OHS Primary Care Subgroup
Draft Core Practice Team Functions
Revised as of July 20, 2021

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

Commented [EC1]: Edits to this core function are based on suggested recommendations from DSS.

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

3. Practice teams formally **designate a lead clinician**[1] for each patient. That person fosters a continuous, longitudinal relationship.

4. The practice team coordinates all care for its patients across the continuum of care. To support such work, the practice team includes a) an **embedded clinical care management function** to support patients with chronic conditions and disabilities and patients experiencing transitions of care, and b) an **embedded non-clinical care coordination function** 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 ~~behavioral~~ mental health clinicians who are members of the practice and screening and referral for substance use treatment.*

Commented [EC2]: Edits to this core function are based on suggested recommendations from OHS' Consumer Advisory Council.

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.

[1] Designated medical professional within a practice team who holds lead responsibility for an individual patient relationship.

DRAFT

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

9. **Patients are engaged** and supported for healthy living and self-management of chronic conditions.

10. The practice team **utilizes data** from the EHR, HIE, and payers to identify patient care needs, monitor change over time, and inform targeted **quality and equity improvement** activity.

11. The practice team demonstrates an awareness of health and social issues in the community it serves and delivers ~~team takes steps to understand the health needs of its community through assessment of both quantitative and qualitative data and implements, with community participation,~~ community-oriented ~~interventions~~ care to address health and social needs.

*Alternative approaches involving virtual care may be required for very small practices, including those in rural communities.

DRAFT