2025 PCMH Learning Network Statewide Wrap-Up Session

November 13, 2025

Pittsburgh Regional Health Initiative

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

Continuing Education Information

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Learning Objectives

- ✓ Describe key highlights and progress from the sprints
- ✓ Describe examples of how PCMHs have implemented a key intervention in each sprint

Snapshots from 2025 Sprints

Robert Ferguson, MPH
Chief Policy Officer
Pittsburgh Regional Health Initiative

Social Determinants of Health Interventions Sprint

Which key intervention are you most proud of working to implement this year, and why?

- Transitioned from an “on-call” approach to a coordinated care model with follow-up and referral tracking.
- Expanded outreach efforts—both face-to-face and telephonic—for patients with identified social determinants of health (SDOH) needs.
- Established an SDOH champion and enhance screening rates to better identify and address SDOH needs.

How do you plan to sustain or expand the changes you've made after the sprint ends?

- Continue developing coordination model to expand provider capacity to address SDOH during the visit.
- Continue to adapt our workflow to further increase our connection with patients in person.
- Collaborate with leadership to review progress and establish priorities for change in 2026.

Post Hospital Follow-up & Readmission Prevention Sprint

Which key intervention are you most proud of working to implement this year, and why?

- Strengthened transition of care (TCM) processes by refining nurse care manager and patient care coordinator roles, enhancing communication with nursing staff, and collaborating with HIE organizations to improve ADT data use.
- Implemented structured post-discharge follow-up within 48 hours to review medications, confirm appointments, and support smoother transitions
- Standardized outreach and workflows across health systems, incorporating ADT reports into weekly practice and improving timeliness and consistency of two-day follow-ups.

How do you plan to sustain or expand the changes you've made after the sprint ends?

- Continue strengthening TCM processes through things like monthly staff trainings, ongoing communication improvements, and collaboration with local admitting organizations
- Build program capacity by hiring a dedicated case manager and adding team members such as a nurse care manager and medical assistant.
- Focus on sustainability by keeping the team engaged, sharing success stories, and maintaining alignment between nurses and community health workers rather than expanding too rapidly.

Well Child & Adolescent Well-Care Visits Sprint

Which key intervention are you most proud of working to implement this year, and why?

- Established an immunization cross-functional team to enhance coordination, knowledge sharing, and alignment of strategies across stakeholders.
- Implemented a real-time follow-up process for patients under age 2 who miss well visits, maintaining open cases until appointments are scheduled.
- Utilized a childhood registry/WCC dashboard to monitor and track children overdue for visits.

How do you plan to sustain or expand the changes you've made after the sprint ends?

- Educated and engaged new leadership on the QI project plan and the biweekly care gap cross-functional meetings to support ongoing implementation and tracking/reporting of ongoing efforts and outcomes.
- Continue to work on contacting patients' caregivers in real time to reschedule the missed well visit and address language barriers and health literacy for better completion rates.

Blood Pressure Control Sprint

Which key intervention are you most proud of working to implement this year, and why?

- Empowered trained team members to conduct chart audits, perform patient outreach, review BP management plans, and coordinate follow-up care.
- Introduced the heart visual tool to prompt staff to complete required second BP readings, achieving and exceeding the 66% goal with a 67% rate.
- Implemented clinical pharmacist–led CPAs, a new policy and EMR form, and provided free home BP cuffs to uninsured patients.

How do you plan to sustain or expand the changes you've made after the sprint ends?

- Continue using designated staff for chart audits and patient outreach to schedule follow-up blood pressure checks, along with ongoing use of self-monitoring BP kits and Heart Visual tool education for new staff.
- Maintain pharmacist–led CPAs and clinical education.
- Sustain improvements by keeping uncontrolled hypertension as a priority initiative, expanding the pilot across the network, and monitoring site-level performance and form utilization.

Pediatric Nursing Care Sprint

Which key intervention are you most proud of working to implement this year, and why?

- Continuing to build our workflow foundation and developing a structured process for our quarterly team reviews.
- Incorporating a proactive transitions of care workflow for our patients who are transitioning to adult health care.

How do you plan to sustain or expand the changes you've made after the sprint ends?

- Continue to solidify our current process with a focus on our quarterly team meetings.
- Developing a questionnaire/form for new home health requests by parents/caregivers and working with providers to define what is appropriate for home health referrals.

PCMH Spotlights

PCMH Spotlight

- What is the most impactful change you implemented in 2025?
- How did you track and measure your progress?
- What are you planning for next steps and/or sustainment?

Spotlight: Social Determinant of Health Interventions

Becky Clouse, MS, Community Health Program Manager at Independence Health System

Angela Kypriotis, MSW, LCSW, Director, Extended Care Teams Allegheny Health Network

Independence
HEALTH SYSTEM

Social Determinants of Health

November 13,2025

Initiation of the assessment

- Starting in Fall of 2020
  - Paper assessments, phone calls
- Realizing the importance and impact
- Significant challenges and barriers
  - Phone attempts

Overcoming Barriers

- New EMR
- New opportunities within inpatient and outpatient
- Getting buy in from several areas
- Creating the branch off committee
  - Reviewing what already existed

Several Teams and Tasks

- Multi- Disciplinary
- Building out templates in EMR
- Creating pathways for codes- what is a loinc code?!?!
- Making it match for all patients (ambulatory and inpatient)
  - All one EMR, one patient

Got the buy in– Now what?
Positive assessments –Now what?

- Positive assessments
- How to provide appropriate follow up
- Challenges
- Community Relationships

Moving Forward

- Recent reporting requirement changes- no changes in our practices
- Continuing to build and strengthen community relationships.
- Coding and reviewing
- Keep asking the questions.

Questions?

Thank you!

Spotlight: Post Hospital Follow-up & Readmission Prevention Sprint

Andrew Eckert, DO, MPopH, FACOI, Medical Director, Population Health Management, Value-Based Care, and Clinical Call Services, UPMC Central PA

UPMC LIFE CHANGING MEDICINE

Creating a Transition of Care Dashboard: Improving Acute Care Discharge Follow-up in Central PA

Andrew Eckert, DO, Medical Director, Population Health

Nicole Holmes, MSN, RN, Ambulatory Director, Clinical Call Services

UPMC Central PA Medical Group

BACKGROUND

- Transitional Care Management (TCM) or Transition of Care (TOC) is a billable encounter type designed for primary care doctors and specialists to improve the care they provide to patients who have been discharged from hospitals or other facilities.
- UPMC Central PA uses a variety of people and processes to facilitate TCM, including hospital scheduling, an ambulatory TOC team that contacts patients within 2 days of discharge, individual primary care office staff and provider compensation incentives.
- Despite these efforts, TCM scheduling and appointment completion has been inconsistent, payor contract goals have not been met, and providers have not had a complete picture of their patient discharge data.
- Leadership within UPMC Central PA Medical Group was charged with creating a solution to improve provider engagement and ensure consistent, accurate, and actionable internal discharge data.

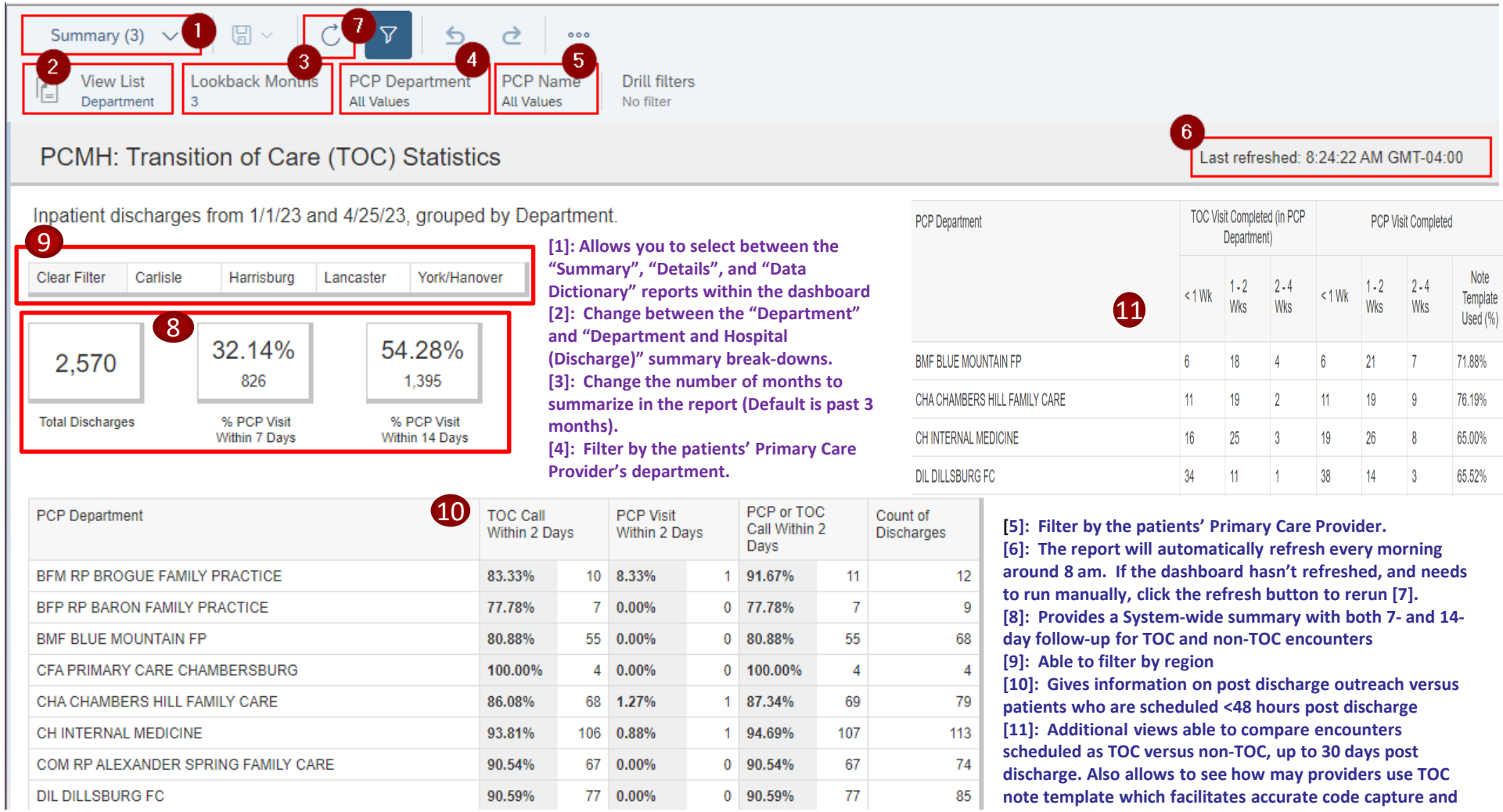
OBJECTIVE

- Primary objective was to create a single data platform that could be accessed by all service line leaders and eventually individual providers.
  - A dashboard provided the most concise format.
    - The dashboard had to:
      - Include all primary care practices
      - Include discharges from all 7 Central PA hospitals
      - Include information on post discharge patient contact
      - Exclude discharges that didn’t require TCM
      - Include patient NO-SHOWS
      - Provide current, filterable, and patient-level data

APPROACH

- Formed a workgroup with stakeholders from the medical group, and IT
- Set goals for data definitions, including exclusion and inclusion criteria
- Three major data goals defined by the group:
  - % completion rate of TOC outreach call
  - # of patients seen at given intervals of 2, 7, and 14-, and 30-days post discharge
  - % usage of medical group TOC note template
- Based on the report requirements, we discussed the business process/workflow behind each of the metrics
- We used the workflows to identify discrete data elements in Epic for reporting.
- Once the dashboard was developed, we performed manual validation of the metrics to a review of patient charts.
- If there were discrepancies, we amended the metric data lineage until the dashboard aligned with original requirements.

RESULTS



[1]: Allows you to select between the "Summary", "Details", and "Data Dictionary" reports within the dashboard
[2]: Change between the "Department" and "Department and Hospital (Discharge)" summary break-downs.
[3]: Change the number of months to summarize in the report (Default is past 3 months).
[4]: Filter by the patients' Primary Care Provider's department.

11

PCP Department	TOC Visit Completed (in PCP Department)			PCP Visit Completed			
	< 1 Wk	1 - 2 Wks	2 - 4 Wks	< 1 Wk	1 - 2 Wks	2 - 4 Wks	Note Template Used (%)
BMF BLUE MOUNTAIN FP	6	18	4	6	21	7	71.88%
CHA CHAMBERS HILL FAMILY CARE	11	19	2	11	19	9	76.19%
CH INTERNAL MEDICINE	16	25	3	19	26	8	65.00%
DIL DILLSBURG FC	34	11	1	38	14	3	65.52%

10

PCP Department	TOC Call Within 2 Days		PCP Visit Within 2 Days		PCP or TOC Call Within 2 Days		Count of Discharges
BFM RP BROGUE FAMILY PRACTICE	83.33%	10	8.33%	1	91.67%	11	12
BFP RP BARON FAMILY PRACTICE	77.78%	7	0.00%	0	77.78%	7	9
BMF BLUE MOUNTAIN FP	80.88%	55	0.00%	0	80.88%	55	68
CFA PRIMARY CARE CHAMBERSBURG	100.00%	4	0.00%	0	100.00%	4	4
CHA CHAMBERS HILL FAMILY CARE	86.08%	68	1.27%	1	87.34%	69	79
CH INTERNAL MEDICINE	93.81%	106	0.88%	1	94.69%	107	113
COM RP ALEXANDER SPRING FAMILY CARE	90.54%	67	0.00%	0	90.54%	67	74
DIL DILLSBURG FC	90.59%	77	0.00%	0	90.59%	77	85

[5]: Filter by the patients' Primary Care Provider.
[6]: The report will automatically refresh every morning around 8 am. If the dashboard hasn't refreshed, and needs to run manually, click the refresh button to rerun [7].
[8]: Provides a System-wide summary with both 7- and 14-day follow-up for TOC and non-TOC encounters
[9]: Able to filter by region
[10]: Gives information on post discharge outreach versus patients who are scheduled <48 hours post discharge
[11]: Additional views able to compare encounters scheduled as TOC versus non-TOC, up to 30 days post discharge. Also allows to see how may providers use TOC note template which facilitates accurate code capture and submission

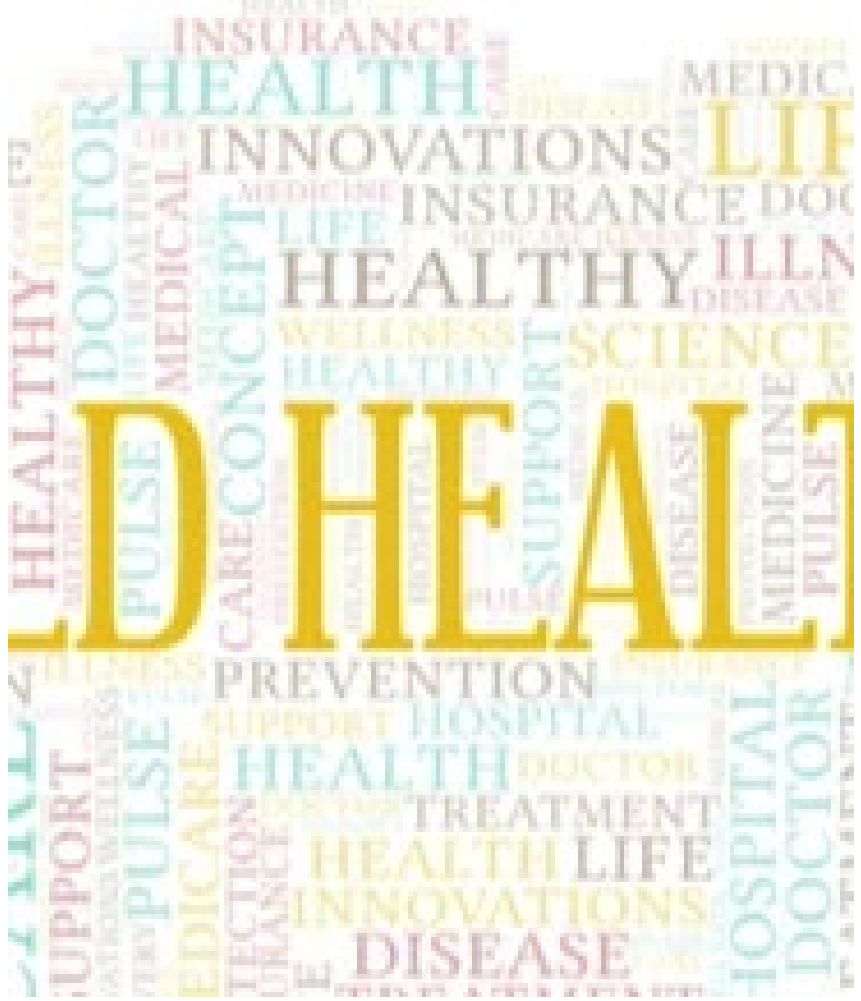
UPMC LIFE CHANGING MEDICINE

DISCUSSION

- First and foremost, dashboard allowed us to verify previously observed trends of TOC visit completion rate.
- Roughly 30% of patients are seen by a provider in the PCP's practice within 7 days of discharge; 50% within 14 days.
- The data also allowed us to verify that one office not utilizing our central TOC outreach team had a significantly lower outreach rate, and lower TOC appointment completion. FTE was approved to support the addition of that office to use our central TOC outreach team.
- Key limitation in the dashboard is lack of external data. Many patients in central PA, particularly in certain counties, do not use UPMC facilities for acute care. While this decreases data for some practices, we felt the dashboard was valuable to highlight how to improve our internal workflows.

Spotlight: Well Child & Adolescent Well Visits Sprint

Tina Ross, Sr. Director of Quality, Hamilton Health Center, Inc.



HAMILTON HEALTH CENTER
PCMH Learning Network

CHILD AND ADOLESCENT WELL VISIT SPRINTS

PROGRAM METRICS
Childhood Immunization

2022	2023	2024	31 May 2025
UDS Rate: 22.2% Quartile 4	UDS Rate: 24.8% Quartile 3	UDS Rate: 11.5% Quartile 4	**GOAL: Improve pediatric immunization rates (prior to age 2) by 18 percentage points (12% to 30%) by May 31, 2025.**

PDSA CROSS-FUNCTIONAL APPROACH

CREATE CROSS-FUNCTIONAL TEAM CONSISTING OF CLINICAL, MEDICAL, QUALITY, AND BILLING

SENIOR LEADERSHIP SUPPORT AND INVOLVEMENT

CROSS-POLLINATION OF INTERVENTIONAL STRATEGIES

EXPANSION OF KNOWLEDGE SHARING ACROSS DEPARTMENT REPRESENTATIVES

COMPREHENSIVE UNDERSTANDING OF IMPACT TO MEASURE

COORDINATION WITH INTERNAL AND EXTERNAL STAKEHOLDERS, AN

DEMONSTRATED IMPLEMENTATION OUTCOMES.

PROJECT OBJECTIVES

OBJ 1: Identify barriers to vaccination adherence and create approaches to resolve barriers to vaccination by April 30, 2025.

establish baseline procedures for educating parents/caregivers on importance of vaccination,	educate staff on accurate delivery of vaccinations (inclusive of education)	evaluate state system change impacts (PA SiiS to PIERS)	evaluate Care Everywhere use / resolution by providers	evaluate access to vaccinations	evaluate notification process for vaccination adherence

OBJ 2: Audit eligible population for vaccination (UDS CI Measure) by May 31, 2025

Review comparisons by breakouts (i.e., location, provider, payor, age)	Review eligible preventive visits (HEDIS Well Child measures)

BENCHMARKS (SOURCES): UDS (HRSA) / HEDIS (NCQA) / Trending Reports (Pfizer)

OBJ 1: Barriers and Interventions

Significant “No Show” rate

- Increase telehealth services / proactively use in inclement weather
- Revamp weekly outreach/reminder call efforts

Knowledge gap in parental education / importance of vaccination

- iQIP for VFC Program
- Provider education for parents on vaccine effects/risks/side effects
- Capitalize on vaccine manufacturer training for medical/clinical staff

Accurate administration of vaccines

- Evaluate and address any staff educational gaps on VFC vaccine management, vaccine interactions/side effects, vaccine costs

Reat time access to / transfer of patient vaccines / vaccination information

- Confirm transfer to new PA SiiS to PIERS system
- Validate market inventory and revamp vaccine ordering/tracking to ensure availability

OBJ 2: Audit Eligible Population for Vaccination

Delay in access to UDS information in 1Q of each year

- Create UDS measure specific reports with location, provider, and payor details and use during 1Q while UDS Dashboard is reset
- Review reports for outliers and share with Peds Dept for outreach
- Absence of patient records for past vaccination status

Lack of patient vaccination records

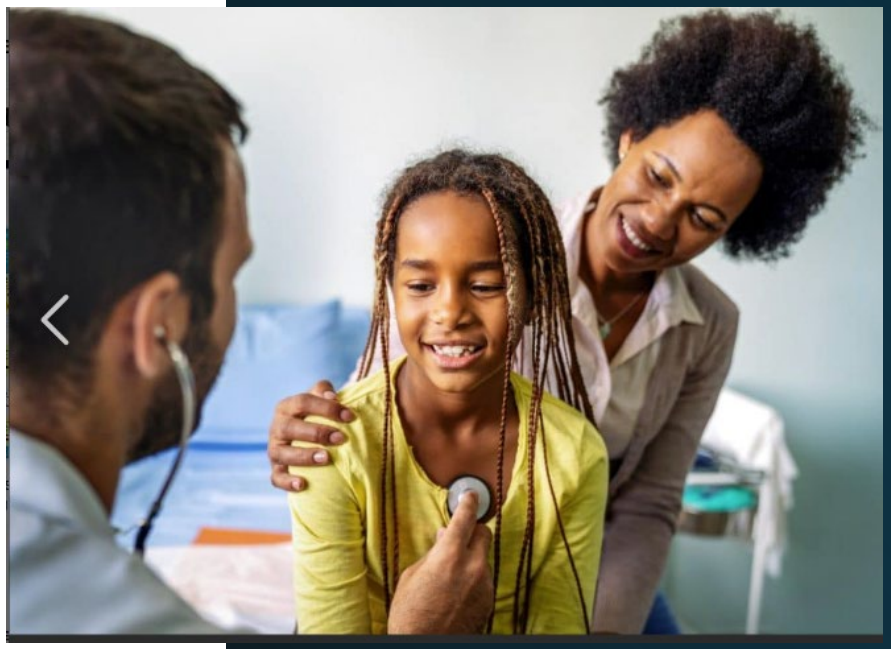
- Outreach to parents, schools, and refugee program to obtain records
- Correlate Well-Child Visits with requesting vaccine records

Absence of formal audit process and tool

- Craft format audit process and related tool to identify causative factor(s) to declining measure results

Driving Engagement / Sustained Intervention

- New leadership (new Pediatric department manager and supervisor) educated on the QI project plan (PDSA QI Process)
- Attendance by key project members at biweekly care gap cross-functional meetings
- Implementation tracking for completion of assigned accountabilities
- Analysis of findings and determination of priorities
- Ongoing reporting of outcomes and any identified barriers to continued success



PROJECT RESULTS

- Training completion, including VFC Call The Shots Modules 10/16
- Attendance at Annual PA Immunization Conference
- Annual update of VIS sheets
- New patient outreach with reminders to bring vaccine information
- Post WCV scheduling for next vaccinations
- Universal provider template for patient discharge summary
- Increase postcard/text messaging for non-compliant population
- Audit findings warranted outreach to EPIC / HRSA to resolve PCV-20 non-coding issue (affected all FQHCs across nation)
- **RESULTING UDS SCORE: 35% YTD**

Spotlight: Blood Pressure Control Sprint

Paula Keenan, RN, CNO, Chief Nursing Officer, Scranton Primary Health Care Center, Inc.

the Clinics
at Scranton Primary Health Care Center
care - compassion - community

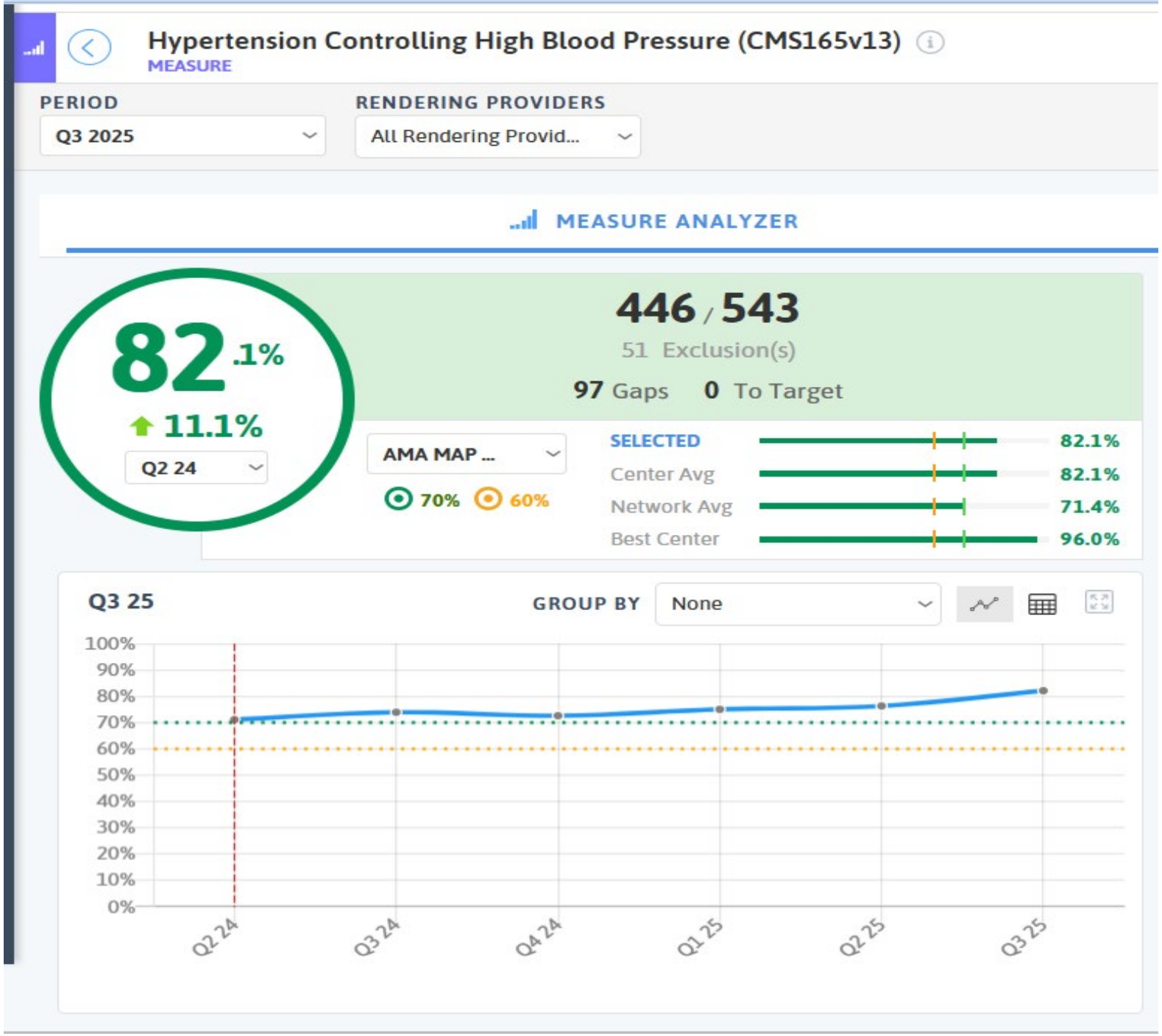
Blood Pressure Control

Scranton Primary Health Care Center, Inc.

November 13, 2025

What is your overall approach and workflow for these measures?

- 3 Internal Medicine Physicians, 2 Family Medicine CRNP's, 3 Nurses, & 6 Medical Assistants
- Staff is proactive when speaking with patients on the phone or at a visit in educating patient on need for follow-up visits to monitor BP.
- Staff proactive in taking second blood pressure when first is elevated-wait for a few minutes in between: also correct position of arm when taking BP
- IT works with NextGen and Azara to generate reports of patients with elevated BPs.
- Providers and staff are educated to address elevated blood pressures and document correctly
- QI staff monitor and review data periodically to provide feedback.
- Automated text messaging reminder system for upcoming appointments, as well as staff places reminder calls day before to all patients



Scranton Primary Health
BP Control Improvement

- Q2 2024 = 71%
- Q3 2024 = 73.9%
- Q4 2024 = 72.6%
- Q1 2025 = 75.0%
- Q2 2025 = 76.3%
- Q3 2025 = 82.1%

Questions ?

Thank you for your interest

Paula Keenan, RN, CNO

the Clinics
at Scranton Primary Health Care Center
care - compassion - community

Spotlight: Pediatric Nursing Care Sprint

Heather Goshorn, BSN, RN, Director of Enabling Service and **Tracy Shoop, RN** Care Manager, Keystone Health

KEYSTONE HEALTH PCMH-PNC PROGRAM

Heather Goshorn, BSN, RN

Director of Enabling Services

Keystone Health

IMPACTFUL CHANGES IN 2025

- Focused on growth and structure of our PNC program
- 2 areas of significant improvement:
    1. Quarterly team meetings
    2. LOMN Workflow
- Bonus Impacts

IMPROVED QUARTERLY COLLABORATION

Structured schedule for the reviews -> enrollment list divided into 12-week rotation

Increased provider confidence in the program -> more active participation in reviews and care plan development

Strong networking system with the home health agencies -> increased collaboration between the care manager and home health teams

Identifying and building collaborative relationships with specialty office team members

LOMNS - IMPROVING EFFICIENCY AND APPROACH

Expanded proactive approach - the care manager is notified of all referrals and tracks to ensure LOMNs are completed within the expected time frames

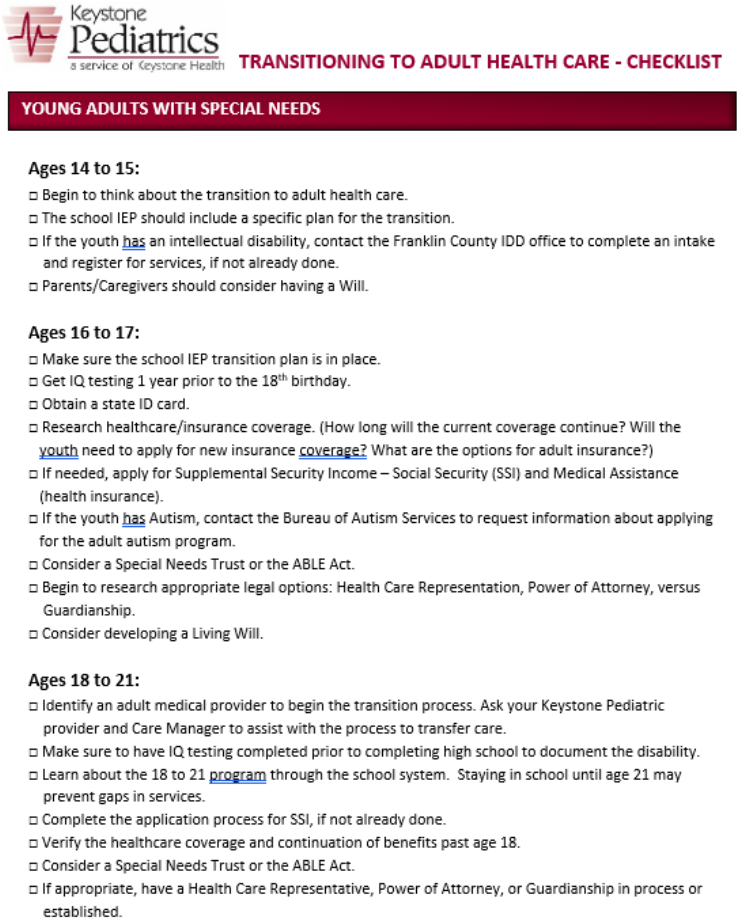
Building and sustaining collaborative relationships between the home health agencies and care managers

Developed a provider/care manager collaborative team to create more efficient workflows

Collaborating with our local medical network to share ideas and develop a documentation workflow within our EHR

BONUS IMPACT EXAMPLE: TRANSITIONS TO ADULT CARE WORKFLOW

- Identified need for a more proactive and structured process to assist families with disabled children plan for the transition to adult health care
- Developed a guide, checklist, and resource list
- Goals:
    1. Initiate the conversation with families when the child is between 14-15 years old
    2. Collaborate with and guide the family through the transition process



Keystone Pediatrics
a service of Keystone Health

TRANSITIONING TO ADULT HEALTH CARE - CHECKLIST

YOUNG ADULTS WITH SPECIAL NEEDS

Ages 14 to 15:

- ☐ Begin to think about the transition to adult health care.
- ☐ The school IEP should include a specific plan for the transition.
- ☐ If the youth has an intellectual disability, contact the Franklin County IDD office to complete an intake and register for services, if not already done.
- ☐ Parents/Caregivers should consider having a Will.

Ages 16 to 17:

- ☐ Make sure the school IEP transition plan is in place.
- ☐ Get IQ testing 1 year prior to the 18th birthday.
- ☐ Obtain a state ID card.
- ☐ Research healthcare/insurance coverage. (How long will the current coverage continue? Will the youth need to apply for new insurance coverage? What are the options for adult insurance?)
- ☐ If needed, apply for Supplemental Security Income – Social Security (SSI) and Medical Assistance (health insurance).
- ☐ If the youth has Autism, contact the Bureau of Autism Services to request information about applying for the adult autism program.
- ☐ Consider a Special Needs Trust or the ABLE Act.
- ☐ Begin to research appropriate legal options: Health Care Representation, Power of Attorney, versus Guardianship.
- ☐ Consider developing a Living Will.

Ages 18 to 21:

- ☐ Identify an adult medical provider to begin the transition process. Ask your Keystone Pediatric provider and Care Manager to assist with the process to transfer care.
- ☐ Make sure to have IQ testing completed prior to completing high school to document the disability.
- ☐ Learn about the 18 to 21 program through the school system. Staying in school until age 21 may prevent gaps in services.
- ☐ Complete the application process for SSI, if not already done.
- ☐ Verify the healthcare coverage and continuation of benefits past age 18.
- ☐ Consider a Special Needs Trust or the ABLE Act.
- ☐ If appropriate, have a Health Care Representative, Power of Attorney, or Guardianship in process or established.

MEASURING PROGRESS

- Quarterly team collaborations completed in a timely manner
- Improved bi-directional communication between the home health agencies and the care managers
- No gaps in home health services due to reasons within our control
- Identified point of contacts at specialty offices
- Increased engagement of providers with the care planning and quarterly team meetings
- Improved family satisfaction with a singular point of contact for care needs
- Team collaborations leading to increased awareness of concerns and improved collaboration to address needs
- Improved rates of routine PCP visits and reduction in hospital admissions

NEXT STEPS AND SUSTAINMENT

Care management focus on pediatric home nursing services has become a necessity!

- Improve coordination of care for the children and families
- Manage the increasing demands on our providers
- Meet the expectations of the payers

Goals for 2026:

- Implement our improved workflow and documentation for the LOMNs
- Maintain the payer specific PNC program but expand similar coordination of care to all children receiving services
- Continue to build and strengthen relationships with the specialty offices, DME providers, and new home health agencies
- Identify additional needs where our care management team can further support the families and providers

THANK YOU

Heather Goshorn, BSN, RN

Director of Enabling Services

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Keystone Health

Next Steps & Wrap Up

Robert Ferguson

2026 PCMH LN Enrollment

- PCMH 2026 Learning Network will have 4 sprint topics:
  - Behavioral Health Integration in Primary Care for Adults and Adolescents
  - Comprehensive Diabetes Care and Health Equity
  - Perinatal Care in Family and Pediatric Offices
  - The Pediatric Nursing Care Program, with a focus on multi-disciplinary Pediatric Nursing Care teams, the Family-Centered Plan of Care, and collaborating with Pediatric Complex Care Resource Centers
- Notification and survey link sent November 3rd
- Enrollment & QI Plans Due by January 15th; TA is available

2026 PCMH Learning Network

Enrollment Form and QI Plan due by 1/15

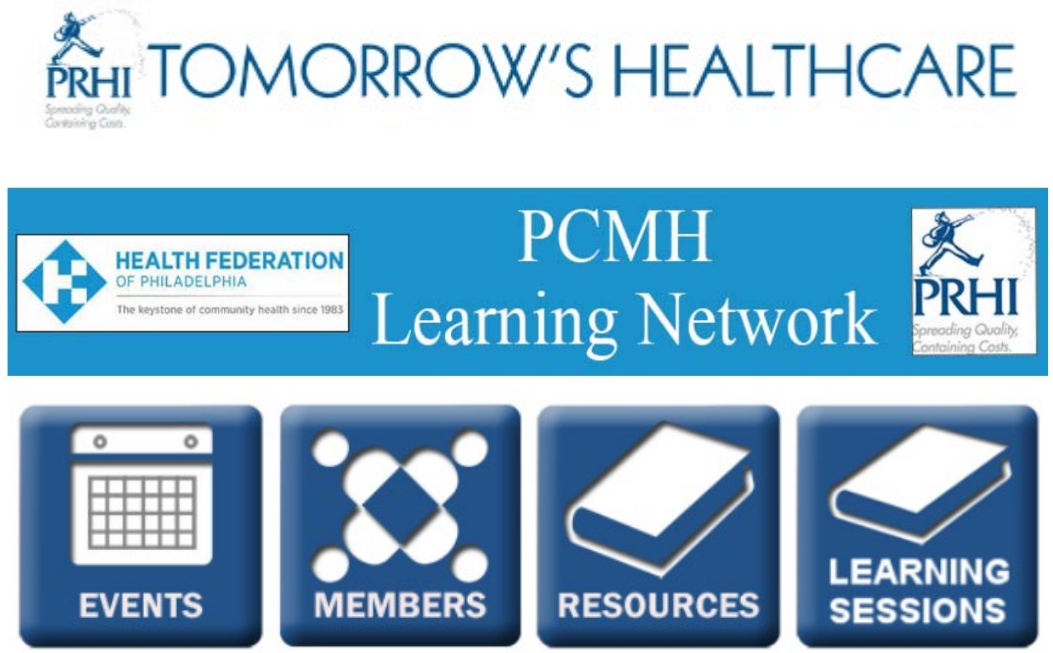
QI Plan Updates Submitted After Each Virtual Session

QI Plan Updates Submitted After Each Virtual Session

PCMH Online Community

https://www.tomorrowshealthcare.org/

To request a new login, please email J. Ashenayi, MPH, Program Associate (Ashenayi@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/QBK8HZ2 by Thursday, November 20th

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.

1. The UPMC Center for Continuing Education will follow up with you via email after **November 20th** 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!