Advanced Primary Care: Defining a Shared Standard

The California Quality Collaborative (CQC), a program of the Purchaser Business Group on Health, has articulated attributes[1] 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 stakeholders required to achieve Advanced Primary Care on a broad scale:

- patients and purchasers of health care 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
- supporting entities, including CQC, will have insight into where support is needed to scale Advanced Primary Care

This definition of Advanced Primary Care sets an intentionally high standard of attributes that are either in-place or require development. Attributes were developed using evidence from the literature[2] and CQC's first-hand experience supporting change in primary care practices. A fundamental principle is to center the definition of Advanced Primary Care around the patient and how the patient experiences care.

1 For more details about these attributes see Advanced Primary Care: Defining a Shared Standard Technical Brief

2 Barbara Starfield's pillars of primary care; UCSF Center for Excellence In Primary Care's The 10 Building Blocks of High Performing Primary Care; Stanford Clinical Excellence Research Center's findings on attributes of high value primary care

For more information about CQC's Advanced Primary Care attributes and initiatives, visit our website.

PBGH California Quality Collaborative

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Attributes

Person- and family-centered

Care is designed around the needs and priorities of patients and families, encourages patient and family participation in improvement efforts and incorporates feedback. Patients share preferences and goals of treatment, engage in shared decision-making with their care team and should be made to feel their choices are respected and integrated into care plans.

Relationship-based

Patients choose a primary care provider who best meets their needs. Patients consistently communicate with and receive care from their selected primary care provider and supporting care team members, who work collaboratively with the patient, their family and their extended care team to build trusting relationships.

Accessible

Patients get the right care at the right time with a care team that is familiar with their needs. Accessible care includes same-day care for urgent needs through in-person and virtual services with their care team, care provider availability after appointment hours, secure messaging with the team and an online medical record.

Comprehensive

Patients receive screening and care for behavioral and social needs integrated into their primary care team, as well as common procedures by their primary care team instead of scheduling a separate appointment with a specialist. Patients' care needs are proactively identified by care teams that reach out for anticipated care needs and offer additional support for those patients at high or rising risk.

Team-based

Patients know and receive care from a primary care provider who is supported by members of an interdisciplinary care team, such as a medical assistant, nurse, pharmacist, psychiatrist, health coach or community health worker. Under the direction of the primary care provider, care team members communicate and coordinate across the team to address patients' needs and provide care appropriate to their training and expertise.

Integrated

Patients' physical, mental and social needs are communicated across their primary care team and with other care providers and settings. Health information and care activities outside of the primary care team are integrated into patients' care plans.

Coordinated

Patients are guided through care transitions between hospitals, emergency care, specialty care and their primary care teams. Patients can navigate across settings with established referral pathways to high-value specialist providers, with which the primary care team exchanges information and coordinates care.

Equitable

Patients receive and experience care services and health outcomes that do not vary in quality or access due to personal characteristics, such as gender, race, ethnicity, language, socioeconomic status or sexual orientation/gender identity. Primary care teams proactively monitor their care to identify, eliminate and prevent care and health disparities.