

Domain 2 Tool: Care Accountability Decision Guide

Purpose: This guide supports care teams in identifying who holds primary accountability for patient coordination at any given time, and how that responsibility should evolve as patient needs, engagement, and conditions change.

This tool distills complex care coordination decisions into five distinct Care Accountability Types, representing the most common real-world accountability structures. Each type outlines:

- The context in which it applies
- The recommended care accountability structure
- The rationale behind patient assignment
- The engagement and coordination approach best suited to that situation
- And when to reassess accountability as the patient's condition or care relationships evolve

The goal is to ensure that every patient has a clearly identified lead for coordination, even temporarily, and that accountability remains transparent, adaptive, and well-documented across all care transitions.

Summary Table of Care Accountabilities:

Care Accountability Type	Responsible Party	Duration	Examples
Type 1 PCP-Led	Primary Care	Annual or sooner if trigger event occurs	AWV, urgent care, retail, preventative services
Type 2 Episodic Care	Specialist	Acute, discharge transition of care	Surgical episodes (ortho, cardiac, GI, etc.)
Type 3 Longitudinal	Specialist	90-days or when treatment plans change	Chronic care tied to specific clinical conditions
Type 4 Shared Accountability	Primary Care + Specialist	60- to 90-days or when conditions change	Consultations and diagnostics
Type 5 Care Navigator	Interim Care Manager, Care Navigator, Intake Coordinator	30- to 45-days care transition and warm handoff	Patient outreach, transitions from clinical setting to home and community

Care Accountability Type 1 | PCP-Led

Criteria	Details
Context	A patient receiving routine or ongoing care for a stable condition or preventive health needs. No recent trigger events have occurred, and existing care plans are being followed. The patient is engaged, adherent, and care coordination needs are minimal. Examples include annual wellness visits, urgent care visits, retail, preventative services, etc.
Recommendation	PCP-Led
Rationale	When a patient's condition is stable and no specialty-dominant episode or new trigger is present, the primary care physician should maintain full accountability for care coordination. This ensures continuity, preventive focus, and efficient management without unnecessary escalation.
Engagement and Coordination Approach	<p>Maintain standard follow-up cadence for preventive or chronic care. Ensure documentation is current, labs and screenings are completed on schedule, and referrals are coordinated as needed. Care manager involvement is minimal unless a new trigger arises.</p> <p><i>Escalated Protocol</i> New issue or increased intensity that requires a higher-touch approach: the care manager increases outreach frequency, confirms barriers to adherence, and facilitates re-engagement with the patient and care team. The care manager adjusts follow-up cadence, updates care plans, and monitors for resolution. Once engagement improves, the case returns to its prior coordination tier.</p>
Follow-Up Point	<p>Annually, or sooner if a trigger event occurs (e.g., hospitalization, new diagnosis, treatment change, or evidence of declining engagement).</p> <p><i>Escalated Protocol</i> New issue or decline in patient engagement triggers the need for temporarily intensified coordination. Examples may include missed appointments, poor adherence, new social barriers, or emerging gaps in communication across providers.</p> <p>When engagement, communication, or system barriers jeopardize continuity, accountability should not shift, but the intensity of coordination should increase until stability is restored. The goal is to proactively address issues that could otherwise escalate into acute events or care fragmentation.</p>

Care Accountability Type 2 | Specialist-Led (Episodic Care)

Criteria	Details
Context	A patient experiences a trigger event requiring short-term, condition-specific intervention (e.g., acute hospitalization, new treatment episode, or transition to home or post-acute care). A specialty clinician assumes the lead for clinical decision-making and coordination for a period of time during treatment. Examples include surgeries (e.g., general, GI, orthopedic, cardiac, etc.).
Recommendation	Specialist-Led (Episodic Care)
Rationale	During periods of acute or high-intensity care, the specialist is responsible for the triggering event, while the PCP is still point for underlying/ongoing health monitoring. For the duration of the episodic event, specialists ensure timely decision-making and continuity across care settings. The PCP remains engaged in a consultative or supportive capacity until the episode stabilizes.
Engagement and Coordination Approach	The specialist leads coordination during the acute or post-acute phase. The care manager facilitates communication among the specialist, PCP, and patient; ensures follow-up planning; and monitors for stability. The PCP and specialist ensure clearly defined hand-off processes for seamless transitions. The PCP is informed of progress and re-engages as discharge or transition approaches.
Follow-Up Point	Within seven to 30 days of stabilization, discharge, or resolution of the acute episode to determine whether accountability should return to the PCP or shift to a shared model. Any disease progression or new issue should follow escalated protocols.

Care Accountability Type 3 | Specialist-Led (Longitudinal)

Criteria	Details
Context	A patient requires continuous management of a condition or set of needs that fall primarily within a specialty domain. The episode is not short term, the specialist directs ongoing treatment, and the patient routinely engages with that specialty team for primary management. Examples include chronic care management where repeated encounters with clinicians are tied to clinical conditions.
Recommendation	Specialist-Led (Longitudinal)
Rationale	When care is specialty-dominant and long-term (e.g., therapies, procedures, or disease monitoring that remain under specialty oversight), accountability should remain with the specialist to ensure consistency and outcome tracking. The PCP stays involved in a supportive role for preventive and general health maintenance.
Engagement and Coordination Approach	The specialist leads all aspects of treatment planning and coordination across ancillary services. The PCP maintains periodic check-ins to monitor general health and address comorbidities. The care manager supports communication, shared documentation, and ensures the patient's broader health needs are not overlooked.
Follow-Up Point	Every 90 days or when treatment plans change, the patient transitions to a different phase of care, or there is a shift in engagement or clinical complexity that may warrant shared or PCP-led accountability.

Care Accountability Type 4 | Shared Accountability (PCP + Specialist)

Criteria	Details
Context	A patient has multiple ongoing conditions or care needs that require active involvement from both a PCP and one or more specialists. Neither role independently encompasses full accountability, and coordination between the two is essential to ensure alignment across care plans. Examples can also include diagnostics, screening/testing, certain diagnostic procedures, and consultations, where shared communication between PCP and specialists ensure patient access and early clinical interventions.
Recommendation	Shared Accountability (PCP + Specialist)
Rationale	<p>Shared accountability ensures that both general and condition-specific care are addressed when patient needs overlap domains. This model prevents gaps, duplication, or conflicting recommendations and establishes mutual responsibility for communication and care outcomes.</p> <p>Once the condition stabilizes and no longer requires intensive specialty oversight, returning accountability to the PCP promotes continuity, cost-effective management, and holistic patient monitoring. This transition also ensures that specialty care becomes consultative rather than directive.</p>
Engagement and Coordination Approach	<p>The PCP and specialist jointly develop a coordinated plan of care, clarify who leads on specific elements, and document shared goals. The care manager facilitates regular updates between teams, ensures care plans are synced in the electronic health record, and monitors patient engagement and follow-through.</p> <p>The specialist and PCP communicate directly to confirm readiness for transition, summarize care provided, and align on follow-up plans. The care manager ensures documentation is updated, patient understanding is confirmed, and any outstanding referrals or lab work are completed prior to the handoff.</p>
Follow-Up Point	Every 60-90 days, or when there is a change in condition severity, engagement, or care complexity that may shift the balance toward either PCP-led or specialist-led accountability.

Care Accountability Type 5 | Interim Care Manager/Care Navigator/Intake Coordinator

Criteria	Details
Context	A patient does not have an established PCP or consistent care relationship. They may be new to the system, recently discharged, or in a transitional period following a trigger event. To prevent gaps in care, a care manager or intake coordinator temporarily assumes responsibility for coordination and follow-up. Examples are particularly relevant and important when applied to patient outreach activities, screenings, and transitions from clinical to home, community, and social care.
Recommendation	Interim Care Manager/Care Navigator/Intake Coordinator
Rationale	Assigning a short-term accountable clinician ensures that patients without a PCP still receive guided navigation, timely follow-up, and access to services. This prevents loss to follow-up and helps the patient connect to a sustainable, long-term care management relationship.
Engagement and Coordination Approach	The care manager or intake coordinator conducts a rapid needs assessment, confirms contact information, and screens for acute or chronic issues. They facilitate linkage to an appropriate PCP or ongoing care team, educate the patient on the value of continuous primary care, and document all coordination activities.
Follow-Up Point	Within 30-45 days to confirm successful PCP assignment. If no PCP is secured, the care manager continues as interim care navigator and reassesses every 90 days until stable linkage is achieved.