Attributes of Advanced Primary Care

How Employer-Identified Practice Attributes Align with the Shared Principles of Primary Care

This table crosswalks employer-identified attributes of advanced primary care (APC) with the Shared Principles of Primary Care. It is a first step on the path to achieving APC. Measures, including those reported by and about patients, that assess the extent to which a practice has achieved advanced primary care are forthcoming. We will continue to engage with all the stakeholders in primary care and expect that these attributes will evolve over time.

		Shared Principles of Primary Care						
		Person & Family-Centered	**Continuous**	**Comprehensive & Equitable**	**Team-based & Collaborative**	**Coordinated & Integrated**	**Accessible**	**High Value**
		The patient statements below offer examples of what patients want from primary care. They were developed by PBGH through a multi-stakeholder process.						
		"I can get care and information from my primary care team when I need it and in the way that best meets my needs"	*"My primary care team knows me and keeps me well."*	*"My primary care team knows and supports the whole me—not just my body."*	*"My primary care team can meet most of my healthcare needs."*	*"When I do need a specialist, [my primary care team] helps me find the right one and communicates with them about me. "*	*"I can get care and information from my primary care team when I need it and in the way that best meets my needs"*	*"When I need planned surgery or emergency care, [my primary care team] knows what happened and support me in becoming well again."*
Employer-Identified Attributes of Advanced Primary Care*	**Enhanced access for patients**							
	Patients can access care in a way that meets their needs and preferences without financial barriers to access, including via: same-day and walk-in appointments; virtual care; a secure patient portal to view their medical records, receive labs and communicate with their care team; access to a care team member after hours.	✓	✓				✓	
	Optimize time with patients							
	Patients are active participants in their care through: shared decision-making; input on their care plan and treatment goals; opportunities to share their preferences, including serious illness conversations, advanced directives, and end-of-life care; and addressing barriers due to their social determinants of health.	✓		✓				
	Realigned payment methods							
	Practices are paid in a way that that enables and promotes quality, access, efficiency, team-based patient-centric care and population health management. Primary care payments are tied to patient experience and outcomes, and not volume or face-to-face visits.	✓	✓	✓	✓	✓	✓	✓

pcc primary care collaborative

PBGH PACIFIC BUSINESS GROUP ON HEALTH

National Alliance of Healthcare Purchaser Coalitions Driving Innovation, Health and Value

Employer-Identified Attributes of Advanced Primary Care*	Shared Principles of Primary Care						
	Person & Family-Centered	Continuous	Comprehensive & Equitable	Team-based & Collaborative	Coordinated & Integrated	Accessible	High Value
Organizational & infrastructure backbone							
Practices invest in their staff and infrastructure to deliver patient care. Staff are continuously trained, and non-provider team members perform care-related tasks such as prescription refills and patient education. The practice utilizes advanced analytics, reporting, and communication within, and outside, the organization, such as knowing when a patients visits the ED or has been hospitalized. The practice is actively engaged and leads the coordination of patients' care across the continuum of care, especially transitions of care.	○	✓	○	✓	✓	✓	✓
Disciplined focus on whole-person health							
Practices proactively manage population health, including: risk stratifying patients and managing those identified as 'rising risk' and 'high risk'; adopting a systematic approach to gaps in care; contacting patients with reminders for preventive screenings and labs; reviewing patients' medication lists at every appointment; and assessing how ready and able patients are to manage their own health through holistic lifestyle approaches.	✓	○	○	✓	✓	○	✓
Behavioral health integration							
Practices meet their patients' physical and behavioral health needs through screening, treatment and/or referrals. Behavioral health screenings (e.g. for depression, anxiety, SUD) are standard, and practices manage/treat conditions as appropriate, while referring to external providers as needed. With patient consent, information is shared with BH providers as part of a closed loop feedback system to track outcomes over time.	✓	○	✓	✓	✓	○	○
Referral and care management							
Practices make fewer, more appropriate, and higher quality referrals. Patients can receive common procedures (such as skin biopsies, cortisone injections, and IUD insertions) at the primary care office without a separate specialist appointment. Practices coordinate patient care, including having care coordination agreements with high-volume specialty referrals and closed loop feedback systems for referrals, including those for social needs.	○	✓	○	✓	✓	○	✓

*The employer-identified attributes are adapted from the National Alliance of Healthcare Purchaser Coalitions's "Improving Healthcare Value with Advanced Primary Care" and the Pacific Business Group on Health's "Advanced Primary Care: Defining a Shared Standard".

**Over 350 organizations have signed on in support of The Shared Principles of Primary Care: https://www.pcpcc.org/about/shared-principles

Thank you to the PCC's Primary Care Innovators Network for their contributions to this work.