Attributes of Advanced Primary Care

How Practice Attributes Align with the Shared Principles of Primary Care

This table crosswalks 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 largely developed by PBGH through a multi-stakeholder process.						
		"I make decisions about my care in partnership with my primary care team who respects my needs and preferences."	*"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."*
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; and engage in cost conversations with their care team.	✓	✓				✓	
	Optimize time and partnership with patients							
	Patients and caregivers are active and respected partners in their care through: shared decision-making; co-developed care plans and treatment goals; integration of patient preferences, including serious illness conversations, advanced directives, and end-of-life care; and addressing barriers due to social drivers of health. Visits include sufficient time to meet patients' needs and to develop an ongoing relationship that addresses health literacy and whole-person health over the long-term.	✓		✓				
	Realigned payment methods							
	Practices are paid in a way that that enables and promotes a balanced scorecard of quality, access, equity, efficiency, team-based patient-centric care and population health management. Primary care payments are tied to patient experience and outcomes, not volume, and allow for flexibility in how care is delivered. These payments are also appropriately risk-adjusted to account for social risk with sufficient monitoring to ensure no unintended negative consequences that exacerbate disparities.	✓	✓	✓	✓	✓	✓	✓

pcc primary care collaborative

PBGH Purchaser Business Group on Health

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

		Shared Principles of Primary Care						
		Person- & Family-Centered	Continuous	Comprehensive & Equitable	Team-Based & Collaborative	Coordinated & Integrated	Accessible	High-Value
Attributes of Advanced Primary Care*	**Organizational & infrastructure backbone**							
	Practices use an electronic health record and 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; collects appropriate individual and population-level data to allow providers to meet social needs of the individual and needs of the community such as knowing when a patient visits the ED or has been hospitalized; and collects race, ethnicity, and socioeconomic data from their patients.	○	✓	○	✓	✓	✓	✓
	Disciplined focus on population 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.	✓	○	✓	✓	✓	○	○
	Effective referral and care management							
	Practices make fewer, more appropriate, data-informed, 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, especially transitions of care. They have care coordination agreements with high-volume specialty referrals and closed loop feedback systems for referrals, including those for social needs. Efforts are made to understand the financial and quality implications of referral patterns. Care teams engage family caregivers when coordinating care.	○	✓	○	✓	✓	○	✓

*These attributes are adapted from the National Alliance of Healthcare Purchaser Coalitions' "Improving Healthcare Value with Advanced Primary Care" and the Purchaser Business Group on Health's "Advanced Primary Care: Defining a Shared Standard", with input from Families USA, the National Partnership for Women & Families, AARP, and the Institute for Patient and Family-Centered Care.
**Over 350 organizations have signed on in support of the Shared Principles of Primary Care: https://www.pcpcc.org/about/shared-principles

These organizations have signed on to these attributes:

AARP®

INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE®
Transforming health care through partnerships

national partnership for women & families