
# Join Your Colleagues and Collaborate in Transforming Health Care

An Official Conference by NCQA

## PCMH Congress

**September 14–16, 2018**

San Diego Convention Center
San Diego, CA

**Plus!** Thursday Pre-Conference on PCMH Recognition Annual Reporting

**pcmh**congress.com

PCMH Congress™

An Official Conference By NCQA Measuring quality. Improving health care.

Whether your organization is already PCMH recognized, considering recognition, or you are a consultant focused on guiding others through the process, you've made a big step in the commitment to improved care delivery.

There's one more important step you should take: **Join us for the PCMH Congress.**

This is integrated learning for those involved with patient-centered care. Receive tips, tools, and ideas to apply right away through interactive conference sessions tailored to your organization's needs; engage one-on-one with leading PCMH experts who can assist in answering critical questions; and network with peers from around the country who can share insight into common challenges and offer potential solutions.

## Who will benefit from PCMH Congress?

- **Practice Managers and Staff**
- **Quality Managers**
- **Administrators**
- **Health Care Consultants**
- **Physicians, Nurses, Nurse Practitioners, and Allied Health Professionals**
- **Federally Qualified Health Centers**
- **Pharmacists**
- **Health IT Professionals**
- **PCMH Certified Content Experts**
- **Medical Residents, Fellows, and Emerging Clinicians**

**And anyone else engaged in the NCQA Recognition process**

**"It was just an outstanding opportunity to learn what is currently going on with PCMH and a wonderful opportunity to network."**

## Pre-Conference

### PCMH Recognition Annual Reporting: Succeeding Through Continued Transformation

**Thursday, September 13 | 1:00 PM–4:30 PM**

This highly anticipated program has been designed to help PCMH practices understand the larger goals of annual reporting and prepare for submission under PCMH Recognition. An examination of the annual reporting requirements will be discussed, including expectations for those transitioning from 2014 recognition as well as those achieving recognition under the 2017 requirements. View full pre-conference details online.

## AGENDA HIGHLIGHTS

### DAY 1 — FRIDAY, SEPTEMBER 14

- **WELCOME AND OPENING REMARKS** from NCQA President Margaret O'Kane, MHS
- **OPENING SESSION:** Return on Investment: Show Me the Dollars in the Value of PCMH
- **KEYNOTE:** Together Everyone Achieves More: How Teamwork Impacts Patient Care presented by Greg Bell
- **GRAND OPENING:** Exhibit Hall Reception with Complimentary Refreshments

See pages 6–7 for the complete lineup.

### DAY 2 — SATURDAY, SEPTEMBER 15

- **PCMH** as the Foundation for Global Health Care Transformation with the "godfather" of the PCMH movement, Paul Grundy, MD, MPH, FACOEM, FACPM
- **FEATURED SESSION:** Addiction Intervention: Addressing the Opioid Epidemic within the Medical Home with Andrey Ostrovsky, MD, former CMO of the Center for Medicare & Medicaid Services
- **EXHIBIT HALL RECEPTION:** Join us for networking, festivities, and prize announcements.

See pages 8–9.

### DAY 3 — SUNDAY, SEPTEMBER 16

- **Legislating the PCMH:** What You Need to Know About Federal Regulations
- **Culture Shock:** How to Start Working Together Toward Transformation
- **CLOSING SESSION:** Value-Based Payment: A Case-Model Presentation and Panel Discussion

See pages 12–13 for the full details.

# Steering Committee

**On behalf of the entire PCMH Congress Steering Committee, welcome and thank you for your support and interest in advancing the PCMH model of care.**

**The knowledge you will gain at PCMH Congress—from lectures and information discussions with colleagues—will lead to immediate improvements in patient care when brought back to your practice."**

**Michael S. Barr, MD, MBA, MACP, FRCP**
Executive Vice President
Quality Measurement and Research Group
National Committee for Quality Assurance
Washington, DC

**Patricia Marine Barrett, MHSA, PCMH CCE**
Vice President
Product Design and Support
National Committee for Quality Assurance
Washington, DC

**Candace J. Chitty, RN, MBA, CPHQ, PCMH CCE**
President
Quality First Healthcare Consulting, Inc.
Winter Park, Florida

**Joseph E. Fojtik, MD, FACP, PCMH CCE**
Mercy Health Systems
Medical Coordinator
Illinois Department of Finance and Professional Regulations
Chicago, Illinois

**Mina Harkins, MBA, PCMH CCE**
Assistant Vice President
Recognition Programs Policy and Resources
National Committee for Quality Assurance
Washington, DC

**Paul Klintworth, MSPM, HIT**
Public Health Analyst
Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
Crofton, Maryland

**James Tan, MD, MPH, MBA, CPE**
Vice President, Value and Resource Stewardship
Northwest Permanente, PC
Kaiser Permanente
Portland, Oregon



## KEYNOTE SPEAKER

**Greg Bell**
Author and Thought Leader
Founder, Water the Bamboo Center for Leadership

## DISTINGUISHED FACULTY

**Shari M. Erickson, MPH**
Vice President, Governmental Affairs and Medical Practice
American College of Physicians

**Paul Grundy, MD, MPH, FACOEM, FACPM**
Global Director, Healthcare Transformation
HealthTeamWorks

**Vanessa Guzman**
Associate Vice President, Quality Improvement
Montefiore Health System

**Michael S. Hoben, MD**
Community Medicine Service Line Leader
Novant Health Cotswold Medical Clinic

**Amber L. Karol, RN, BSN**
Clinic Administrator
Novant Health Endocrinology

**Ashley Ligue, RMA, PCMH CCE**
Lead Patient-Centered Medical Home Advisor
Advocate Physician Partners

**Beth Ann Marootian, MPH**
Director of Business Development
Neighborhood Health Plan of Rhode Island

**Len Nichols, PhD**
Director, Center for Health Policy Research and Ethics
Professor of Health Policy
College of Health and Human Services
George Mason University

**Andrey Ostrovsky, MD**
CEO
Concerted Care Group

**Jenney Samuelson**
Associate Director, Blueprint for Health
Department of Vermont Health Access

**Evan Saulino, MD, PhD**
Providence Milwaukie Family Residency
Providence Center for Outcomes Research Education
Clinical Advisor, Oregon's Patient-Centered Primary Care Home Program

**Alvia Siddiqi, MD, FAAFP**
VP, Innovations and Government Programs
Advocate Physician Partners

**Adam F. Spitz, MD**
Novant Health Endocrinology

## FACULTY

**Adele M. Allison, BSPS**
National Director, Provider Innovation Strategies
DST Health Solutions

**Shrujan Amin, MS**
Data Scientist, Clinical Analytics
Care Coordination Institute

**Michael J. Attanasio, DO**
Ritner Medical Associates

**Jeanette Ball, BSN, RN, PCMH CCE**
Delivery Manager, Advisory Services
CTG Health Solutions

**Steven D. Blatt, MD**
Professor of Pediatrics
Director, Division of General Pediatrics
Upstate Medical University

**Kristi Bohling-DaMetz, RN, BSN, MBA**
Chief Strategy Officer
HealthTeamWorks

**Antonella Bojanich**
Project Manager, Medicine Service Line
Northwell Health

**Scott Bolhack, MD, MBA, CMD, CWSP, FACP, FAAP**
CEO and Medical Director
TLC HealthCare Medical Group
CMO, Sunbelt Medical Group

**Nelly Burdette, PsyD**
Director, Integrated Behavioral Health
Providence Community Health Centers

**Brigid Byrne, EdD, ARNP-BC, CPHQ, PCMH CCE**
Practitioner, Agape Clinic of Dallas
Director, Clinical Transformation
Premier, Inc.

**Susanne Campbell, RN, MS, PCMH CCE**
Senior Project Director
Care Transformation Collaborative of Rhode Island

**Kimberly Combahee, CMPE**
Director of Physician Operations
Piedmont Athens Regional

**John Custer, LCSW**
Mental Health Department Administrator
Kaiser Permanente Northwest

**Tammy D. Daniels, MBA, PCMH CCE, PHR**
Senior Program Manager
Healthcare Improvement
Baylor Scott & White Health

**Kristin David, PsyD**
Integrated Behavioral Health Specialist, Associates in Primary Care Medicine

**Richard J. Dom Dera, Jr., MD, FAAFP, PCMH CCE**
Advanced Primary Care Medical Director
NewHealth Collaborative

**Tammy Donnelly**
Program Manager, PCMH Content Expert Certification
National Committee for Quality Assurance

**David Ehrenberger, MD**
Chief Medical Officer
HealthTeamWorks

**Briar Ertz-Berger, MD, MPH**
Assistant Director, Operations for Special Population
Kaiser Permanente

**Emily Fisk, MHA, PCMH CCE**
Advisor, Practice Advancement Strategies
Healthcare Association of New York State

**Nathan Fleming, MD, MPH**
Physician Lead, Quality and Health Equity
Children's Hospital of Wisconsin – Urgent Care

**Carmen Francavilla, MBA, BSN, RN-BC, PCMH CCE**
Director, Practice Advancement Strategies
Healthcare Association of New York State

**Nicole Friedman, MS**
Department Administrator
Kaiser Permanente

**Matt Gannon, PCMH CCE**
Manager, Practice Transformation Programs
Primary Care Information Project
NYC Department of Health and Mental Hygiene

**Nicole Harmon, MBA, PCMH CCE**
Senior Director, Practice Advancement Strategies
Healthcare Association of New York State

**Xiaoyan Huang, MD, MHCM, FACC**
Medical Director, Clinical Transformation
Providence Heart Institute Oregon

**Scott Hultstrand, JD**
Director, Performance Improvement
Care Coordination Institute

**Brenda Jenkins, RN, D.Ay, CDOE, CPEHR, PCMH CCE**
Senior Program Administrator
Healthcentric Advisors

**Deborah Johnson Ingram**
Program Director, Primary Care Development Corporation

**Barbara Keber, MD, FAAFP**
Vice Chair, Department of Family Medicine
Northwell Health

**Martin Kerzer, DO**
President
Associates in Primary Care

**Jameson King, MHA, PCMH CCE**
Senior Analyst, Practice Transformation Programs
Primary Care Information Project
NYC Department of Health and Mental Hygiene

**Lesley Jones Larson, MHA, FACHE**
Director of Clinical Operations

**Nancy LaVine, MD**
Associate Chief, Clinical Affairs
Division of General Internal Medicine
Northwell Health

**Lucy Loomis, MD, MSPH, FAAFP**
Director, Family Medicine
Denver Health

**Janice Magno, MPA**
Assistant Director, Strategy
Primary Care Information Project
NYC Department of Health and Mental Hygiene

**Amy Malkin**
Chief Operating Officer
Pioneer Health

**Stacey Mallin, MPA, CPHQ, CLSSBB, PCMH CCE**
Director, Program Operations
Northwell Health

**Angelo Marciano, MHA, PCMH CCE, CPC**
Project Manager
Primary Care Development Corporation

**Maria Casaverde Marin, PCMH CCE**
Quality Improvement Operations Coordinator
Denver Health

**Joshua Marx, MPH, PCMH CCE**
Healthcare Transformation Specialist
New Jersey Academy of Family Physicians

**Jennifer McCloskey, MPH, PCMH CCE**
Project Director
Toledo-Lucas County Health Center

**John P. Metz, MD, CAQSM**
Associate Director
Hackensack Meridian Health JFK Medical Center

**Cari Miller, MSM, PCMH CCE**
Manager, Value-Based Programs
Horizon Blue Cross Blue Shield of New Jersey

**Jeffrey S. Musmacher, MBA**
Senior Director
Medicine Service Line
Northwell Health

**Carlie Nikel, PsyD**
Licensed Clinical Psychologist and Family Medicine Behaviorist
Department of Community and Family Medicine
University of Missouri Kansas City School of Medicine

**Jenica O'Malley, DO**
Assistant Professor of Pediatrics
Upstate Medical University

**Patrick W. Page, MD**
Family Physician
Colorado Mesa University
Family Physician, Primary Care Partners PC

**Hilary Pauli, MPH, PCMH CCE**
Practice Transformation Specialist
Primary Care Information Project
NYC Department of Health and Mental Hygiene

**Angel Perez, BSN, PCMH CCE**
Practice Transformation Coordinator
University of Colorado Health Sciences Center

**Stephanie Phibbs, PhD, MPH**
Regional Care Collaborative Organization Coordinator
Denver Health

**Natasha N. Rishi-Bohra, MPH**
Strategy Manager, Practice Transformation
Primary Care Information Project
NYC Department of Health and Mental Hygiene

**Robert T. Rohloff, MD**
Director of Quality and Patient Safety – Primary Care
Children's Hospital of Wisconsin

**Beth Rosemergey, DO, FAAFP**
Program Director, University of Missouri Kansas City Family Medicine Residency
Vice Chair, Outpatient Care
Community and Family Medicine
Truman Medical Center Lakewood

**Jackie Ryan, MPH**
Program Manager, Clinical Quality and Population Health
Kaiser Permanente Northwest

**Andrew Saal, MD, MPH**
Chief Medical Officer
Providence Community Health Centers

**Megan Santanna, MA, PCMH CCE**
Director, Practice Optimization
Ritner Medical Associates

**Stephanie Selby, RN, CPHQ, PCMH CCE**
Director, Healthcare Improvement
Baylor Scott & White Health

**Vipul Shukla, MS**
Student, University of Toledo

**Sharon Smith, LPC**
BHC Team Supervisor
Kaiser Permanente Northwest

**Gila Stadler, MPH, PCMH CCE**
Practice Transformation Specialist
Primary Care Information Project
NYC Department of Health and Mental Hygiene

**Cynthia J. Stevens, DNP, MSN, RN**
Senior Director
Texas Tech University Health Science Centers

**Karen Sullivan**
Senior Operations Manager, PM PCMH/CPC
Akron Children's Hospital

**Kathryn Tynan, MSN, A/GNP, WCC, ACHPN**
Chief Clinical Services, Sunbelt Medical Group

**Thomas W. Wells, MD, FACP**
Regional Medical Director of Quality and Population Health
Piedmont Clinic

**Lisa Winkler, RN**
Nurse Manager, Upstate Pediatrics and Adolescent Center
Upstate Medical University

DAY 1

# FRIDAY, SEPTEMBER 14

7:00 AM–8:00 AM
**Registration and Complimentary Breakfast**

8:00 AM–8:15 AM
**Welcome and Opening Remarks from NCQA President Margaret O'Kane, MHS**

## OPENING SESSION

8:15 AM–9:15 AM
### Return on Investment: Show Me the Dollars in the Value of PCMH
Advocates of the PCMH model of care are often asked to show the value in transformation. Although developing and implementing a PCMH requires a number of investments—including time and capital—understanding the return on investment (ROI) is instrumental in creating a path toward success. This session will explore the potential ROI in PCMH transformation, including a real-world case from Advocate Physician Partners in Illinois.

**Ashley Ligue, RMA, PCMH CCE; Beth Ann Marootian, MPH; Alvia Siddiqi, MD, FAAFP**

**WORKSHOPS** (Select 1 of 3) | 9:25 AM–10:25 AM

### Creating a Sustainability Approach in a Multisite Organization
Practice transformation cannot be a "check the box" approach, increasing the likelihood of practices slipping back into old ways. Instead, by integrating a sound sustainability approach from the beginning, practice team members have clear expectations, roles, and responsibilities for the practice's long-term success. This session will cover how this is especially important in an environment with multiple practice locations.

**Nicole Harmon, MBA, PCMH CCE**
PCMH Transformation

### A Successful Blueprint for Integrating Behavioral Health into Primary Care
The primary care practice team needs to learn new skills and workflows in order to apply a targeted approach to systematically identify patients with behavioral health needs and use this information to develop team-based strategies for improving clinical and financial outcomes. This presentation will provide attendees with a tested framework for integrating behavioral health into primary care using population health and performance improvement approaches.

**Susanne Campbell, RN, MS, PCMH CCE; Kristin David, PsyD; Martin Kerzer, DO**
Behavioral Health

### Impact MACRA: Essential Strategies for the PCMH
The goal of this presentation is to help attendees master the complexities associated with economic reform, as well as gain an understanding of how to leverage NCQA PCMH and health IT to actualize measurable quality and value in care delivery. In doing so, providers will secure their economic future, one that is focused on managing and rewarding patient health status over production-based health care.

**Adele M. Allison, BSPS**
Payment Models

**WORKSHOPS** (Select 1 of 3) | 10:35 AM–11:35 AM

### Lessons Learned from Implementing the School-Based Medical Home Model
This presentation will share lessons learned from the implementation of SBMH framework in a multisite school-based health program in New York City. This presentation will compare the similarities and differences between transformation in a traditional primary care setting and a school-based setting. We will address the unique challenges SBHCs face in their vital role as part of the medical neighborhood.

**Janice Magno, MPA; Natasha N. Rishi-Bohra, MPH; Hilary Pauli, MPH, PCMH CCE**
Unique Practice Settings

### Effective Use of Health Information Technology within the Patient-Centered Medical Home Model
The purpose of this session is to provide information about Health IT product management methodologies that are critical for delivering high-quality primary care services. The utilization of these methodologies results in a greater chance of organizational success and solutions that are well suited to meet provider and practice needs. This session will educate practice administrators on how properly utilizing their HIT can benefit their practice's operations and care delivery.

**Deborah Johnson Ingram; Angelo Marciano, MHA, PCMH CCE, CPC**
Health IT

### Optimizing Geriatric Care Using a Patient-Centered Medical Home Framework
With a rapidly growing geriatric population, primary care practices need to identify specific, sustainable initiatives that care teams can use to provide best-in-class care for geriatric patients. The goal of this session is to explore specific benefits that PCMH-recognized practices provide to geriatric patients.

**Tammy D. Daniels, MBA, PCMH CCE, PHR; Stephanie Selby, RN, CPHQ, PCMH CCE**
Collaborative Care

11:45 AM–12:45 PM
### Meet the Specialists: PCSP and PCMH as the Cornerstones of the Medical Neighborhood
Optimization of patient-centered care requires a buy-in from all stakeholders within the medical neighborhood. The relationship between primary care and specialist physicians is critical to building a strong foundation for collaborative care. Join Dr. Michael Hoben, Dr. Adam Spitz, and Amber Karol, RN, as they share their real-world experiences collaborating within the medical neighborhood of Novant Health.

**Michael S. Hoben, MD; Amber L. Karol, RN; Adam F. Spitz, MD**

12:45 PM–2:05 PM
**Industry-Supported Lunch Symposia**
Lunch in the Exhibit Hall

**WORKSHOPS** (Select 1 of 3) | 2:15 PM–3:15 PM

### Addressing Behavioral Health Needs in the Primary Care Setting: The Behavioral Health Consultant Model
With an estimated 40% of all premature mortalities being attributed to behavior, there is a clear unmet need in the primary care setting. As such, Kaiser Permanente Northwest developed a Behavioral Health Consultant model, enabling them to address mental health and substance abuse issues in a patient's primary care medical home. This session will cover the current state, successes, challenges, and lessons learned from implementation.

**John Custer, LCSW; Jackie Ryan, MPH; Sharon Smith, LPC**
Behavioral Health

### A Practical and Team-Based Approach to Risk Stratification for the Entire Patient Panel
Risk stratification for an entire patient panel can be a daunting challenge. The goal of this presentation is to describe a two-stepped risk stratification process involving the entire care team. This risk-stratified patient panel is then the starting point around which longitudinal care management is built. Learn how to customize a risk-stratification process to best fit your practice, and also how risk stratification can be used to help smaller practices decide how to deploy their limited resources.

**Richard J. Dom Dera, Jr., MD, FAAFP, PCMH CCE**
PCMH Transformation

### A Volunteer Team-Based Approach to Patient-Centric Care in a Unique Practice Setting for the Working Poor
Non-traditional outreach programs and leveraging community volunteers provide incentives for citizens to contribute to their health and wellness. The goal of this presentation is to understand how non-traditional practices provide patient-centric population health to the working poor.

**Brigid Byrne, EdD, ARNP-BC, CPHQ, PCMH CCE**
Unique Practice Settings

**WORKSHOPS** (Select 1 of 3) | 3:25 PM–4:25 PM

### Reducing Socioeconomic Barriers to Health and Health Care for High-Risk and High-Cost Populations
Despite a wealth of evidence on the impact of social and economic needs on health outcomes, health care systems currently lack the necessary tools and strategies to systematically identify and document these needs within electronic health records. This session will show how addressing social determinants of health has been operationalized within patient-centered primary care to provide an enhanced level of care to a high-risk patient population through comprehensive case management and a community resource referral system. By addressing non-medical social and economic needs, patients may be able to focus on their health needs and engage in appropriate health care use that reduces preventable emergency department visits and health care costs.

**Briar Ertz-Berger, MD, MPH; Nicole Friedman, MS**
PCMH Transformation

### Data-Driven Decision-Making to Catalyze PCMH Transformation
With the onset of MACRA and other value-based payment programs, up-to-date and actionable quality and cost data on clinicians are critical to achieving better performance and aiding PCMH transformation. To perform meaningful analyses that enable informed decisions by executive leadership, a combination of traditional and non-traditional sources of provider analysis is needed to fully understand how the data intersects and correlates. This session will provide a detailed overview of how to think creatively about data sources, propose innovative ways to join and visualize the results to answer critical questions, and operationalize the answers that the data provide to achieve practice transformation in both quality improvement and high-risk care management efforts.

**Shrujan Amin, MS; Scott Hultstrand, JD**
Health IT

### Mind the Gap: The Quality Improvement Journey of Grand Junction's Frailty Workgroup to Impact Social Determinants of Health
The electronic frailty index has shown the strongest predictive value of adverse outcomes for the elderly population. Most PCMH systems and governmental quality improvement metrics are disease-focused and do not account for social determinants of health. This session will describe the accumulated deficit theory of frailty, its predictive power, and impact on case plans for the elderly; assess the medical neighborhood's obstacles to planned patient-centered care for the frail population; and identify local collaboration partners to improve quality of care across the spectrum of care for the frail population.

**Patrick W. Page, MD**
Collaborative Care

## KEYNOTE

4:35 PM–5:35 PM
### Together Everyone Achieves More: How Teamwork Impacts Patient Care
Teams are the foundation of organizational life. Yet any leader knows that building and leading high-performing teams is one of today's most complex challenges. A strong team-building plan is critical for growing organizations. Giving organizations an under-the-hood look at the characteristics of high-performing teams, Greg Bell explores how to build and nurture teams that consistently perform better, innovate more, and achieve collaborative success.

**Greg Bell**

5:35 PM–7:05 PM
**Exhibit Hall Grand Opening**

DAY 2

# SATURDAY, SEPTEMBER 15

7:00 AM–8:00 AM
**Complimentary Breakfast in Exhibit Hall**

**WORKSHOPS** (Select 1 of 3) | 8:00 AM–9:00 AM

### Akron Children's: The Journey and Transition from a Fee-For-Service Culture into a Value-Based Care Model

This session will show how two organizations worked collaboratively to meet the requirements necessary for Akron Children's to enter into the Ohio State Comprehensive Primary Care (CPC) Medicaid Early Adoption program and gain NCQA PCMH Recognition. Together, they developed the processes and IT tools necessary to meet these requirements, as well as expand their quality program and develop an integrated risk stratification system to drive their new Care Management and Population Health departments. This session will demonstrate how, in a short time, Akron Children's has successfully implemented multiple processes that have transformed how care is delivered and prepared them for the movement to value-based medicine.

**Jeanette Ball, BSN RN, PCMH CCE; Karen Sullivan**
Payment Models

### Partnering with Patients: Gaining Perspective from a Patient Family Advisory Council

This presentation focuses on the institution and sustainability of a Patient Family Advisory Council (PFAC) in a small primary care office. We share our experience firsthand through a media-driven time lapse with our practice as we grow through the successes and struggles of practice transformation with our patients and families over the course of 9 months. Join us as we explore partnering with patients to better understand patient motivations, barriers to care, social determinants, and their impacts on health outcomes.

**Michael Attanasio, DO; Megan Santanna, MA, PCMH CCE**
Collaborative Care

### Medication Adherence: A Toolkit for Clinicians and Care Teams

Join NCQA as they explore the new medication adherence toolkit and the role of the PCMH in improving patient adherence to treatment.
PCMH Transformation

**WORKSHOPS** (Select 1 of 3) | 9:10 AM–10:10 AM

### The Post-Acute Care PCMH: A Temporary Home for the Geriatric Patient in Transition from the Hospital

Creating a medical home for the patient in transition from the hospital often requires stops along the way in rehabilitation facilities and skilled nursing facilities, where the involvement of the primary care physician is neglected. In this session, we will review the metrics that we utilize to monitor this system of care; the steps necessary to create a narrow network of professionals and healthcare companies to meet the patients' goals in the transition of care; and outline the unique qualities of the clinical team necessary to meet the challenges of the patient transferred out of the hospital.

**Scott Bolhack, MD, MBA, CMD, CWSP, FACP, FAAP; Amy Malkin; Kathryn Tynan, MSN, A/GNP, WCC, ACHPN**
Unique Practice Settings

### Capitalizing on Health Information Technology in the Pre-Visit Huddle to Improve Preventive Care

Primary care providers deal with multiple competing agenda items at each clinical visit with patients. Pre-visit team meetings, or huddles, are invaluable in patient-centered care, both for agenda setting and identifying needed services for patients. This session will explore how we sought to streamline our pre-visit huddle process by capitalizing on IT advancements in the documentation of preventive care needs for patients.

**Barbara Keber, MD, FAAFP; Nancy LaVine, MD; Jeffrey S. Musmacher, MBA**
Health IT

### The Nuts and Bolts of Patient-Centered Medical Home Content Expert Certification Exam Preparation

Achieving the title "NCQA Patient-Centered Medical Home Certified Content Expert™ (PCMH CCE)" demonstrates a comprehensive knowledge of medical home concepts and NCQA's PCMH 2017 Recognition Program requirements. Candidates interested in becoming a PCMH CCE must demonstrate their expertise by completing prerequisite coursework and passing a standardized examination. This session will be facilitated by current content experts (PCMH CCEs) and is designed to help prepare candidates for the required exam. Our experts will discuss the best methods to prepare for the exam and share helpful hints and frequently asked questions to help ease anxiety regarding the test. As a participant in this session, you are encouraged to bring your questions. This session will not offer CME/CNE/CPE credit.

**Tammy Donnelly; Nicole Harmon, MBA, PCMH CCE; Cari Miller, MSM, PCMH CCE**
PCMH Transformation

**WORKSHOPS** (Select 1 of 3) | 10:20 AM–11:20 AM

### Practice Facilitation: Creating Sustainable Transformations

Driving change requires a unique skill set. In this session, practice facilitators will learn key skills and activities necessary to create true and sustainable practice transformation, such as motivational interviewing, engaging team members, and building practice capacity.

**Nicole Harmon, MBA, PCMH CCE**
PCMH Transformation

### Integration of Behavioral Health into a Family Medicine Residency Clinic

Utilizing the various stakeholders of integration of behavioral health into primary care, we will explore the decision-making process associated with initial integration of a psychologist into a family medicine residency continuity clinic. This session will focus on the costs and benefits, as well as the barriers and future goals, of integration from the viewpoint of a psychologist, clinical medical director, administrator, and family medicine resident. In addition, we will analyze the impact of integration on the culture and language change of our clinic's resident physicians.

**Carlie Nikel, PsyD; Beth Rosemergey, DO, FAAFP**
Unique Practice Settings



### Leveraging PCMH as a Foundation for Succeeding in Value-Based Care Programs

This session is designed to show how a family medicine residency practice leveraged its six-year PCMH certification journey to prepare them for recent value-based payment opportunities, such as CPC+ and the Medicare Shared Savings Program (MSSP). The session will describe their high-level use of PCMH structure as a foundation for organizing the practice and will also dive into their process of addressing two areas of transformation: risk stratification and care coordination via ED/hospital discharge management.

**Joshua Marx, MPH, PCMH CCE; John P. Metz, MD, CAQSM**
Payment Models

11:30 AM–12:30 PM
**PCMH as the Foundation for Global Health Care Transformation**

"What patients want is that deep relationship with a healer; this is the foundation upon which we need to build health care." This is true not just here, but around the world. Hear from the godfather of PCMH, Paul Grundy, as he shares what is happening in the field on a global scale and introduces the organizations driving this worldwide change.

**Paul Grundy, MD, MPH, FACOEM, FACPM**

12:30 PM–1:50 PM
**Industry-Supported Lunch Symposium**
Lunch in the Exhibit Hall

**WORKSHOPS** (Select 1 of 3) | 2:00 PM–3:00 PM

### Achieving Better Access, Care Coordination, Patient Experience, and Operational Efficiency Through Patient-Centered Specialty Practice Transformation

This session will include a discussion on PCSP standards and share real-world experiences with strategic planning, operational improvement, and project management. With specialty practices being slow to adopt PCSP and care coordination continuing to be a challenge for primary care and specialists alike, the goal of this session is to help motivate and inform other specialty practices to embark on systematic practice improvement in specialty care.

**Xiaoyan Huang, MD, MHCM, FACC; Lesley Jones Larson, MHA, FACHE**
Collaborative Care

### Improving Primary Care Using Point-of-Care, Technology-Driven Enhancements

Primary care practices are continually challenged to achieve more with fixed resources. Providers need better tools to support practice transformation to a PCMH. Many current electronic health record systems provide access to an abundance of data, but this data is not always presented in a comprehensive or efficient way. This session will present technological enhancements to provide an improved experience for the patient, provider, and staff, which will result in improved quality of care.

**Antonella Bojanich; Nancy LaVine, MD; Jeffrey S. Musmacher, MBA**
Health IT

### From 1 to 100: PCMH for All Practice Sizes

Not all PCMH-recognized practices are able to approach transformation and optimization of patient-centered care in the same way. Each practice requires a custom approach based on a variety of factors, including size and resources. From an independent single-site practice to a large multi-site health care organization, hear how the same challenges have been approached from different perspectives.

**Brenda Jenkins, RN, D.Ay, CDOE, CPEHR, PCMH CCE; Angel Perez, BSN, PCMH CCE**
PCMH Transformation

**WORKSHOPS** (Select 1 of 3) | 3:10 PM–4:10 PM

### Developing a Patient-Centered Plan of Care to Meet Multiple Payer and NCQA Requirements

The most efficient way to implement Medicare and Medicaid Care Coordination requirements within a multiple-payer context is unclear. In this session, attendees will increase their knowledge of Payer Care Coordination requirements and how they can operationalize these requirements to meet PCMH guidelines, as well as be able to develop a business plan to implement Care Coordination models in their practices that are financially self-sustaining.

**Maria Casaverde Marin, PCMH CCE; Lucy Loomis, MD, MSPH, FAAFP; Stephanie Phibbs, PhD, MPH**
Payment Models

### Establishing a PCMH in an Inner-City Pediatric Resident Clinic

Being a PCMH is ideal for an inner-city population. To educate the next generation of providers in delivering excellent primary care well into the future, the health care systems need more successful PCMH practices in which to train residents. This session will detail many of the steps necessary to develop and maintain a successful PCMH home in an academic, pediatric, inner-city office with almost 50 residents and 15 faculty.

**Steven D. Blatt, MD; Jenica O'Malley, DO; Lisa Winkler, RN**
Unique Practice Settings

### Population Health Meets Integrated Behavioral Health within an FQHC

To better understand and serve patients accessing care at an urban multisite, multi-lingual FQHC, an interdisciplinary team engages in universal screening for depression, anxiety, and substance abuse. This program will explore the rationale behind standardized screening for core behavioral health conditions within a busy primary care clinic, as well as the lessons learned during a large-scale implementation of the program.

**Nelly Burdette, PsyD; Andrew Saal, MD, MPH**
Behavioral Health

**FEATURED SESSION**

4:20 PM–5:20 PM
### Addiction Intervention: Addressing the Opioid Epidemic within the Medical Home

According to the U.S. Department of Health and Human Services, 11.5 million Americans misused prescription opioids in 2016. The medical home model has the potential to help clinicians risk stratify, identify, and monitor those at risk for opioid abuse and provide effective intervention when abuse occurs. Join Dr. Ostrovsky as he provides his unique perspective on the opioid epidemic, drawing from his experience as a clinician, former Chief Medical Officer of CMS, and his own personal family experience.

**Andrey Ostrovsky, MD**

5:20 PM–6:50 PM
**Exhibit Hall Reception**

# CONFERENCE HIGHLIGHTS

## Join Us in Transforming Health Care

### Bring a Colleague

Call now! Organizations can receive $100 or more off each subsequent colleague registration.

### PCMH Education

See the full agenda designed with NCQA, including sessions on payment models, unique practice settings, behavioral health, and more.

### CCE Session Topics

Look for this icon next to can't-miss sessions for CCEs.

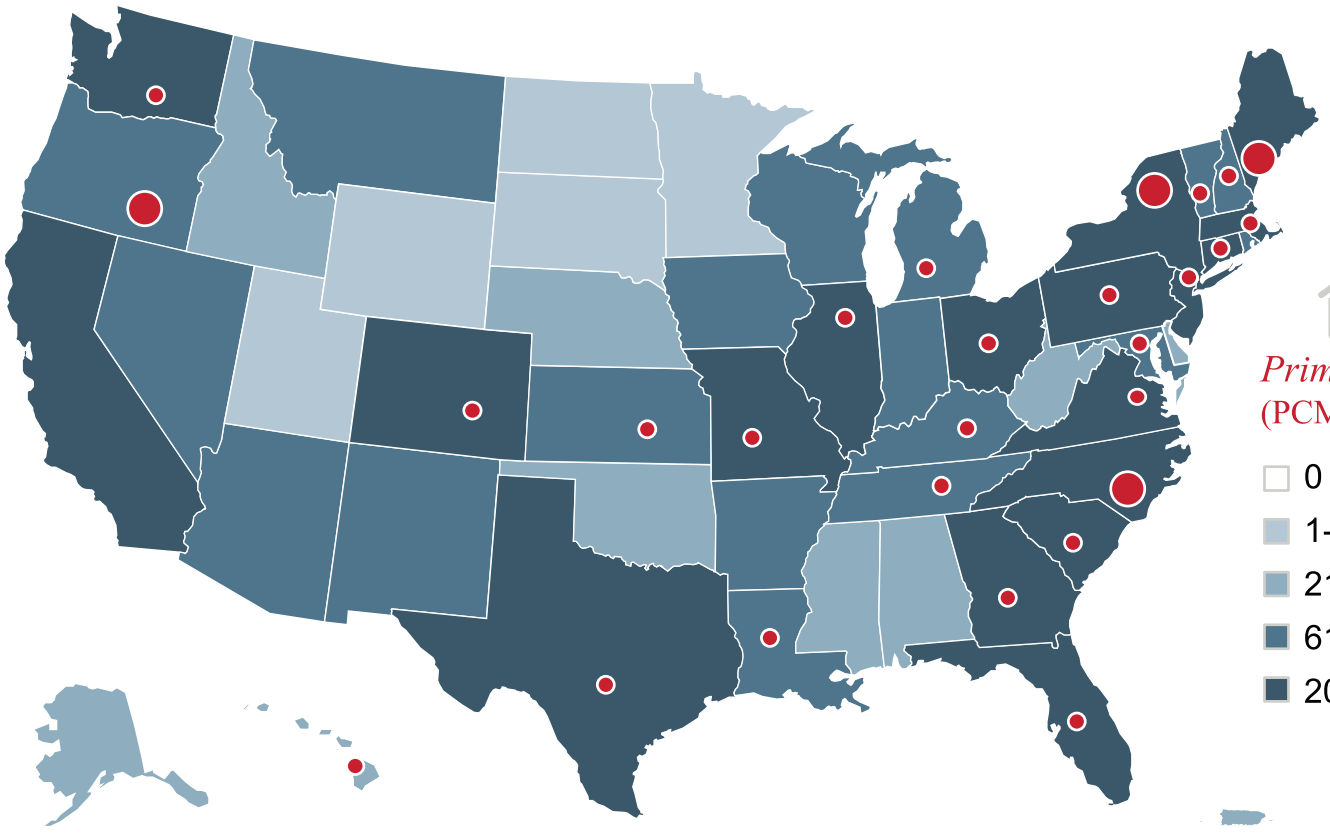
### Pre-Conference

PCMH Recognition Annual Reporting: Succeeding Through Continued Transformation

## NCQA Medical Neighborhood Recognition

*Closing the Loop Between Primary & Specialty Care*

**More Than** *15,200* **Total Sites Recognized** PCMH & PCSP




As of 3/31/2018

*Map & statistics provided by*

NCQA Measuring quality. Improving health care.

DAY 3

# SUNDAY, SEPTEMBER 16

7:00 AM–7:30 AM
**Breakfast**

7:30 AM–8:30 AM
## Legislating the PCMH: What You Need to Know About Federal Regulations
Understanding the impact of recent legislation is vital to the optimization of the medical home. This session will review recent legislation, including the 21st Century Cures Act, the Trusted Exchange Framework Common Agreement (TEFCA), and more.

**Shari M. Erickson, MPH; Len Nichols, PhD**

**WORKSHOPS** (Select 1 of 3) | 8:40 AM–9:40 AM

## The Comprehensive Care Management Process at Mercy Health Systems
PCMH clinical teams need access to patients who have multiple chronic conditions outside of the traditional clinical encounter or office visit. A PCMH model of care dictates that the clinical team somehow interact with patients when they are not in the office—when the "chart is on the rack." The CCM process explained in this session will help educate on one facet of care that can do so.

**Joseph Fojtik, MD, FACP, CCE**
Collaborative Care

## Culture Shock: How to Start Working Together Toward Transformation
While PCMH transformation requires a leader within a practice or group to spearhead transformation, optimized PCMH care cannot be achieved without a cohesive team. This session, which will include a diverse panel of a physician, nurse, and administrator, will explore common challenges faced by the PCMH team and how to overcome these conflicts and create the ideal PCMH team.

**Kimberly Combahee, CMPE; Thomas W. Wells, MD, FACP**
PCMH Transformation

## To Save a Life: Integrating Behavioral Health in a West Texas FQHC
Integrating behavioral health providers into the same facility as primary care providers shortens the length of time between a positive screening test and an appointment with a LCSW or LPC, possibly preventing a loss of life, suicide attempt, or overdose. This session will discuss the barriers in implementation of a behavioral health program at a federally qualified health center (FQHC) and approaches for improving the mental and physical health of a medically underserved population.

**Cynthia J. Stevens, MSN, RN**
Behavioral Health

**WORKSHOPS** (Select 1 of 3) | 9:50 AM–10:50 AM

## Incorporating Cost and Value into Practice Assessments
Though traditional PCMH assessment tools can readily identify practice workflows, staff roles, and patient populations for the transformation work plan, these assessments do not capture vital information regarding practices financial, budgeting, and coding processes, resulting in a gap in understanding a practice's readiness to participate in value-based payment (VBP) contracts. In this session, we will share the development process and framework for an enhanced assessment tool we created, including how the tool has helped practices understand their readiness for VBP and lessons learned from the implementation of the enhanced assessment tool.

**Matt Gannon, PCMH CCE; Jameson King, MHA, PCMH CCE; Gila Stadler, MPH, PCMH CCE**
Payment Models

## Assessing Opioid Overdoses in Population Health through Data Validation
Data collection in opioid deaths is not uniform; the Centers for Disease Control, state departments of health, and local departments of health all utilize different monitoring, classification, and analysis techniques. In order to compare and analyze the data, it is necessary to standardize data collection. This session will discuss the need for a unified approach to data collection and monitoring at the national, state, and local levels, to ensure that the data provided can be utilized effectively.

**Jennifer McCloskey, MPH, PCMH CCE; Vipul Shukla, MS**
Health IT

## Bringing the Medical Neighborhood to Life: Key Drivers of High Performing Delivery Networks
Advanced Network Integration is the foundation of high-performing, regional delivery networks and the primary driver of Quadruple Aim performance. It requires formal provider engagement, collaboration, and accountability. This session will describe the four pillars and key drivers of performance for Advanced Network Integration: Network Referral Management Systems; Advanced Systems of Primary Care; Specialty Care and Advanced Team Work; and Community-Integrated Primary Care Structure, Systems, and Resources. Attendees will learn what's working in delivery networks around the country, including models of advanced integration and their impact.

**Kristi Bohling-DaMetz, RN, BSN, MBA; David Ehrenberger, MD; Paul Grundy, MD, MPH, FACOEM, FACPM**
PCMH Transformation

11:00 AM–12:00 PM
**Industry-Supported Brunch Symposia**

**WORKSHOPS** (Select 1 of 3) | 12:10 PM–1:10 PM

## How We Built Our Medical Neighborhood: Our Story Narrated by Champions of PCMH, PCCC, and PCSP
This session will educate clinical staff on how to implement PCMH, Connected Care, or PCSP recognition within their health care systems and what benefits they may receive as a result of that recognition. Thinking beyond what can be offered in the patient-centered medical home and looking at what care the patient needs from their medical neighborhood is where our thinking needs to shift.

**Nathan Fleming, MD, MPH; Robert T. Rohloff, MD**
Collaborative Care

## MACRA: Road Map to Physician Payment Reform
Physician payment reform will require shifting from fee-for-service to value-based payment. MACRA and the Quality Payment Program (QPP) provide a framework for alignment in managing cost and improving quality of care. This presentation will discuss strategies to apply participation in MACRA/QPP to population management across attributed patients.

**Emily Fisk, MHA, PCMH CCE; Carmen Francavilla, MBA, BSN, RN-BC, PCMH CCE**
Payment Models

## Making Practice Transformation Simple for Solo and Small Community-Based Practices
Practice transformation can be daunting to any practice, but imagine if you are a solo or small community-based practice in an urban or suburban setting with a large Medicaid patient population. By working with a large number of these primary care practices through the Delivery System Reform Incentive Payment (DSRIP) program, making things simple was a key to success in achieving recognition. In this session, attendees will learn techniques and strategies that will assist in a successful transformation.

**Stacey Mallin, MPA, CPHQ, CLSSBB, PCMH CCE**
Unique Practice Settings

1:20 PM–2:20 PM
## Value-Based Payment: A Case Model Presentation and Panel Discussion
The payment landscape in U.S. health care continues to shift toward value-based payment. This session will present case experiences from across the field of value-based care and provide real-world tools for implementation.

**Vanessa Guzman; Jenney Samuelson; Evan Saulino, MD, PhD**

2:20 PM–2:30 PM
**Conference Summary and Conclusion**


**Register now with the promo code PCMHMVP** and receive a 2018 Syllabus of your choice, plus PCMH On-Demand **FREE** with your registration.*

*Restrictions may apply.

## ACCREDITATION INFORMATION

**INTENDED LEARNERS**
This conference is designed for professionals devoted to transforming care through the medical home model of care, including clinicians, allied health professionals, practice administrators, quality managers, and consultants.

**LEARNING OBJECTIVES**
After attending the PCMH Congress 2018 meeting, participants should be able to:
- Outline best practices for the optimization of a PCMH within the medical neighborhood
- Identify critical roles within the collaborative care environment
- Discuss how individual roles in a collaborative care environment impact patient-centered care
- Impact patient and population health outcomes using the PCMH model of care

**ACTIVITY OVERVIEW**
The interactive educational conference will occur at the San Diego Convention Center in San Diego, California from September 14–16, 2018. A question-and-answer session with the faculty will follow each presentation.

To be eligible for documentation of credit, participants must attend the full activity and submit a completed evaluation form. Participants who complete the evaluation online at PCMHCongress.com within 4 weeks of the live meeting will immediately receive documentation of credit.

**HARDWARE/SOFTWARE REQUIREMENTS**
The evaluation is accessible after the activity via a PC (Windows 7 or newer) or Mac (Mac OS 10.6 or later) computer with current versions of the following browsers: Internet Explorer, Mozilla Firefox, Google Chrome, or Safari. A PDF reader is required for print publications. Please direct technical questions to webmaster@naccme.com.

**ACCREDITATION**
In support of improving patient care, this activity has been planned and implemented by the National Committee for Quality Assurance and the North American Center for Continuing Medical Education (NACCME), LLC. The National Committee for Quality Assurance is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

NCQA designates this live activity for a maximum of 21.0 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This continuing nursing education activity awards 21.0 contact hours.

This activity is approved for 21.0 contact hours (0.21 CEU) of continuing pharmacy education (UAN 0850-9999-18-004-L04-P).

Activities will provide 15 hours of maintenance of certification credit for PCMH CCEs.

**ADA STATEMENT**
NACCME and NCQA comply with the legal requirements of the Americans with Disabilities Act and the rules and regulations thereof. If any participant in this educational activity is in need of accommodations, please call 609-371-1137.

**INNOVATION THEATERS (NON-ACCREDITED)**
These are promotional programs and no CE credits are offered. All attendees, please be advised that information—e.g., your name and the value of any meal you receive during these promotional programs—may be publicly disclosed pursuant to applicable federal and/or state laws. If you are licensed in a state or are an employee of an organization that limits or prohibits meals from pharmaceutical companies, please identify yourself so that everyone is able to comply with such requirements.

**CANCELLATION POLICY**
Please note that the cutoff date for cancellation is July 31, 2018. All cancellations must be received in writing and postmarked by that date. Full registration (less a $100 processing fee or full registration amount, whichever is less) will be refunded only to cancellations received in writing before the above date. No refunds will be issued after July 31, 2018; no exceptions. Registrations are transferable at any time. Payments made may not be applied toward tuition for future PCMH Congress conferences, or other meetings or products offered by HMP, NACCME, or NCQA.

**PRIVACY POLICY**
NACCME protects the privacy of personal and other information regarding participants, educational partners, and joint sponsors. NACCME and our joint sponsors will not release personally identifiable information to a third party without the individual's consent, except such information as is required for reporting purposes to the appropriate accrediting agency. NACCME maintains physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

Copyright © 2018 by North American Center for Continuing Medical Education, LLC. All rights reserved. No part of this accredited continuing education activity may be reproduced or transmitted in any form or by any means, electronic or mechanical, without first obtaining permission from North American Center for Continuing Medical Education.

Jointly provided by North American Center for Continuing Medical Education, LLC, an HMP Company, and the National Committee for Quality Assurance.

# HOTEL & TRAVEL

## Choose from Our San Diego Hotels!

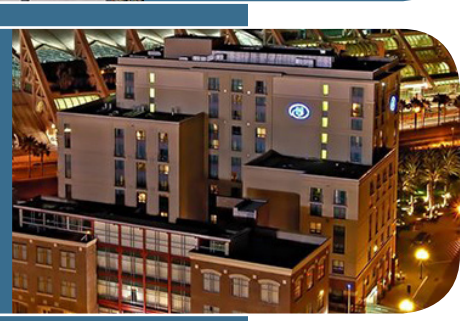
Reservations are available in limited room blocks, now through September 8, 2018.

Please note that a non-refundable deposit equal to the cost of one night's stay is required to hold your reservation.

**MANCHESTER GRAND HYATT**
From
**$259** per night

**OMNI SAN DIEGO**
From
**$239** per night

**HILTON GASLAMP QUARTER**
From
**$229** per night



For more information on hotel reservations, airline discounts, and ground transportation options, please visit pcmhcongress.com/hotel-travel.



## THE 2018 PCMH CONGRESS WILL BE HELD AT THE SAN DIEGO CONVENTION CENTER.

**2–10% OFF**
**Airfare Discounts**
DELTA UNITED AIRLINES

USE PROMO CODE
**PCMHMVP**
FREE SYLLABUS + ON-DEMAND

# REGISTRATION

| | Super Saver 4/7/18 to 7/20/18 | Early Bird 7/21/18 to 8/17/18 | Last Chance 8/18//18 to 9/13/18 | Regular/Onsite 9/14/18 to onsite |
|---|---|---|---|---|
| **Health Care Providers and CCEs** | | | | |
| General Admission | $1,149 | $1,299 | $1,499 | $1,599 |
| **Federally Qualified Health Centers and Look-Alikes*** You must qualify for funding under Section 330 of the Public Health Service Act (PHS). | | | | |
| FQHC Rate | $849 | $899 | $949 | $999 |
| **Non-Health Care Providers*** If you are employed by Industry, you must register as a Non-Health Care Provider. | | | | |
| Industry Rate | $1,899 | $1,899 | $1,899 | $1,899 |

*Additional discounts do not apply. For student, resident, fellow, and active military rates, please call 800-218-3185.

First Name _____ Last Name _____ Degree/Credentials _____

Position/Title _____ Company/Organization _____

Business Address _____ City _____ State _____ Zip _____ Country _____

Phone _____ Fax _____ Email (Confirmations will be sent via email.) _____

### Affiliation
☐ General Registration ☐ Federally Qualified Health Center
☐ Non-Health Care Provider

### I am an NCQA PCMH-Recognized
☐ PCMH ☐ PCCC ☐ PCSP ☐ PCMH CCE ☐ PIQ ☐ GRIP
☐ HIT ☐ Distinction in Behavioral Health Integration
☐ Oncology Medical Home Recognition
☐ Not part of any NCQA-Recognized Program
☐ In the process of NCQA Recognition
☐ Other_____

### Professional Category
☐ Administration ☐ Business Development ☐ Director
☐ MD ☐ DO ☐ HIT ☐ Nurse (MSN) (BSN) (RN) (LPN)
☐ NP ☐ Quality ☐ Pharmacist ☐ PA ☐ Manager
☐ Population/Public Health ☐ Practice Consultant
☐ Other_____

### Number of Clinicians in Your Practice
☐ Single-site; 1–12 clinicians ☐ Single-site; 13+ clinicians
☐ Multi-site; 1–12 clinicians ☐ Multi-site; 13+ clinicians
☐ Independent Consultant ☐ N/A

### PCMH Familiarization
☐ New to the Role ☐ PCMH CCE Consultant ☐ Very familiar
☐ Somewhat familiar ☐ Other _____

**WAYS TO REGISTER**
Customer Service: 800-218-3185

CALL 800.218.3185
FAX 610.560.0502
VISIT PCMHCongress.com
MAIL HMP, 70 E. Swedesford Road, Suite 100 Malvern, PA 19355

### CONFERENCE ADD-ONS

☐ **$349 Thursday Pre-Conference per Attendee**

☐ **$75 Optional Syllabus**
Check ONE: ☐ Printed Book ☐ USB

☐ **$200 Optional On-Demand Recordings of the 2018 PCMH Congress Sessions**

☐ **Yes!** Use Promo Code PCMHMVP for Free Syllabus + On-Demand.

### Total Payment Enclosed: $ _____

### Method of Payment (Please choose from the following options.)
☐ Check made payable to HMP.
All checks must be drawn on a U.S. bank in U.S. funds. In memo line, please note "Registration for PCMH."
Mail to HMP, 70 E. Swedesford Road, Suite 100, Malvern, PA 19355

Credit Card ☐ American Express ☐ MasterCard ☐ Visa

Name on Card _____ Credit Card No. _____ Expiration Date _____

Security Code _____ Billing Postal Code _____

Signature of the Cardholder (required) _____

**Cancellation Policy** Please note that the cutoff date for cancellation is July 31, 2018. All cancellations must be received in writing and postmarked by that date. Full registration (less a $100 processing fee or full registration amount, whichever is less) will be refunded only to cancellations received in writing before the above date. No refunds will be issued after July 31, 2018; no exceptions. Registrations are transferable at any time.

Payments made may not be applied toward tuition for future PCMH Congress conferences, or other meetings or products offered by HMP, NACCME, or NCQA.

**Questions?** For additional registration information, please contact Sheila Donato at 800-218-3185 or sdonato@hmpglobal.com.

An Official Conference by NCQA

# PCMH Congress

**September 14–16, 2018**

San Diego Convention Center
San Diego, California

## JOIN YOUR COLLEAGUES AND COLLABORATE IN TRANSFORMING HEALTH CARE.

Offer Inside!
Free Syllabus & On-Demand

**Register today**
**pcmh**congress.com

NCQA
Measuring quality. Improving health care.

70 E. Swedesford Road
Suite 100
Malvern, PA 19355