The Five Principles of Effective Primary Care-Based Care Coordination for Reducing Potentially Preventable Readmissions

Five principles, or fundamental concepts, inform effective primary care-based care coordination. The principles are listed here and explained in detail below:

1. The primary care team should serve as a key integrator for postdischarge patient care.
2. Several critical steps differentiate a postdischarge followup visit from a typical visit.
3. Within the primary care practice, transitions can be improved by defining team-based care that encompasses the admission, immediate postdischarge period, first followup visit, and immediate postvisit period, including additional followup visits.
4. At the healthcare systems level, primary care should be encouraged to develop and implement a systematic approach to timely, appropriate, bidirectional information exchange and coordination with hospitals, post-acute care agencies, and behavioral health and social support services.
5. The primary care team should systematically assess and address whole-person needs in a patient-centered fashion that leverages the clinician-patient relationship.

These five principles reflect overarching concepts primary care practices can incorporate into their strategic management. Primary care practices' use of these principles will vary based on the patient population, practice resources, current operations, and other local factors. In addition, primary care teams should consider individual patients' risk factors for developing postdischarge adverse events. Routinely assessing patient risk during this period is critical to facilitate tailoring appropriate resources of the primary care team to the patient's needs.

Principle 1: The primary care team should serve as a key integrator for postdischarge patient care. When patients leave the hospital, they should look toward primary care practices to provide care and support, seamlessly picking up care from where the inpatient team left off. The focus should be on facilitating a smooth transition of patients and their care plans back to the primary care team in concert with other providers. The primary care team, using its members' different strengths, should collaborate to fulfill the responsibilities needed to serve as the patient's nexus of care.

Principle 2: Several critical steps differentiate a postdischarge followup visit from a typical visit. After a patient's hospital discharge, primary care practices will need more time, preparation, and followup than for a usual patient visit. They should allocate more time for postdischarge followup visits than for routine visits; identifying and labeling these visits as postdischarge followup within the scheduling system can enhance patient care. Ideally, the first followup visit should be with the patient's primary care provider and with other appropriate team members who can address tasks specific to posthospital care.

Principle 3: Within the primary care practice, transitions can be improved by defining team-based care that encompasses the admission, immediate postdischarge period, first followup visit, and immediate postvisit period, including additional followup visits. Work among clinical and nonclinical team members should include clearly delineated, explicit roles and responsibilities. The system should include a timely process to obtain and review admission, discharge, and transfer notifications and prompt next steps in postdischarge care. This structure facilitates productivity and enhances various strengths of the interprofessional care team.

Principle 4: At the healthcare systems level, primary care should be encouraged to develop and implement a systematic approach to timely, appropriate, bidirectional information exchange and coordination with hospitals, post-acute care agencies, and behavioral health and social support services. Domains for communication may include notifications of admission and discharge with appropriate followup care; collaboration in discharge documentation, including diagnostic and therapeutic plans; coordination of home care and specialty consultations; and engagement of community-based resources.

Principle 5: The primary care team should systematically assess and address whole-person needs in a patient-centered fashion that leverages the clinician-patient relationship. If left unaddressed, behavioral health and social needs are key risk factors for postdischarge adverse events. The primary care team should elicit care priorities or barriers to engagement related to behavioral health, social needs, and transportation. In addition, the primary care team should assess health literacy, coping strategies, and social support to ensure that the plans are understandable and appropriate for the patient.

Integrating the Five Principles Into Workflow

The implementation of these five principles would be facilitated by creating a system for "reaching in" during hospitalization to the patient and inpatient care team, which is especially critical for medically or socially complex patients. Ideally, while the patient is hospitalized, the primary care team should develop systems to communicate with the patient and family members, when relevant, during the hospitalization. This "bridging" effort helps the primary care team assure the patient that they are aware of and involved in the patient's care; it may also help communicate the primary care team's confidence in the inpatient team to the patient, as well as establishing expectations for timely followup care.

Below is a suggested workflow for primary care teams to implement the five principles. The proposed workflow is divided into four periods: during hospitalization, after discharge and before first followup visit, during first followup visit, and after first followup visit. Some of these elements, such as screening for behavioral health and patient education needs, occur on a routine basis. However, facilitating the implementation of these elements is important to enhance patient safety since the risk of adverse events increases after hospitalization.

During Hospitalization

- Receive notifications of hospitalization of primary care patients.
- Maintain a list of currently hospitalized patients.
- Contact patient in person, by phone, or with other technologies as appropriate and available to provide emotional support, answer questions about hospitalization, discuss patient goals and care priorities, and confirm contact information.
- Ensure the patient knows how to contact provider or primary care staff to schedule a followup appointment.

After Discharge and Before First Followup Visit

- Contact the patient, preferably within 48 hours of discharge, and assess the patient and family's (or caregiver's) understanding of the hospitalization.
- Clarify any outstanding questions with the inpatient team.

- Communicate with home health care about perceived patient medical and social needs, patient home environment, and care coordination, if appropriate.
- Schedule patients for followup care as needed, within a timeframe that matches the patient's medical and psychosocial needs. Highlight in the schedule that this visit is a postdischarge followup.
- Discuss any potential barriers for first followup visit, such as transportation.
- Confirm that the discharge summary and any other relevant discharge documentation is available; submit requests if not.

During First Followup Visit

- Discuss patients' goals and priorities with an emphasis on their understanding of what contributed to and occurred during their hospitalization.
- Perform medication reconciliation, including use of open-ended questions to assess patients' understanding of their current medication regimen and identify changes needed. Consider using a pharmacist for complex medication regimens or high-risk patients.
- Address chronic illnesses, as necessary and if possible, by coaching patient and family and sharing disease specific self-management support information.
- Print and review the care plan with the patient and family to ensure they understand it and address any questions they may have. Discuss any new diagnoses and highlight key pieces of information and next steps, such as labs and specialty appointments.
- Advise high-risk patients to let the primary care practice know if they are thinking about going to the hospital. If patients do end up in the hospital, encourage them to notify the practice as quickly as possible.
- Screen for social and behavioral health needs, and then refer as appropriate.
- Schedule suggested primary care followup and, if needed, discuss specialty referrals and tests before the patient leaves the clinic.

After First Followup Visit

- Focus on tasks that may remain, such as scheduling appointments and addressing transportation needs.
- Continue bidirectional communication with home health care nurses, case managers, or other caregivers who interact with the patient; pay particular attention to changes to the care plan, changes to medications, and changes in the patient's condition.
- Conduct intermittent followup calls or visits with complex patients over the next 30 days to determine if they are having any problems following their care plan.

Considerations for Implementation of the Principles

As noted previously, primary care teams should be encouraged to adjust these principles as needed based on patient factors such as age, discharge diagnosis, social needs, and goals. Risk stratification may help practices more efficiently allocate resources to high-risk patient groups. Primary care practices should examine how they can adapt the described concepts that are most appropriate and valuable for them, as primary care sites can be diverse with regard to their information technology capabilities, relationship to nearby hospitals, staff, and existing workflows.

The project's fieldwork demonstrated that even small, independent primary care practices can benefit from specifying and implementing an effective posthospitalization care transition system. Recognizing and acknowledging the difficulties of system change, both in terms of process and cultural issues, is an important step to implementation. Sustainable implementation will be facilitated by working with leadership and stakeholders for input to reinforce the patient-centered and patient safety values these principles and concepts engender.

Primary care practices should attempt to connect with inpatient care teams to foster bidirectional consultation as needed with more medically or socially complex patients. Adoption of these principles in primary care settings will be facilitated by incorporating health system changes. Finally, these principles and concepts offer a new approach primary care teams can use to engage patients and families to help reduce postdischarge adverse events.

AHRQ Publication No. 20(21)-0035-2-EF
March 2021