Primary Care
Reaffirmed 2026

DR. ROBERT BREE COLLABORATIVE

Primary care is the cornerstone of the healthcare system, acting as a usual source of health promotion, disease prevention, and care for acute and chronic health conditions. In Washington state, access to regular, high-quality primary care is a challenge for many. In 2020, the Bree Collaborative elected to develop standards for a state-wide definition for primary care to support multi-payor payment reform, with a focus on defining primary care, the components of primary care with large impact, and measuring primary care. **In 2026, the Bree Collaborative reaffirms our Primary Care Guidelines.**

PRIMARY CARE IS team-based care led by an accountable provider that serves as a person's source of first contact with the larger healthcare system and coordinator of services that the person receives. Primary care includes a comprehensive array of appropriate, evidence-informed services to foster a continuous relationship over time. This array of services is coordinated by the accountable primary care provider but may exist in multiple care settings or be delivered in a variety of modes.

PRIMARY CARE INCLUDES:

- Care coordination
- Chronic condition management
- Disease prevention and screening
- Health promotion
- Integrated behavioral health
- Medication management
- Person-centered care that considers physical, emotional, and social needs

PRIMARY CARE IS MEASURED through claims data: care delivered in an ambulatory setting by a predefined group of providers and team members as a proportion of total cost of care

Access the full report here (published in 2020)

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For Clinicians and Clinics

Primary Care Site MUST HAVE Elements

- **Team-based care strategies** *(e.g., huddles, care management meetings, high-risk patient panel review)* **are consistently used** through co-located or integrated models.
- **Behavioral health provider(s) are part of the care team** through co-located or integrated models
- **Active patients are assigned or attributed to a primary care provider or team for advanced clinical judgment**
  - the primary care team may/may not reside in the same physical setting and does not need to have the same organizational affiliation to act as a team
- Care is **evidence-based and/or evidence informed**
- **Services that address the whole person (multiple organ systems) are regularly offered including:**
  - Active management of chronic diseases
  - Acute care for minor illnesses and injuries
  - Office-based procedures and diagnostic tests
  - Preventive services including USPSTF recommended cancer screenings
  - Vaccinations
  - Patient education
  - Self-management support
  - Medication management
  - Chronic condition management
  - Behavioral health support
- **Convenient and flexible care options** allow easy access to the right care in the right setting when needed.
- **At least one alternative to traditional physical and behavioral health office visits is offered** *(e.g., e-visits, phone visits, group visits, home visits, alternate location visits)*
- **Site also offers expanded hours** (e.g., early mornings, evenings, weekends)
- **Health information technology is in place** that supports **management of the patient panel at a population health level** while also supporting **optimal care at the individual patient level.**
  - To be effective, the primary care provider must be "connected" to the broader healthcare ecosystem through some mechanism that supports interoperability, such as a Health Information Exchange (HIE) that supports a longitudinal patient-centric record and near/real time alerts to support

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For Clinicians and Clinics

STRONGLY RECOMMENDED for High Quality Primary Care

- **Infrastructure**
  - Forms/protocols reflect **open and affirming environment**
  - **Age-appropriate and culturally inclusive reading/audiovisual material** and aids available

- **Access**
  - **Physically accessible** to those with mobility issues
  - **Translation services available** for languages common among the patient population (providers, certified interpreters) **Do NOT rely on family or friends**
  - Patient-facing forms and information are **readable at a 4-6th grade level**, available in **relevant languages and accessible formats**, use **inclusive and nonstigmatizing language**, and reaffirm **confidentiality**

- **Information**
  - **Health records for each active patient contain at least the following**:
    - problem list
    - medication list
    - surgical history
    - allergies
    - race and ethnicity (if disclosed)
    - preferred language
    - sexual orientation
    - gender identity
    - chosen pronouns and name
    - BMI/growth chart, immunization
    - parenting intention in the next year (if applicable)
    - advance directive or other advance care planning
    - other care needs (e.g., oral, dental)
  - **Care plan is coordinated, documented and accessible** to all primary care team members
  - **Risk stratification process in place** that includes medical need, behavioral health diagnoses, and health-related social needs
  - At least every 2 years, site **post-visit surveys conducted** to measure patient-reported outcomes
  - **Whole-person needs are identified and met at a population level**
  - Quality and effectiveness **improve over time**
  - Patient visits with assigned clinician/team are **tracked and reported to health plans**
  - Capacity to **query and use data** to support clinical and business decisions

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- **Referrals**
  - **Agreements or contracts among providers, plans and other organizations to coordinate transitions are in place**, including:
    - Emergency department and inpatient visits
    - Residential and partial treatment facility stays
    - Stays at substance use disorder treatment facilities
    - Community resources to support non-medical social needs that impede health improvement
  - **Referrals to offsite services are tracked**, and **overdue referrals prompt outreach** to the patient
  - **Referral patterns are identified and adjusted** to improve patient outcomes and reduce cost and unnecessary care
  - **Hospitals and EDs responsible for most patients' hospitalizations and ED visits are identified;** timeliness of notification and information transfer is assessed.
  - **Opportunities to work with accountable communities of health (ACHs)** to improve community supports are identified.

- **Content of Care**
  - **People are screened at least annually using a validated instrument for:**
    - Depression
    - Anxiety
    - Suicidality
    - Tobacco Use
    - Alcohol
    - Other drug use
  - **A process for follow-up, brief intervention, brief treatment and/or referral to treatment** is documented
  - **Coordination of care** and meeting care needs
  - During a clinical visit, **patients and providers engage in:**
    - Self-management support
    - Shared decision-making as appropriate
    - Motivational interviewing for behavior change

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For Health Plans and Purchasers

Both Health Plans and Purchasers

- Members/Employees receive information about the **value of primary care, how to access primary care within the network**, and are **asked/encouraged to select a primary care provider/team** at enrollments

Health Plans

- Members **select or are paneled to a primary care provider/team** through a process **transparent to the purchaser and the individual member.**
- Members are **notified when a primary care provider is held accountable for their care. Members can change their preferred provider** by notifying the health plan.
- Data from care delivery sites is **collected and aggregated to understand variation in care and look for disparities in access or services provided** within and across:
  - Race and ethnicity
  - Language
  - Sex
  - Screening for relevant cancers of the sexual and reproductive health system
  - Prenatal and postpartum;
  - Perinatal care outcomes reported for those who are Black, Indigenous, and people of color
- Health plan records **accurately reflect a person's gender, pronouns, and chosen name**
- **A payment mechanism supports primary care features that are not reimbursed through traditional fee-for-service payments,** including value-based reimbursement (e.g., FFS enhancements, prospective PMPM) that could incent transformation, performance-based incentives, or more expansive capitation.
  - **Multipayor models** are prioritized
  - **Share relevant information including cost** with providers/practices
  - Payment mechanisms are **clearly articulated to employers**

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Purchasers

- **Benefit designs are structured to encourage the use of primary care** including Value-Based Insurance Design (VBID) mechanisms tied to primary care, such as:
  - **$0 cost for specified in-person or virtual care services** delivered by the individual's named primary care provider
  - **Lower out-of-pocket cost for specialty care** accessed after seeing one's primary care provider/team
  - When qualified high deductible health plans with Health Savings Accounts (HSA's) are in place, **rules allowing for first dollar coverage under expanded "preventive services" are applied**
- Agree to **support non-fee-for-service payment mechanisms for primary care** in partnership with other purchasers
- **Non-fee-for-service forms of primary care payment are clearly articulated by plans and supported by employers**; qualifications for payment eligibility and success measures clearly understood and openly shared.
- **Contracts with health plans and/or directly with delivery systems require:**
  - Measurement of primary care spend
  - Total cost of care
  - Measurement of quality of care
  - Measurement of disparities in care outcomes by race/ethnicity;
  - Reporting of primary care spend
  - Targets for primary care spend
  - Requirement that consumers select or be paneled to a primary care provider or team
  - When individual selectionis not in place, the primary care provider/team to whom the individual is assigned is clearly communicated and the individual has the ability to change that assignment
  - Penalties for indicators of not-managed and not-coordinated care, like avoidable hospital readmissions or avoidable ED

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Bree Collaborative Board Members

Name	Title	Organization
Jake Berman, MD, MPH	Medical Director for Population Health Integration	UW Medicine and UWM Primary Care and Population Health
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