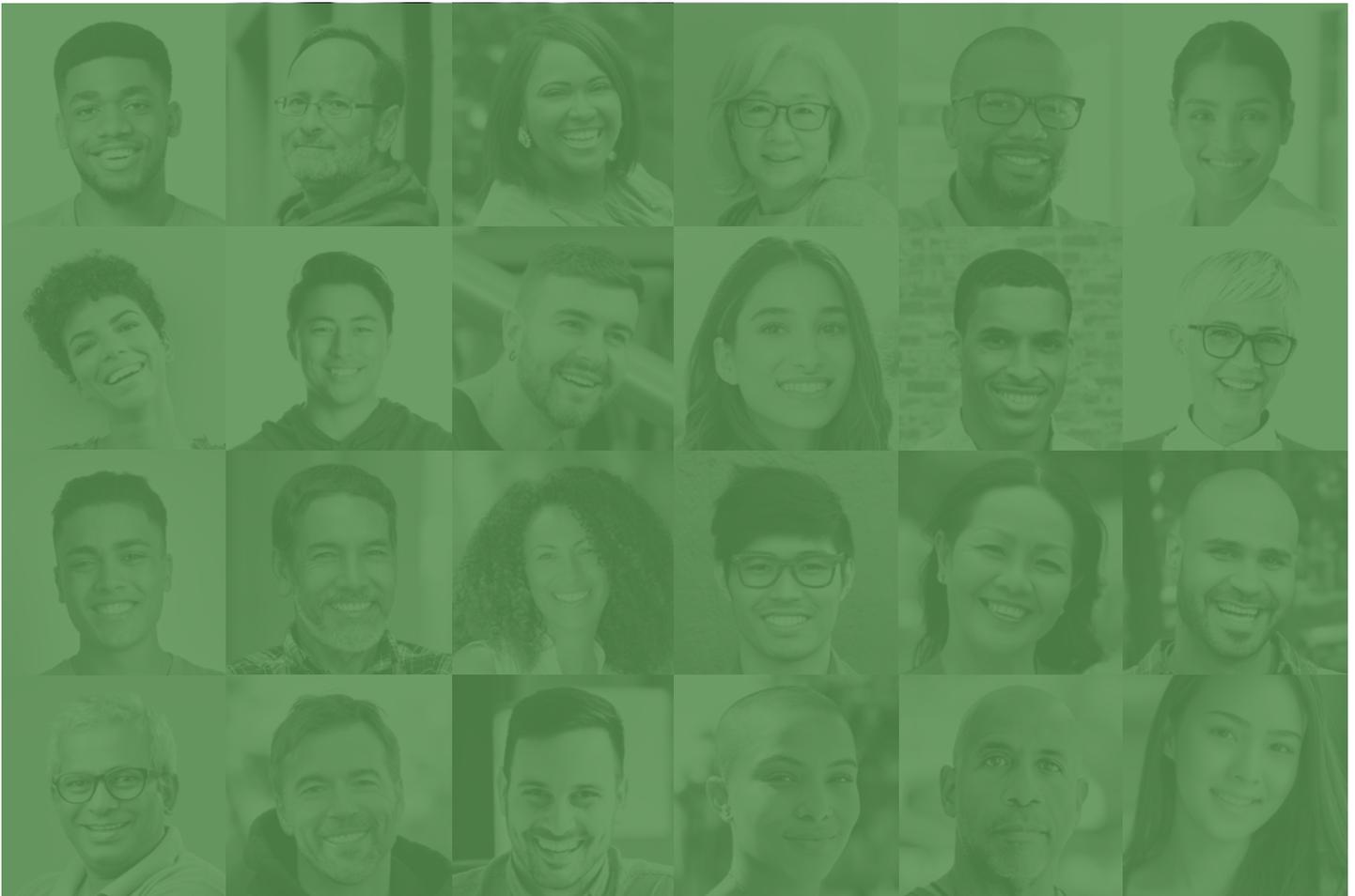# Advanced Primary Care:
Defining a Shared Standard

Pacific Business Group on Health (PBGH) and the California Quality Collaborative (CQC) have articulated attributes and benchmarks to define Advanced Primary Care, which ensures high-quality, lower-cost primary care that keeps patients at the center of every interaction. The goal of this work is to activate the many fronts required to achieve Advanced Primary Care on a broad scale:

- patients and purchasers of healthcare will be able to recognize it when they see it, and, thus, will pay differently for it;

- providers not yet meeting the standard will have a clear idea of what's needed to get there; and

- supporting entities like CQC will have a clear picture of where support is necessary for scaling Advanced Primary Care.

While other programs[1] exist in California to recognize improvement and high performance in specific areas, we are clear that this particular effort defines an intentionally high standard of attributes and performance that are either in place or require development. So, by definition, we expect only a small proportion of primary care delivered in the State to meet this standard (at least initially). A fundamental principle is to center the definition of Advanced Primary Care around the patient and how the patient experiences care.

As CQC has developed the definition, the work is being shepherded through a multi-stakeholder process to ensure alignment. The CQC Steering Committee, made up of key stakeholders across California, including most commercial payers, Covered California, DHCS and provider groups, has endorsed the attributes defined below.

The definition of Advanced Primary Care was developed by applying the following fundamental principles:

- Based on evidence from the literature,[2] and confirmed by firsthand experience in CQC's 4-year statewide Practice Transformation Program, shown to improve quality and decrease cost of care.

- Defined by, and centered around, the patient receiving care and how it is experienced by each patient.

- Agnostic to the methods, or 'the how', each element was achieved and solely concerned with meeting the benchmarks and characteristics defined.

- Articulates the highest order care processes which require many other foundational elements and processes assumed or implied (e.g. identifying high risk patients requires empanelment and use of tools, such as registries and HIEs).

- Inclusion of a small set (under development) of outcomes-based measures that are aligned across existing State and National reporting programs, to be used as a quality gate to discern where clinical quality in primary care is highest and help uncover where Advanced Primary Care is likely happening.

[1]Examples include IHA's Regional Cost & Quality Atlas and APG's Standards of Excellence Survey
[2]SBarbara Starfield's pillars of primary care; UCSF CEPC's The 10 Building Blocks of High Performing Primary Care; Stanford Clinical Excellence Research Center's findings on attributes of high value primary care

Attributes of Advanced Primary Care:

Patient Voice	Practice Attributes	Domains and Rationale
"I can get care and information from my primary care team when I need it and in the way that best meets my needs."	• The practice provides its patients with adequate access to same day appointments for urgent, office appropriate matters, and also provides care outside the face-to-face office visit (e.g. virtual, phone, group visits) in a manner that is sufficient to meet patient needs and preferences. • A care team member or other care provider is available to speak to after hours and can access patients' medical record. • Patients can message their provider or care team (physician, nurse, medical assistant) through secure email or an online patient portal, receive responses to non-urgent questions within 2 business days, and can see their medical records (lab tests, medication list, prescription refills, health maintenance schedule and provider communications) online.	• Appointment availability is an important indicator of ease of **access** to care by patients, and also ensures patients' **continuity** of care with the same team remains high • Options to receive care and information through a variety of modalities, and communicate with the care team in a non-visit setting, is **patient-centered** and improves **access** to care.

Patient Voice	Practice Attributes	Domains and Rationale
"My primary care team knows me and keeps me well; when I need planned surgery or emergency care, they know what happened and support me in becoming well again."	• Patients are contacted proactively – via text, email, phone, or portal messaging – to remind them when screenings or regular blood tests are due before upcoming appointments. • The practice knows when a patient visits the ED or has been hospitalized and actively manages transitions back to primary care to support recovery and avoid complications. • The patient has the opportunity to share with their primary care team what their preferences and goals of treatment are in advanced care and end-of-life (or serious illness) situations, through the use of tools such as advanced directives and serious illness conversations). • The care team assesses how ready and able patients are to manage their own conditions, accounting for family and caregivers input, and adjusts care plans and treatment goals accordingly. • The practice reviews and reconciles medications, including medications for behavioral health. The practice also maintains a medication list that is reviewed at all office visits and documents non-prescription medications. • The practice can identify rising risk and high-risk patients and conducts outreach to this population to provide needed care.	• The ability to risk stratify patients and perform in-reach and outreach are fundamental to primary care that is **population based** and effectively performs chronic **care management.** • Notifications on hospital admissions and ED visits are crucial for actively managing patient transitions back to primary care and effective **care coordination.** • **Patient-centered** primary care employs structured tools, such as advanced directives, POLST and serious illness conversation guides, and includes family members/caregivers as important patient resources. • Managing all patient medications – including those prescribed outside of primary care – is a critical part of **care coordination.**

Patient Voice	Practice Attributes	Domains and Rationale
"My primary care team can meet most of my healthcare needs; when I do need to see a specialist, they help me find the right one and communicate with them about me."	• The patient can receive the following common procedures (among others) without having to schedule a separate appointment with a specialist: freeze a wart, perform a skin biopsy, inject a knee with cortisone to treat arthritis, and conduct women's health procedures such as inserting an IUD. • Other care team members besides the provider (such as a medical assistant, pharmacist, health educator, community health worker or health coach) can perform care-related tasks: refilling medications, pre-visit planning, educating patients on condition/diagnosis, and coaching patients on goals for managing chronic conditions. • The practice has established referral pathways and completed care coordination agreements with high-volume specialty referrals.	• Managing as deeply as possible into episodes of care, including performing certain procedures, is important for **comprehensive** primary care. • Ensuring each care team member is performing tasks that maximize their training and certification (working at top of licensure) creates shared responsibility for the practice's patient population through **team-based care** and means clinicians are not overly burdened with tasks that do not match their skills and training. • When patients require care from a specialist, the practice acts as hub for **care coordination** across episodes of care, including referral to specialty and ensuring closed loop communication about the care provided.
"My primary care team knows and supports the whole me - not just my body."	• The practice screens for behavioral health concerns, manages and/or treats conditions in the office as appropriate and refers to external providers as needed; for referrals, the practice shares information with behavioral health providers based on patient consent, and has a closed loop feedback system to track patient outcomes over time. • Patients are screened for social needs and referred to community-based services and supports, ideally with closed loop feedback system.	• Primary care services are **comprehensive** and **patient-centered,** and include physical and mental health, and consider environmental and social impacts on health. • For both mental health care and referrals to social needs, practices know about the care and services that were accessed by the patient.