PCMH MUSTS
PRACTICE TRANSFORMATION

- PCMH requires ePrescribing, patient-physician agreements, team practice, a disease registry and documented office policies.
- Patient-physician agreements are provided by PCPPC and should be given to and discussed with **all** of your patients, including mailing to patients not regularly seen in the office.
- Use of an all-payer chronic disease registry for **all** your diabetic, asthmatic, CHF, CAD and CKD patients.
- Your office procedures must be written and updated at least annually. Your staff must be trained according to the documented procedures. Template available from PCPPC. Procedures should include the at least the following:
  - Ongoing staff education process that includes information regarding the PCMH concept and the chronic care model
  - Use of evidenced base care guidelines (MQIC) – imbedded in the registry and available via PCPPC website.
  - 24/7 access to care and follow-up, including same day appointments for both urgent and routine visits
  - Test tracking and follow-up
  - Referral management
  - Coordination of care across the continuum
  - Planned visits, may include standing orders
  - Self-management of chronic diseases

Primary Care Physicians PC
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