Knowing the questions and the answers just isn’t enough. It all comes down to real-world applications. That’s the lesson Mary Naylor, PhD, RN, learned developing the Transitional Care Model (TCM).

From unmet medical and social needs to high rates of preventable hospitalizations and poor care experiences, the economic and human aftermath of poor transitions can be “devastating,” especially for seniors, says Naylor, who is the Marian S. Ware professor in gerontology and director of the NewCourtland Center for Transitions and Health at the University of Pennsylvania School of Nursing.

And it’s a problem with a solution—several solutions, in fact. The evidence is clear and abundant on how to improve care transitions. The challenge, Naylor says, is to create a bridge across the chasm separating theory and practice. Evidence must be turned into action.

As chief architect of the Transitional Care Model (www.transitionalcare.info), Naylor has devoted much of her career to building that bridge. TCM provides a blueprint for health care organizations to improve health outcomes by applying practical, high-quality, cost-effective, evidence-based solutions to care transitions. Developed at the University of Pennsylvania, TCM initially focused on comprehensive in-hospital planning and home follow-up for chronically ill, high-risk older adults who have been
hospitalized—as well as their family caregivers. In recent years, this approach has been expanded to preventing hospitalizations of community-dwelling older adults.

**Defining the problem**

The scope of the problem is well known. Poorly coordinated care transitions from the hospital to other care settings costs billions, and human consequences include poor outcomes and injuries due to medication errors, complications, infections and falls.  

At least two out of every three older Americans have multiple chronic conditions, and more than 10 million Medicare beneficiaries—roughly 20 percent of those Americans—now live with five or more chronic conditions. Too often, these patients don’t receive the care they need as they transition through the health care system. Among Medicare beneficiaries readmitted to the hospital within 30 days of a discharge, half have no contact with a physician between discharge from their initial hospitalization and subsequent readmission.

Transitions have always been a concern, especially to professional case managers. The issue has taken on more urgency because of the Affordable Care Act. The ACA provides opportunities for achieving higher-value health care—reductions in spending without reductions in quality—by preventing avoidable hospital readmissions.

Professional case managers recognize that transition points are the weakest links in the chain of care, and they also understand that better transitions and optimized care coordination can decrease those avoidable hospitalizations, improve health outcomes, lower costs and enhance the patient experience, says Patrice Sminkey, chief executive officer for the Commission for Case Manager Certification™. “The good news is that research results are in, and they support the value of proactive efforts designed to improve care coordination and care transitions.”

Naylor’s Transitional Care Model is one such effort.

**Understanding transitional care**

Transitional care, Naylor explains, refers to a broad range of time-limited services designed to ensure health care continuity and avoid preventable poor outcomes for at-risk patients as they move across care settings. As she noted in *Health Affairs*, “The hallmarks of transitional care are the focus on highly vulnerable, chronically ill patients throughout critical transitions in health and health care, the time-limited nature of services, and the emphasis on educating patients and family caregivers to address root causes of poor outcomes and avoid preventable rehospitalizations.”

The Transitional Care Model addresses the negative effects associated with common breakdowns in care when older adults with complex needs transition from hospital to home or another care setting. Through pre- and post-discharge coordination of care for these patients, it prepares them and their family caregivers to more effectively manage their health.

Among the key elements of the model:

- **Nurse-coordinated, team-based:** Care is delivered and coordinated by the same advanced practice nurse (APN), supported by a care team. The APN works with high-risk older adults within and across all health care settings (e.g., hospital, skilled nursing facility, home, etc.).

- **Continuity:** The APN serves as the “point person” across the entire episode of care, starting with hospital admission. The APN makes regular home visits and provides ongoing telephone support for an average of two months post-discharge.

- **Early intervention:** The model emphasizes early identification of, and response to, health care risks and symptoms to

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1 Improving Care Transitions, *Health Affairs Health Policy Brief*, Sept. 13, 2012
4 Achieving Quality, Traditional Care Model [http://www.transitionalcare.info/](http://www.transitionalcare.info/)
5 Care Transitions: Best Practices and Evidence-based Programs, Policy Paper, Center for Healthcare Research & Transformation, Jan. 15, 2014
avoid the need for preventable acute care and improve quality of life. Naylor notes that symptom management is different from disease management. The symptoms themselves—pain, shortness of breath, etc.—interfere with the patient’s quality of life. They need to be taken as seriously as the condition itself.

- **Comprehensive, holistic assessment:** The APN assesses the patient’s priority needs, goals and preferences. This includes not only the reason for the primary hospitalization, but also other complicating issues, such as poverty, lack of transportation or inability to understand how and when to take the appropriate medications.

- **Evidence-based:** The APN uses evidence-based protocols supported by decision-support tools.

- **Patient engagement:** The care plans align with each patient’s goals and needs, and involve active engagement and support from patients and their families. Rather than imposing a care plan, the APN asks, “What matters to you? What do you hope to achieve?” By modifying the plan accordingly, she says, the APN is in a much better position to foster lasting change.

- **Collaboration:** Strong collaboration and communication among patients, family caregivers and health care team members across episodes of acute care and in planning for future transitions, such as palliative care is essential.

### Evidence abounds

Why is this approach effective? Because TCM focuses on increasing value over the long term—specifically, lowering costs and bettering the quality of care, she explains. Multiple studies7,8,9,10 demonstrate TCM’s positive impact on outcomes and costs. Early research—from the late ’90s through the mid-2000s—found that it increased access, reduced errors, controlled costs and enhanced care experience. (See Figures 1 and 2 on pages 4 and 5.)

In theory and in practice, TCM leads to:

- **Avoidance of hospital readmissions for primary and complicating conditions.** TCM has resulted in fewer hospital readmissions for patients. Additionally, among those patients who are rehospitalized, the time between their discharge and readmission is longer and the number of days spent in the hospital is generally shorter than expected.

- **Improvements in health outcomes after hospital discharge.** Patients who received TCM services have reported reduction in symptoms and improvements in physical health, functional status and quality of life.

- **Enhancement in patient and family caregiver experience.** Overall patient satisfaction is increased among patients receiving TCM services. In ongoing studies, TCM also aims to lessen the burden among family members by reducing the demands of caregiving and improving family functioning.

- **Overall lower costs.** TCM was associated with lower total costs and lower average per-patient costs. A 2004 study pegged the mean savings in

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total health care costs at nearly $5,000 per patient.11

Naylor and her team were thrilled with the results. “These were significant findings. We published widely, in prestigious journals. And we waited.” In vain: The findings received considerable attention, but no one was putting the findings into practice.

From theory to practice

“The way we were talking about delivering care—longitudinal, team-based care across different settings—was not the norm at the time. It wasn’t how payment incentives were structured and it wasn’t how health care professionals were trained to act,” she explains. “We were confronting organizational, cultural and financial challenges.”

So Naylor and her UPenn research team put the model in motion themselves. They formed partnerships with payers—including Aetna and Independence Blue Cross—and collaborating health systems to test real-world applications of the research-based model of care among high-risk seniors.

They succeeded.12 Among the results: improvements in all quality measures, increased patient and physician satisfaction, reductions in rehospitalizations and cost savings.

The key, Naylor and her team discovered, was building tools to translate evidence alone into evidence-based practice. Tools include the following:

- Preparation and training of TCM nurses, teams and sites
- Documentation and quality monitoring, including use of clinical information systems
- Quality improvement
- Evaluation

Naylor’s own institution, University of Pennsylvania Health System, has adopted TCM. More broadly, evidence generated from testing this approach has informed how ACA innovations have unfolded. Her team at UPenn has developed a web-based Foundations of Transitional Care seminar to orient nurses and other health team members to the model, and articulate the value and core components of TCM so they can take it to their own institutions.

Variations on a theme

When it’s put into practice, TCM’s benefits cease to be theoretical. It enables patients and caregivers to realize the desired results. Preliminary findings from the Commission’s 2015 evidence-based Role and Function Study also highlight the value of these very practical benefits, Sminkey says. “When you see critical research support the importance of transitions, and address how the health care team can best be engaged—the heart of professional case management—you know you are on the cutting edge of transformational health care.”

Success comes through adapting and applying the evidence to a specific situation, says Naylor. “We aren’t the only ones to get it

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11 Journal of the American Geriatrics Society, op. cit.
Part of adapting and interpreting may involve systemic changes in structures, care processes, and health professionals’ roles and relationships to each other and the patients and families they support, she adds. Several such “variations on a theme” projects are underway. One explores how sites in health systems and communities across the country are implementing TCM. Another focuses on patient-centered medical homes, comparing the outcomes of a PCMH with TCM to outcomes achieved by the PCMH alone in preventing hospitalization for at-risk community-based older adults. Lessons learned will help advance the larger-scale effort.

Translations, necessarily, vary with the nuances of different texts. Although the fundamentals remain the same, each time the model is implemented it will be a little different. Professional case managers can help accomplish successful adaptations, she says. “Solving complex problems requires multidimensional solutions. There’s no cookbook.”

The case manager’s role

Board-certified case managers, with their extensive education and hands-on experience, are ideally suited to the task of marrying concept to execution, research to practice, says Sminkey. It also aligns with the case manager’s focus on the patient. “Much of the talk about care transitions has been about provider organizations. This is a reminder that, as case managers, our first concerns are to advocate for the client and protect the consumer,” she says. “We do not work with cases. Actually, we have never worked with cases. We work with people. And board-certified case managers are instrumental in protecting the public interest when the focus changes, as it has with care transitions.”

Board-certified case managers, brought in as part of the team at the beginning of a complex hospital admission, play an integral role in assessing the social, emotional and physical needs of the patient and the family caregiver beyond discharge, and bring a wealth of knowledge about how current acute-care needs must be considered in the context of whole-patient care. Working at the top of their license, case managers can and must be part of the solution. “We can begin to mend the broken system. The aims of these best practices for care transitions are ones we can all agree on: improved health, better care and lower costs,” Sminkey says.

For her part, Naylor is eager to engage professional case managers. There is, she says, a critical need for case managers who are following these patients on their journeys, aligning service availability with their goals and their needs. “It’s not simple, but it’s our future. You are our future.”

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* Total costs were calculated using average Medicare reimbursements for hospital readmissions, ED visits, physician visits and care provided by visiting nurses and other health care personnel. Costs for TCM care are included in the intervention group total.


Patrice Sminkey, Chief Executive Officer, The Commission for Case Manager Certification

Sminkey comes to the Commission from URAC, where she most recently served as senior director of sales. Prior to that, she was senior vice president, operations and client management, Patient Infosystems in Rochester, N.Y. She brings a proven track record in operations management in small and large operations, multilevel services and cross-functional teams. She has extensive experience in client management and coordination, including marked improvement in client retention, timely and fiscally sound program implementation and an expanding book of business.

As chief executive officer, Sminkey oversees the management of all activities related to the Commission’s operations, including all programs, products and services; and the provision of quality services to and by the Commission. She is a direct liaison to the Commission’s Executive Committee. She works with CCMC’s volunteer leadership to evaluate and develop potential new products for implementation by CCMC, and she establishes and maintains communication and working relationships with other organizations, agencies, groups, corporations and individuals.

She holds a diploma of nursing from the Chester County School of Nursing.

Mary D. Naylor, PhD, FAAN, RN

Naylor is the Marian S. Ware professor in Gerontology and director of the NewCourtland Center for Transitions and Health at the University of Pennsylvania School of Nursing. Since 1989, Naylor has led an interdisciplinary program of research designed to improve the quality of care, decrease unnecessary hospitalizations, and reduce health care costs for vulnerable community-based elders. Naylor is also the national program director for the Robert Wood Johnson Foundation program, the Interdisciplinary Nursing Quality Research Initiative, aimed at generating, disseminating and translating research to understand how nurses contribute to quality patient care.

Naylor was elected to the National Academy of Sciences, Institute of Medicine in 2005. She also is a member of the RAND Health Board, the National Quality Forum Board of Directors and is immediate past-chair of the board of the Long-Term Quality Alliance. She was appointed to the Medicare Payment Advisory Commission in 2010.

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