

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.**

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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.

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.



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.

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

Measures To Track Change

RACI Completion: Approved RACI for all clinic roles



Staff Training: 100% completion



Decreased ED/Urgent Visit utilization



Reduced no show rate



Increased patient and provider satisfaction



Schedule and provider utilization target: 100%

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.



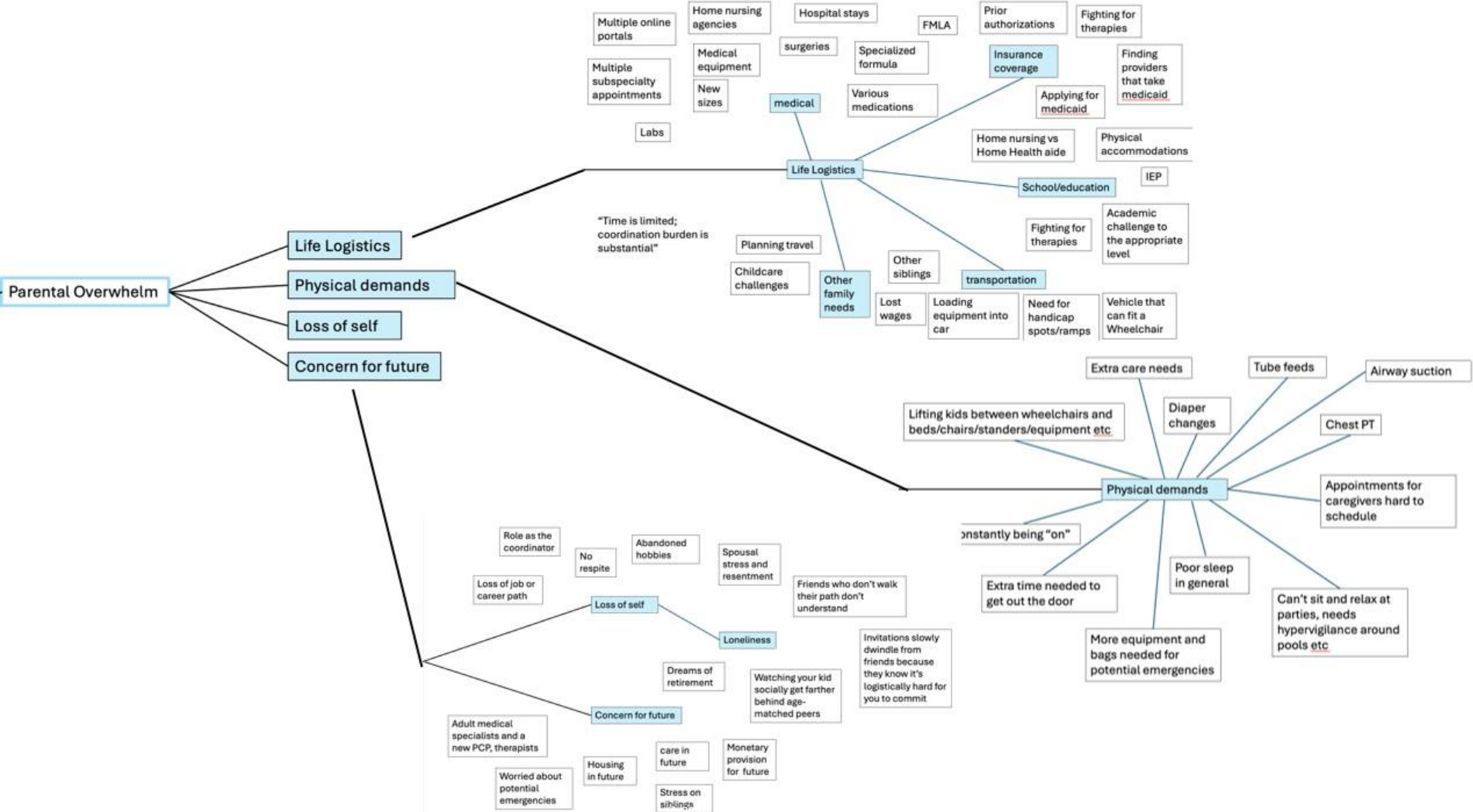
PCMH Spotlight: LG Health Physicians Roseville Pediatrics

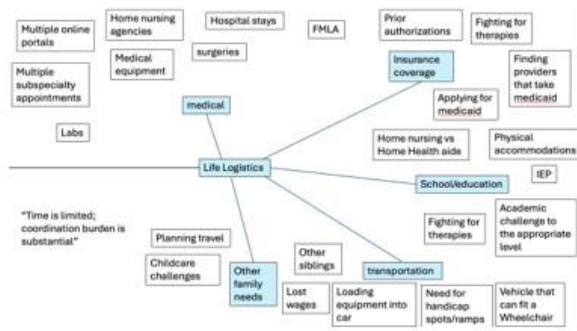
PCMH Sprint Session #4
Roseville Pediatrics Lancaster General Health Penn Medicine
Presentation of Project and Progress:

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







Understanding the parents and caregivers of Medically Complex Children



- 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

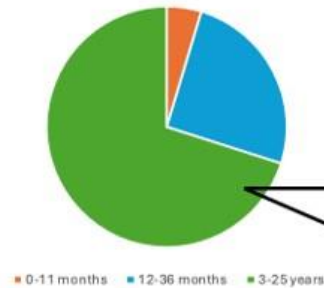
Progress through Cycle 1

Preliminary data through patient surveys

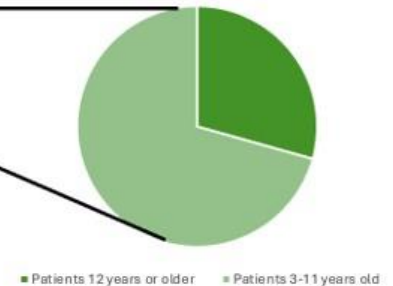
Establishing the categories for the curriculum

Enlisting patients/families to be in our initial cohort for the Transition of Care Clinic (TOC)

Current RPA CCC Patients

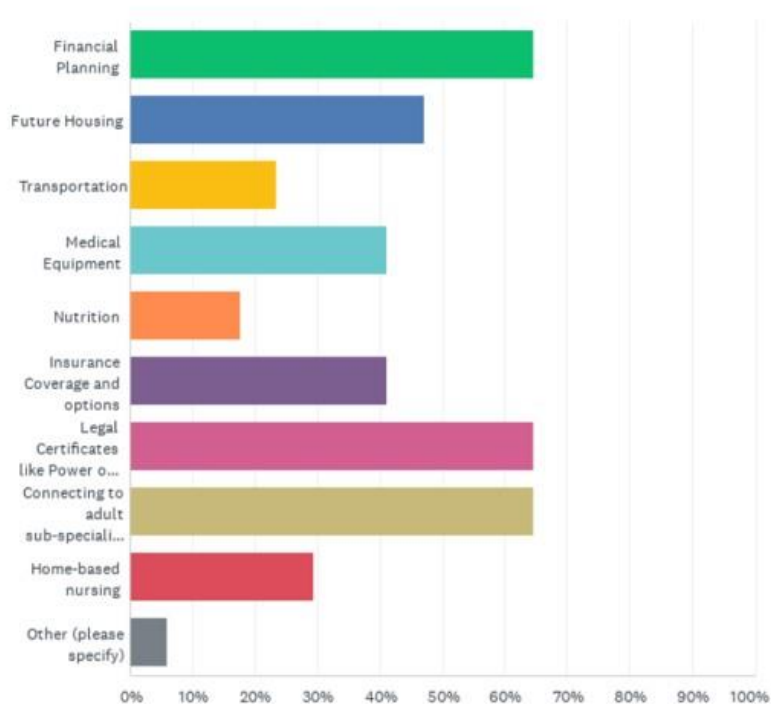


Transition Clinic Need Currently at RPA CCC



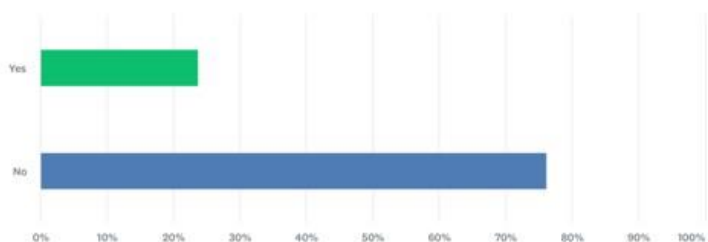
Survey Data - Preliminary

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



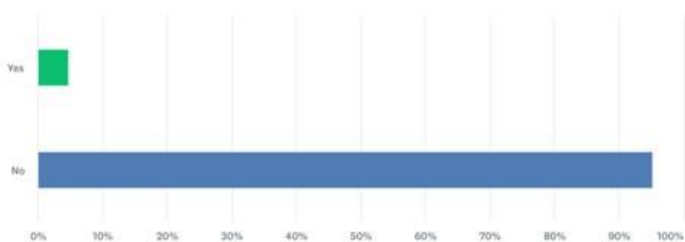
Are you knowledgeable about the steps to take to enroll your child in adult health insurance?

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

3. Nutrition

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

5. Medications

- a. List of meds
- b. Pharmacy contact information

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

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

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

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

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

10. Housing and Transportation

- a. Current housing
- b. Future housing plans
- c. Current transportation needs
- d. Future transportation needs and plans

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

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

11. Insurance

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

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

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

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

Supplemental Sessions

HIV Screening, Prevention, and Treatment

July 29, 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

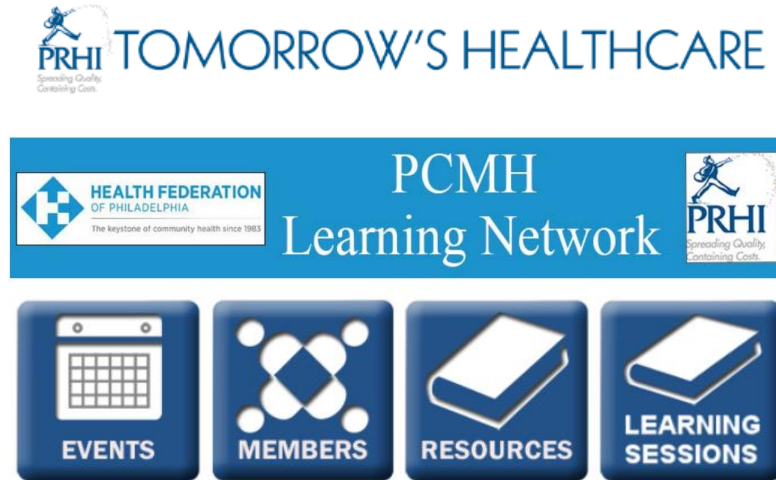
9:00 am – 10:00 am



PCMH Online Community

<https://www.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/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!
