After you’ve laid the foundation for your practice transformation, you’re ready to tackle the core principles of the patient-centered medical home (PCMH) model. Work with your practice staff to create a plan around your practice’s organization, quality care, and patient-centered care goals. Remember to work at your own pace—the practice transformation process takes time. Even incremental change will result in practice improvement.

**CHECKLIST**

**Practice Culture**
- □ Establish a PCMH transformation team and define your goals.
- □ Develop a project plan, lead practice change, and monitor progress.

**Staffing: Team-Based Care**
- □ Understand the basics of team-based care.
- □ Define team member roles and implement team-based care.

**Integrated and Coordinated Care**
- □ Create a team to oversee care transitions.
- □ Coordinate and monitor care transitions across the medical neighborhood.
- □ Use performance measures to evaluate and improve care transition processes.
- □ Build relationships with community resources.

**Population Health Management**
- □ Learn about population health management.
- □ Select and use patient registries for population health management.
- □ Implement planned care for chronic and preventive services.

**Patient Access to Care**
- □ Give patients the ability to schedule same-day appointments.
- □ Add extended-hours access to routine and urgent care.

**Patient Self-Management**
- □ Prepare to implement patient self-management support.
- □ Use and develop patient care and action plans.
- □ Consider home monitoring for chronic conditions.
- □ Use motivational interviewing to coach patients.

Implement this checklist with the help of step-by-step guides. Purchase the PCMH Planner at aafp.org pcmhplanner.