Potentially Preventable Readmissions: Conceptual Framework To Rethink the Role of Primary Care

Executive Summary

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INTRODUCTION

To study how primary care can improve quality of care and patient safety, the Agency for Healthcare Research and Quality (AHRQ), through an Accelerating Change and Transformations in Organizations and Networks III (Action III) task order, contracted with John Snow, Inc., to:

- Conduct exploratory research on how to develop a primary care counterpart to the AHRQ Re-Engineered Discharge (RED); and
- Identify a conceptual framework to serve as the foundation for future research on the role of primary care in preventing potentially avoidable readmissions.

PROJECT ACTIVITIES

To inform the project, the team conducted the following activities:

- Convened a technical expert panel with diverse backgrounds, including primary care research, health centers, patient advocacy, human factors, social work, and pharmacy;
- Produced an environmental scan of peer-reviewed and grey literature on primary care and reducing readmissions;
- Conducted key informant interviews with experts on patient-centered medical homes (PCMHs), existing tools and resources, and promising practices in independent primary care settings;
- Analyzed current postdischarge workflow processes from the perspectives of primary care staff, community agency staff, and patients in partnership with nine diverse primary care sites in Boston, Denver, and Los Angeles; and
- Identified a conceptual framework on the role of primary care in reducing potentially avoidable readmissions to improve the quality and safety of care for patients.

These project activities were conducted from September 2015 to September 2018.

CONCLUSION

With input from multiple stakeholders involved in discharge and postdischarge care, our research is a unique contribution to the care transitions field. The project resulted in the development of a conceptual framework for high-quality and safe care for patients that involves the primary care clinician “reaching in” to participate in care coordination during hospitalization and then serving as the “lead integrator” of care during the postdischarge period.

The project model goals and processes dovetail neatly with other primary care transformation efforts, such as the PCMH and provider-led accountable care organizations. Further research to test the project’s principles and components, including more robust implementation, will help to refine the conceptual framework and enhance the usability and value of the research for other primary care practices.