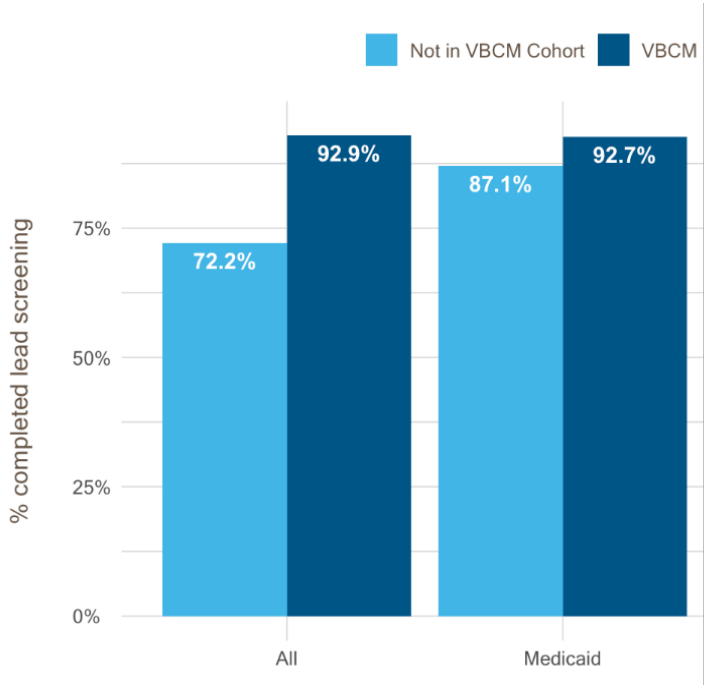
VBCM Impact on Lead Screenings



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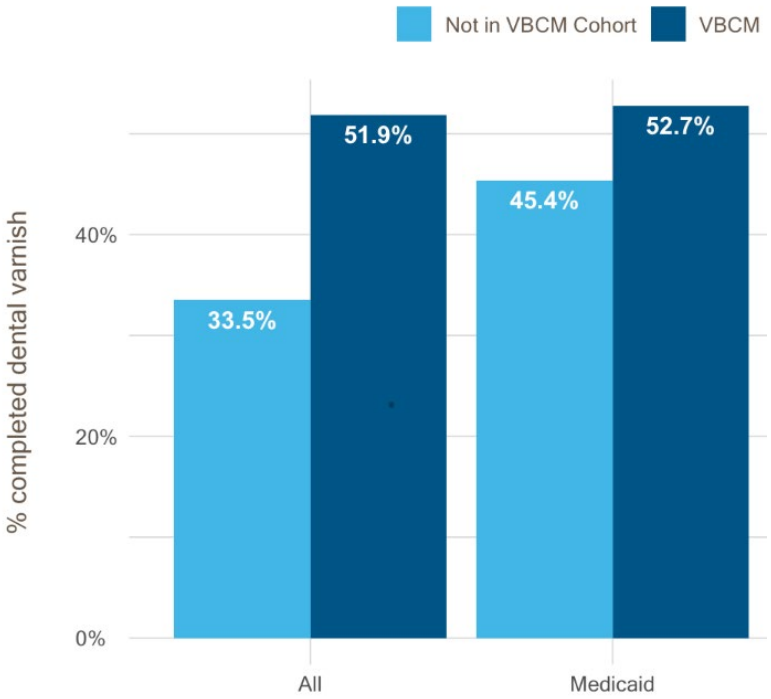
VBCM Impact on Dental Varnish Applications



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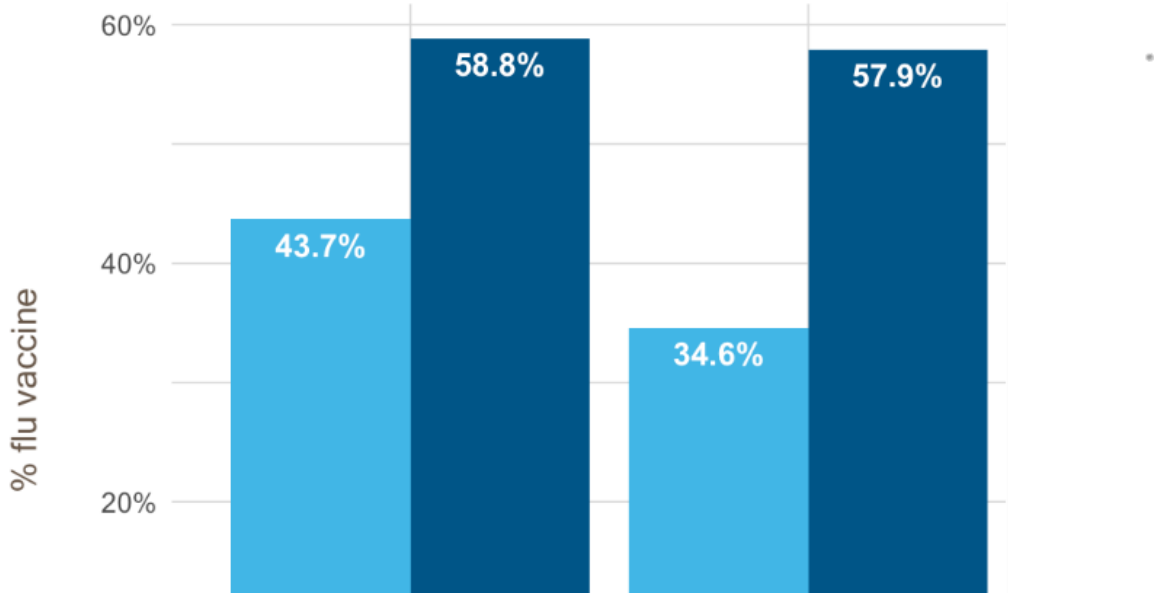
VBCM Impact on Influenza Vaccinations



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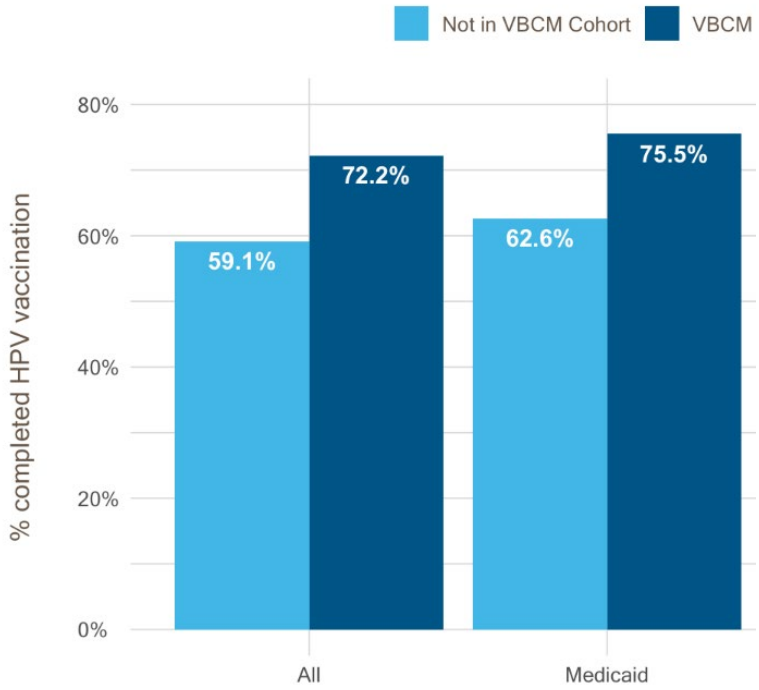
VBCM Impact on HPV Vaccinations



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Thank you!
Program Related Questions?
• CareCoordination@chop.edu
Contract Related Questions?
• Program Director
Tyler Doherty - DohertyT@chop.edu
• Medical Director
Dr. Brian Jenssen - JenssenB@chop.edu

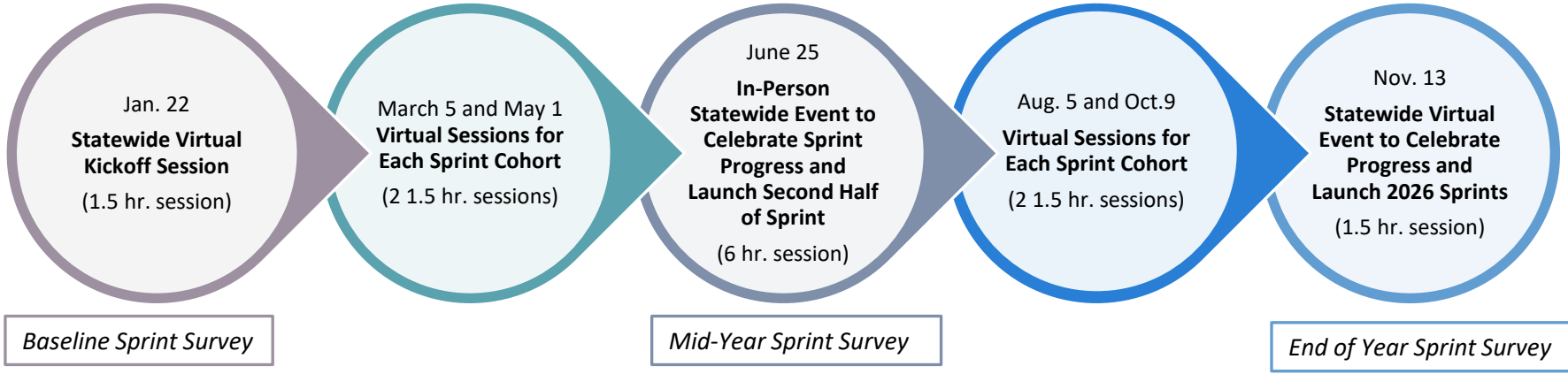
Discussion with MCOs and PCMH-PNCs

Wrap Up & Next Steps

Lisa Boyd, Program Specialist, PRHI

2025 PCMH Learning Network

Sessions Dates for Pediatric Nursing Care Sprint

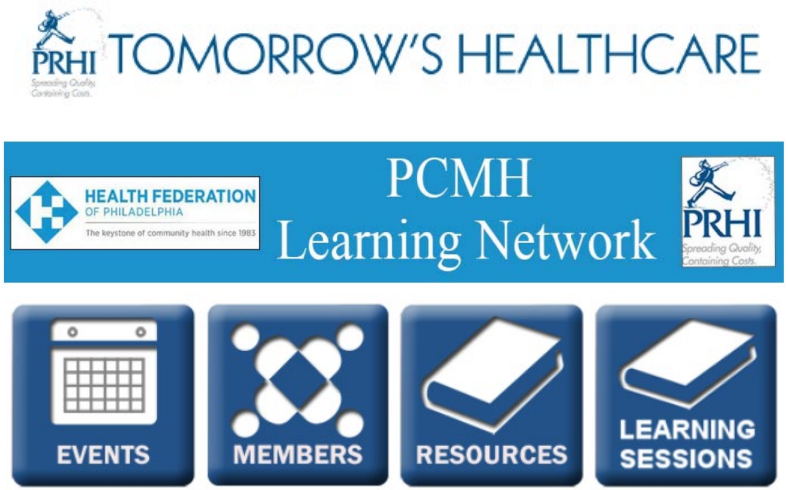


Optional Case-Based Learning Sessions on Clinical Topics Offered throughout the Year

PCMH Online Community

https://www.tomorrowshealthcare.org/

If you don't have an account, email Lisa at Boyd@jhf.org



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

CEU Process

You will receive a follow up email with links to:

Complete the survey at: https://www.surveymonkey.com/r/QHFR7R9 by Wednesday, August 12th

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 **August 12th** 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.

Thank You!