

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.tomorrowshhealthcare.org

2026 PCMH Pediatric Nursing Care Sprint Session #2

May 5, 2026

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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New Resource: Shift Care Information Sheet & FAQs

- How to Request Services and What to Include in the Letter of Medical Necessity (LOMN)
- Key Information for the LOMN
- Level of Services and Scope of Practice for Home Health Aide (HHA) and Skilled Nurse (SN)
- Other Daily Needs Not Considered as Part of HHA or SN and Appropriate for Lay Caregiver, Applied Behavior Analysis Program, Therapeutic Staff Support Worker, or Feeding Therapist
- Processes for Providing Additional Information to MCOs

**SHIFT CARE
INFORMATION SHEET AND FAQs**

INTRODUCTION: Shift Care services are managed by the physical health managed care organizations to provide in-home and community skilled nursing, personal care, medical daycare, and home health aide services to a member under the age of twenty-one (21) years.

HOW TO REQUEST SERVICES: A medical provider for the member must submit a Letter of Medical Necessity (LOMN) to the PH-MCO which includes:

- Request on **practice letterhead signed and dated by the ordering medical provider (physician, physician assistant, or credentialed nurse practitioner)**
- **Include member's full legal name, DOB, and member ID**
- **Member's diagnoses and medications, which support the need for services**
- **The level of services requested:** skilled nurse or home health aide (One of these levels of care must specifically be requested in the letter. We cannot approve services that just state caregiver, home care, care, attendant, etc.)
- **Reason for services** (to support caregiver, caregiver is working, caregiver is disabled, etc.)
- **Location of services** home, school, camp, etc.
- **Duration of services** maximum duration is **6 months**, unless the provider and MCO agree on a longer duration under specific circumstances.

KEY INFORMATION FOR THE LETTER OF MEDICAL NECESSITY (LOMN):
Information in the request should reflect:

- the provider's medical expertise regarding member's diagnosis
- a recent physical exam (less than 12 months) supporting the member's needs and recent office visit notes within the last 6 months from Ordering Provider, PCP, or Specialist
- hours requested should match the member's medical needs and time needed to complete member's needs
- services that the member is currently receiving (e.g., IEP, PT, OT, Speech) and needs related to deafness or hard of hearing (devices for Augmentative and Alternative Communication)
- the provider could also include relevant work and psychosocial information if relevant to the requested services (e.g., available and trained caregivers in the home, hours of work, who they live with in the home, number of children, any an stressors)
- Any additional relevant information (e.g., child ADLs, child's education location and hours, DME needs, the skills needed, any feeding needs or oxygen/trach needs, asthma action plans, and seizure action plans)

Learning Objectives

- ✓ Discuss principles and tools for creating and sustaining standard work for new team roles
- ✓ Describe examples of how PCMHs are defining roles and standard work for PCMH-PNC Case Managers

PCMH-PNC Program Overview & Role of Case Manager

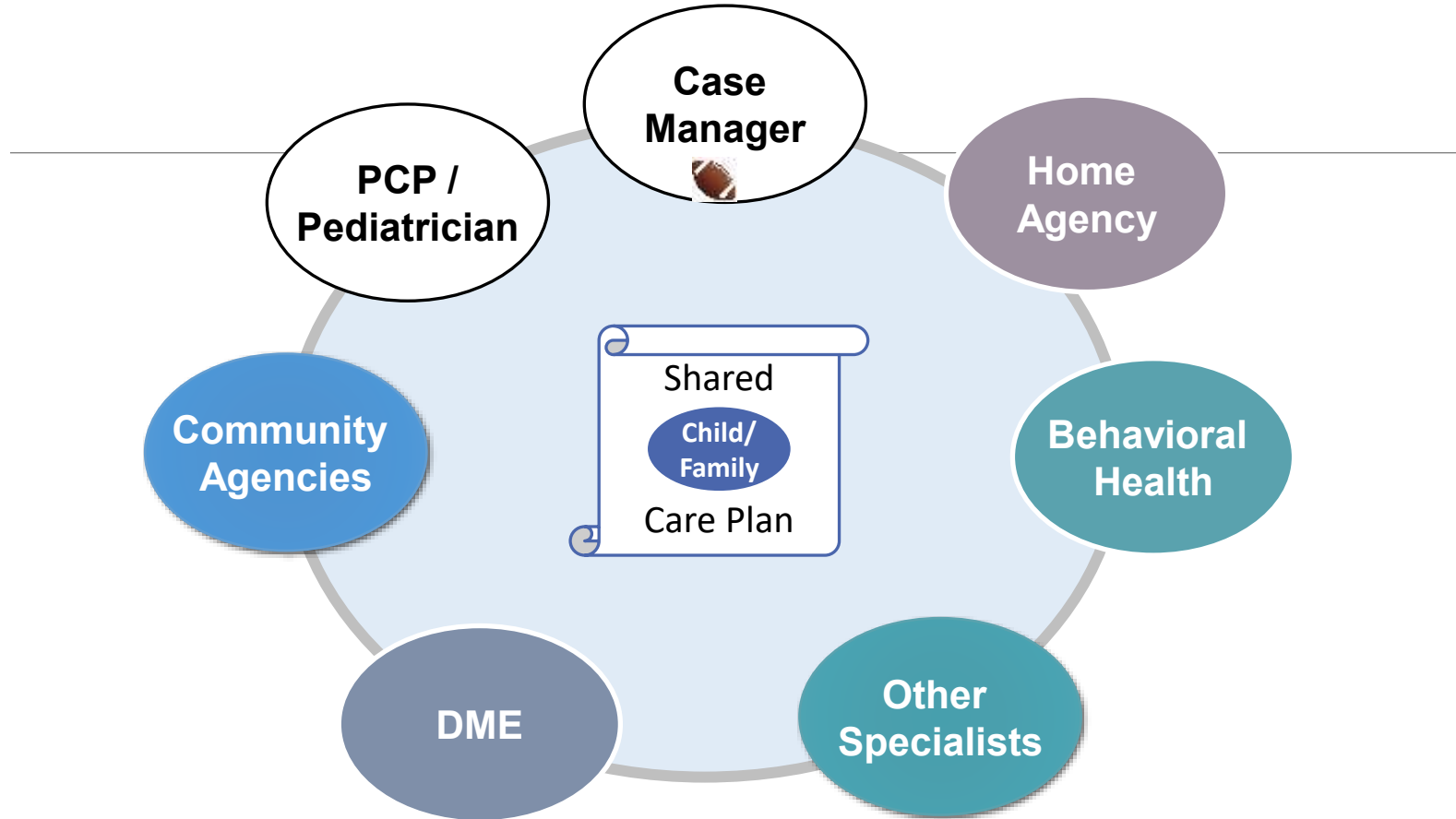
HealthChoices PCMH Pediatric Nursing Care Program

PH-MCOs recognize HealthChoices PCMHs that serve at least 20 children receiving shift care nursing services to participate.

PCMH-PNCs provide **care management** and **team-based care planning** to meet child's medical, social, education, legal, therapeutic, DME, skilled nursing, and behavioral health needs

Exhibit DDD

PCMH-PNC Care Team

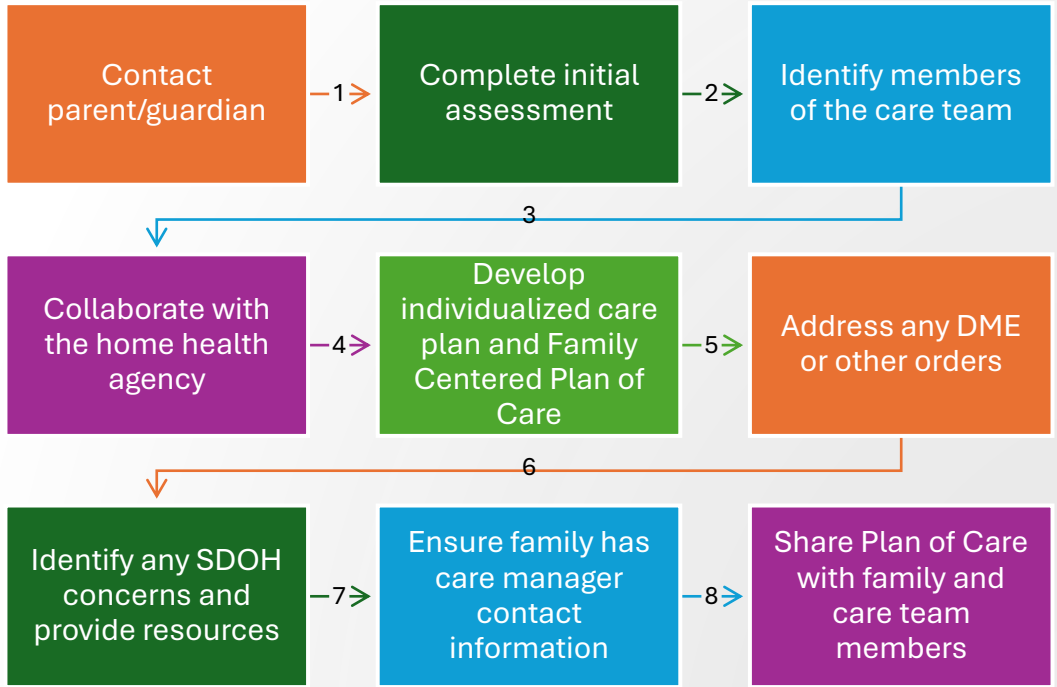


PCMH-PNC Case Manager Roles

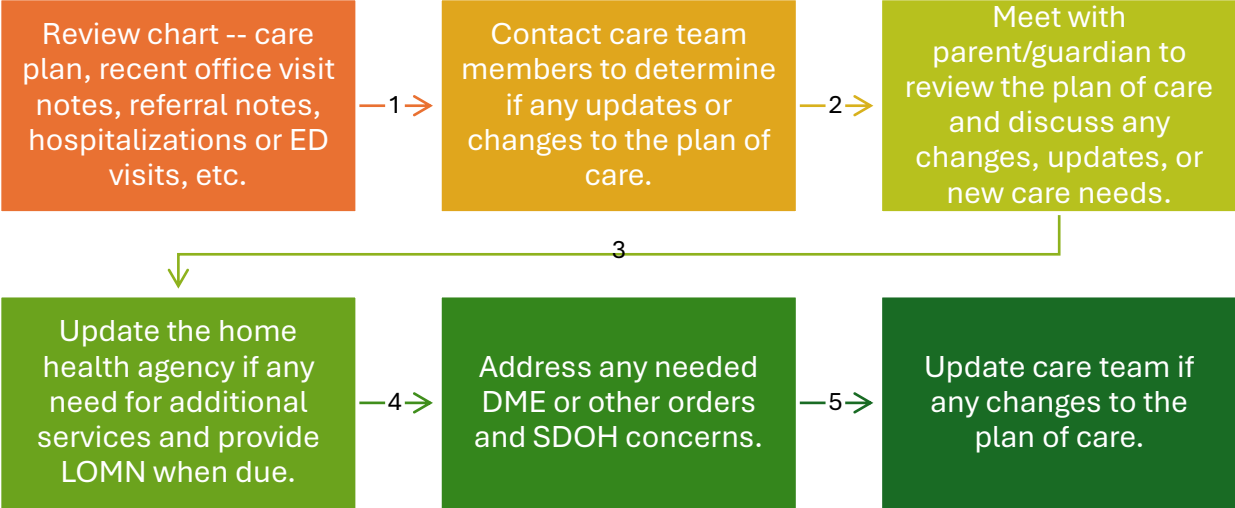
- ✓ Convene care team meetings at least quarterly to:
 - ✓ Maintain medical orders and initiate and maintain necessary and authorized services.
 - ✓ Ensure that all members are working from the most current version of the **Family-Centered Plan of Care**
 - ✓ Assist the HHA(s) with scheduling of shifts by identifying appropriate skills needed by nurse/home health aide
- ✓ Maintain a **family-centered plan of care**
- ✓ Make warm hand off referrals to meet needs identified in the assessments
- ✓ Coordinate all case management services (including PH-MCO case management, HHA services, DDME, Early Intervention, Behavioral Health, and education)

See [Exhibit DDD](#)

Keystone Health Example of a PCMH-PNC Role



Quarterly Review Role



Additional PCMH-PNC Roles:

- Review the care plan quarterly and as needed
- Review the full Family Centered Plan of Care annually or if there are any changes
- Parents/guardian support - individualized care coordination and direct contact for concerns
- Provider support
- Point of contact for home health agencies and specialty offices
- Communicates with the Special Needs Unit as appropriate
- Transitions of care follow up
- Participates in warm hand-off referrals to services as needed
- Development of a structured transitional process to adult health care
- Development of a tracking process for the PNC patients

Guidance for Creating Standard Work for a New Team Role

Suggested Steps

1. List all the roles of the PCMH-PNC Position
2. Observe one role at a time
3. Create a process map for that one role (the sequence of steps to carryout that role)
4. Outline the standard work

Standard Work = Reliability

Standard work:

- creates stability of a process, role, and system, i.e. the capability to produce consistent results over time = reliability.
- Documents the process for everyone.

Foundation for QI: We can't improve a process unless we know how it happened in the first place.

The Power of Observation...

- Observe one role at a time
- Watch how work is **actually** occurring
 - Capture events as they unfold
- In-depth and detailed understanding of current state of roles and processes for those roles

Steps for Observation...

Observation Steps:

1. Preparation
2. Go and See
3. Analyze Observation Data to Create Process Maps and Outline Standard Work

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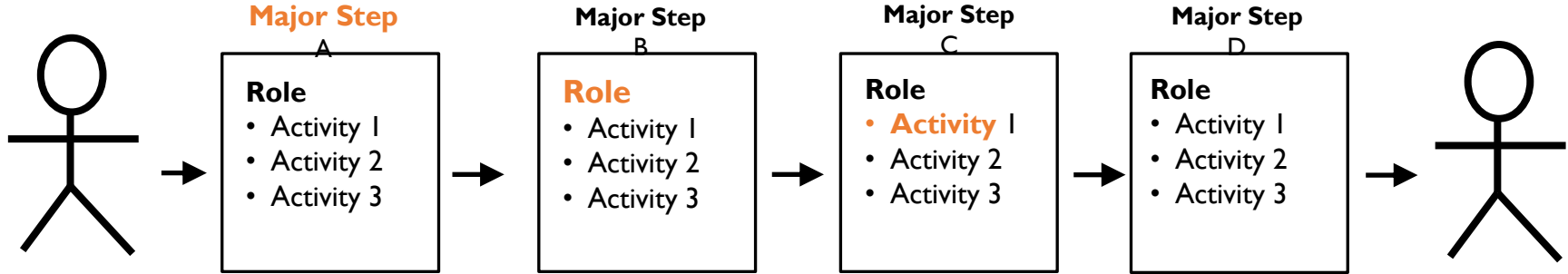
Observation Form

Date: July 15, 2016

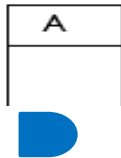
Site: Centre Behavioral Health

	TIME	LOCATION	ACTIVITY	OTHER
Registration	0:00	Registration	Consumer arrives, checks in at registration desk, and is told to wait	"you will be called"
	1:35	Waiting Room	Takes seat in waiting room.	
	10:42	Waiting Room	Consumer is paged to the registration booth.	
	10:52		Consumer asks another Consumer for advice on which booth to go to before then goes to correct booth.	Consumer didn't hear page.
	11:41	Registration	Consumer completes paperwork, provides insurance information	
	17:05		Consumer is asked to take a seat and wait to be called to exam room.	Clinician not notified.
Rooming	27:49		Clinician calls Consumer name and escorts Consumer to office.	
		Office #4	Clinician greets Consumer and begins to discuss agenda for visit	
	38:03		Computer system is down	
			Clinician leaves to get system restored	
Care	41:28		Consumer waits for therapist	
	1:08:36	Office #4	Clinician re-enters room and resumes visit.	Clinician is very attentive and organized
Check Out	1:31:41		Clinician completes consumer assessment and plan.	
	1:36:41	Front Desk	Consumer proceeds to check out and waits in line.	Four people waiting
	1:50:42		Consumer completes check out.	
	1:53.43		Consumer leaves center.	©2018 PRHI

Process Map Template: Mapping Your Workflow



Process Map Symbols



Major step in the process



Recognized benefit



Delay in the process



Opportunity for Improvement

Guiding Principles for Mapping

Rule 1: Specify each step

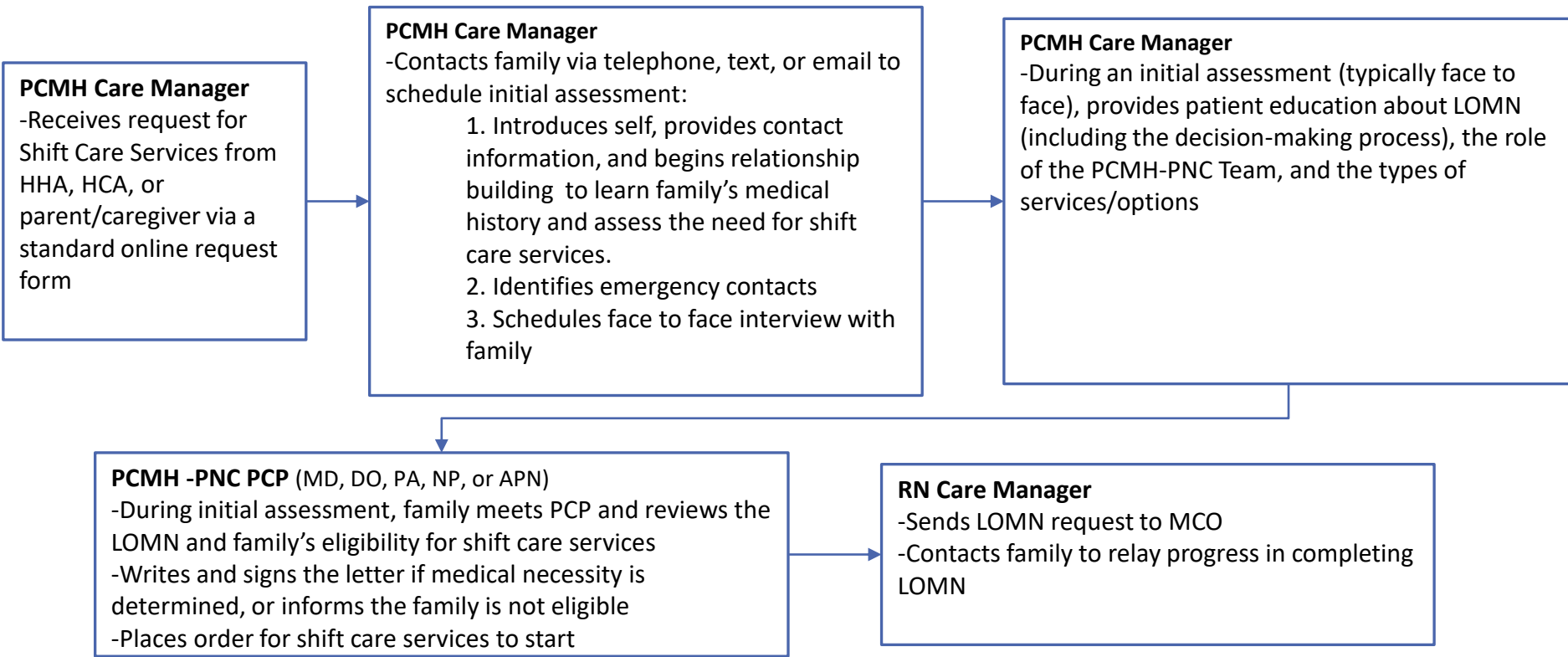
Rule 3: Follow simple and direct pathways.

Rule 2: Communicate directly

Rule 4: Let staff members and data drive process improvements.



Example Workflow for the PCMH-PNC Role to Initiate Services



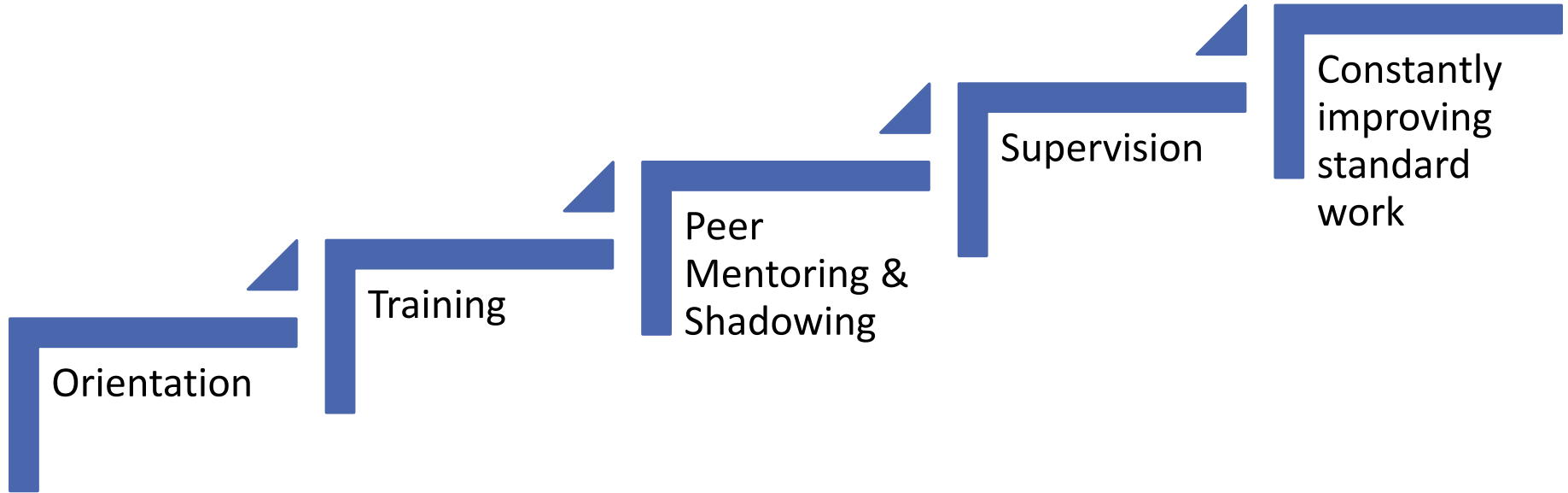
Standard Work Template

OUTREACH WORKER STANDARD WORK

Minority AIDS Initiative- identifying individuals lost to care to engage and retain in medical care

Step	Content	Location	Timing	Outcome
Identification	1. Review referrals from Case Managers	Office	Daily	Clients are added to lost to care list for outreach
	2. Review closed cases for clients who fell out of contact	File Room	Monthly	
	3. Print performance measures and identify high risk patients	CAREWare	Monthly	
	4. Answer physician referral calls	Phone	Daily	
Contact	5. Call/E-mail client primary information	Phone/Computer	3 attempts over 10 days	Client engages in care outreach
	6. Call/E-mail client emergency or alternate contact	Phone/Computer	3 attempts over 10 days	
	7. Call/E-mail provider to research client contact information	Phone/Computer	3 attempts over 10 days	
	8. Initial contact with client	Phone	15 minute increments	

Guidance for Onboarding More People for that Role



Orientation

Training

Peer
Mentoring &
Shadowing

Supervision

Constantly
improving
standard
work

Regular Staff Check-ins

Supervisor: _____

Program: _____

Cover the following questions during each round:

1. What is working well?
2. What systems or processes need improvement?
3. What tools/training do you need to do your job?
4. Is there anyone I can recognize today?
5. Follow-up from previous rounding (“Last time you mentioned...”)

- Make it part of your regular schedule
- **Have staff share what is working well and what is not**
- Be **supportive, recognize** employees, build teams, and hold **accountable**
- **Model the behavior** you expect to see in others

- Are there any problems interfering with your work?
- With clients?
- Do you have what you need to do your job?
- What ideas do you have improvements?

PCMHs' Sharing of PDSA Plans and Peer-to-Peer Learning

Next Steps, Wrap Up & Session Evaluation

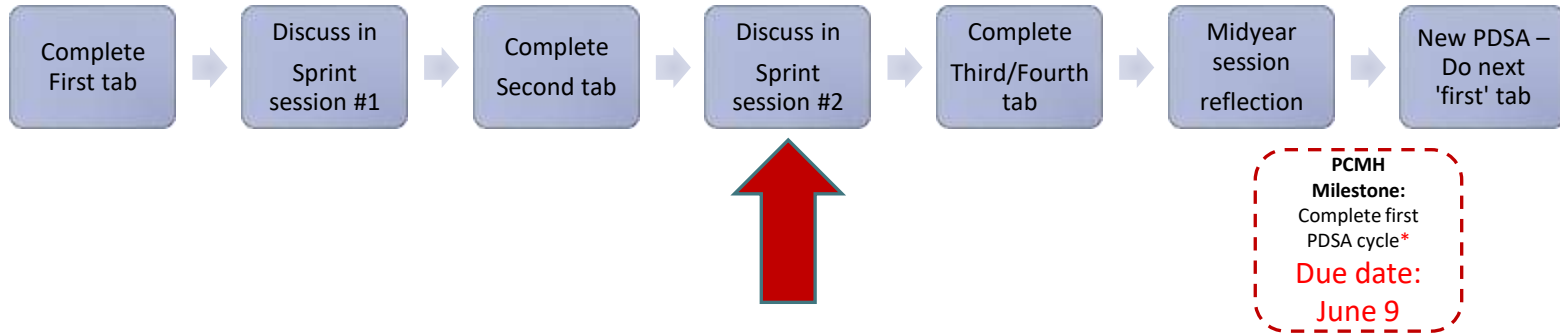
Lisa Boyd, Program Specialist

Pittsburgh Regional Health Initiative

Next Steps from Today's Session

1. PDSA Plan Updates
2. Reach out with any questions or to request 1:1 support or TA
3. Make sure you and your team are registered for the Statewide Midyear Session
Tuesday, June 2nd at 9:00 – 10:30 a.m. via Zoom

PDSA Cycle One Wrap-Up



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

PDSA due dates are designed to prepare PCMHs for each session.

2026 PCMH Learning Network

3rd and 4th Sprint Session

Sprint Session 3

Tuesday, July 14th at 1-2:30 pm

- **LN** provides Tactical how-to information related to PCMHs' QI plans
- **PCMHs** share PDSA 2nd Cycle "Plan" through facilitated peer-to-peer learning
- **LN** provides guidance for completing 2nd cycle of Study and Act



Sprint Session 4

Thursday, October 1st at 9-10:30 am

- **LN** provides Tactical how-to information related to PCMHs' QI plans
- **PCMHs** share 2nd Cycle of "Study" and "Act" through facilitated peer-to-peer learning
- **LN** provides guidance on completing PDSA cycles (e.g., standardizing and scaling improvements) and preparing for the final session



2026 PCMH Learning Network

Final In-Person Session November 10th at 8:30 a.m. to 3:00 p.m.

Final In-Person Session

PCMH Milestone:

Complete at least 2 PDSA cycles and share at the in-person event*

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

Supplemental Sessions

Sepsis in Primary Care Settings

June 4, 2026

5:00 pm – 6:00 pm

HIV Screening, Prevention, and Treatment

July 9, 2026

5:00 pm – 6:00 pm

Oral Cancer Prevention and Early Detection

September 24, 2026

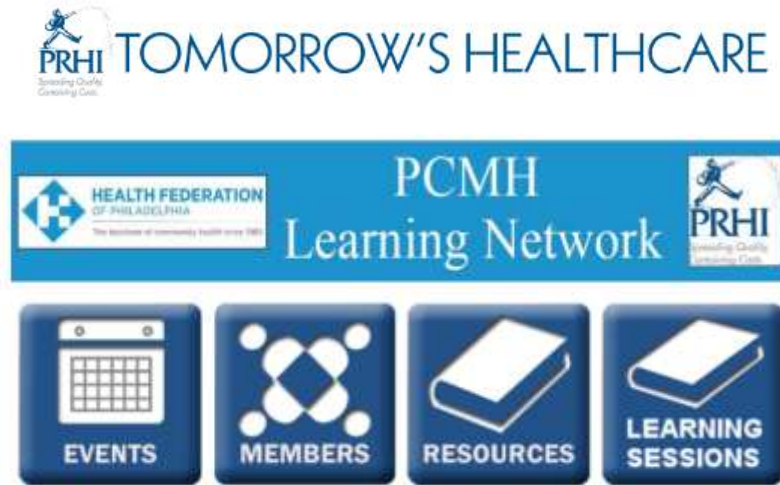
5:00 pm – 6:00 pm



PCMH Online Community

<https://www.tomorrowshhealthcare.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/DKQPSVQ> by Wednesday, Tuesday, May 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 May 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!
