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Restrooms are located on each floor.

Free guest Wi-Fi is available. Use the network name **Hilton Honors** and password **112026**

Check your program for the schedule, including break and lunch times.

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2026 PCMH Learning Network Statewide Event

November 10, 2026

Pittsburgh Regional Health Initiative &

Health Federation of Philadelphia

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Learning Objectives

- ✓ Describe the evolution of the HealthChoices PCMH and PCMH-PNC Programs from the perspectives of the PA DHS, MCOs, and PCMHs
- ✓ Describe strategies to help patients maintain Medicaid coverage in 2027
- ✓ Discuss tactics, results, and lessons learned from the PCMHs' Plan, Do, Study, Act cycles in the PCMH Learning Network's 2026 Sprints

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Learning Objectives

- ✓ Recognize the achievements of the PCMHs' in the PCMH Learning Network's 2026 Sprints
- ✓ Describe the goals and topics for the PCMH Learning Network's 2027 Sprints
- ✓ Prepare for the PCMH Learning Network's 2027 Sprints

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Physical HealthChoices MCOs















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HealthChoices PCMH and PCMH-PNC Programs: History, Evolution, and Future Directions

David K. Kelley, MD, MPA, Chief Medical Officer, Office of Medical Assistance Programs, PA Department of Human Services; **Gwendolyn B. Zander**, Esq. Director, Bureau of Managed Care Operations, Office of Medical Assistance Programs, PA Department of Human Services

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Patient Centered Medical Homes and Pediatric Nursing Care

Dr. David Kelley, Chief Medical Officer

Gwendolyn Zander, Director of Managed Care Operations

Office of Medical Assistance Programs

History of PCMHs

- **Planning began in 2016 under the Wolf Administration, and requirements were added to the 2017 HealthChoices Agreement**
  - Elected not to use ACA health home or NCQA accreditation due to reporting requirements and instead developed a unique Pennsylvania model through iterative, intensive stakeholder input over a year or so
    - Legislatively-mandated Advisory Council was convened and issued a report in 2019
      - Act 198 of 2014
  - Added $1.00 PMPM to rates, has increased to $1.50 PMPM

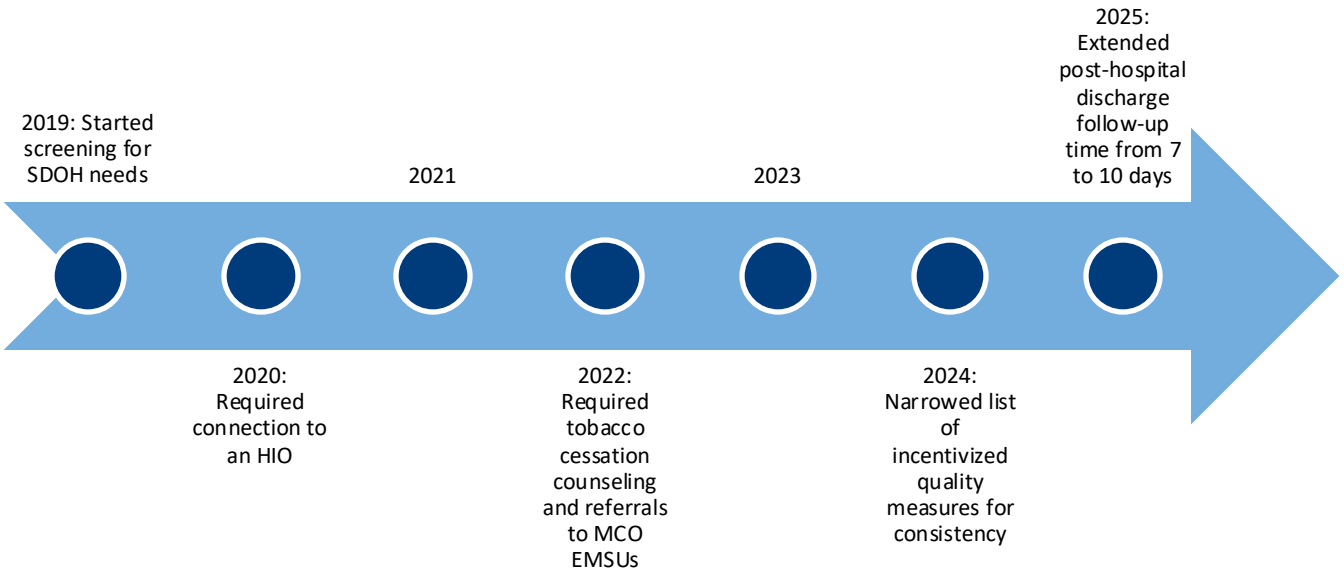
History of PCMH-PNCs

Pennsylvania
Department of Human Services

- **Convened MCOs, home health agencies, and family representatives over 18 months to develop a White Paper of strategies to improve pediatric shift care in Pennsylvania**
  - One set of recommendations centered around service coordination, including the option to provide medical homes for children with medical complexities that would take the lead for coordinating all of the children's care and meeting family's needs
- **ARPA Funding was provided by the federal government, and CMS approved DHS's proposal to use some of these funds to create PCMH-PNCs in at the end of 2021**
  - Added to the 2023 HealthChoices Agreement
  - Will continue after ARPA funding expires in 2026

Evolution of PCMHs

Pennsylvania
Department of Human Services



PCMHs by the Numbers

Pennsylvania
Department of Human Services

	2025	2024	2023	2022	2021	2020	2019	2018
Number of PCMHs	1,906	1,428	1,700	1,744	2,229	1,835	1,939	1,058
Number of PNCs	152	154	6					
Number of Members in PCMH	819,699	826,923	931,815	994,084	1,040,164	898,730	778,430	697,063
Number of Members with SPMI	109,890	104,445	123,979	129,116	123,809	106,162	96,300	83,574

PCMH Quality Outcomes

Pennsylvania
Department of Human Services

P4P Quality Metrics	2025 Average	2025 vs 2024	2024 Average	2024 vs 2023	2023 Average	2023 vs 2022	2022 Average
Annual Dental Visit	54.17%	↓	55.19%	↓	61.63%	↓	65.50%
Asthma Medication Ratio	68.56%	↑	68.41%	↓	71.87%	↑	68.89%
Child and Adolescent Well Care Visits	61.28%	↓	62.68%	↑	54.24%	↓	55.22%
Comprehensive Diabetes Care: HbA1c Poorly Controlled (>9%)	43.14%	↑	41.67%	↓	43.74%	↓	50.11%
Controlling High Blood Pressure	62.76%	↓	63.67%	↑	55.65%	↑	54.99%
Developmental Screening in the First Three (3) years of Life	61.10%	↑	54.46%	↓	54.70%	↑	46.44%
Lead Screening for Children	79.77%	↑	78.36%	↑	71.87%	↓	72.62%
Plan All Cause Readmissions	0.95/1000	↓↓	1.25/1000	↓↓	2.33/1000	↑↑	1.03/1000
Postpartum Care	78.38%	↓	79.12%	↑↑	73.81%	↑	62.30%
Prenatal Care in the First Trimester	80.67%	↓	81.88%	↑	80.79%	↑	73.51%
Well-Child Visits in the first 30 months of Life-(first 15 months age band)	74.05%	↑	72.04%	↑	64.51%	↓	71.15%

KEY
P4P Quality Metrics Required as of 2024
↑ or ↓ = Change of less than 10%
↑↑ or ↓↓ = Change of 10% or more

PCMH Quality Outcomes

Pennsylvania
Department of Human Services

- **Other non-P4P measures vary by MCO/PCMH and include:**
  - Potentially preventable ER visits/ED utilization
  - Rate of follow-up within 7 days of hospital discharge
  - SDOH screening rates
  - Immunizations
  - Breast, cervical and colorectal cancer screenings
  - HBA1c testing
  - Pharmaceutical utilization measures
  - Chlamydia screenings
  - Eye exams and kidney health evaluations for people with diabetes
  - Weight assessments/counseling for nutrition/physical activity in children and adolescents

PCMH-PNC Quality Measures

Pennsylvania
Department of Human Services

- **Trending has not yet begun but will start next year (in 2027)**
  - 2023 was the implementation year, and 2024 was the first year we received full reporting.
  - DHS currently has two years of reporting: CY 2024 and CY 2025. Until we have three years of data, we are unable to trend.
  - Trending will begin next year upon receipt of the CY 2026 data.
- **Measures that MCOs and PCMH-PNCs will be evaluating include:**
  - Appropriate shift care coverage
  - Well child visits
  - Plan All Cause Readmissions
  - Oral Evaluation Dental Services
  - Potentially Preventable ER Visits

The Future of PCMHs

Pennsylvania
Department of Human Services

- **Advancing DHS's VBP Strategic Plan**
  - Whole-person, whole-family, whole-community care
  - Prioritizing pediatric preventive care and management of adult chronic conditions
  - Coordinating care for special populations, including those with heightened health-related social needs, such as those being served by the Keystones of Health 1115 waiver
  - Integrating care for those with serious, persistent mental illness and/or substance use disorders
- **Advancing the Commonwealth's Maternal Health Strategic Plan**
  - Ameliorating maternity care deserts
  - Improving birth outcomes
  - Addressing maternal mortality

The Future of PCMHs

Pennsylvania
Department of Human Services

- **Updates to Exhibit DDD of the HealthChoices Agreement for Calendar Year 2027**
  - Supporting the Rural Health Transformation Program's initiative focused on peripartum depression
  - SDOH/HRSN screenings
    - G0136 procedure code added for assessments using validated tools
    - G9919 can still be used for screenings that result in positive findings and G9920 for screenings that result in negative findings
    - G0019 is *not* included – this is not a screening code
  - PC-AICC requirement has been removed from this exhibit and placed in the VBP portion of the Agreement
    - No changes to the requirement
    - Only clarifying that the PC-AICC is not necessarily required to be a PCMH

The Future of PCMH-PNCs

Pennsylvania Department of Human Services

- **Continuing to expand in numbers and staffing**
  - MCOs will continue to fund now that ARPA funding expired earlier in 2026
  - MCOs can count members together to identify PCMHs who jointly serve more than 20 children receiving shift care services so more PCMHs are eligible for the funding
- **Coordinating with regional Pediatric Complex Care Resource Centers and Family Facilitators**
  - PCCRCs help coordinate care for children receiving shift care
  - Family facilitators help bring children back home or to community-based settings from residential facilities or hospitalizations
- **VBP arrangements that incentivize:**
  - Decreased missed shifts
  - Higher patient/family satisfaction
  - More complete care plans being shared and used by the whole care team
  - Better health outcomes, including decreased ED and hospital utilization

Keeping Beneficiaries Covered

Pennsylvania
Department of Human Services

- Sign up for the Human Services Helpers Substack
- Make use of PROMISe's Eligibility Verification System to identify categories of eligibility, program status codes, and eligibility closure dates
- Remind patients/members to update their addresses with the CAO and USPS
- Remind patients/members to check their mail
- Use DHS's Communications Toolkit to get the word out and to fact check information being shared
- Get familiar with PA Navigate's education, training, employment, and volunteer resources
- Become a Compass Community Partner

MCO Panel: PCMH Program Highlights

With representatives from Amerihealth Caritas PA, Geisinger Health Plan, Highmark Wholecare, Jefferson Health Plan, United Health Care, and UPMC For You

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MCO Panel: PCMH Program Highlights

Colleen Hoffman, Amerihealth Caritas PA

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AmeriHealth Caritas
Care is the heart of our work®

PCMH Measure Comparison 2024-2026 Claim Period 1/1-6/30

November 10th, 2026

PA PNM & PMD

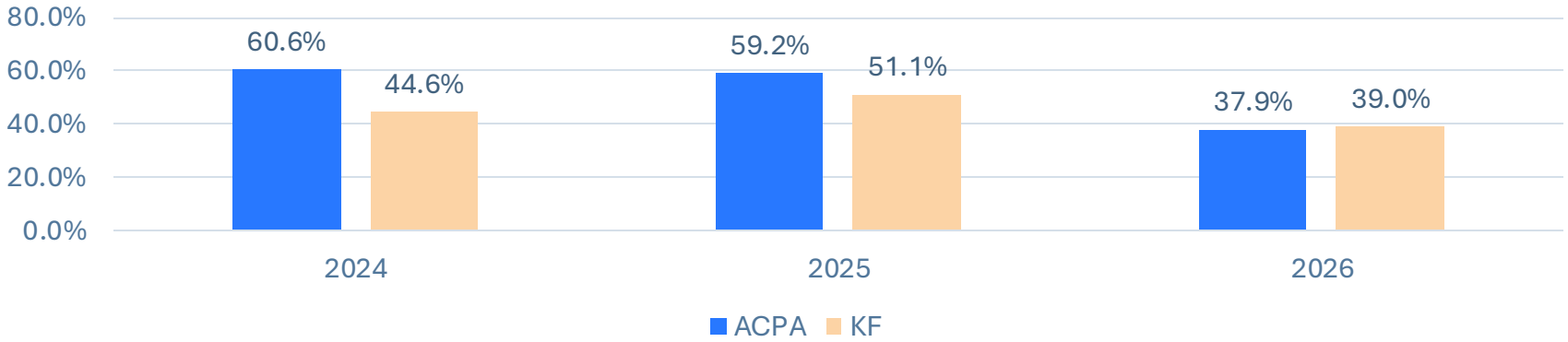
2024, 2025, 2026 PM CHD Data Comparison

1/1/XX-6/30/xxxx – Date Range for each year

Member Engagement

Target Description

The plan created this as an additional goal for our PCMH program groups. The goal is to have the member seen at least once in a 12 month period.



Potential Reasons for Target Decline

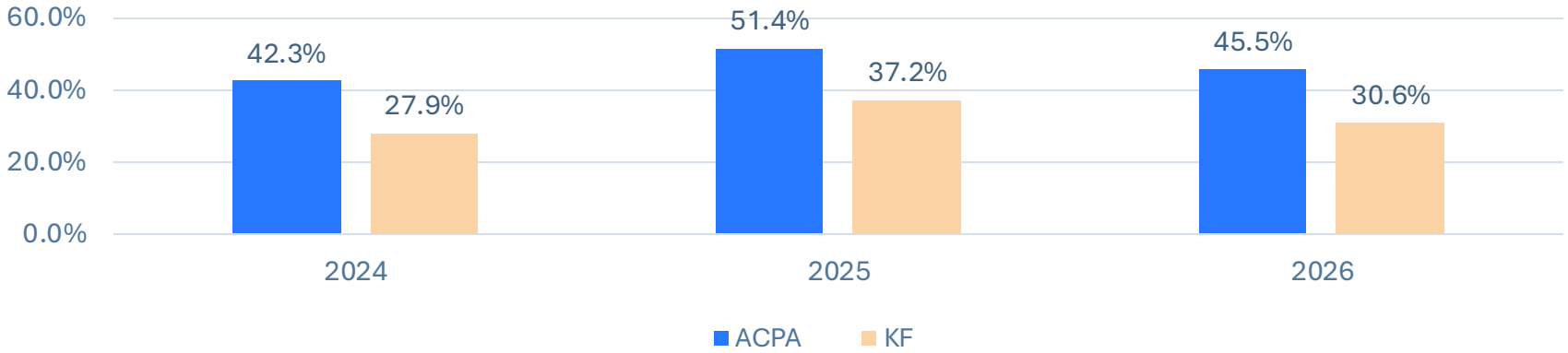
- Continued membership attrition resulting in a smaller eligible population.
- Remaining members have higher acuity and more complex healthcare needs.
- Increased difficulty reaching and engaging members with complex social and medical barriers.
- Challenges connecting with members who may have competing priorities, transportation issues, or limited responsiveness to outreach efforts.
- Reduced opportunities for successful engagement due to changes in membership composition.

2024, 2025, 2026 PMCH Data Comparison

Discharge

Target Description

See 75% of patients within 10 days of discharge from the hospital with an ambulatory sensitive condition. This includes a follow-up visit with a specialist Provider. The specialist Provider must share the patient's follow-up visit notes with the PCMH to meet this requirement.



Potential Reasons for Target Decline

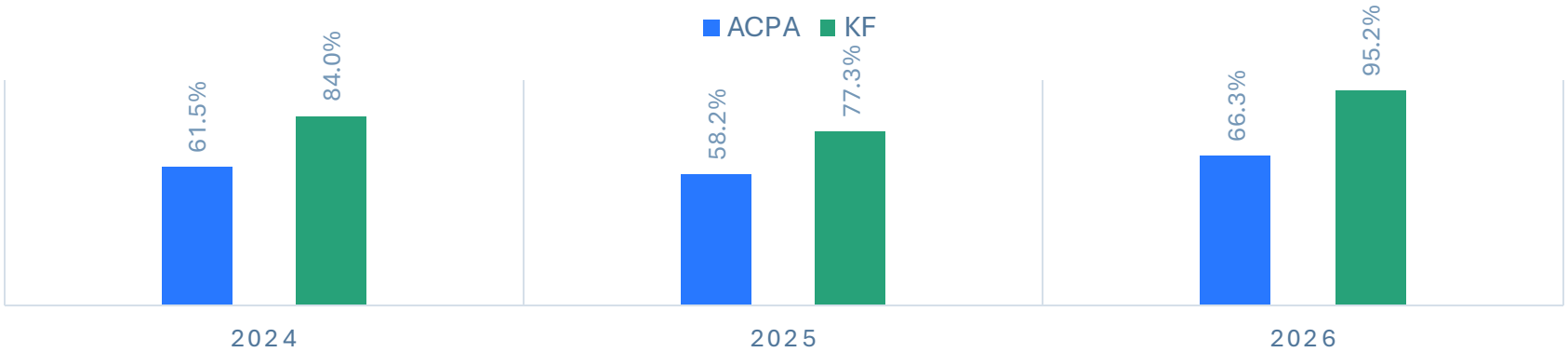
- Post-COVID membership decline, resulting in a smaller population with more complex healthcare needs.
- Higher acuity among remaining members, which can make timely follow-up more challenging.
- Difficulty identifying qualifying discharges through HIO/ADT notifications.
- Limited diagnosis detail in ADT messages, making it difficult to distinguish ambulatory care-sensitive conditions and target members for appointments.

2024, 2025, 2026 PMCH Data Comparison

HRSN – Z Code

Target Description

Will complete a health-related social needs (HRSN) assessment at least annually and more frequently for patients who screen positive, using a nationally recognized tool focusing on the following domains: food insecurity; health care/medical access/affordability; housing; transportation; childcare; employment; utilities; clothing; and financial strain, and then submit ICD-10 diagnostic codes for all patients with identified needs.



Potential Reasons for Target Improvement

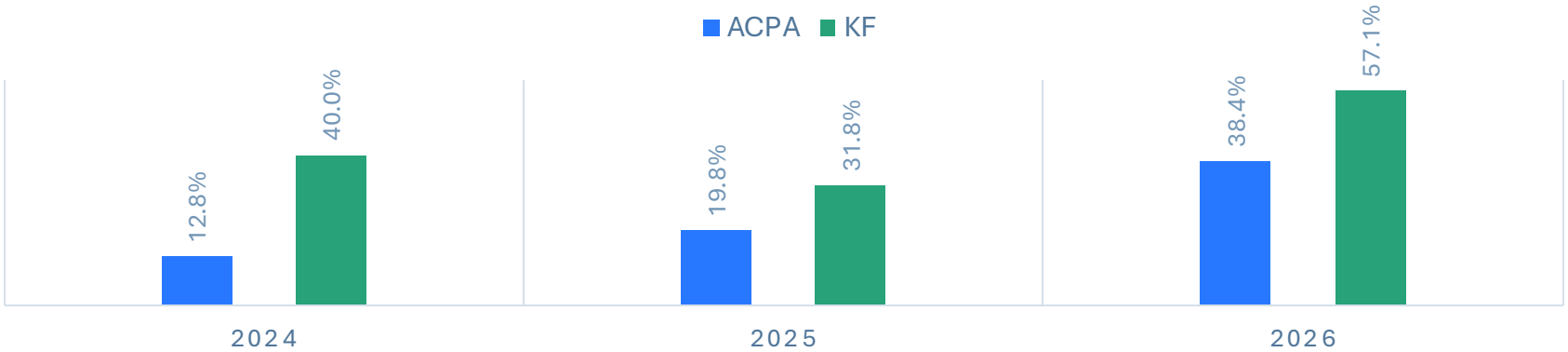
- Increased provider awareness of HRSN screening and coding requirements.
- Improved workflows for documenting and submitting ICD-10 Z-codes.
- Ongoing education and outreach regarding HRSN measure expectations.
- Greater integration of HRSN assessments into routine patient visits.
- Enhanced focus on identifying and addressing social needs impacting health outcomes.
- Improved EMR prompts and documentation processes supporting code capture. However, one concern was that having the Z code could potentially populate on clinical summary print outs.
- Increased collaboration between clinical and administrative staff to ensure accurate coding and claim submission.

2024, 2025, 2026 PMCH Data Comparison

G Code

Target Description

The PCMH must track referrals and outcomes and be able to submit a report as requested via claims submissions regarding the outcome of every HRSN assessment performed using HCPCS code G9919 (positive screening result) or G9920 (negative screening result).



Potential Reasons for Target Improvement & Challenges

- Increased provider awareness of G9919 and G9920 reporting requirements.
- Improved workflows linking HRSN screenings to claim submission.
- Greater participation in provider education and PCMH learning sessions.
- Enhanced EMR prompts and coding support tools.
- Increased focus on documenting and reporting HRSN screening outcomes.

Steps for Engagement & Improvement

1. Practice Performance Meetings

Practice Performance Meetings provide an opportunity to review performance data, identify opportunities for improvement, and partner on strategies that improve quality outcomes, member experience, and overall practice performance.

2. Top Performer Incentive

The Top Performer Incentive recognizes practices that demonstrate strong performance across both quality measures and PCMH program requirements, supporting improved health outcomes and comprehensive patient-centered care.

3. PMD attending PCMH Learnings

PCMH Learning Sessions provide practices with education, resources, and best practices to support quality improvement, strengthen PCMH requirement performance, and improve member health outcomes.

4. Actionable Data

Providing actionable data and insights that help practices identify care gaps, target improvement opportunities, and drive better quality and PCMH performance outcomes.

5. Member Incentives

We support provider groups by offering member incentives tied to specific quality measures to encourage completion of recommended care and help close care gaps.

ACPA/KF

MA Redetermination

Any member/participant found to no longer have coverage the plan will help the member/participant find other possible options, if needed.



1/1/2027 - CHANGES

- Renewing Medicaid every 6 months
- Meeting Work Requirements



NaviNet – Redetermination Pop Up

- In the Eligibility and Benefits screen under Patient Alerts there is a "Redetermination Report" that will display the members/participants upcoming eligibility redetermination date.



NaviNet – Redetermination Report

- Under the Administration Report Inquiry there is a report available for PCPs to pull a full report of all members/participants on your current roster who have upcoming eligibility redetermination date.

MCO Panel: PCMH Program Highlights

Lauren Stark, Erin Griffith, and **Peter Bond**, Geisinger Health Plan

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Geisinger Health Plan: Geisinger Clinic PCMH Social Needs Strategy



Geisinger

Geisinger:
Integrated health system with $8.2 billion in combined revenues

We care for patients.

- **10** hospital campuses
- **160+** primary and specialty clinics
- **27,500+** employees
- **1,800+** employed physicians

We provide quality, affordable healthcare coverage.

- **More than 550,000** Geisinger Health Plan enrollees
- **More than 71,000 c**ontracted providers in network
- **217** hospitals in network

We shape the future of medicine.

- **500+** MBS/MD students at Geisinger College of Health Sciences
- **100+** students at Geisinger School of Nursing
- **1,400+** active research projects

Geisinger Health Plan + Geisinger Clinic

Our Goal

- A centralized resource
- Identify and address HRSN effectively
- Maintain quality across all the PCMH PCP offices
- Improve health and well-being.

Our Outcomes

Met all goals above
Resource expansions to eventually support to all Geisinger Clinic Patients
Resolve HRSN in a supported and person-centered manner

PCMHs must consider factors outside the exam room that shape health outcomes

- Food insecurity
- Housing
- Transportation
- Childcare
- Employment
- Health care/medical access/affordability
- Utilities
- Clothing
- Financial strain

Social Needs Resource Hub

Geisinger Health Plan + Geisinger Clinic

Strengthening the connection between

- GHP Family Members
- Geisinger Clinic PCMH PCPs
- Community Resources
- Health plan supports

Community and Social Health Strategy

Vision: To advance health and contribute to the transformation in health outcomes, quality, and innovation by addressing factors impacting total health for patients, members and communities. Maximize impact by looking strategically at each of these data driven areas of focus through the lens of compliance, regulatory, community needs and patient care.



Access to Food and Nutrition



Social Needs Coordination



Workforce Development



Removing Barriers to Care



Chronic Disease Impact



Behavioral Health

Social Needs Strategy: Comprehensive approach for the Clinical Enterprise and GHP to address social needs that includes **screening and information, interventions, and outcomes**

Screening and Information

Interventions

Outcomes

Social Needs Screening

Screening

- Screening tool is standardized across Geisinger (household or adult screening)
  - Custom screening tool designed to identify urgent needs and meet regulatory requirements
- Screen for social needs annually to meet regulatory, contractual and accreditation requirements
  - Rescreen logic available to rescreen at 6 months if at least one positive screening
- Screenings fire in various clinical depts (ex: outpatient, ED, IP)
  - Short and long version

Methods

- EMR workflows (MyChart, waiting room, rooming process)
- Health plan workflows determine screening frequency
- Translated into various languages (paper screenings in clinics that are entered into EMR)

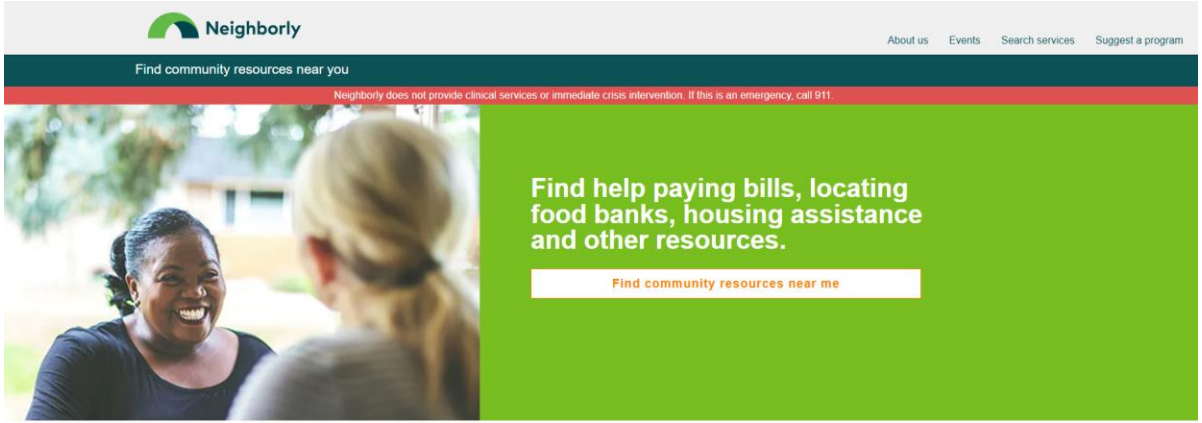
Intervention

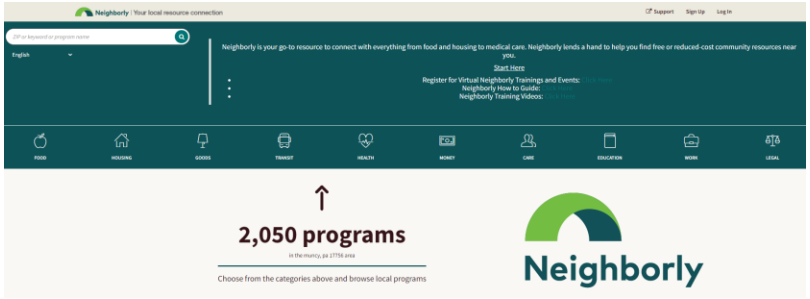
- Neighborly
- Clinical workflows
- Social Needs Resource Hub

Neighborly

- Launched online resource in March 2020
- Over 11,000+ programs and services listed and growing in Pennsylvania (local, statewide and national resources) and over 600,000 in the United States
  - Program and service categories: food, housing, childcare, transportation, utility assistance, education, health care, legal services, financial assistance resources
- Partners with local community organizations to connect members and patients with services
- Available at www.NeighborlyPA.com and as a dedicated staff site and launchable in EHR
- Connected to PA Navigate through coalition sharing

Care closer to home

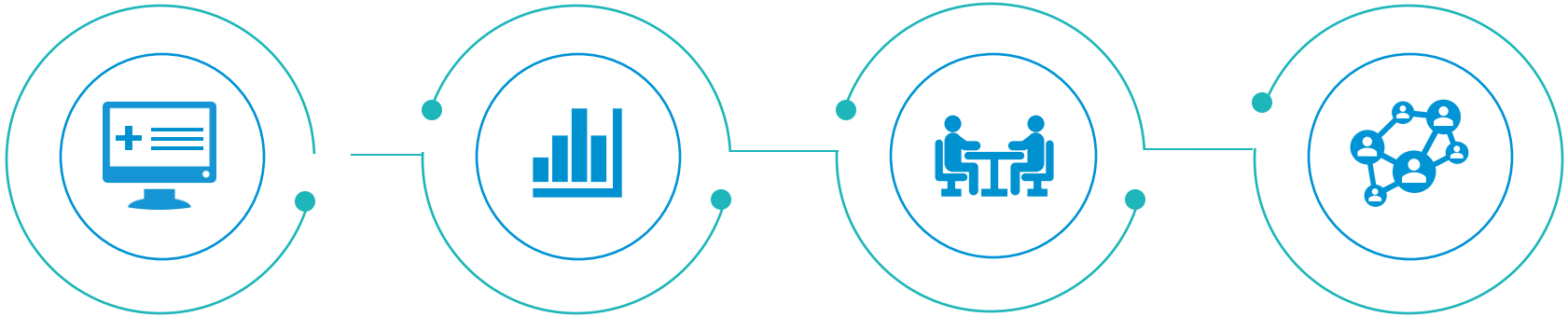




Neighborly

Using our data to develop strategies

Data-driven approach drives all strategy creation to build a network to address social needs in members and patients



*Food is Health, Housing, Transportation, Workforce, Maternal Resources

Strategic Approach to Identify Organizations

Top needs identified in each zone

Data sources focus areas: Social Needs screening data, Neighborly, Social Needs Resource Hub and Community Health Needs Assessment (CHNA) clinical and GHP data

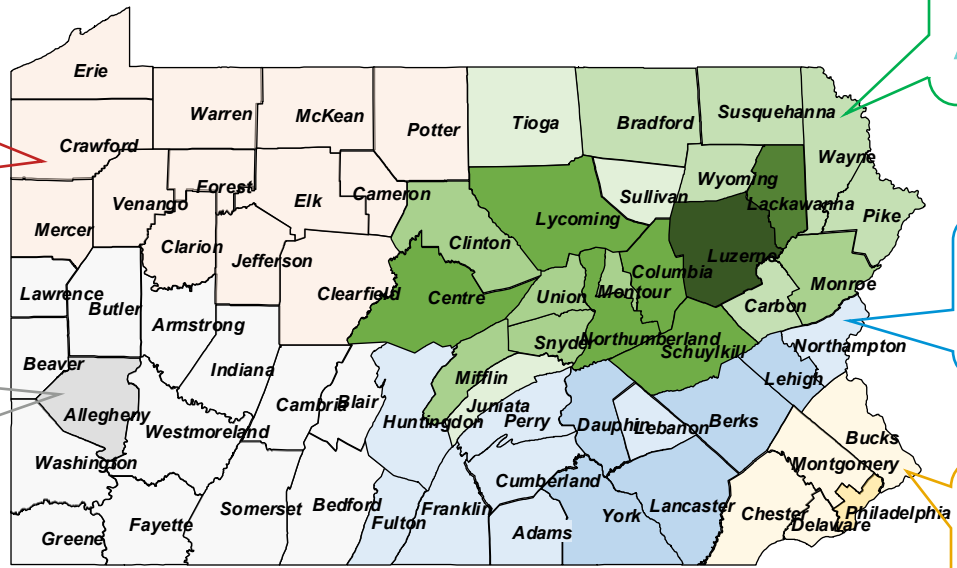
Northwest Zone Top Needs

Northeast Zone Top Needs

Lehigh Cap Zone Top Needs

Southwest Zone Top Needs

Southeast Zone Top Needs



Identified Needs

- Food
- Housing
- Utilities
- Transport
- Workforce
- Maternity
- Hygiene
- Health

State-wide:

- Neighborly
- Workforce & GEDWorks

Social Needs Resource Hub

Empowering Health Through Social Resource Connections

Access to Care

- Launched in August 2025, is a team interacting telephonically, to connect members and patients to essential social services; organizational rollout through 2026 and 2027

Integration of Supports

- Support both the Clinical Enterprise and GHP

Empowerment of Individuals

- Enables individuals to confidently navigate and manage their social needs for better well-being

Innovation in Service Delivery

- Leverages existing technology such as Neighborly, EPIC Healthy Planet and community partnerships

Social Needs Addressed by the Hub

- Food
- Housing
- Transportation
- Medication
- Social Isolation*
- Safety
- Childcare
- Clothing
- Utilities
- Employment
- Emotional Wellness
- Internet**

**adult only*
***household only*

Year one by the numbers



6,399

referrals to social needs resource hub



83%

Graduation rate — individuals connected to resources that addressed their social need



Referrals

74% Screeners
23% Orders
3% Other



44%

of referrals were resolved on the first contact

60%
Roll out implementation across organization

7 playbooks
Best practice playbooks developed

Marketing campaigns
Patient TV, provider desktop and MyChart Neighborly, newsletters

Data: current 9/30/2026

Leveraging Technology

- In May of 2025 new features were released in EMR to provide automation opportunities for better coding integration

- Teams are actively building enhancements that include:
  - Automated capture of G9919 (positive screen) and G9920 (negative screen) to improve coding consistency and reduce reliance on manual provider documentation
  - Automated alignment of positive social needs screening results with the appropriate ICD-10 Z code to support accurate social determinants of health (SDOH) documentation
  - Standardized coding workflows across participating departments to improve data quality, reporting, and operational efficiency

- Comprehensive post-go-live evaluation planned to quantify efficiency gains, measure operational impact, and capture lessons learned to inform future automation opportunities.

What's next

- Advance technology-enabled workflows through automated G/Z code capture
- Expand the Social Needs Resource Hub across additional Clinical Enterprise locations, building on the current organizational rollout
  - Strengthen transitions of care by connecting ED and inpatient workflows with social needs support and primary care follow-up
- Continue building the community-based organization network using social needs data to identify priority needs and strengthen connections to community resources
- Explore additional data sharing through P3N network

Thank you

Geisinger

MCO Panel: PCMH Program Highlights

Graham Hawley and **Lakshmi Reddy**, MD, Highmark Wholecare

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Highmark Wholecare

PCMH Learning Network

November 10th, 2026

HIGHMARK. WHOLECARE.

Quality Comparison - PY2025 PCMH vs. Non-PCMH

PCMH providers performed favorably compared to non-PCMH providers in 11 of 12 core quality measures in 2025.

PY2025 PCMH VS Non PCMH Quality Summary

Final 2025 Quality Data:- Claims Data PT April 2026

Based on Active PCMH Tins from Aug 2026 VB Tin List

Measure Abbreviation	Measure Name	Inverse Measure	PCMH Providers	Non PCMH Providers	Difference
AMRTOTAL	Asthma Medication Ratio	No	75%	77%	-2%
CBPCBP	Controlling Blood Pressure	No	72%	65%	7%
CISCO10	Childhood Immunization Status (Combo 10)	No	23%	21%	2%
DEVNUMA	Developmental Screening in First Three Years of Life	No	83%	75%	8%
GSDGT9	Hemoglobin A1c Control for Patients With Diabetes	Yes	28%	34%	-5%
IMACO2	Immunizations for Adolescents (Combo 2)	No	40%	31%	8%
LSCLSC	Lead Screening in Children	No	90%	85%	4%
PPCPPC	Postpartum Care	No	79%	73%	6%
PPCTOPC	Timeliness of Prenatal Care	No	84%	82%	3%
W300TO14MTH	Well-Child Visits in the First 15 Months of life, 6 or more visits	No	78%	71%	7%
WCVTOTAL	Child and Adolescent Well-Care Visits (Total)	No	65%	61%	3%
PCRMCD	Plan All Cause Readmission (Observed - to - Expected Ratio)	Yes	1.05	1.07	-0.02

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Clinical Initiatives

Dr. Lakshmi Reddy – Senior Medical Director

HIGHMARK WHOLECARE

MCO Panel: PCMH Program Highlights

Michael Kornhauser, MD, United Health Care

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MCO Panel: PCMH Program Highlights

Valerie Van Buren, Jefferson Health Plan

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MCO Panel: PCMH Program Highlights

Tina Novotni, MBA, UPMC For You

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UPMC *for You*
PCMH Program Highlights

Tina Novotni, Director of Government Products

Areas of Focus

~4%

drop in UPMC *for You's* PCMH membership from 2024 to 2025, due to the PHE unwinding

Utilization Metrics (2024 to 2025)

UPMC *for You* (overall membership)

+3.4%

Inpatient utilization

+0.7%

Emergency department utilization

PCMH groups

64%

of groups decreased ED utilization

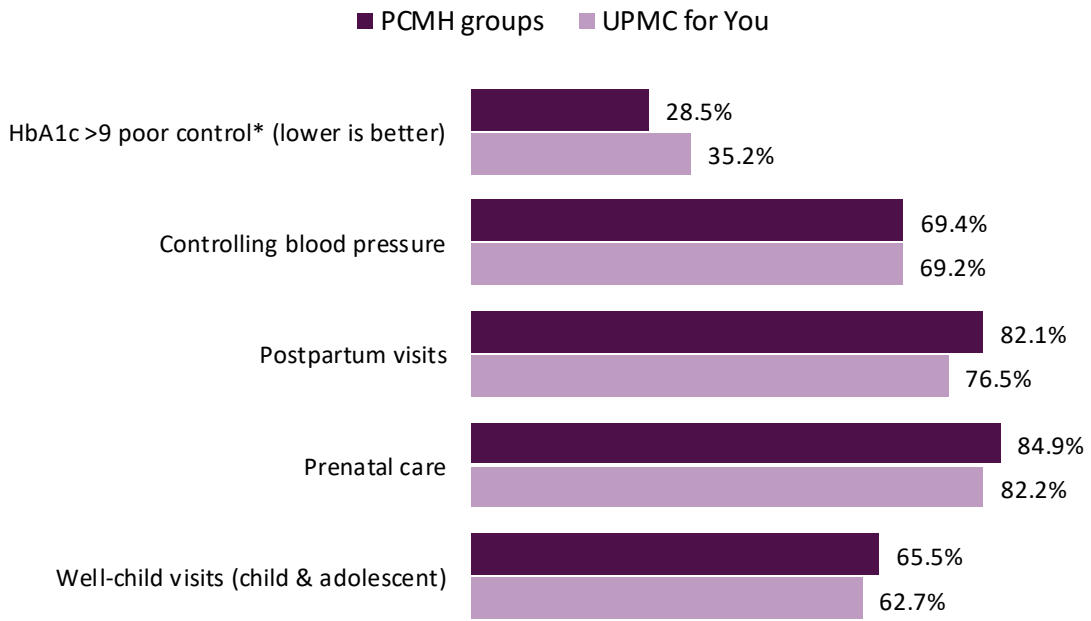
73%

of groups decreased inpatient utilization

55%

of groups increased 10-day follow-up rates

2025 Quality Metric Performance



Key takeaways

Diabetes control: biggest gap
6.7 pts fewer patients in poor control (28.5% vs 35.2%)

Maternal health leads
Postpartum visits +5.6 pts; prenatal care +2.7 pts

Steady on child & BP measures
Well-child visits +2.8 pts; blood pressure nearly tied (+0.2 pts)

*Rates are based on admin data only. For HbA1c >9, a lower rate is better.

2026 Highlights

Successful implementation and rapid growth of PNC program

2026 focused on phased program implementation and refinement of processes

Continued collaboration between UPMC *for You* and PCMH's to address HRSN

UPMC *for You* resources support/complement existing resources within each PMCH

Expanded use of CHW's

Partnerships with CBO's to support membership with referrals related to utilities, transportation, SNAP and LIHEAP applications, housing support, childcare, and educational needs.

HR-1 Efforts

Proactive member outreach

- Broad multi-channel renewal outreach to all Medicaid member households
- Digital Marketing efforts tailored to H.R.1 requirements

Direct Member Support

- Internal H.R.1 training/education for member-facing staff
- Dedicated internal Renewal Support Team – COMPASS Community Partner Access for telephonic redetermination

Provider support

- Provider OnLine – eligibility verification
- Medicaid Panel Rosters
- Future enhancements

PDSA Poster Session

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PDSA Poster Session Report-Out

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PDSA Poster Session Report-Out

What did you learn from the poster session that is **applicable to your work** and that will **help you address a problem or challenge** in your practice?

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Networking Lunch

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PCMH Sprint Spotlights & Recognitions

Lisa Boyd, Program Specialist
Pittsburgh Regional Health Initiative

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Allegheny Health Network

The PCMH Learning Network presents your team with the Silver Award

in recognition of your quality improvement efforts:

Improving behavioral health consultation billing workflows, leading to a reduction in date-of-service billing errors from 53 in February 2026 to just 1 in May 2026.

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Berks Community Health Center

The PCMH Learning Network presents your team with the Bronze Award

in recognition of your quality improvement efforts:

Improving the consistency of referral and follow-up processes for integrated behavioral health services.

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Delaware Valley Community Health

The PCMH Learning Network presents your team with the Bronze Award

in recognition of your quality improvement efforts:

Increasing completed diabetes care visits from 13 to 19 and expanded scheduling capacity to 45 slots to address no-shows and improve care gap closure.

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East Liberty Family Health Center

The PCMH Learning Network presents your team with the Silver Award

in recognition of your quality improvement efforts:

Decreasing A1C noncomliance by 3% per year with standardized diabetes order sets, proactive patient scheduling, and provider training.

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Esperanza Health Center

The PCMH Learning Network presents your team with the Bronze Award

in recognition of your quality improvement efforts:

Expanding access to diabetic retinal screenings through screening events and optometry referrals while tracking A1C control and identifying barriers to care for uninsured patients.

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Fair Hill Community Physicians

The PCMH Learning Network presents your team with the Gold Award

in recognition of your quality improvement efforts:

Establishing on-site services at all practices to improve diabetes lab completion, with 48% of patients having A1C above 9% or missing results as of April 2026.

&

Increasing monthly diabetic eye exams from 22 to 76 in July through dedicated screening staff, coordinated scheduling, and targeted outreach.

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Family Practice Center, P.C.

The PCMH Learning Network presents your team with the Silver Award

in recognition of your quality improvement efforts:

Created trackable fields, educated providers, and build QRDA reports to improve tracking of positive depression screen follow-ups from 34% in April to 51% in October.

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Greater Philadelphia Health Action

The PCMH Learning Network presents your team with the Gold Award

in recognition of your quality improvement efforts:

Expanding retinal screening to three days per week at the pilot site, completing 154 screenings and refining workflows to improve screening access and image quality.

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Guthrie Medical Group

The PCMH Learning Network presents your team with the Silver Award

in recognition of your quality improvement efforts:

Increasing systemwide diabetes bundle compliance to 36.5%, exceeding the 34.3% goal, through targeted patient outreach, expanded retinal screening access, and improved care gap tracking.

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Hamilton Health Center

The PCMH Learning Network presents your team with the Silver Award

in recognition of your quality improvement efforts:

Establishing partnerships with 4 home health agencies and developed clinical criteria to identify children with complex care needs, improving coordination of pediatric shift nursing services and family support.

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Jefferson Health – Einstein

The PCMH Learning Network presents your team with the Silver Award

in recognition of your quality improvement efforts:

Initiating nurse-led diabetes management and tracked outreach efforts toward a goal of 75% of patients achieving A1C below 9%

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Keystone Rural Health Center

The PCMH Learning Network presents your team with the Silver Award

in recognition of your quality improvement efforts:

Defining medical necessity criteria and performance measures for a standardized pediatric home nursing referral tool to reduce care manager documentation time and improve referral efficiency.

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Keystone Rural Health Center

The PCMH Learning Network presents your team with the Gold Award

in recognition of your quality improvement efforts:

Piloting standardized diabetes care recalls at two primary care sites, achieving post-recall visit completion rates of 27% and 69%.

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Kid's Plus Pediatrics

The PCMH Learning Network presents your team with the Gold Award

in recognition of your quality improvement efforts:

Achieving a 99% postpartum depression screening rate and identifying 12 birthing parents with positive screens for expanded behavioral health support.

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Jonathan B. Levyn D.O. PC

The PCMH Learning Network presents your team with the Silver Award

in recognition of your quality improvement efforts:

Identifying 9 patients with A1C levels of 5.7% or higher for patient outreach, while compiling diabetes education and healthy food resources.

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LGH Family Medicine Norlanco

The PCMH Learning Network presents your team with the Gold Award

in recognition of your quality improvement efforts:

Increasing the rate of depression screening from 30% to 42% with tracking fields and provider education.

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LGH Family Medicine Twin Rose

The PCMH Learning Network presents your team with the Bronze Award

in recognition of your quality improvement efforts:

Introducing paper-based interconception care screening during check-in to address a decline in completion rates from 70% to 50%.

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LGH Roseville Pediatrics

The PCMH Learning Network presents your team with the Gold Award

in recognition of your quality improvement efforts:

Launching a Transition of Care Clinic, completed two rounds of evaluation demonstrating improved caregiver preparedness and reduced stress, and established weekly clinic sessions beginning January 2027.

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Pediatric Care Specialists

The PCMH Learning Network presents your team with the Silver Award

in recognition of your quality improvement efforts:

Standardizing medical necessity reviews through annual well visits, achieving 100% visit completion from May through August to support appropriate skilled nursing utilization.

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Penn Medicine

The PCMH Learning Network presents your team with the Silver Award

in recognition of your quality improvement efforts:

Increasing A1C control by 1.4% through a three-part provider education series on continuous glucose monitoring, clinical workflows, and billing support.

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Penn State Health

The PCMH Learning Network presents your team with the Bronze Award

in recognition of your quality improvement efforts:

Identifying gaps in diabetes follow-up, A1C testing, and retinal screenings, and began developing provider-level patient lists and pharmacy-supported care strategies to improve diabetes management.

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Primary Health Network

The PCMH Learning Network presents your team with the Bronze Award

in recognition of your quality improvement efforts:

Establishing nurse-led diabetes care visits at two pilot sites, using A1C levels above 9% to identify patients for education, follow-up, retinal screenings, and kidney health evaluations.

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River Valley Health and Dental

The PCMH Learning Network presents your team with the Gold Award

in recognition of your quality improvement efforts:

Increasing point-of-care A1C testing capacity, updated standing orders, and completed staff training to reduce missed testing opportunities and improve A1C poor control toward a 25% target.

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Scranton Primary Health Care Center

The PCMH Learning Network presents your team with the Bronze Award

in recognition of your quality improvement efforts:

Targeting patients with A1C ≥9% or overdue testing through chart audits, follow-up scheduling, and resource referrals, while identifying workflow gaps contributing to a 33.2% baseline poor-control rate.

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Temple University Health System

The PCMH Learning Network presents your team with the Gold Award

in recognition of your quality improvement efforts:

Increasing diabetic eye exam completion to 50.56% through weekly care gap reports, staff feedback, and coordinated screening schedules.

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Tower Health - Reading

The PCMH Learning Network presents your team with the Silver Award

in recognition of your quality improvement efforts:

Increasing A1C control from 71.4% to 71.9% through practice-level QI initiatives, weekly care gap reporting, targeted patient outreach, and continuous glucose monitoring data integration.

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UPMC Central PA

The PCMH Learning Network presents your team with the Silver Award

in recognition of your quality improvement efforts:

Expanding telehealth services to increase referrals to integrated behavioral health services from 9 referrals in March to 90 referrals in June 2026.

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UPMC Children's Community Pediatrics

The PCMH Learning Network presents your team with the Silver Award

in recognition of your quality improvement efforts:

Improving PNC program staffing coverage to 73% and strengthened workflow adherence through standardized staff training, simplified tracking tools, and ongoing compliance audits.

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UPMC Children's Primary Care Center

The PCMH Learning Network presents your team with the Bronze Award

in recognition of your quality improvement efforts:

Identifying barriers to caregiver influenza vaccination and proposing offering vaccinations during pediatric primary care visits to increase uptake and protect infants.

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UPMC Community Medicine, Inc.

The PCMH Learning Network presents your team with the Gold Award

in recognition of your quality improvement efforts:

Closing diabetes care gaps across through targeted member outreach, standardized care management documentation, and expanded referrals.

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Valley Health Partners Community Health Center

The PCMH Learning Network presents your team with the Silver Award

in recognition of your quality improvement efforts:

Establishing a partnership with the regional Pediatric Complex Care Resource Center (PCCRC) and implementing a standardized referral tracking process to improve family access to support services.

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Wayne Memorial Community Health Center

The PCMH Learning Network presents your team with the Silver Award

in recognition of your quality improvement efforts:

Increasing behavioral health referrals by 121% and working to ensure follow-up and adequate staffing.

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WellSpan - Bannister Street

The PCMH Learning Network presents your team with the Silver Award

in recognition of your quality improvement efforts:

Standardizing A1C testing through medical assistant standing orders, in-office lab collection, and EHR reminders to address a 36% baseline uncontrolled A1C rate and reduce missed testing opportunities.

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WellSpan Community Health Center

The PCMH Learning Network presents your team with the Silver Award

in recognition of your quality improvement efforts:

Conducting workflow observations and identifying staffing barriers to implementing care coordination models, escalating resource needs to senior leadership.

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The Wright Center for Community Health

The PCMH Learning Network presents your team with the Bronze Award

in recognition of your quality improvement efforts:

Implementing Collaborative Care Management rollout with a target of 50 patients within the first year.

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The Wright Center for Community Health

The PCMH Learning Network presents your team with the Silver Award

in recognition of your quality improvement efforts:

Increasing HBV vaccination acceptance among 2 families who initially declined at birth through parent education and counseling, while tracking vaccine hesitancy and RSV immunization needs.

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2027 PCMH Learning Network Goals, Sprint Topics, Structure and Next Steps

Suzanne Cohen, Senior-Director, Population Health,

Health Federation of Philadelphia

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2027 Learning Network Objective

All PCMHs in the HealthChoices PCMH Program complete at least 1 cycle of a PDSA in at least 1 sprint by October 2027

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Cross-cutting theme

Keeping MA Beneficiaries Insured

Within and across sprints, the PCMH Learning Network will focus on HR1 implications, including:

- Increased documentation burden and recertification frequency for patients
- Support for practices to understand who is most at risk for dropping off MA
- Resources to support patients/members and practices to reduce churn and coverage loss

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2027 LN – Sprint topics

Trauma-Informed Behavioral Health Screening and Follow-up

With options to focus on:

- pregnancy/postpartum depression (OB family medicine and pediatric settings)
- integrated care models (e.g., Collaborative Care Management or Behavioral Health Consultants)
- tobacco screening and cessation counseling
- inter-partner violence screening and follow-up
- how to use patient advisors for trauma-informed approaches

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Example

Trauma-Informed Behavioral Health Screening and Follow-up

QI Goal: Increase the % individuals with a delivery in the past year who were screened using the EPDS and the % who received follow-up care within 30 days.

Plan: Organize a focus group, create suggested language for introducing and following-up on the screens with recommended actions based on depression severity, and design and test the workflow.

Do: Tested the workflow in one office for a month and reviewed the data.

Study: Data indicated 8% positive rate, 70% screening rate, and 65% follow-up rate.

Act: Decided to reconvene patient advisors to offer feedback on whether the screening is being done in a universal and trauma-informed way.

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2027 LN – Sprint topics

Community-Based Care Management (CBCM) Teams

With options to focus on:

- Pharmacists
- CHWs
- Care Managers
- Peer Recovery Specialists
- CBCM caseloads
- CBCM team retention
- Patient communication and engagement skills

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Example

Community-Based Care Management (CBCM) Teams

- ***Goal:*** improve care for patients with substance use disorder through peer recovery supports.
- **Objective:** Incorporate a peer recovery specialist (PRSS) into our care teams so that the PRSS can begin to provide community-based services within six months.
- ***Measurable Outcomes:***
  - Established and tested protocols and workflows for onboarding, supervising, and utilizing PRSS
  - PRSS hired
  - X# referrals made to the PRSS
  - At least X# patients served within six months.
- ***Plan:*** QI leads and clinical champion establish protocols and workflows with the care team, including the referral, patient engagement, and documentation process.
- ***Do:*** Hire and train/orient PRSS. Test protocols, workflows and documentation for onboarding, supervision, and incorporating PRSS into care teams. Implement referral workflows for patients needing support as captured through screening in primary care.
- ***Study:*** Review referral numbers and number connected to PRSS services. Assess percentage of those screening positive for SUD referred and engaged. Interview PRSSs and care team members on what worked, did not work and what could improve the interaction between care team members and patients.
- ***Act:*** Revise protocols and workflows as needed. Train/retrain as needed. Spread to additional care teams if successful.

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2027 LN – Sprint topics

Preventing Readmissions, Admissions, and Unnecessary ER Visits for Ambulatory-Sensitive Conditions

With options to focus on:

- 10-day follow-ups
- Collaborating with specialists
- Leveraging P3N-certified HIO data and functions

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Example

Preventing Readmissions, Admissions, and Unnecessary ER Visits

Goal:
Reduce the number of patients using the hospital for ASCs and reduce all cause readmissions, by improving primary care engagement for patients with a history of inpatient stays for ambulatory sensitive conditions.

Measurable Outcomes:

- improve immediate follow up for this population (within 10 days for hospitalizations)
- Increase the target patient population's use of primary care for well visits and chronic disease management.
- Decrease all cause readmission rate.

Plan: Analyze the past six months of hospital discharge data to understand who is being admitted due to ASCs/readmitted and why.

Do: Assign these patients to a care coordinator and begin outreach. Prioritize those with multiple past hospitalizations. Aim to increase primary care engagement among this population to manage chronic diseases and preventive care. Ensure that members of this population who go back to the hospital have immediate outreach from the care coordinator, and that they are brought in for TOC visits with PCPs or members of their team within ten days.

Study: After five months, review data on the patient population, looking at additional hospitalizations and ED visits, primary care engagement both in general and post-hospital, and outreach attempts and successes. Meet with staff to learn what worked and where the process did not work

Act: Revise processes based on input. Depending on results, consider expanding this pilot to additional locations.

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2027 LN – Sprint topics

PCMH-Pediatric Nursing Care: Coordinating Shift Care Services

With options to focus on:

- Standardizing LOMNs
- Standardizing Family-Centered Plan of Cares
- Including family members to advise practices on improvements

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Example

PCMH-Pediatric Nursing Care: Coordinating Shift Care Services

QI Goal: Decrease the % of LOMNs for shift care services that result in requests for additional information.

Plan: Review the reasons for previous requests to identify what needs to be added to our LOMN template. Create a workflow to collect this information during the initial assessment.

Do: Revised and tested the template for a month to collect occupational or physical therapy notes.

Study: Data indicated a decrease, suggesting that the revised template was working.

Act: Decided to monitor the measures and share the revised template with the PCMH-PNC Learning Network.

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Picking a Sprint

Items to consider:

- Can you align organizational QI priorities with one of the sprint topics?
- Is there a goal and a population that makes sense considering other work your teams are doing?
- Do you have access to data that will demonstrate measurable results in the short to medium term, and data that can be used to measure the implementation process?
- Is leadership invested in the implementation and results of this QI project?
- Are clinicians/care teams invested? If not, can you get them there?
- Is this an area where your Medicaid patients have disparities with other populations? (Remember, this is a Medicaid program)

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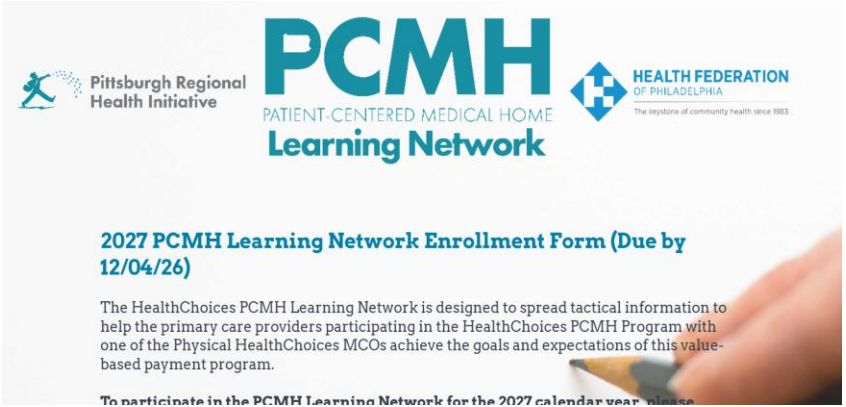
2027 Learning Network Structure & Calendar

- Enrollment forms are due by December 4, 2026
- Sprint sessions start in January
- Four sprint sessions for each sprint
- PDSA submissions due 2 weeks before the session date using a new form, not spreadsheet
- Mid-year cross-sprint session in May



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2027 Learning Network Structure & Calendar

Sprint	Session 1	Session 2	Midyear Statewide Session	Session 3	Session 4	In-Person Event
PNC (facilitated by PRHI)	1/27	4/14	5/26	6/23	9/09	11/10
Hospital and ER Prevention (facilitated by Health Fed.)	2/3	4/21		6/30	9/22	
Behavioral Health (facilitated by PRHI)	2/10	4/28		7/14	9/29	
CBCM Teams (facilitated by Health Fed.)	2/17	5/5		7/21	10/6	

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Knowledge Cafés to Prepare for 2027 Sprints

Lisa Boyd, Program Specialist

Pittsburgh Regional Health Initiative

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Next Steps & Wrap-Up

Lisa Boyd, Program Specialist
Pittsburgh Regional Health Initiative

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Next Steps from Today's Session

1. Select a PCMH LN 2027 sprint topic and enroll with your team by **December 4th**
2. Contact the PCMH LN team for technical assistance in choosing a sprint topic & PDSA focus area

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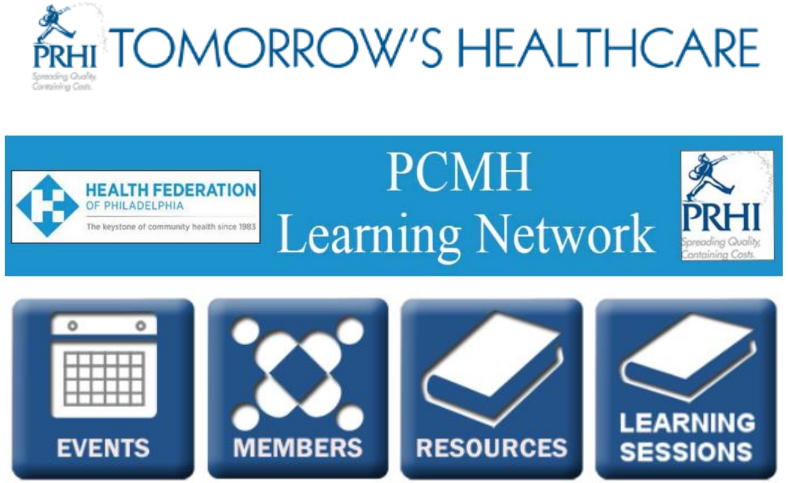
PCMH Online Community

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"

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CEU Process

You will receive a follow up email with links to:

Complete the survey at: https://www.surveymonkey.com/r/HJYWY6Z by Tuesday, November 17th

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 November 17 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

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Thank You!

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