OHS CONNECTICUT Office of Health Strategy

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Primary Care and Community Health Reforms Workgroup – Guiding Principles

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1. Person & Family Centered

- Primary care is focused on the whole person – their physical, emotional, psychological and spiritual wellbeing, as well as cultural, linguistic, ~~and~~ social and socioeconomic needs.
- Primary care is grounded in mutually beneficial partnerships among clinicians, staff, individuals and their families/care partners, as equal members of the care team. Care delivery is customized based on individual and family/care partner strengths, preferences, values, goals and experiences using strategies such as care planning and shared decision making.
- Individuals are supported in determining how their ~~family or other~~families/~~-~~care partners may be involved in decision making and care.
- There are opportunities for individuals and their families/care partners to shape the design, operation and evaluation of care delivery.

2. Continuous

- Dynamic, trusted, respectful and enduring relationships between individuals, families and their clinical team members are hallmarks of primary care.
- There is continuity in relationships and in knowledge of the individual and their family/care partners that provides perspective and context throughout all stages of life including end of life care.

3. Comprehensive & Equitable*

- Primary care addresses the whole person with appropriate clinical and supportive services that include acute, chronic and preventive care, behavioral and mental health, oral health, health promotion, education and more. Each primary care practice will decide how to provide these services in their clinics and/or in collaboration with other clinicians outside the clinic.
- Primary care clinicians seek out the impact of social determinants of health and societal inequities. Care delivery is tailored accordingly.
- Primary care ~~practices~~ clinicians and staff partner with health and community-based organizations to promote population health and health equity, including making inequities visible and identifying avenues for solution.
    - Models apply a data-driven approach to identifying historical, current, and potential health disparities in all populations, including racial health disparities.
    - Proactive interventions in care planning reduce or eliminate identified inequities.
    - Care models promote awareness of organizational and individual implicit biases and utilize evidence-based practices to eliminate discrimination and prejudice from the provision of care.

4. Team-Based and Collaborative

- Interdisciplinary teams, including individuals and families/care partners, work collaboratively and dynamically toward a common goal. The services they provide and the coordinated manner in which they work together are synergistic to better health.
- Health care professional members of the team are trained to work together at the top of their skill set, according to clearly defined roles and responsibilities. They are also trained in leadership and communication skills, as well as how to partner with individuals and families/care partners, based on their priorities and needs.

5. Coordinated and Integrated

- Primary care integrates the activities of those involved in an individual's care, across settings and services.
- Primary care proactively communicates across the spectrum of care and collaborators, including individuals and their families/care partners.
- Primary care helps individuals and families/care partners navigate the guidance and recommendations they receive from other clinicians and professionals, including supporting and respecting those who want to facilitate their own care coordination.
- Primary care is actively engaged in transitions of care to achieve better health and seamless care delivery across the life span.

6. Accessible

- Primary care is readily accessible, both in person and virtually for all individuals regardless of linguistic, literacy, socioeconomic, cognitive or physical barriers. As the first source of care, clinicians and staff are available and responsive when, where and how individuals and families/care partners need them.
- Primary care facilitates access to the broader health care system, acting as a gateway to high value care and community resources.
- Primary care provides individuals with easy, routine access to their health information.

7. High-Value

- Primary care achieves excellent, equitable outcomes for individuals and families/care partners, including using health care resources wisely and considering costs to patients, payers and the system.
- Primary care practices employ a systematic approach to measuring, reporting and improving population health, quality, safety and health equity, including partnering with individuals, families/care partners, and community groups.
- Primary care practices deliver exceptionally positive experiences for individuals, families/care partners, staff and clinicians.

8. Improved Clinician and Staff Experience

- ~~Development of~~Primary care models ~~of care~~ emphasize~~s~~ enhanced efficiency~~,~~ and payer alignment, ~~and~~ while minimizing the administrative burden on clinicians and practices.
- ~~Through multi-disciplinary team-based care, clinicians are empowered to routinely work at the top of their healthcare licensure and scope of practice.~~
- Clinicians and staff are adequately funded for required services and rewarded for the quality and value of care provided. Volume-driven incentive structures are phased out where possible.
- Clinical health information technology and data sharing tools prioritize useability and value to clinical decision-making and care through rigorous pilot testing with practicing clinicians.

9. Community-Focused

- 'Community health' means that the social, economic, and physical conditions within a geographic community enable individuals and families to meet their basic needs~~,~~ and achieve their health and well-being goals~~, and thrive~~ throughout their lives.
- Reforms ~~will~~ aim to ~~accelerate~~ achieve the integration of community health and wellbeing with person and family/care partner centered healthcare to ~~confront~~ address health inequities and socioeconomic risk factors ~~and~~ in order to transform all Connecticut neighborhoods into healthy communities.
- Interdisciplinary team members ~~will~~ have clear roles and shared accountability for agreed-upon goals and services, collaborate effectively toward shared outcomes, and commit to actively identifying solutions or alternative pathways when barriers to implementation arise. Sustainable financing is ~~tied~~ linked to community health, equity and wellbeing.
- ~~Stakeholders work to achieve the systematic integration of community health and wellbeing with person and family centered healthcare.~~

*Throughout the principles, references to health disparities or health inequities include, but are not limited to, disparities or inequities based on race, ethnicity, religion, national origin, sex, gender identity or expression, sexual orientation, mental disability, physical disability, blindness, or status as a veteran.