Advanced Primary Care: Defining a Shared Standard

The California Quality Collaborative (CQC) has created attributes to define Advanced Primary Care (APC), which ensures high-quality, patient-centered, lower-cost primary care. The goal is to activate the many stakeholders required to achieve APC on a broad scale.

This definition sets an intentionally high standard of attributes and is complementary to a standard APC measure set. Attributes were informed by literature[1] and CQC's firsthand experience driving primary care transformation.

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 provider and supporting care team members, who work collaboratively with them, their family and their extended care team to build long-standing, continuous, trusting relationships.

Accessible

Patients get the right care at the right time with an integrated care team that is familiar with their medical and behavioral health needs. Accessible care includes same-day care for acute primary care needs through in-person and virtual services with their care team, same day facilitated connections (e.g., warm hand-offs) to behavioral health professionals, provider availability after appointment hours, culturally and linguistically responsive care, and secure messaging with the integrated team and an online medical record.

Comprehensive

Patients receive evidence-based routine screening and care for behavioral and social needs from their integrated primary care team, as well as care for most of their acute and chronic care needs and common procedures by their primary care team instead of scheduling a separate appointment with a specialist. Patients' care needs are proactively identified by integrated care teams that reach out for anticipated care needs and offer additional support for those patients at high or rising risk. When patients' health needs change, their care team has a defined process for ensuring they are referred to the best place for subsequent care.

Team-based

Patients know and receive care from integrated primary care teams that include an array of professionals (e.g., medical assistant, nurse, pharmacist, health coach, community health worker). This team includes integrated behavioral health providers (e.g., licensed clinical social worker (LCSW), licensed marriage and family therapist (LMFT), psychologist, behavioral health care managers, peer counselors). In collaboration with 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, behavioral and health-related social needs are communicated across their integrated primary care team and with other care providers and settings. Health information and care activities outside of the integrated primary care are reflected in a comprehensive care plan. There are clear mechanisms in place for data sharing and collaborative management of patient's physical, behavioral and social health needs.

Coordinated

Patients are guided through care transitions between hospitals, emergency care, specialty care, external behavioral health providers and their integrated primary care teams. Patients can navigate across settings with established referral pathways to high-value specialist providers and community-based organizations that address social needs, with which the integrated primary care team exchanges information and coordinates care.

Equitable

Patients receive and experience care 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. Integrated primary care teams proactively monitor their patient's care to identify, eliminate and prevent disparities across access, care, and health outcomes.

PBGH California Quality Collaborative

For more information about CQC's Advanced Primary Care work, visit our website.

1 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