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 Pediatric Nursing Care Sprint Session #3

July 14, 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

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 an example of how PCMH-PNCs can improve the patient and family transition from pediatric to adult care
- ✓ Discuss how PCMH-PNC teams can use tools like Gemba Walks and the RACI matrix to define roles and standard work for PCMH-PNC Case Managers
- ✓ Discuss progress in PCMH-PNC quality improvement projects
- ✓ Describe strategies to implement the second PDSA sprint cycle

PCMH Spotlight: WellSpan Community Health Center

Community Health Center Complex Care Clinic

LuAnn Hess, Sr. Clinical Director

July 14, 2026

Why is a Complex Care Clinic Needed?

- Children and youth with special healthcare needs require specialized, coordinated care to effectively address their unique medical, behavioral, and social needs.
- Within WellSpan, the Community Health Center cares for the majority of these patients and has providers with experience and expertise in managing complex pediatric conditions.
- Creating a dedicated care model that leverages provider expertise, Case Management, and ancillary services can improve coordination and streamline care delivery.

WellSpan Health

Problem Statement

- When patients with complex or high-risk conditions are not connected to the right level of support at the right time, their care becomes fragmented.
- This can result in higher utilization, increased caregiver stress, avoidable ED visits or hospitalizations, and poorer patient outcomes.
- Strengthening team alignment will ensure that every patient receives coordinated, proactive, and appropriate support throughout their care journey.
- By improving our internal processes, we will enhance care continuity, reduce confusion for both staff and families, and better fulfill the core PCMH goals of comprehensive, patient-centered, and well-coordinated care.

WellSpan Health

Why This Matters

- Timely connection to the appropriate level of support is essential for patients with complex and high-risk conditions.
- Delays or gaps in support can lead to fragmented care, resulting in:
    - Increased healthcare utilization
    - Higher caregiver stress
    - Avoidable Emergency Department (ED) visits and hospitalizations
    - Poorer patient outcomes

Impact of Improvement

- Strengthen team alignment and role clarity.
- Ensure patients receive coordinated, proactive, and appropriate support throughout their care journey.
- Improve care continuity and communication across the care team.
- Reduce confusion for staff, patients, and families.
- Advance core PCMH goals of:
    - Comprehensive care
    - Patient-centered care
    - Coordinated care

Desired Outcome: A reliable, coordinated process that connects high-risk patients with the right resources at the right time, improving outcomes and enhancing the patient experience.

Current Understanding

- Our team has conducted Gemba walks and performed direct observations to better understand the current workflow and identify areas of inefficiency.
- These activities have provided valuable insights into how processes are carried out in real time. However, we have also identified a need for a clearer and more comprehensive understanding of individual roles and responsibilities within the workflow.
- Gaining this clarity will help us more accurately assess gaps, reduce variation, and ensure that improvement efforts are aligned with the actual duties and expectations of each team member.
- In the current model, children with complex health care needs may appear anywhere in a provider schedule. This makes it difficult to provide necessary resources, as supportive services (e.g., Case Management, Dietary, etc.) may not be readily available.

WellSpan HEALTH

Proposed Change

A detailed RACI is being developed to clarify role expectations, enhance accountability, and support consistent coordination across the team.

The proposed future-state care model includes the implementation of a dedicated Complex Care Clinic to provide coordinated, comprehensive care for patients with complex needs.

Care Team and Development of RACI

A	B	C	D	E	F	G	H	I
Task / Activity	**Examples**	**Physician**	**RN Navigator**	**Care Management / Social Work**	**Dietician**	**Clinical Staff**	**Front Office Staff**	**Centralized Services**
LOMN	ongoing (q6 months) and initiation							
Transportation - one-time	can't make a specific appointment							
Transportation - ongoing	can't make most appointments							
Post-hospitalization follow-up	determining if need sooner appt							
Post-ED follow-up	determining if need sooner appt							
Contacting specialist for initial referral	Pt referred to Pediatric Pulmonology at HMC							
Contacting specialist for result of referral	Pt saw Pediatric Pulmonology at HMC two weeks ago							
Special Formulas/Feeds								

Proposed Complex Care Clinic Model

Proposed Pediatric Complex Care Clinic Model

Clinic Structure

- Dedicated **Complex Care Clinic held one day per week**
- Clinic operates during a **full-day session**:
  - Morning: **8:30 AM – 12:00 PM**
  - Afternoon: **1:00 PM – 4:30 PM**

Patient Scheduling

- **14 patients scheduled per clinic day**
- **60-minute appointment slots** for each patient

Provider Coverage

- Clinic staffed by a Community Health Center pediatrician

Integrated Team-Based Care

- Approximately **30 minutes** dedicated to provider-patient/family interaction
- Remaining time focused on:
  - Care coordination
  - Case management
  - Multidisciplinary support services (e.g., Clinical Dietitian)
- Support staff dedicated to the clinic and available on-site throughout the day

WellSpan Health

Measures To Track Change

Barriers to Implementation

Staffing and Workflow Challenges

- Additional staffing resources are needed to support the care management functions required for the Complex Care Clinic.
- Current care management workflows differ from the proposed clinic model and will require redesign and standardization.
- Dedicated time for care coordination, case management, and ancillary support services must be identified and allocated.
- Clear role definition and resource alignment are needed to ensure successful implementation and sustainability.
- Workforce capacity constraints may impact the ability to fully execute the proposed multidisciplinary care model.

Impact: Without adequate staffing and workflow alignment, implementation may be delayed and the clinic's ability to provide comprehensive, coordinated care may be limited.

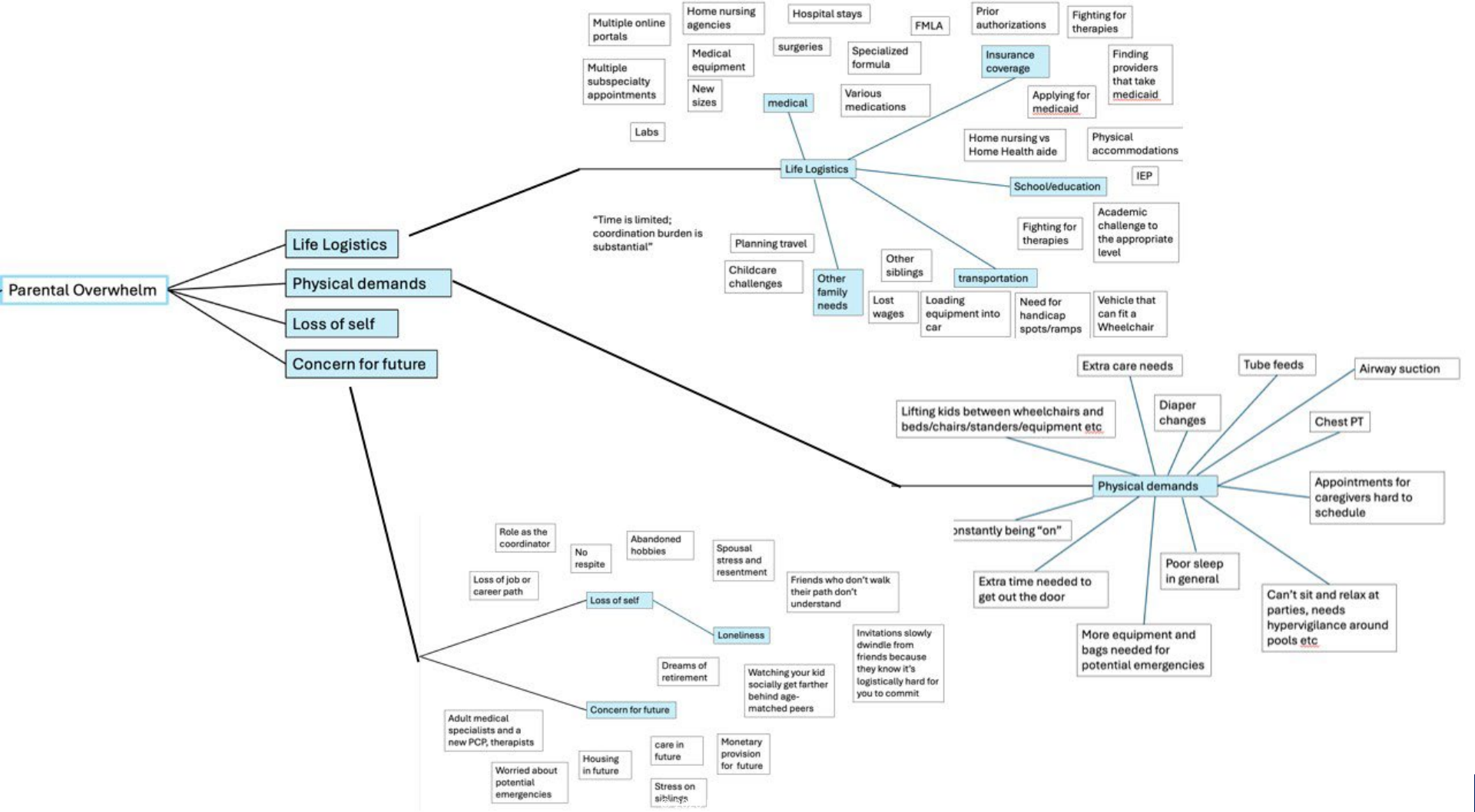
WellSpan HEALTH

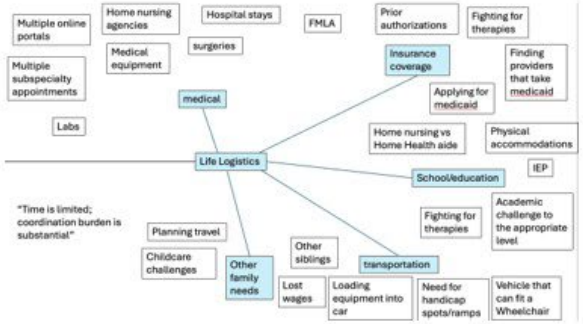
PCMH Spotlight:
LG Health Physicians
Roseville Pediatrics

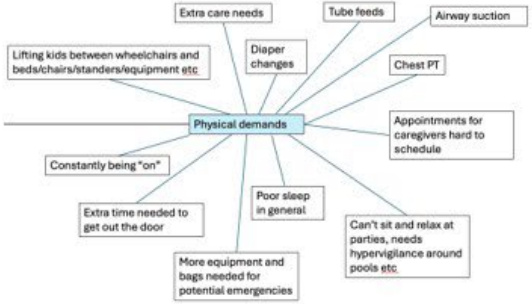
PCMH Sprint Session #4
Roseville Pediatrics Lancaster General Health Penn Medicine
Presentation of Project and Progress:

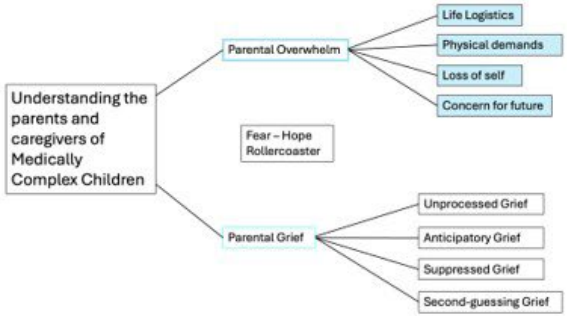
Creating and Implementing a Curriculum for the Transition of Care for Medically Complex Pediatric Patients to Prepare for Adult Care Needs

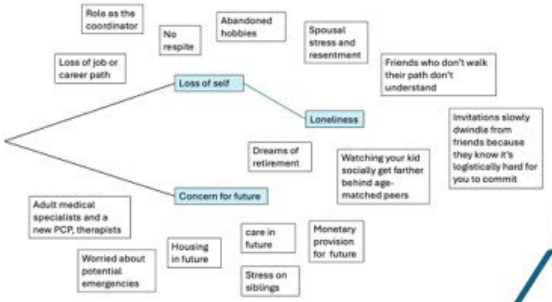
Joan Thode, MD
Lauren Duff, RN, BSN


Parental Overwhelm
Life Logistics
Physical demands
Loss of self
Concern for future
Multiple online portals
Home nursing agencies
Hospital stays
FMLA
Prior authorizations
Fighting for therapies
Medical equipment
surgeries
Specialized formula
Insurance coverage
Finding providers that take medicaid
Multiple subspecialty appointments
New sizes
medical
Various medications
Applying for medicaid
Labs
Home nursing vs Home Health aide
Physical accommodations
Life Logistics
IEP
School/education
"Time is limited; coordination burden is substantial"
Planning travel
Fighting for therapies
Academic challenge to the appropriate level
Other siblings
Childcare challenges
Other family needs
transportation
Lost wages
Loading equipment into car
Need for handicap spots/ramps
Vehicle that can fit a Wheelchair
Extra care needs
Tube feeds
Airway suction
Lifting kids between wheelchairs and beds/chairs/standers/equipment etc
Diaper changes
Chest PT
Physical demands
Appointments for caregivers hard to schedule
onstantly being "on"
Poor sleep in general
Extra time needed to get out the door
Can't sit and relax at parties, needs hypervigilance around pools etc
More equipment and bags needed for potential emergencies
Role as the coordinator
Abandoned hobbies
No respite
Spousal stress and resentment
Loss of job or career path
Friends who don't walk their path don't understand
Loss of self
Loneliness
Invitations slowly dwindle from friends because they know it's logistically hard for you to commit
Dreams of retirement
Watching your kid socially get farther behind age-matched peers
Concern for future
Adult medical specialists and a new PCP, therapists
care in future
Monetary provision for future
Housing in future
Worried about potential emergencies
Stress on siblings









Often birth trauma, loss of a "normal experience" that becomes fresh grief every time there's an extra hardship for their kid that other kids don't experience

Dread and pre-grieving, especially related to terminal illness or a progressive condition

Guilt about one's feeling angry or sad about their situation when others have a comparatively worse situation: "Well, at least my kid doesn't have X, so I should be thankful."

Sadness and persistent worry that they are making the wrong decision for their child in the moment while not being able to perfectly predict the future.

Grief over lost friendships and changed relationships, including friends, spouse, family members, and the child themselves

Problem 1: On a day-to-day basis, parents of medically complex children are juggling a considerable amount of stress and coordination, often superseding planning for the future

Problem 2: Parents are not aware of all of the aspects of their child's future care that require preparation, most of which falls outside of the direct medical care

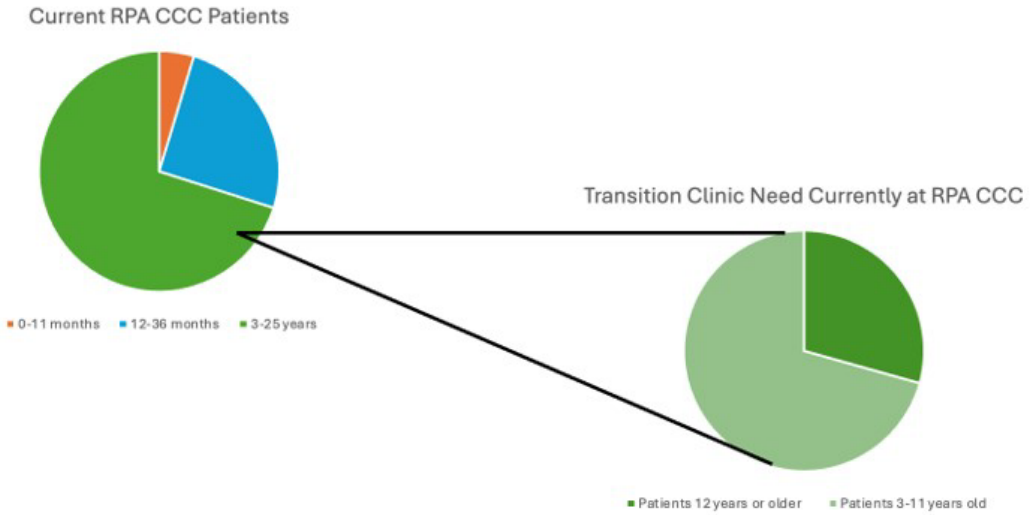
Problem 3: Parents are often unprepared legally and financially for the provision for their medically complex child's adult life, and these are harder to establish after the child turns 18 yrs old.

Problem 4: Gaps in healthcare and financial strain on families of adult patients with medical complexity often lead to extended hospital stays, a burden to the healthcare system, and a significantly decreased quality of life for the patient

PCMH Sprint Project: Establish a curriculum and roadmap for families of children with medical complexity to follow within and outside of our Complex Care Clinic such that this preparation starts at age 12, education of the needed planning and resources is integrated into the patient's care, and all needed legal, medical, and financial coordination is completed by their 18th birthday

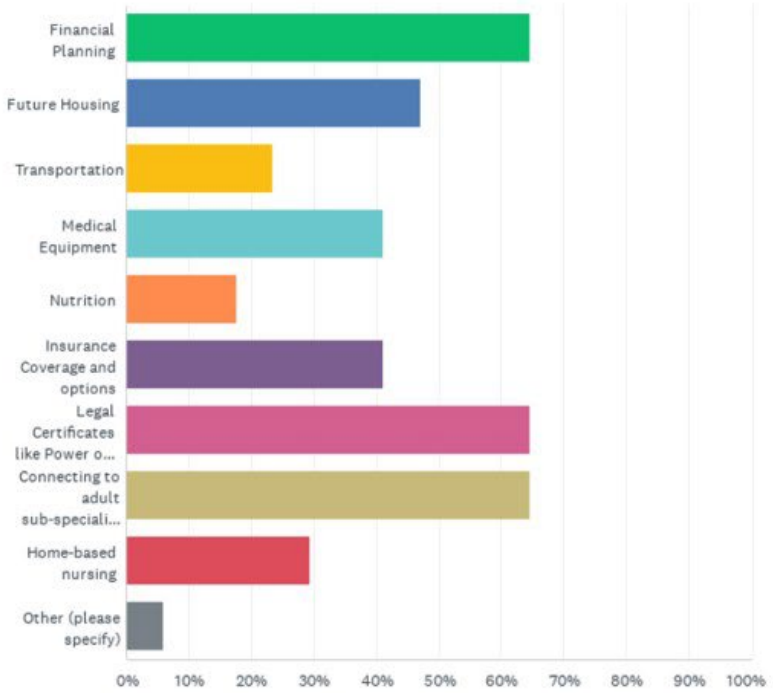
Progress through Cycle 1

- Preliminary data through patient surveys
- Establishing the categories for the curriculum
- Enlisting patients/families to be in our initial cohort for the Transition of Care Clinic (TOC)



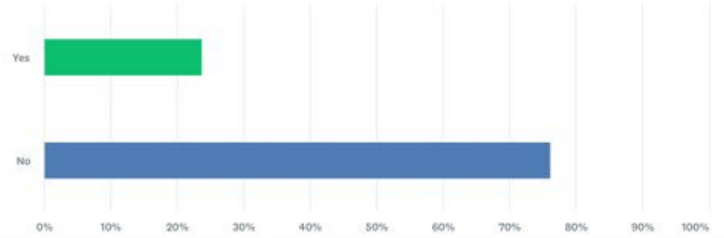
Survey Data - Preliminary

What areas do you currently feel you would need additional support in getting connected/resources for your child's future (select all that apply)?



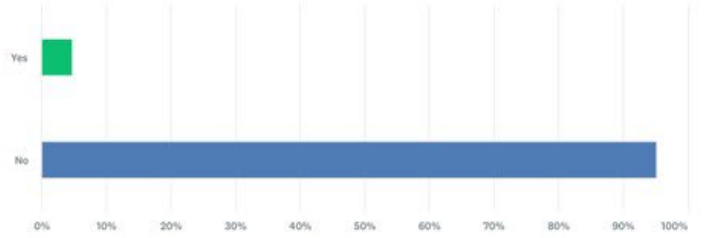
Are you knowledgeable about the steps to take to enroll your child in adult health insurance?

Answered: 21 Skipped: 0



Have you established legal guardianship for your child once they turn 18? If this has already occurred, please answer as of their status at their 18th birthday.

Answered: 21 Skipped: 0



Progress through Cycle 2

- Design of the curriculum
- Create a binder of resources for reference that follows the sections of curriculum
- Create a mock binder that we would give to patients for them to use in the clinic/fill out at home

Outline of our Curriculum

1. Medical Professionals
    a. Current Pediatric docs, nutritionist, and their contact numbers
    b. Intended adult equivalent docs, nutritionists
    c. Ability to free-write in appt times under each dr name entry

2. Therapies
    a. Listed current therapies and therapists
    b. Intended adult therapy equivalents
    c. Ability to free-write in appt times under each dr name entry

3. Nutrition
    a. Current feeds
    b. Click boxes with oral vs GT vs JT vs NG
    c. Current nutritionist
    d. Intended adult nutritionist

4. Medical Equipment
    a. DME company
    b. Intended DME company in adult life
    c. List of equipment
    d. Orthotist contact
    e. Equipment maintenance companies and contacts
    f. Ventilator contact
    g. Home oxygen company contact

5. Medications
    a. List of meds
    b. Pharmacy contact information

6. Home nursing services
    a. Current service and nurses
    b. Intended adult nurse service
    c. Current Supports Coordinator through County name and #
    d. Adult support waiver funding status

7. Care Coordination Staff
    a. BHDS supports coordinator
    b. County-based advocate
    c. BHDS Intellectual and Dev Disability branch contact
    d. Social Worker
    e. Medical care nurse coordinator
    f. Special needs unit Case worker
    g. Lawyers

Curriculum cont.

8. Legal
    a. Legal POA for child
    b. Legal Representative
    c. Parental Living will
    d. Child's living will
    e. Legal Guardianship
    f. Estate planning

9. Financial
    a. Financial planning team members and info
    b. Estate Planning
    c. Special Needs trust
        i. First party
        ii. Third party
    d. Able account information
    e. SSI
    f. Other governmental benefits

10. Housing and Transportation
    a. Current housing
    b. Future housing plans
    c. Current transportation needs
    d. Future transportation needs and plans

11. Insurance
    a. Current Medicaid
    b. Current other insurance
    c. Application status for adult medicare
    d. Application status for adult medicaid

12. Quality of Life
    a. Hobbies
    b. Interests
    c. Social groups
    d. Camps
    e. Potential job interests/skill sets
    f. Educational plans
    g. Quality-of-Life Plan

Forms links:

1. HIPPA Release form
2. POA form
3. Guardianship form
4. Specific camp forms (AA, graystone, etc)
5. Quality-of-Life Plan
6. Link to the PEEL educational planning tool

Progress through Cycle 3

Enrollment of 4 initial families

Preparation of pre-, during-, and post-surveys to gauge level of understanding and action on the categories that have been addressed in TOC clinic

Administer first pre-survey and put together physical binders etc.

Schedule and see current patients in office TOC Clinic

Lessons Learned from the First 2 sprint sessions now integrated into our project:

- Existence of PCCRCs and our region's contact
- Importance of obtaining regular (scheduled) feedback from not only the parents/patients but also the staff involved in the clinic's day-to-day logistics and day-of clinical coordination
- Information of improving LOMNs for obtaining shift care services
- Hearing about the structure of other programs and how they approach similar difficulties to ours

Planned Roadmap of our Project in final stages, Plan for long-term integration within our clinic

Each pt under age 3 = follows the typical WCC schedule.

Every pt 3-11 yrs = 2 visits per year (WCC + 6 month follow-up coordination appt)

Every patient 12-20 yrs = 3 visits per year (WCC + 6 month follow-up coordination appt + Transition clinic)

Binders

Phone follow-up with CCM coding

Surveys – use to guide improvements; publish data

Adding to our resources binder

Matching up with a lawyer and financial planning firm that specifically do estate planning for child

Grant for an App

Q&A

Thank you!

Joan.thode@pennmedicine.upenn.edu

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

Discussion Questions

1. Briefly describe your PCMH's goal, intervention(s), and findings for the first PDSA cycle.
2. How have your early findings influenced the focus of your second PDSA cycle?
3. As you move into the second PDSA sprint, what implementation challenges are you anticipating, and what strategies are you considering to address them?
4. Thinking about the strategies discussed by today's speakers, what ideas or approaches are most relevant to your practice's next phase of improvement work?

Next Steps, Wrap Up & Session Evaluation

J. Ashenayi, Program Associate

Pittsburgh Regional Health Initiative

Next Steps from Today's Session

1. Update your PDSA plan
2. Reach out with any questions or to request 1:1 support or TA
3. Register for the final sprint session, the final in-person wrap-up session, and supplemental sessions

2026 PCMH Learning Network

4th Sprint Session & November 10th In-Person Session

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

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

Final In-Person Session

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

Supplemental Sessions

HIV Screening, Prevention, and Treatment
July 29, 2026 (*New*)
9:00 am – 10:00 am

Community Home Health Referrals
September 8, 2026 (*New*)
9:00 am – 10:00 am

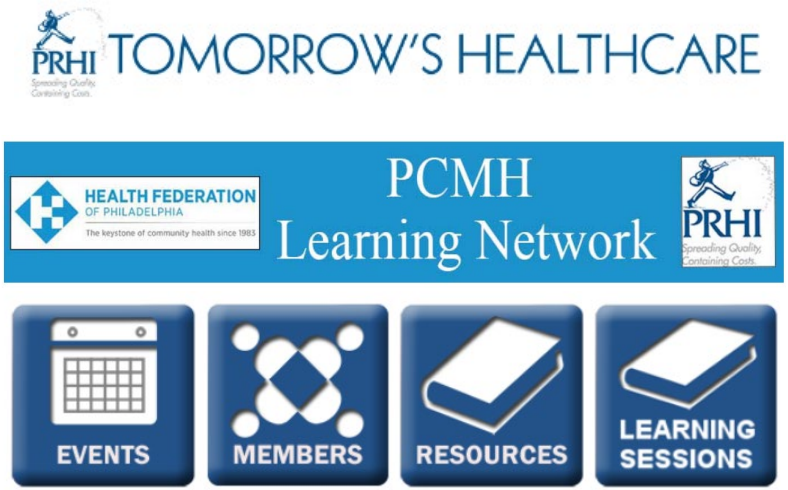
Oral Cancer Prevention and Early Detection
September 24, 2026
9:00 am – 10:00 am

Contraceptive Care: IUD Pain Management
October 29, 2026
9:00 am – 10:00 am

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/7VB8YDD by Tuesday, July 21st

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 July 21st 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!