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

2026 PCMH Learning Network Kickoff

January 27, 2026

Pittsburgh Regional Health Initiative & Health Federation of Philadelphia

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

No members of the planning committee, speakers, presenters, authors, content reviewers and/or anyone else in a position to control the content of this education activity **have relevant financial relationships** with any entity producing, marketing, re-selling, or distributing health care goods or services, used on, or consumed by, patients **to disclose**.

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Learning Objectives

- ✓ Describe the structure and expectations of the 2026 PCMH Learning Network sprints
- ✓ Discuss how PCMHs will use their QI Plans to track their progress over the course of the sprint
- ✓ Describe strategies to refine and enhance the “Plan” and “Do” stages of a PDSA cycle

Overview of the 2026 PCMH Learning Network Structure and Expectations

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

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

Physical Health MCOs

Pittsburgh Regional Health Initiative

PCMH
PATIENT-CENTERED MEDICAL HOME
Learning Network

HEALTH FEDERATION OF PHILADELPHIA
The keystone of community health since 1983

Disseminating best practices for achieving the HealthChoices PCMH expectations

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Program Associate

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PLEASE ADD TO SAFE SENDERS LIST

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Program Specialist

Robert Ferguson, MPH

Chief Policy Officer

Suzanne Cohen, MPH

Senior Director of Population Health

Claire Lasky

Program Manager

Laura Line, MS

Consultant

2026 PCMH Learning Network Sprints

Laura Line, MS, Consultant, Health Federation of Philadelphia

Sprints are focused, concerted learning and improvement efforts

Behavioral Health Integration in Primary Care for Adults and Adolescents

Data: In 2024, 24.39% of adults in Pennsylvania experienced any mental illness, 18.11% of adults reported a substance use disorder, and 26.70% reported an unmet need for mental health treatment

 # PCMHs in this Sprint: 11

Examples of what PCMHs will be working on:

- Addressing low screening rates; Improve and standardize behavioral health (BH) screening processes (e.g., PHQ-2 for depression, SCARED for anxiety)
- Strengthen documentation, follow-up processes, and access to resources after positive depression and anxiety screenings
- Integration of CHWs
- Expand and scale integrated care models across more offices
- Long-term financial and program sustainability, including use of CoCM and BHI billing codes

Related initiatives: PA Rural Health Transformation Plan's behavioral health integration focus

Comprehensive Diabetes Care and Health Equity

Data: 2023, MY 2023 HealthChoices Weighted Averages:

- HbA1c Control (<8%) = 59.54%
- HbA1c Poor Control = 31.20%
- Retinal Eye Exam = 58.03%
- Kidney Health Evaluation = 48.06%

Number of PCMHs: 26

Examples of what PCMHs will be working on:

- Reducing A1C levels and increasing completion of routine monitoring, including A1C testing, kidney health evaluations, retinal eye exams, and foot exams
- Engaging diabetes care coordinators, implementing standardized workflows, and increasing standing orders and clinical huddles
- Addressing SDOH barriers, improving access to care, and expanding culturally appropriate and equitable patient education
- Enhancing diabetes self-management through community engagement, lifestyle education, and coordinated follow-up with PCPs, endocrinology, dietitians, and home care services.

Perinatal Care in Family and Pediatric Offices

Data: Data from March of Dimes shows in 2023 approximately 74.5% of infants were born to women receiving “adequate / adequate-plus” prenatal care. 2023 HEDIS measures show Follow-Up on Positive Postpartum Depression Screening rates of 55.68%.

Number of PCMHs: 5

Examples of what PCMHs will be working on:

- Caregiver influenza vaccine uptake; offering and administering adult flu vaccines at pediatric visits
- Improve follow-up and connections to resources for mothers with positive post-partum depression screens
- Identify and address gaps/differences in comprehensive prenatal care services between practices.

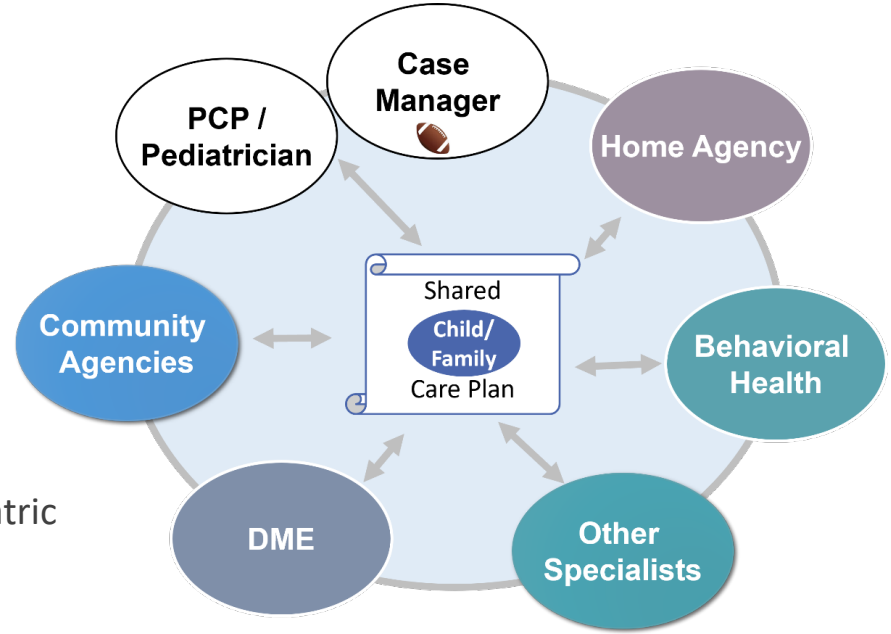
Related initiatives: Birth Hospitals in the PA Perinatal Quality Collaborative will be improving transitions of care in 2026

Pediatric Nursing Care Program

Number of PCMHs: 9

Examples of what PCMHs will be working on:

- Increasing family engagement in Plans of Care
- Planning for transitions to adult care
- Better connections to community resources
- Improving comprehensive support for non-medical needs for families and caregivers
- Advancing nursing integration into routine pediatric care for high-risk/high-cost patient populations



Q&A

2026 PCMH Learning Network Sprints

Robert Ferguson, MPH, Chief Policy Officer

Pittsburgh Regional Health Initiative

2026 PCMH Learning Network Objective

Objective: *All PCMHs in the HealthChoices PCMH Program complete at least 2 cycles of a PDSA in at least 1 sprint by November 2026*

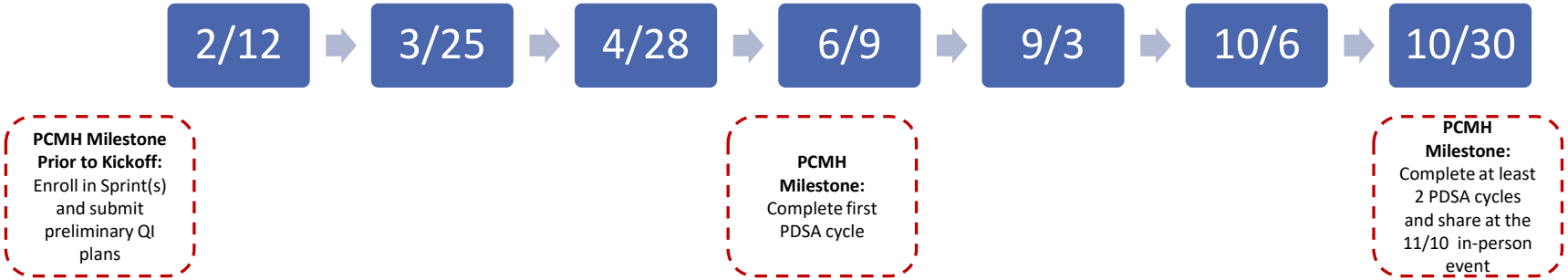
- The scope of your PCMH's PDSA is an important factor for whether 1, 2, or more improvement cycles is achievable.
- The PCMH's Learning Network structure for 2026 is designed to achieve this goal

PDSA Plan Submission Form

1. **Problem Statement:** Please describe the problem that your team is working to improve and why this is important to your PCMH?
2. **QI Team:** Who is on your team to improve this problem?
3. **Current Understanding:** Please describe your team's understanding of the current process and causes of the problem?
4. **QI Goal:** What is your measurable goal to address this problem and improve the process?
5. **Proposed Change:** What are you planning to change in the process to achieve this goal?
6. **Measures to Track Change:** What measures are you planning to use to track whether the change was implemented as intended (e.g., a process measure) and whether this new process is moving towards your goal (e.g., an outcome measure)?
7. **Action Plan:** Who is doing what on your team by when to test this change and track the measures you described above?
8. **Studying:** When your PDSA cycle is in the first Study phase, what are the initial results from the data you are tracking? What are you learning?
9. **Acting:** When your PDSA cycle is in the first Act phase, what adjustments is your team planning to make? What are your next steps?

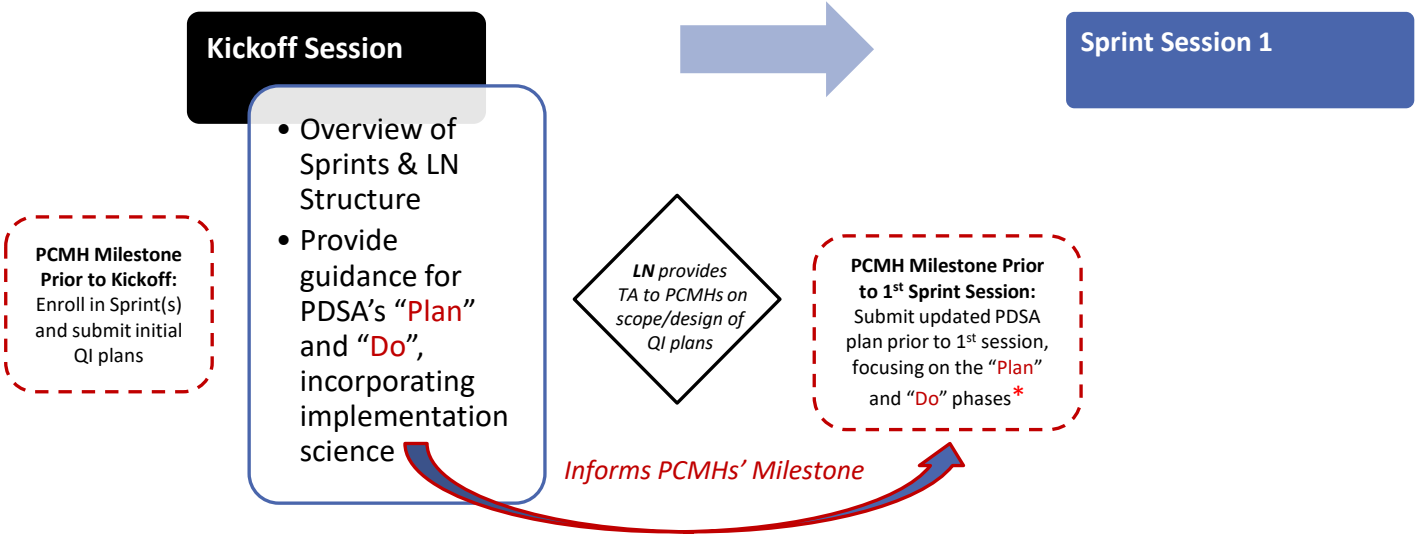
Does the PCMH Learning Network have your PCMHs' approval to share this PDSA plan with your affiliated MCOs for alignment, coordination, and quality improvement purposes?

PDSA Plan Submission Due Dates



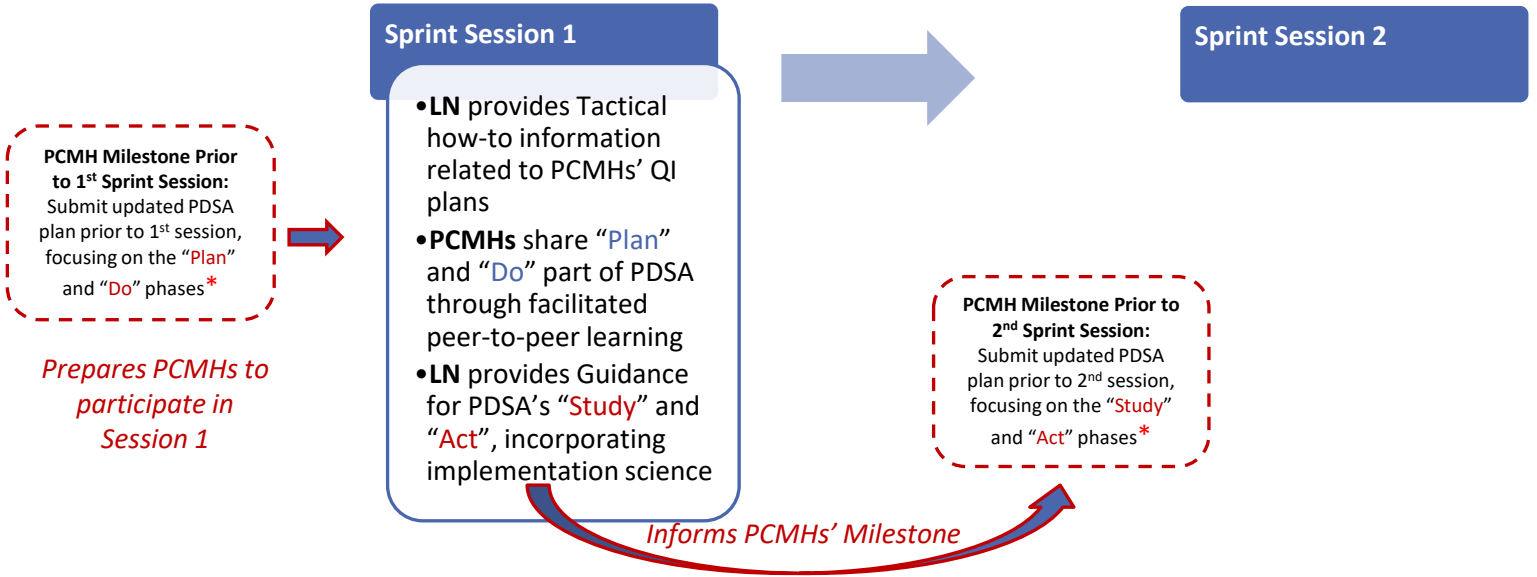
2026 PCMH Learning Network Structure

Kickoff Session and PCMH Expectations Before 1st Sprint Session



2026 PCMH Learning Network

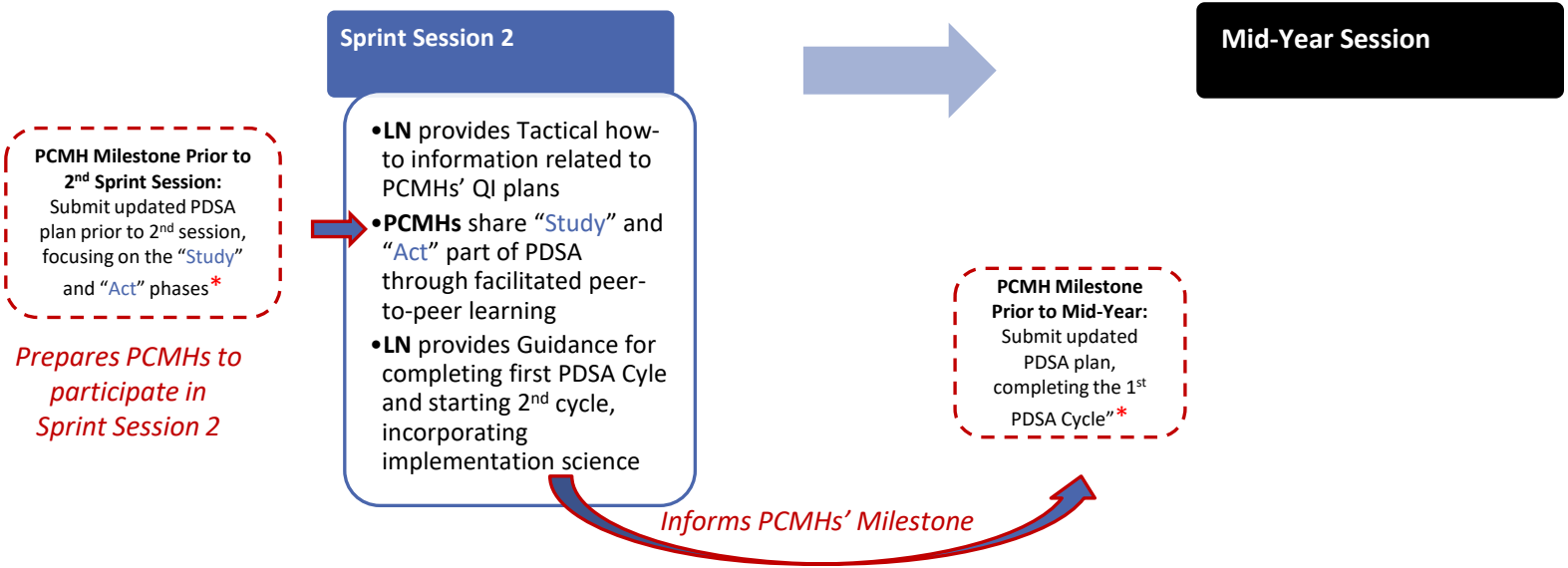
1st Sprint Session and PCMH Expectations Before 2nd Sprint Session



If your PCMH does not reach the milestone or is at risk of not meeting the milestone, request TA from the PCMH Learning Network

2026 PCMH Learning Network

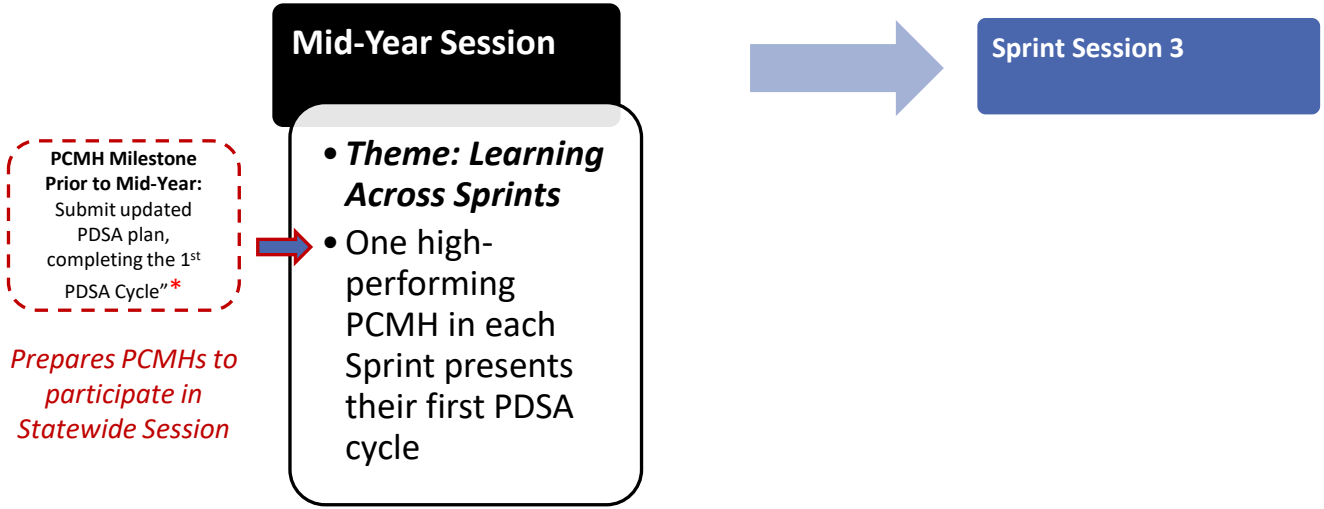
2nd Sprint Session and PCMH Expectations Before Mid-Year Statewide Session



**If your PCMH does not reach the milestone or is at risk of not meeting the milestone, request TA from the PCMH Learning Network*

2026 PCMH Learning Network

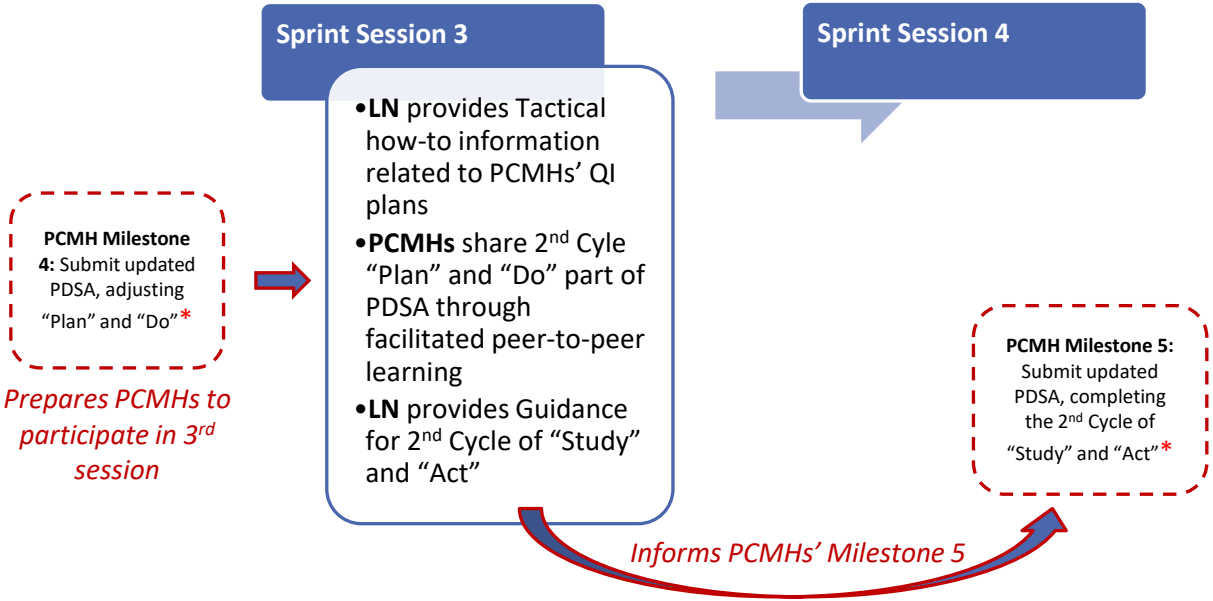
Mid-Year Session and PCMH Expectations Before 3rd Sprint Session



*If your PCMH does not reach the milestone or is at risk of not meeting the milestone, request TA from the PCMH Learning Network

2026 PCMH Learning Network

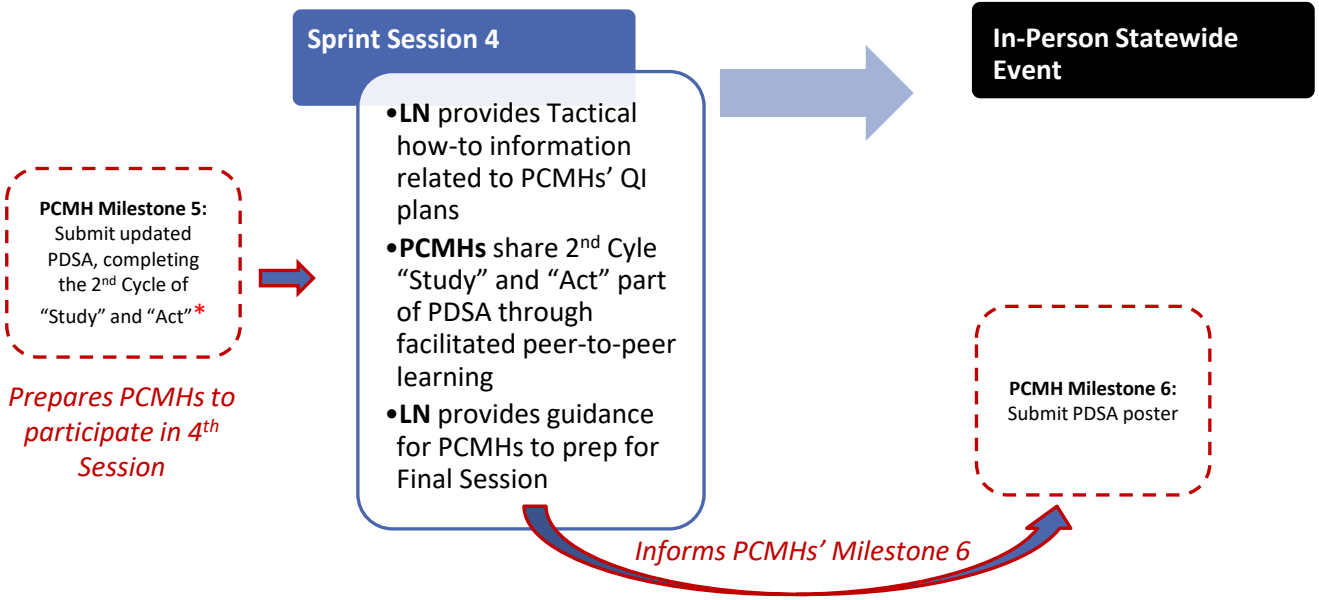
3rd Sprint Session and PCMH Expectations Before 4th Sprint Session



**If your PCMH does not reach the milestone or is at risk of not meeting the milestone, request TA from the PCMH Learning Network*

2026 PCMH Learning Network

4th Sprint Session and PCMH Expectations Before Statewide Event



If your PCMH does not reach the milestone or is at risk of not meeting the milestone, request TA from the PCMH Learning Network

2026 PCMH Learning Network

Final Event and PCMHs' Expectations

PCMH Milestone 6:
Submit PDSA poster

Prepares PCMHs to participate statewide event

Final In-Person Session

- **PCMHs** present their completed PDSA cycles
- **LN** recognizes PCMHs with greatest improvements
- **LN** announces 2027 Sprints

**If your PCMH does not reach the milestone or is at risk of not meeting the milestone, request TA from the PCMH Learning Network*

2026 Sprint Sessions

Comprehensive Diabetes Care & Health Equity

Tuesday, February 24th at 1 – 2:30 pm

Thursday, April 9th at 9 – 10:30 am

Tuesday, June 16th at 1 - 2:30 pm

Thursday, September 10th at 9 – 10:30 am

Perinatal Care in Family & Pediatric Offices

Thursday, February 19th at 1 – 2:30 pm

Wednesday, April 1st at 9 – 10:30 am

Tuesday, June 23rd at 1 – 2:30 pm

Tuesday, September 15th at 9 – 10:30 am

Behavioral Health Integration in Primary Care for Adults & Adolescents

Wednesday, March 11th at 9 – 10:30 am

Tuesday, April 21st at 1 – 2:30 pm

Thursday, July 9th at 9 – 10:30 am

Tuesday, October 6th at 1 – 2:30 pm

Pediatric Nursing Care

Wednesday, March 18th at 1 – 2:30 pm

Tuesday, May 5th at 9 – 10:30 am

Tuesday, July 14th at 1 – 2:30 pm

Thursday, October 1st at 9 – 10:30 am

Throughout the Year…

PCMH Learning Network will also:

- ✓Offer supplemental statewide sessions (e.g., Community Health Workers, sepsis, HIV/AIDS, etc.)

Discussion & Q&A

2026 PCMH Learning Network Sprints

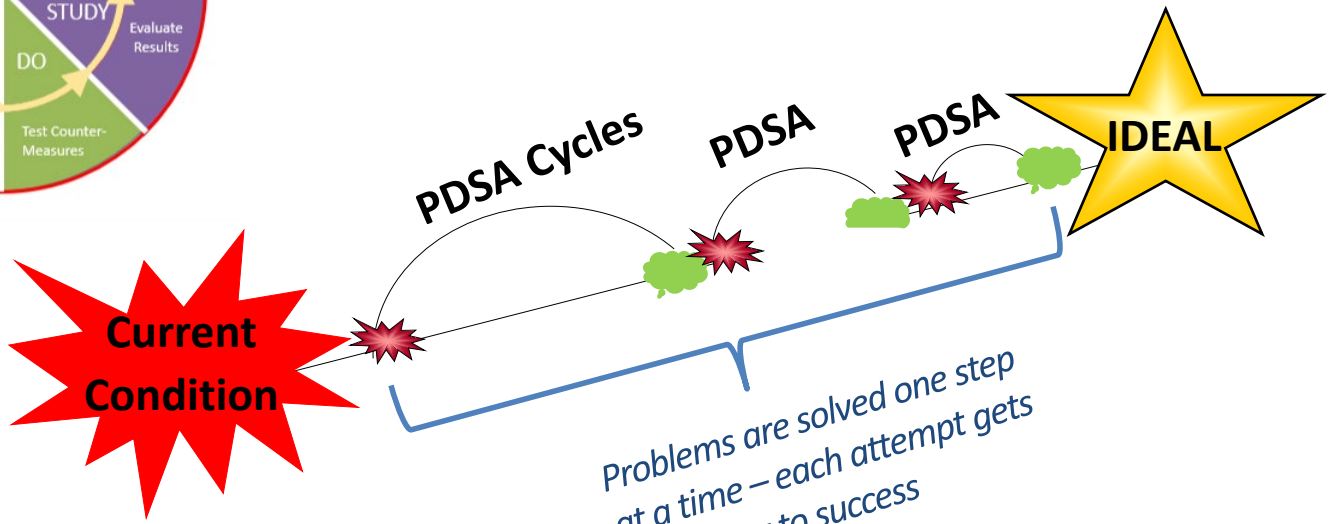
Suzanne Cohen, MPH, Senior Director of Population Health

Health Federation of Philadelphia

Plan Do Study Act

Guidance (Principles and Tools) for “Plan” and “Do”

An Organized Approach To Quality Improvement



PLAN - DO - STUDY - ACT

PDSA Plan

1

PROBLEM STATEMENT

- Identify the process problem: What evidence?
- Describe the scope of the problem: Who? Where? When? How Often?
- Assemble your QI team: Who is in charge? Who is involved? Who is affected?

2

CURRENT CONDITION

- Provide a simple VISUAL overview of the current process and demonstrate a fact-based understanding of problem areas.

ROOT CAUSE ANALYSIS

- Identify the high-priority problem on which staff chose to focus.
- Choose causes on which to focus your efforts.
- Ask "Why?" to see if there is a more basic cause.

3

Test of Change

- Describe the overall goal of the QI effort
- Use the literature, expert opinion, and experience to identify changes
- State the hypothesis you intend to test ("if then" statements)
- Create measures that will indicate if the changes have been implemented (process measures) and results of that change (outcomes).

4

IMPLEMENTATION & MONITORING

- Describe the tasks required to implement each change.
- Identify responsible team member and target date for each task.
- Meet regularly to assess progress and modify approach as needed.
- Collect baseline and follow-up data to track the measures.

SHARING & SYSTEM-WIDE CHANGE

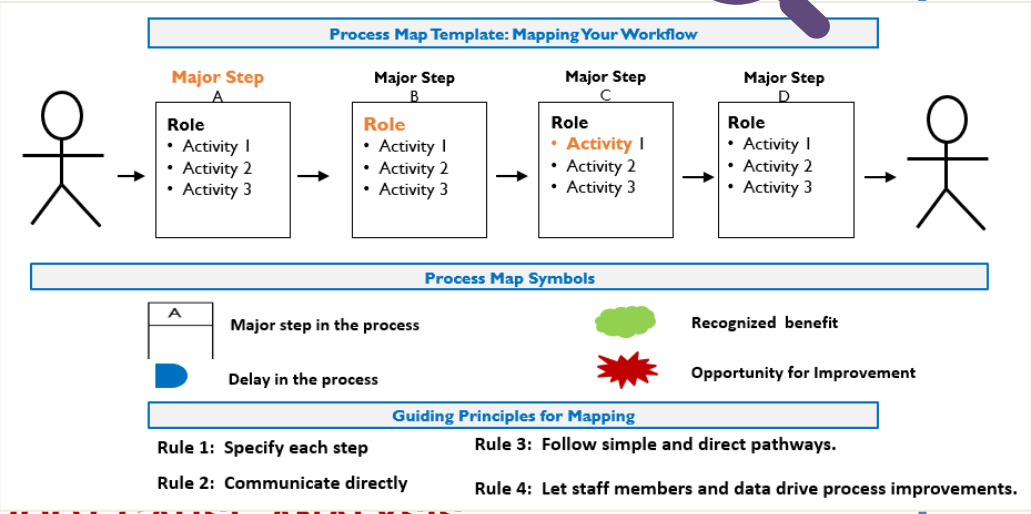
- Present QI journey and results to leadership.
- If the test of change is working, standardize the process and determine how to replicate it across the system
- Mentor other sites in achieving these goals.

PDSA Planning Tools

Process Mapping

CURRENT CONDITION

- Provide a simple VISUAL overview of the current process and demonstrate a fact-based understanding of problem areas.
- Use discussions with staff and actual observations



ROOT CAUSE ANALYSIS

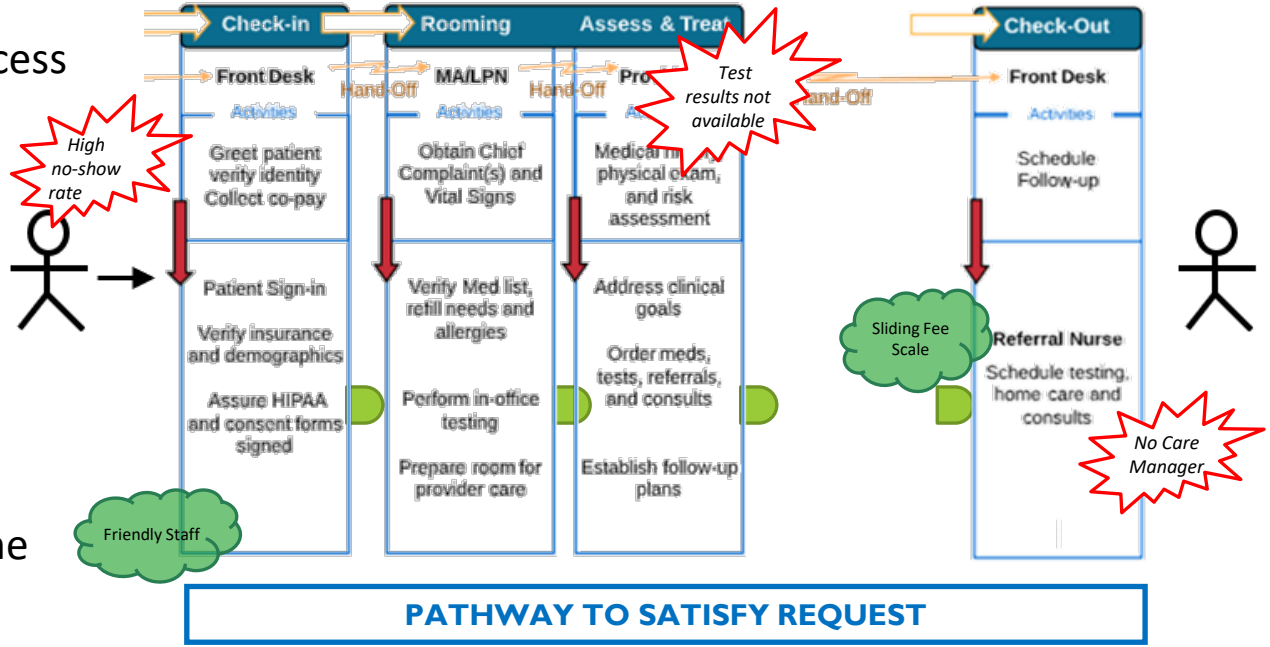
- Identify the high-priority problem on which staff chose to focus.
- Choose causes on which to focus your efforts.
- Ask "Why?" to see if there is a more basic cause.

Benefits Of Process Mapping

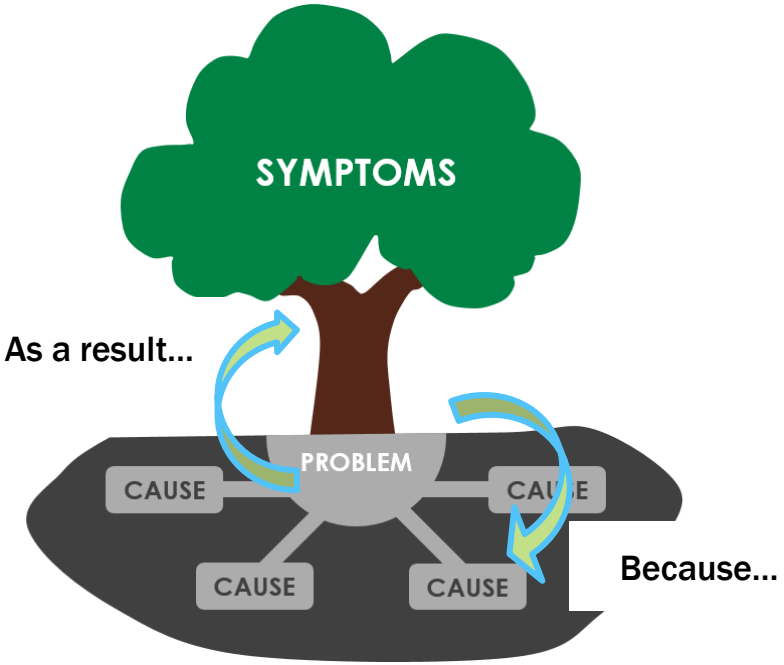
Explore a complicated process involving
- different people
- lots of tasks
- important decisions

Identify opportunities to improve the process
- things that work
- things that don't work

Help people learn about the work to be done
- new employees
- care team
- supervisors



Root Cause Analysis: Key Points



Listen to the people on the front lines, especially staff and consumers

Explore each suggestion, rather than judging it

Identify the causes of the problem not the symptoms

Tools: fishbone diagram, 5 WHY's

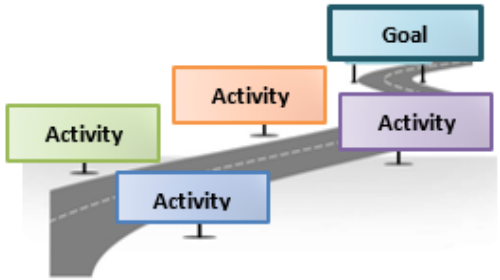
WHY, not Who

It's the process, not the people

Action Planning

What do you plan to do (roadmap)?

Each line is a specified activity



Designate a team member and their role for each activity

Determine a due date for each activity

Track progress toward the due date for each activity

- NOT STARTED
- IN PROGRESS
- BEHIND SCHEDULE
- NEEDS ADDRESSED
- COMPLETED

Indicate the findings for each activity

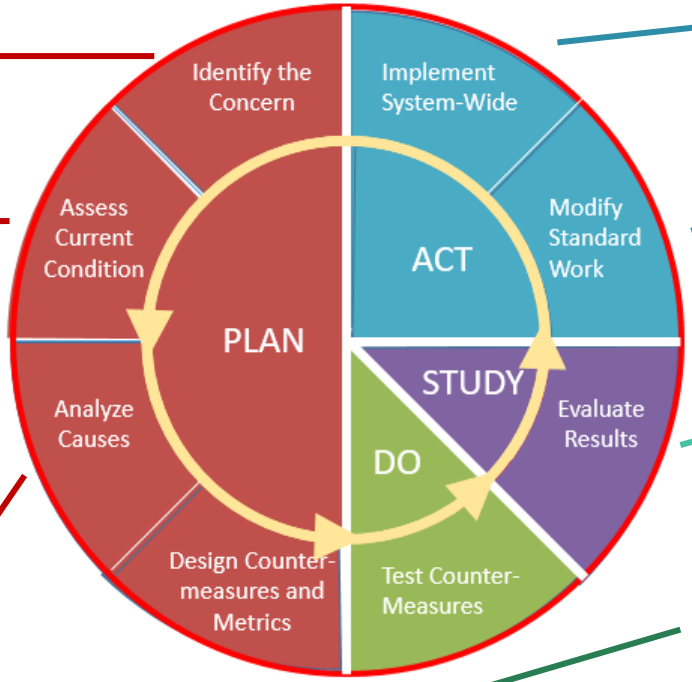
Clearly identify any barriers to achieving the designated activity

Data are essential to each step

"Diabetes testing, outcomes, and P4P payments are below expectations."

"32% of diabetes patients had missing or overdue testing."

"Staff are unaware of >90% of overdue tests when patients are seen."



"80% of primary care sites now have active diabetes care reminders."

"Automated diabetes care reminders have been added to all of diabetes care protocols."

"In the last three months we reduced overdue testing from 32% to 15% and increased P4P by $4000."

"Implement a diabetes test reminder system at time of care to reduce overdue testing by 1/3 in the next 3 months."

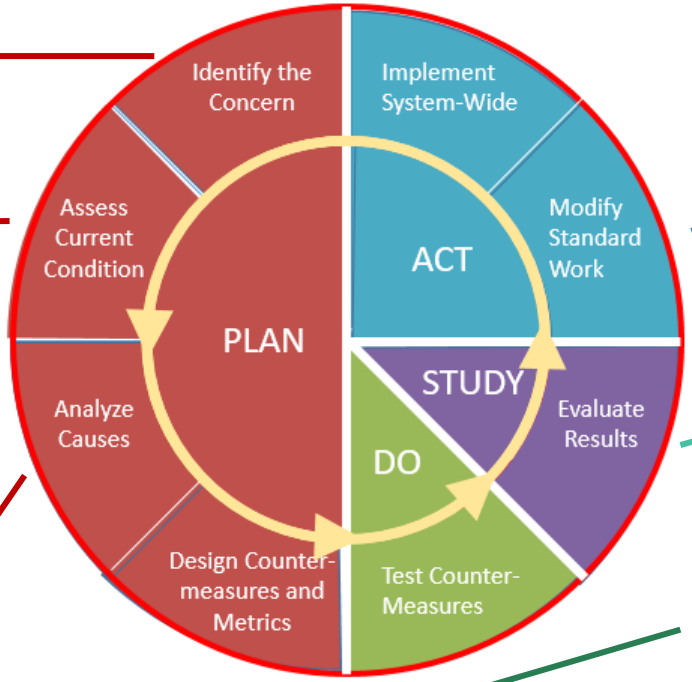
It’s not only important *what* you do, it’s equally important *how* you do it.

Example: Implementing the Validated PHQ-9

"Depression Screening and Follow-up is now a P4P measure."

"There is no current process for depression screening in our office."

"Staff are unaware of the screening tools and how to administer the screens."



Let's look at how this evidence-based screen was implemented at each office.

"In the last three months, the positive screening rate was 5% at office A and 20% at Office B."

"Add the PHQ-2 and PHQ-9 to the EHR's preventive screens during the rooming process."

Example: Implementing the Validated PHQ-9

Office A's Approach

Notified all staff that the PHQ-9 was being added and rooming staff administer the screen

Office B's Approach

Trained rooming staff on PHQ-9 messaging

Practiced messaging with patient simulators

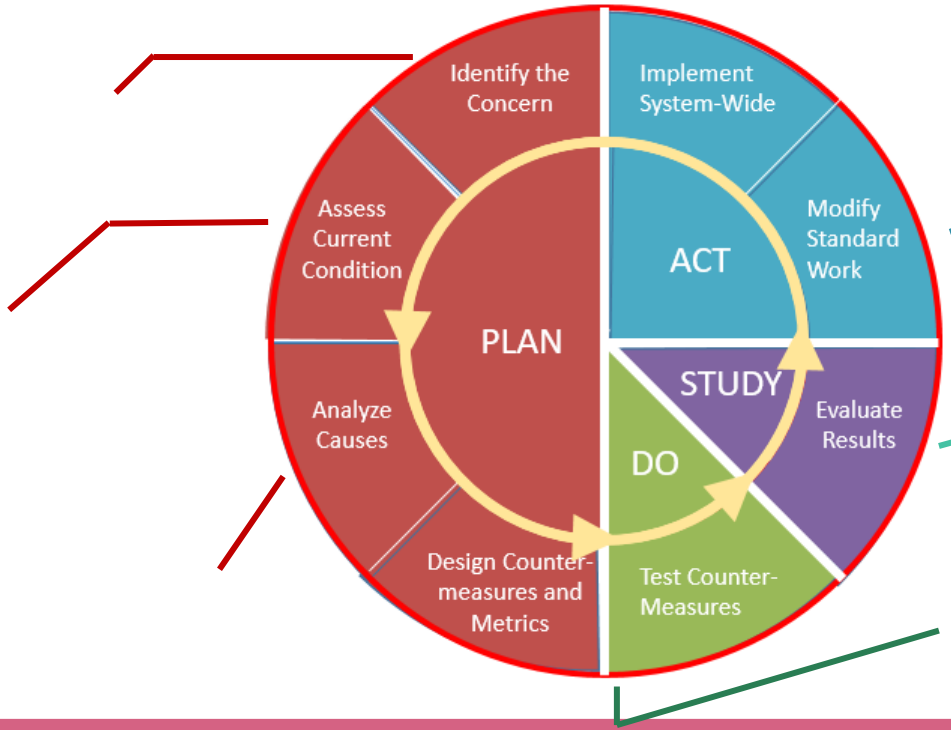
Worked with their patient advisory group to design and post educational materials in the waiting room about the universal depression screening process

Asked their patient advisory group for feedback on the new process

Provided monthly data reports to rooming staff, providers, and leadership

Provided one-on-one coaching and feedback to staff in response to the data reports

Example: Implementing the Validated PHQ-9



Office A and B mapped out their new standard process, presented it to leadership, and asked to implement it system-wide.

"In the last three months, the positive screening rate was 15% at office A and 20% at Office B."

"Office A adapted the implementation model from Office B."

Discussion

Next Steps, Wrap Up & Session Evaluation

Lisa Boyd, Program Specialist, Pittsburgh Regional Health Initiative

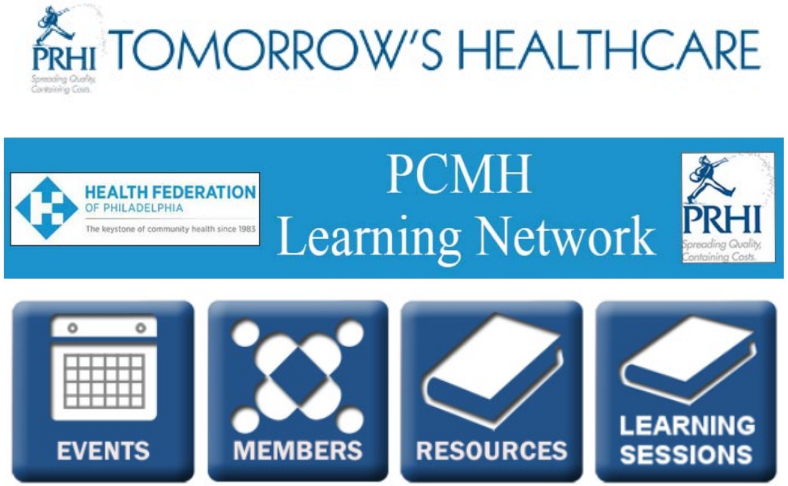
Next Steps from Today's Session

1. Receive feedback form the PCMH Learning Network about the scope of your PDSA plan
2. Further develop the Plan for the PDSA
3. Reach out to the PCMH Learning Network for guidance
4. Submit your updated PDSA by 2/12

PCMH Online Community

https://www.tomorrowshealthcare.org/

Members of your PCMH's multi-disciplinary learning team will receive log-ins



- Access the session materials in "Learning Sessions"
- Look for guides and tools in "Resources"
- Find session dates and registration links under "Events"

CEU Process

You will receive a follow up email with links to:

Complete the survey at: https://www.surveymonkey.com/r/GWXKRJ8 by Tuesday, February 3rd

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 **February 3rd** 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!