OHS Primary Care Subgroup
Core Practice Team Functions
Final as of September 23, 2021

1. Care delivery is centered around what matters to the patient[1], developing **trusted relationships with patients**, making them feel heard and listened to, and instilling person-centered practices from the front desk to post-visit follow-up.

2. Care delivery is **team-based**, with the practice team consisting of a range of clinicians and non-clinicians, working with the patient, all with defined responsibilities that are clear to the patient and support the patient and the practice to the full extent of training and credentials.

3. Practice teams formally **designate a lead clinician[2]** for each patient. That person fosters a continuous, longitudinal relationship.

4. The practice team coordinates care for its patients between visits and across the continuum of care. To support such work, the practice team includes a) **qualified embedded[3] clinical care management personnel** to support patients with chronic conditions and disabilities and patients experiencing transitions of care, and b) **embedded non-clinical care coordination personnel** to connect all patients with community supports to address social risk factors, and work with families and other caregivers.*

5. **Behavioral health** is integrated into the practice team through a) mental health clinicians who are members of the practice and provide assessment, brief treatment and referral, and b) through screening and referral for substance use treatment.*

6. The practice team delivers "**planned care**" at every visit, including reviewing the patient's medical record prior to the visit and addressing all identified issues during the visit.

7. Care is easily **accessible and prompt**, using multiple care modalities, including in-person, electronic and virtual visits, and including time outside of traditional work hours. Care is accessible to persons with disabilities and is culturally and linguistically competent.

---

[1] All references to word "patient" include patient and/or family caregiver.
[2] Designated medical professional within a practice team who holds lead responsibility for an individual patient relationship e.g., a physician or APRN.
[3] All references to word "embedded" mean staff are dedicated to specific practices. They may be physically located full or part-time at the practice site, or should the practice site not afford sufficient physical space, physically located elsewhere.

8. Care delivery follows **evidence-based** guidelines for prevention, health promotion and chronic illness care, supported by EHR clinical decision support.

9. Practices **engage and support patients** in healthy living and in management of chronic conditions.

10. The practice team **utilizes patient information in conjunction with data** from an EHR when utilized by the practice, HIE, pharmacies and payers to identify patient care needs, monitor change over time, and inform targeted **quality and equity improvement** activity, including design and implementation of quality improvement plans.

11. The practice team identifies **social risk factors** affecting its patients and is knowledgeable about **community resources** that can address social needs.

*Alternative approaches are permitted on an exception basis for very small practices and *may* include: exclusively virtual care delivery by some practice team members (e.g., care management, care coordination, behavioral health), formal referral arrangements instead of embedded care for integrating behavioral health into the practice, and shared care management and coordination responsibilities within a practice. Alternative approaches will be defined through subsequent OHS guidance.