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 Statewide Midyear Session

June 2, 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**.

Disclaimer

The information presented at this Center for Continuing Education in Health Sciences program **represents the views and opinions of the individual presenters**, and does not constitute the opinion or endorsement of, or promotion by, the UPMC Center for Continuing Education in the Health Sciences, UPMC / University of Pittsburgh Medical Center or Affiliates and University of Pittsburgh School of Medicine. Reasonable efforts have been taken intending for educational subject matter to be presented in a balanced, unbiased fashion and in compliance with regulatory requirements. However, each program attendee must always use his/her own personal and professional judgment when considering further application of this information, particularly as it may relate to patient diagnostic or treatment decisions including, without limitation, FDA-approved uses and any off-label uses.

Learning Objectives

- ✓ Discuss example of how PCMHs have implemented a PDSA cycle in each sprint
- ✓ Describe strategies for applying findings from the Study and Act stages to develop iterative cycles

2026 PCMH Learning Network Midyear Welcome

Robert Ferguson, MPH, Chief Policy Officer

Pittsburgh Regional Health Initiative

Physical HealthChoices MCOs

AmeriHealth Caritas Pennsylvania

Geisinger HEALTH PLAN

HIGHMARK WHOLECARE

Jefferson Health Plans

Keystone First

United Healthcare

UPMC for You
Affiliate of UPMC Health Plan

2026 PCMH Learning Network Objective

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

Guidance for Developing Iterative PDSA Cycles

Suzanne Cohen, MPH, Senior Director of Population Health

Health Federation of Philadelphia

Plan Do Study Act

Match implementation Strategies

Rule of Thumb

BARRIER TYPE	RECOMMENDED STRATEGIES
Knowledge Gaps	Education, Feedback
Access Gaps	Service Redesign, Equipment, Partnerships
Workflow Gaps	EHR Tools, Standing Orders

The Nudge Unit

Things to Consider

Pre-implementation measures

- Acceptability
- Appropriateness
- Feasibility

- Cost
- Reach

Start with fit, not ambition.

Proctor E, Silmere H, Raghavan R, et al. Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda. Adm Policy Ment Health. 2011;38(2):65-76. doi:10.1007/s10488-010-0319-7

The Nudge Unit

Narrow to Broad Approach

PDSA 1: Initial Improvement Plan

- Focused on:
  - One care team
  - One pod
  - One location
- Goal:
  - Test and refine the improvement project on a small scale
- Results:
  - Demonstrated successful improvement and positive results

PDSA 2: Initial Improvement Plan

- Expand implementation to:
  - Additional care teams
  - Additional pods
  - Additional locations
- Goal:
  - Scale successful practices across broader settings
  - Ensure consistency and sustainability of improvement efforts

Broad to Narrow Approach

PDSA 1

Broad implementation goals

Goal:

- Multiple!
- Ex: improve practice performance on patients completing the full diabetic bundle – A1c, Retina screening, Kidney screening, Statin Rx

Results:

- unclear or uneven

PDSA 2

Narrow and dig into a single metric

Focus on improvement in that one area

Ex: Improve practice performance on retinal screening

Reassess Root Causes & Match Implementation Strategies

PDSA 1: Improve Warm Hand-offs to Integrated Behavioral Health

Assumption:

Low hand-off rates were caused by lack of knowledge or awareness

Intervention:

Train PCPs and behavioral health providers on warm hand-offs

Results:

Warm hand-off rates did not improve significantly

PDSA 2: Workflow & System Redesign

Key Learning from PDSA 1:

Workflow and lack of system supports made warm hand-offs difficult to complete consistently, independent of training/knowledge levels

New Strategy: Focus on systems and workflow

Ex: Create standing orders with system prompts or flags for eligible patients

- Medical Assistants should refer any patient with a PHQ9> X to integrated behavioral health

Use Variation in Results to Inform PDSA 2

PDSA 1: Depression Screening & Referral Improvement

Goal: Increase depression screening and referral to follow-up care

Interventions:

- Train MAs on PHQ-9
- Create standing orders
- Adjust workflows/systems
- Apply across 4 care teams

Results: 2 teams showed improvement, 2 showed little to no improvement

PDSA 2: Investigate & Tailor the Response

Examine implementation differences across the teams

- Were workflows followed consistently?
- Were there staffing barriers?
- Did implementation go as intended?

Possible next steps:

- Re-implement PDSA 1 with better support to care teams with little improvement
- Develop a new intervention tailored to the specific barrier's for each team

Overall Considerations

1. It probably won't be this neat - real life rarely is!
2. PDSA 1 may not be finished. PDSA 2 can be a refinement, or mid-cycle adjustment. It does not need to be a whole new thing.
3. Go back to your implementation science principles. Match the intervention to the outcome and make it realistic!
4. Have a single clearly defined primary outcome and clear methods to collect data to measure process (whether you are implementing your intervention as planned) and whether you are achieving your outcome.

PCMH Spotlights

Comprehensive Diabetes Care & Health Equity

Cynthia E. Wright-Kent, MBA, Director of Managed Care/Population Health

Greater Philadelphia Health Action, Inc.

HEALTHCARE THAT MAKES A DIFFERENCE

GREATER PHILADELPHIA HEALTH ACTION, INC.
RETINAL SCREENING PILOT
AT WOODLAND AVENUE HEALTH CENTER (WAHC)

Canon CR-2 AF Digital Retinal Camera

AGENDA

- The Problem(s)
- Our Workflow
- PDSA Plan for Cycle 1
- Cycle 1 Progress Report
- Cycle 1 Lessons Learned
- Applying Learnings in PDSA Cycle 2

THE PROBLEM(S)

- Low Completion Rate:
  - **18%** of GPHA diabetic patients had completed a retinal screening exam (2025).
- Limited Patient Access:
  - Retinal screening services were only available at 3 of 6 GPHA health centers
  - Service was offer one ½-day per week
- Location of Machine in the Health Center
- Schedule Challenges:
  - Not enough slots to meet the need
  - Managing staffing and coverage
  - Role clarity and ownership

OUR WORKFLOW

Workflow

1. Identify Patients Who Need a Retinal Scan

☐ Confirm the patient has diabetes
☐ Check if the patient is due for a retinal exam (has not had one in the last 12 months)

---

2. Contact the Patient

☐ Call the patient
☐ Explain why yearly retinal exams are important
☐ Help address barriers such as:

- Transportation
- Language
- Fear or concerns
- Cost concerns

☐ Document outreach in the chart/EHR

If unable to reach:
☐ Make a 2nd call attempt
☐ Make a 3rd call attempt
☐ Send a letter if needed
☐ Document "Unable to Reach"

---

3. Schedule the Appointment

☐ Check retinal scan availability
☐ Schedule the appointment in EPM
☐ Select "Retinal Scan Visit" appointment type
☐ Verify patient phone number and contact information
☐ Provide appointment details:

- Date
- Time
- Location

☐ Send reminder to patient

---

4. Enter Referral (If Needed)

☐ Enter referral order in EHR
☐ Select Ophthalmology/Optometry
☐ Include correct diabetes diagnosis code

Day of the Retinal Scan

5. Prepare the Patient

☐ Confirm patient status in workflow
☐ Bring patient to exam room
☐ Review and obtain signed consent form
☐ Perform retinal scan

---

6. Complete Documentation

☐ Mark patient as "Checked Out"
☐ Label encounter "Retinal Scan"
☐ Print retinal result
☐ Upload retinal result to patient chart
☐ Print face sheet and referral
☐ Document that information was sent to Temple

---

7. Send Results to Temple

Email securely to:

- hazel.arroyo@tuhs.temple.edu
- oleg.shuni@tuhs.temple.edu

☐ Attach:

- Face sheet
- Referral

☐ Subject line: "SECURED"

---

8. Clean Equipment & File Documents

☐ Wipe chin and head rest with alcohol pad
☐ Place signed consent in Fast Scan
☐ Place copy of retinal result in provider mailbox

---

9. Update Referral Completion

☐ Go to Order Management
☐ Mark retinal referral as "Completed"
☐ Enter completion date
☐ Add comment: "Report received at clinic"
☐ Enter interpretation/result and save

---

10. Follow Up with Patient

☐ Give patient Temple location form
☐ Inform patient Temple will call within 5–7 days with results
☐ Tell patient to call Temple if they do not hear back

PDSA PLAN FOR CYCLE 1

- Identify our Pilot site (Woodland Ave Health Center) - 12% screening rate
- Extend services from one ½ day per week to 3 days per week
- Test new process:
  - Identify eligible patients ahead of scheduled appointments
  - Complete retinal screenings during visits
  - Documenting results in the EHR
  - Tracking results (completed visits, positives/negatives, etc.)
- Evaluate staff workflow efficiency, provider engagement, documentation completion and accuracy

CYCLE 1 PROGRESS REPORT

- 176 patients
  - Were on the schedule for a routine Medical appointment (From 4/13-5/19)
  - Were past due for a retinal screening
  - 101 patients completed retinal screening visits (57%)
    - 80% retinal reports were successfully uploaded to the patient record
    - Positive and negative results were identified – all are referred
    - Ungradable images (28 people- 27%) occurred, requiring additional follow-up
  - 75 patients were no-shows (43%)

CYCLE 1 LESSONS LEARNED

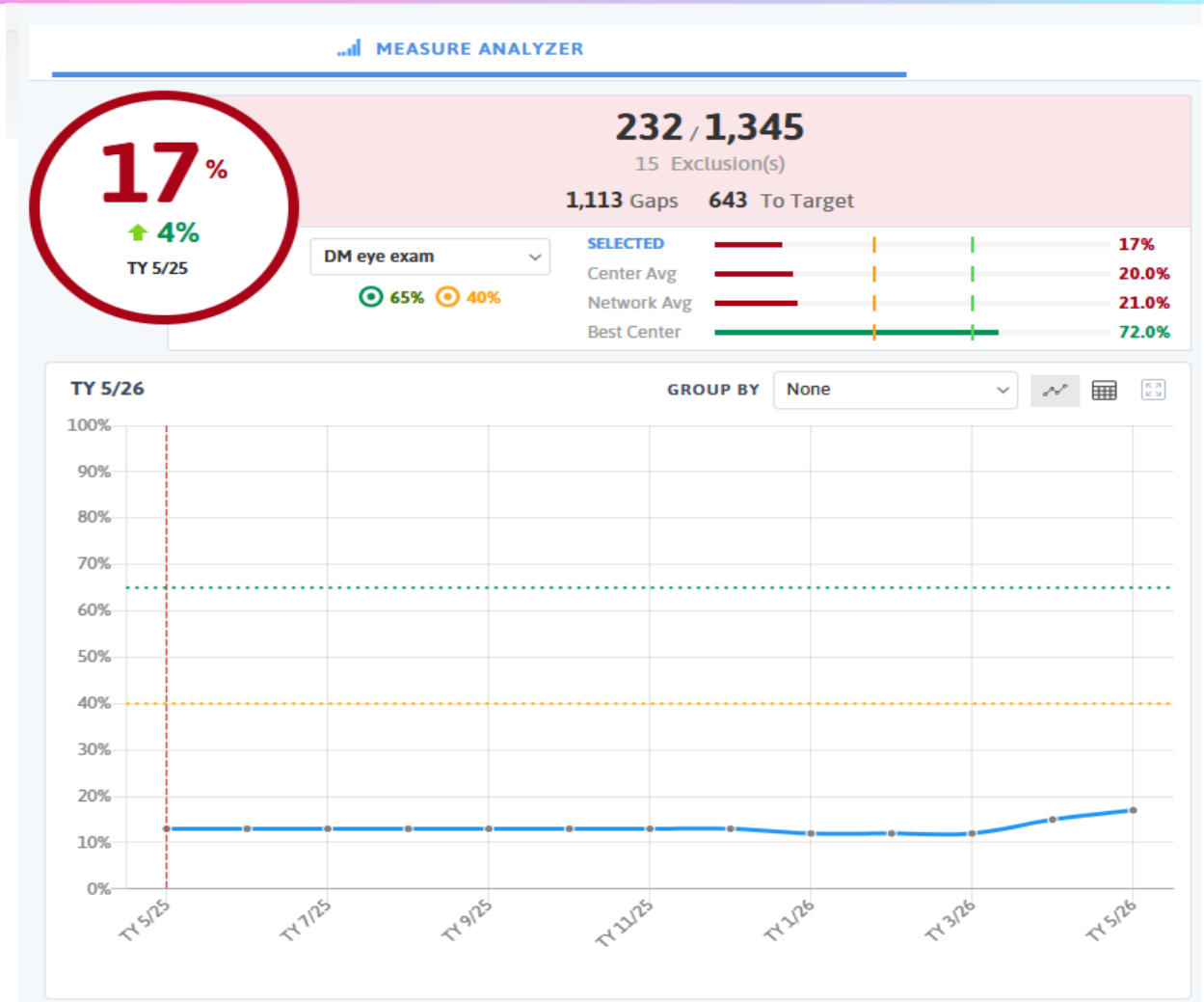
- Consistent documentation workflows are critical
  - some retinal reports were not attached correctly (due to rushing)
  - some encounters were combined with Provider encounter – need to be separate for billing purposes
- Additional outreach/reminders needed to reduce patient no-shows
- Additional staff training is needed to reduce the # of ungradable images
  - Observation and feedback session to improve technique

APPLYING LEARNINGS IN PDSA CYCLE 2

- Wrap up each patient visit (documentation) before moving on (Goal: 100% upload)
- Increase communication with site team regarding encounters.
- Conduct staff observation and feedback session to improve testing technique and image quality (Goal: 90% Gradable Images)
- Expand patient engagement strategies:
  - Reminder and patient education calls
  - Text campaigns
  - Patient incentive opportunities

DATA

(5/19/26)


MEASURE ANALYZER
17%
4%
TY 5/25
232 / 1,345
15 Exclusion(s)
1,113 Gaps
643 To Target
DM eye exam
65%
40%
SELECTED
17%
Center Avg
20.0%
Network Avg
21.0%
Best Center
72.0%
TY 5/26
GROUP BY
None
100%
90%
80%
70%
60%
50%
40%
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20%
10%
0%
TY 5/25
TY 7/25
TY 9/25
TY 11/25
TY 1/26
TY 3/26
TY 5/26

THANK YOU

Perinatal Care in Family and Pediatric Offices

Alicia Hartung, DO, IBCLC

Lisa G. Zur, MPH Health Innovations Program Manager

Kids Plus Pediatrics

PEDIATRIC ASSOCIATES
FAMILY OF COMPANIES

PCMH Sprint: June Update

Kids Plus Pediatrics

THEPAFC.COM

Who We Are

Located in Pittsburgh, we see patients from birth through age 21 at our 3 locations:

- 1 inside the city (Squirrel Hill/Greenfield)
- 1 north of the city (Cranberry/Seven Fields)
- 1 south of the city (Pleasant Hills)

Each office includes the Breastfeeding Center of Pittsburgh where we help infants and their moms initiate and manage breastfeeding.

What is an RCC?

- For 10+ years, we have employed social workers (RCC's) to help address SDOH, mental health, and developmental issues or any other needs our patients and families may have.
- RCC's are a part of of Behavioral Health team
- Resource and Counseling Coordinators (RCC): Provides emotional support, care coordination* services, connections to community-based resources, assistance in navigating medical, behavioral health and education systems, and communicates with medical and other support teams for pediatric patients and families

Perinatal Care in Family & Pediatric Practices:

- Began mid-February in the Cranberry/Seven Fields office
- Monitor postpartum moms through the Edinburgh Postpartum Depression Screen (EPDS) at 1, 2, 4, & 6 month well child checks to ensure moms that screen positive are identified, provided with resources and referrals, then receive personalized follow up

Perinatal Care in Family & Pediatric Practices: Sprint Goals

- Screen >85% of moms for postpartum depression at the 1, 2, 4, & 6 month well child visits using the EPDS
- A score of 9 or more will be referred to an RCC who will follow up within 2 business days, unless mom indicates thoughts of self harm (then follow up immediately in office)
- RCC follow up rate of >75% of moms who screen positive to provide mental health treatment/support resources
- A member of the Behavioral Health team will follow up and reach >50% of moms 1 month post encounter

Results as of April 2026

- Screened 93%+ moms with 2 positives
- 1 accepted resources and referrals
- 1 mom declined
- In April, due to low numbers, we added the Squirrel Hill/Greenfield office
- Screened 98%+
- Will review again in May and June, then add third and final office

Conclusion

We are pleased to see that 98%+ of moms are being screened at the early well child checks. The vast majority are not screening positive for postpartum depression.

*Reports are run based on billing data. Codes do not drop automatically due to EMR limitation so improperly coded screens/results could be missed.

Thank you!

Alicia Hartung, DO, IBCLC: Alicia.Hartung@PediatricAssociates.com

Lisa Zur, MPH: Lisa.Zur@PediatricAssociates.com

Behavioral Health Integration for Adolescents and Adults in Primary Care

Liz Leen, LCSW, Behavioral Health Program Manager

Family First Health

Family First Health's 2026 SPRINT Goal

- **Increase behavioral health (BH) integration for patients with uncontrolled hypertension and/or uncontrolled diabetes.**
- **Measures of Success:**
  - Achieving a 3% increase in the BH integration/penetration rate over the next 6 months.
  - Success will be measured by the proportion of patients with diagnoses of HTN and/or DM who receive a BH warm handoff, referral, or documented BH engagement as part of their primary care visit.

Work Prior to Sprint

August – September 2025

- **Completed 6 hours of training on integrated services models – presented by JBS International and HRSA**
  - 1 Hour for Medical Provider Champions
  - 2 Hours for BHC team , CRS team, School Based (BHA + manager) and CHW champions (5 from across all sites)
  - 2 Hours for Leadership (Medical Operations, Practice Managers, QI)
  - 1 Hour Planning Session

- Direct outcome of this work = Increased warm hand offs and collaboration btw BHC and PCP

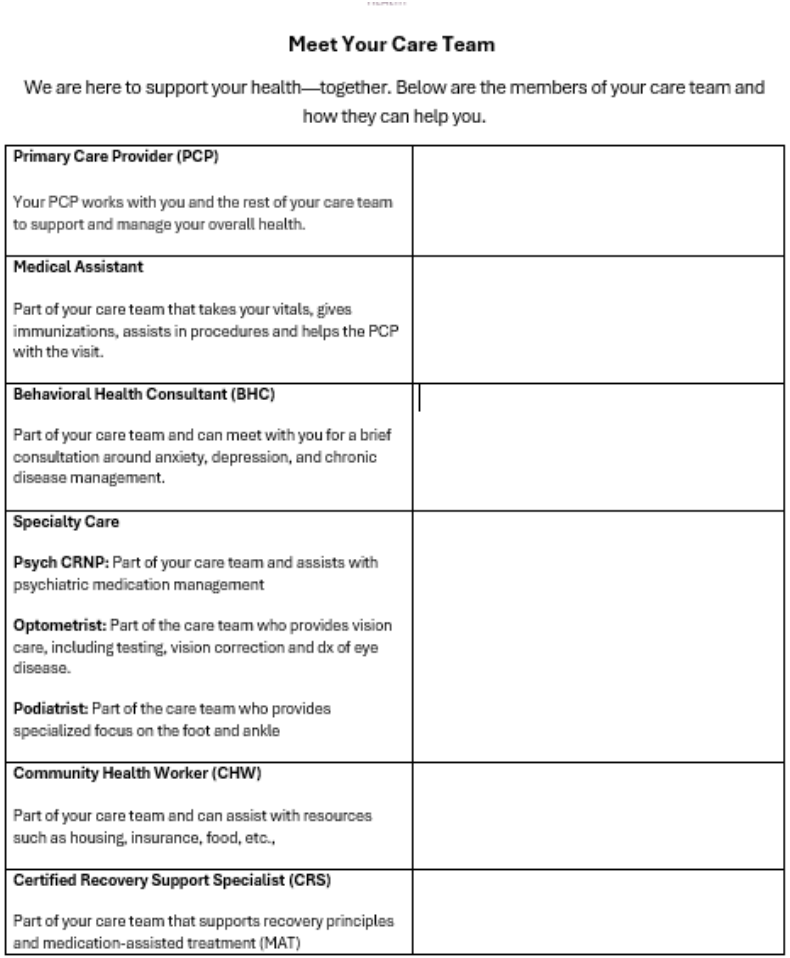
Interventions

- **Education to pilot sites**
  - (Hanover, Gettysburg, and George Street Locations)
- **Enhanced Chart Prep & Collect Baseline Data**
  - BHC's scrubbing PCP schedules for Uncontrolled DM and HTN
  - Established a tracking system for Chronic Condition WHOs
    - Created a searchable phrase
      - HTN:
      - DM:
  - Establishing clinical penetration rate
    - Percentage of medical patients who have had a behavioral health encounter

Interventions

Enhanced Education for Patients, Providers and Clinical Staff Members by:

- **Marketing Strategies**
  - Patient point boards in exam and waiting rooms
  - Get to Know your care team hand outs



Meet Your Care Team

We are here to support your health—together. Below are the members of your care team and how they can help you.

Primary Care Provider (PCP) Your PCP works with you and the rest of your care team to support and manage your overall health.	
Medical Assistant Part of your care team that takes your vitals, gives immunizations, assists in procedures and helps the PCP with the visit.	
Behavioral Health Consultant (BHC) Part of your care team and can meet with you for a brief consultation around anxiety, depression, and chronic disease management.	
Specialty Care **Psych CRNP:** Part of your care team and assists with psychiatric medication management **Optometrist:** Part of the care team who provides vision care, including testing, vision correction and dx of eye disease. **Podiatrist:** Part of the care team who provides specialized focus on the foot and ankle	
Community Health Worker (CHW) Part of your care team and can assist with resources such as housing, insurance, food, etc.,	
Certified Recovery Support Specialist (CRS) Part of your care team that supports recovery principles and medication-assisted treatment (MAT)	

Interventions

Creation of Training Videos

- Developed and Filmed Three Training Videos for onboarding and training
  - How to complete a Warm Hand Off (WHO), WHO for Chronic Conditions and WHO for Suicidal Ideation

Interventions

- **Trainings for the BHC's**
  - Hypertension (May)
    - How to provide patients with self-monitoring blood pressure cuffs
    - Brief three visit template on education and blood pressure control
  - Diabetes Control (June)

Case Study- Pedro

Uncontrolled Hypertension and Diabetes – Warm Hand Off

- Before entering the room, I check last A1C and Blood pressure reading
  - A1C: 12.8 (last 12/2025: 13.3)
  - HTN: 148/94 (04/29/2025)
  - PHQ9: 4/27; Question #9- negative

- Pedro was referred for uncontrolled DM and HTN
- **Presenting symptoms:** stopped taking medications for two months due to job stress, recent job loss, loss of health insurance and income and has illness fatigue, having diabetic neuropathy and foot drop
- **Current Supports:** Children (lives with son who manages his DM injections)

Case Study- Pedro

BHC completes assessment:

- Inconsistent medication adherence
- Lost job and health insurance
- Has already applied for medical assistance and disability
- Lives with his son, who manages his injections for DM – does not like shots but open to a Dexcom once insured
- Illness fatigue – does not take glucose levels
- High stress and anxiety due to lack of income and work
- No substance use reported
- Does not have a blood pressure cuff at home

Case Study- Pedro

BHC Interventions:

- Put blood pressure cuff together – put batteries in it
- Verified arm size for proper cuff sizing – (do they need an extra-large cuff?)
- Walk the patient through and demonstrate how to use the blood pressure cuff and log the recoding on the blood pressure diary
- Provided a handout on at home blood pressure measurements and marking where the patient falls on the chart.
- Provided psychoeducation around stress management, check in on medication adherence and other SDOH needs
- Give homework, even if they are not following up with you:
  - Homework: Pedro, will track his blood pressure 1x per day for the next 2 weeks until his next visit with PCP or BHC or Nurse Visit.
  - Pedro did not want to schedule individual follow – up but open to checking in next visit with PCP. PCP will call WHO for this patient to follow up with whichever BHC is on duty

American Heart Association recommended office blood pressure categories

BLOOD PRESSURE CATEGORY	SYSTOLIC mm Hg (top/upper number)		DIASTOLIC mm Hg (bottom/lower number)
NORMAL	LESS THAN 120	and	LESS THAN 80
ELEVATED	120–129	and	LESS THAN 80
STAGE 1 HYPERTENSION (High Blood Pressure)	130–139	or	80–89
STAGE 2 HYPERTENSION (High Blood Pressure)	140 OR HIGHER	or	90 OR HIGHER
SEVERE HYPERTENSION (If you don't have symptoms*, call your health care professional.)	HIGHER THAN 180	and/or	HIGHER THAN 120
HYPERTENSIVE EMERGENCY (If you have any of these symptoms*, call 911.)	HIGHER THAN 180	and/or	HIGHER THAN 120

*symptoms: chest pain, shortness of breath, back pain, numbness, weakness, change in vision or difficulty speaking

148/94

Handouts are from American Heart Association: heart.org/BP

Preliminary Findings

- Patients without the correct dx codes
  - Example:
    - A1C is 9 but no DM dx
    - Uncontrolled still listed but now controlled
    - 2 out of 65 WHOs were for chronic conditions
- American Heart Association
  - Leverage to get more cuff's allotted to FFH
- Limitations with marketing

Next PDSA Cycle

- Disseminate training videos
  - Onboarding and training for new clinical staff
  - Current staff

- Identify Additional Education Gaps
  - Diagnostic clarity
  - Increased comfortability for BHCs with Chronic Conditions

- Monitor Penetration Rate

Pediatric Nursing Care Sprint

Kayla Whalen, RN, Nurse Care Coordinator
UPMC Children's Community Pediatrics

IMPROVING ENGAGEMENT AND PARTICIPATION ACROSS OFFICES: PCMH / PNC QUALITY IMPROVEMENT PROJECT

Enhancing collaboration to boost healthcare quality initiatives

UPMC Children's Community Pediatrics

PROJECT CONTEXT AND PROBLEM DEFINITION

PROJECT BACKGROUND AND PURPOSE

Project Focus and Goals

The project aims to improve consistent engagement in PCMH initiatives, emphasizing the PNC program across all offices.

Challenges and Variation

Variation in office participation causes uneven implementation, reduced reliability, and missed patient care opportunities.

Alignment and Standardization

Clarifying expectations, strengthening training, and reinforcing workflows help align offices for consistent care delivery.

Outcomes and Organizational Alignment

The project supports reliable processes, better patient experiences, and aligns with goals like value-based care and sustainability.

PROBLEM STATEMENT AND IMPACT OF INCONSISTENCY

Inconsistent Engagement Across Offices

Participation in PCMH initiatives varies by office location, causing inconsistent workflows and program execution.

Impact on Care Quality and Staff Efficiency

Inconsistency negatively affects care quality, staff efficiency, and hampers meeting performance benchmarks.

Operational and Patient Experience Effects

Variable processes create uneven patient experiences and limit operational benefits like incentives and reimbursements.

Importance of Defining Core Problems

Focusing on root causes ensures targeted improvements and reinforces alignment for high-quality care delivery.

CURRENT STATE ANALYSIS AND ROOT CAUSES

UNDERSTANDING THE CURRENT PROCESS

Staffing Variability Challenges

Fluctuations in staffing cause coverage gaps and inconsistent task completion across offices.

Inconsistent Training and Onboarding

Non-standardized training leads to differences in staff knowledge, confidence, and performance.

Uneven Workflow Adherence

Teams vary in following workflows, sometimes bypassing steps due to time or complexity.

Communication Gaps

Lack of clear updates and reinforcement causes misunderstandings and fragmented processes.

ROOT CAUSES DRIVING VARIABILITY

Staffing Fluctuations Impact

Inconsistent staffing affects reliable completion of PCMH tasks and prioritization of immediate clinical needs.

Uneven Buy-In to Practices

Limited understanding and leadership support reduce staff commitment to standardized workflows.

Variability in Training

Inconsistent training leads to different interpretations and execution of PCMH expectations.

Limited Feedback Mechanisms

Lack of timely feedback hinders early issue identification and support provision.

GOALS AND PLANNED PROCESS CHANGES

MEASURABLE IMPROVEMENT GOALS

Standardized Training Objective

Aim to train 90% of team members by end of 2026 to ensure a consistent understanding of workflows and expectations.

Raising Program Awareness

Improve awareness of the PNC program among managers and providers to highlight its benefits on care quality and reimbursements.

Tracking and Alignment

Use specific, time-bound goals to track progress and align daily activities with organizational priorities.

Expected Outcomes

Achieving goals will enhance participation, care quality, and financial performance across offices and teams.

PLANNED CHANGES TO THE PROCESS

Standardized Training and Documentation

Training and expectations will be standardized with clear, accessible documentation to unify staff understanding and workflows.

Standardized Workflow Development

A clear, standardized workflow will outline each process step to reduce ambiguity and ensure consistency across teams.

Regular Check-Ins and Feedback

Introducing routine check-ins and feedback loops to monitor progress, identify challenges, and provide real-time coaching.

Tracking Tools for Consistency

Use of simple tracking tools like checklists and audits to measure consistency and pinpoint gaps promptly.

MEASUREMENT STRATEGY AND STUDY PHASE FINDINGS

MEASURES TO TRACK IMPLEMENTATION AND PROGRESS

Staffing Coverage Monitoring

Monthly check-ins with practice managers ensure adequate staffing support for program implementation.

Workflow Adherence Audits

Audits with checklists or spot checks measure compliance with standardized workflow processes consistently.

Training Completion Tracking

Tracking training completion rates shows progress toward the target of 90% trained staff.

Staff Feedback Collection

Surveys and informal check-ins collect staff input on expectations and barriers to buy-in.

STUDY PHASE RESULTS AND KEY LEARNINGS

Staffing Coverage Challenges

Staffing coverage improved but remains inconsistent at about 73%, below desired levels.

Training Completion Rates

Most staff complete standardized training, indicating effective educational efforts.

Workflow Adherence and Pressure

Workflow adherence improves but gaps occur during high-volume, high-pressure periods.

Process Reliability and Feedback

Process reliability shows improvement; staff feedback notes clearer expectations and rising confidence.

ACT PHASE ADJUSTMENTS AND ONGOING IMPROVEMENT

PLANNED ADJUSTMENTS IN THE ACT PHASE

Staffing Consistency Improvements

Adjust schedules and cross-train staff to reduce gaps and improve coverage during peak times.

Workflow Refinement

Simplify confusing workflow steps to enhance usability and efficiency under pressure.

Enhanced Supervisor Support

Increase coaching frequency and quick check-ins during high-volume periods for better guidance.

Updated Training and Communication

Revise training materials and improve communication with reminders, job aids, and feedback summaries.

ONGOING STRATEGY, FEEDBACK, AND NEXT STEPS

Emphasizing Participation and Communication

The team focuses on ongoing communication, leadership involvement, and education to maintain program participation.

Monitoring and Improvement

Chart audits help monitor compliance and identify areas for improvement in patient care quality.

Support and Training

Ongoing support for enrolled offices and focused training for remaining offices drives engagement.

Learning Network and Future Plans

The team values peer collaboration and plans to expand learning opportunities and troubleshooting sessions.

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 Sprint Session #3

2026 Sprint Session #3 Dates

Comprehensive Diabetes Care & Health Equity

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

Perinatal Care in Family & Pediatric Offices

Tuesday, June 23rd at 1 – 2:30 pm

Behavioral Health Integration in Primary Care for Adults & Adolescents

Thursday, July 9th at 9 – 10:30 am

Pediatric Nursing Care

Tuesday, July 14th at 1 – 2:30 pm

**Remember to ensure you are receiving emails from J. at Ashenayi@jhf.org*

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.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/ZXG5XTN by Tuesday, June 9th

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 June 9th 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.
   - ❑ Please plan to check 2 weeks after the session to ensure your credits are showing up in the UPMC CCE system

Thank You!