

Matching Transitional Care to Patient Risk: A Comparative Review of Clinical Models, Context, and Longitudinal Accountability

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Presidium Health White Paper | July 2026 | Main-text word count: approximately 4,100

Tables: 4 | Figures: 2 | References: 31

Abstract

Background. Transitions across hospitals, post-acute facilities, outpatient care, community services, and home expose patients to medication discrepancies, information loss, delayed follow-up, functional decline, caregiver strain, and avoidable acute-care use. Transitional-care models differ in mechanism, workforce, intensity, duration, and target population.

Objective. To compare major transitional-care models, identify the patients and settings for which each is best suited, and propose a framework linking model selection to time-limited or longitudinal accountability.

Methods. We conducted a comparative integrative narrative review beginning with an author-curated full-text collection and citation list. Supplementary gap-directed searches were conducted July 18-19, 2026 using PubMed/MEDLINE and targeted web searches of publisher, government, and professional-organization websites. Trials, reviews, economic evaluations, qualitative studies, implementation reports, and policy analyses were compared by mechanism, workforce, intensity, setting, outcomes, feasibility, and economic perspective.

Results. BOOST and Project RED strengthen discharge processes; the Care Transitions Intervention builds patient and caregiver capacity; the Transitional Care Model provides sustained clinical continuity; pharmacist programs target medication risk; navigation and health-social models address access and social barriers; and tailored pathways address disease- or setting-specific risks. No model is consistently superior because effects depend on fit among mechanism, patient risk, caregiver capacity, receiving-setting capability, and infrastructure. Patient, caregiver, SNF, and rural studies further show that continuity, explicit accountability, relationships, distance, workforce, and governance influence whether a plan can be carried out. Indirect evidence suggests that premature de-intensification or repeated temporary ownership may destabilize selected patients when no durable receiving relationship has been established. Readmission remains the dominant outcome despite incomplete measurement of function, caregiver outcomes, and long-term stability.

Conclusions. Transitional care should combine universal transition-safety functions, time-limited services matched to the dominant modifiable risk, and persistent longitudinal stabilization for recurrent multidomain instability. De-intensification should be based on stability and a capable receiving relationship rather than a fixed date. Clinical and payment models should be aligned but not conflated.

Keywords: transitions of care; transitional care; continuity of care; relational continuity; hospital discharge; readmission; care coordination; Transitional Care Model; Care Transitions Intervention; Project RED; BOOST; social determinants of health; rural health; value-based payment; skilled nursing facility.

1. Introduction

Transitions across hospitals, post-acute facilities, outpatient care, community services, and home are vulnerable periods. Medication discrepancies, information loss, delayed follow-up, inadequate preparation, and uncertainty about responsibility can lead to adverse events, preventable use, functional decline, caregiver strain, and higher spending [1,2]. Transitional care extends beyond discharge planning: it includes preparation by the sending setting, transfer and acceptance of information and responsibility, and implementation of the plan in the receiving environment [3].

Major models address different failures. BOOST and Project RED improve discharge reliability; the Care Transitions Intervention (CTI) builds self-management; the Transitional Care Model (TCM) provides sustained advanced-practice-nurse continuity; pharmacist-led care targets medication risk; navigation and health-social programs address access and social barriers; and tailored pathways address disease- or setting-specific risks [2-4]. The relevant question is therefore which mechanism fits the patient, pathway, and delivery environment. Discharge planning and symptom monitoring appear necessary but insufficient, and hospital-to-SNF studies show that an otherwise sound plan can fail when capability, information, or responsibility is unclear [4-6].

Most studies emphasize readmission, emergency use, and short-term cost, which incompletely capture symptom control, function, medication understanding, caregiver preparedness, independence, and time at home. Economic findings are also difficult to compare because studies differ in population, perspective, included costs, horizon, and method [4,7-12].

Transitional care is also commonly framed as an episode. A discrete 30-day intervention may suffice after an isolated hospitalization, but recurrent admissions, cognitive impairment, unstable housing, medication complexity, limited support, or absent outpatient care may signal persistent instability [1,13,14]. Repeated temporary programs may improve

individual handoffs while still leaving no organization responsible for the trajectory; patient, care-management, and behavioral-health evidence provides indirect support for this concern [24-26,30,31].

This review asks which mechanism fits which patient, transition, and health-system context, and when time-limited support should give way to longitudinal accountability. We compare models, outcomes, implementation, and economics; use SNF and rural transitions to examine feasibility; distinguish care delivery from financing; and propose a three-tier framework.

2. Methods

We conducted a comparative integrative narrative review because the evidence spans trials, reviews, economic evaluations, qualitative studies, implementation reports, and policy analyses. Heterogeneity in populations, settings, interventions, outcomes, follow-up, and economic perspectives made pooled comparison inappropriate for this review. This was not a formal systematic review and did not include duplicate screening or one risk-of-bias instrument applied to every source.

The review began with an author-curated collection of full-text articles and a citation list. Supplementary searches were conducted July 18-19, 2026 using PubMed/MEDLINE and targeted general web searches of publisher, government, and professional-organization websites. Search concepts combined “transitional care” or “care transitions” with model- and context-specific terms, including Project RED, BOOST, Care Transitions Intervention, Transitional Care Model, pharmacist, patient navigation, social needs, skilled nursing facility, hospital-to-SNF, SNF-to-home, emergency department, rural care, caregiver, cost-effectiveness, payment, relational continuity, and assertive community treatment step-down. Reference lists of relevant reviews and included articles were checked for additional sources. No publication-date restriction was applied; the included literature was published from 2004 through 2026.

We abstracted population, settings, mechanism, workforce, components, duration and intensity, patient and caregiver roles, comparator, outcomes, economic perspective, implementation conditions, social and rural feasibility, and limitations. Interventions were classified as discharge redesign, activation and coaching, longitudinal clinical continuity, medication-focused care, navigation and health-social support, or disease- and setting-specific care; payment was analyzed separately. Evidence was synthesized by mechanism, fit, feasibility, outcomes, and value, with reviews and trials weighted most heavily for effectiveness and qualitative studies used to explain patient priorities, responsibility gaps, and delivery variation. The search was iterative and gap-directed rather than systematic; it did not use duplicate independent screening, a formal PRISMA process, or a comprehensive search of Embase, CINAHL, Scopus, or Web of Science.

3. Conceptual framework

Transitional care is a cross-setting process with three linked stages: preparation by the sending setting, transfer and acceptance of information and responsibility, and implementation and revision in the receiving setting. Recurring functions include medication management, planning, patient and caregiver engagement, information transfer, follow-up, provider engagement, symptom monitoring, social support, functional continuity, and shared accountability [1-4,6]. These functions should be distinguished from the organizational model that delivers them.

Four levels should be kept separate: the clinical model defines what is done and by whom; the organizational configuration allocates responsibility; the transition setting defines the pathway; and financing supports infrastructure and services. BOOST, TCM, a COPD bundle, and capitation therefore occupy different categories [2,4,6,15]. This distinction shifts comparison from which model wins to which problem requires which mechanism, while allowing complex patients to receive several coordinated functions within one accountable plan [2-4].

Intensity and duration should follow risk. We propose reliable baseline safety functions for every patient; focused risks may justify coaching, pharmacy, or navigation, while multimorbidity, cognitive impairment, recurrent use, unstable symptoms, or inadequate support may require sustained multidisciplinary management [2,4,9,13,14,16-20]. Time-limited care assumes that risk diminishes as the patient reconnects with routine services. When vulnerability persists, hospitalization may need to change the intensity of an existing relationship rather than create another temporary owner [1,13,14,17,19].

4. Comparative review of clinical models

The models share core functions but differ in locus of responsibility, clinical authority, intensity, and duration. The sequence below moves from discharge redesign to activation, sustained clinical management, specialist support, and pathway- or geography-specific adaptations [2-4].

4.1 Hospital discharge redesign: BOOST and Project RED

BOOST is a hospital quality-improvement framework using risk identification, medication review, education, checklists, multidisciplinary planning, and structured communication. Its adaptability supports local implementation but can produce incomplete or variable delivery [2,3].

Project RED specifies a patient-facing workflow involving a discharge advocate, individualized education, an after-hospital plan, medication reconciliation, appointment preparation, information transfer, and pharmacist follow-up; its foundational trial reduced post-discharge hospital use [21]. BOOST primarily strengthens organizational reliability, whereas RED more fully specifies the patient experience. Both can support an institutional baseline but do not necessarily provide sustained clinical management [2,3,21].

4.2 Patient activation and coaching

CTI builds patient and caregiver capacity through medication self-management, a patient-held health record, timely follow-up, and recognition of warning signs [22]. It is best aligned with modifiable deficits in navigation and understanding, but is less suitable when cognition, function, housing, caregiver limitations, absent outpatient access, or continuing clinical instability make independent self-management unrealistic [12,13,22].

4.3 Longitudinal clinical continuity: the Transitional Care Model

TCM provides greater clinical continuity than discharge redesign or coaching. An advanced practice nurse becomes involved during hospitalization and follows the patient home through visits, telephone access, caregiver engagement, symptom and medication management, and coordination [2,16]. Based on its mechanism and the populations studied, this intensity appears best aligned with multimorbidity, cognitive impairment, complex regimens, recurrent hospitalization, and high post-acute use; among cognitively impaired older adults, TCM lowered costs relative to augmented standard care at 30 and 180 days [17]. Its workforce and home-visit requirements favor targeted rather than universal use.

4.4 Medication-focused transitional care

Medication discrepancies, access problems, adverse effects, duplication, and misunderstanding are common post-discharge hazards. Pharmacist programs address them through reconciliation, comprehensive review, access and adherence assessment, education, prescriber communication, and follow-up [1,2,11,23]. We treat reconciliation as a universal safety function rather than a complete model; multifaceted pharmacist care appears best aligned with polypharmacy, high-risk drugs, major discrepancies, limited medication literacy, nonadherence, or medication-related hospitalization. Favorable findings from Jacobs et al. are tempered by cluster imbalance and a small intervention group [23].

4.5 Navigation and health-social support

Navigation and health-social models address barriers that education or medication review cannot resolve by connecting patients with clinical, financial, behavioral-health, and community services and addressing transportation, housing, insurance, language, and access [4,13,18,19]. Effects vary by population and design: a safety-net navigator trial found age-related differences in utilization [18], whereas an intensive multidisciplinary practice lowered 180-day costs among adults without a usual source of care [19].

These programs fit transitions threatened by absent follow-up or social and logistical barriers. Their roles, authority, caseloads, duration, and community resources vary substantially across programs [4,18,19]. Screening alone is unlikely to alter outcomes unless the program can close the loop on identified clinical and social needs [13,14,26].

Relationship continuity may be an active mechanism rather than a by-product of navigation. Patients and caregivers emphasize caring relationships, clear accountability, continuity, and fewer unnecessary handoffs [24]. Among frequently hospitalized patients, security, genuineness, and continuity supported motivation and active health management [25]; in social-needs case management, psychosocial work through the relationship operated alongside system mediation and direct assistance [26]. Navigation should therefore not be reduced to referral completion.

4.6 Disease-specific and post-acute pathways

Disease-specific bundles standardize actions for predictable risks. The Alberta COPD bundle addressed inhaler technique, medication optimization, action planning, rehabilitation, smoking cessation, frailty, comorbidity, follow-up, and education. It was associated with shorter stays and lower modeled costs, although the comparison was not fully randomized and used a short payer horizon [27].

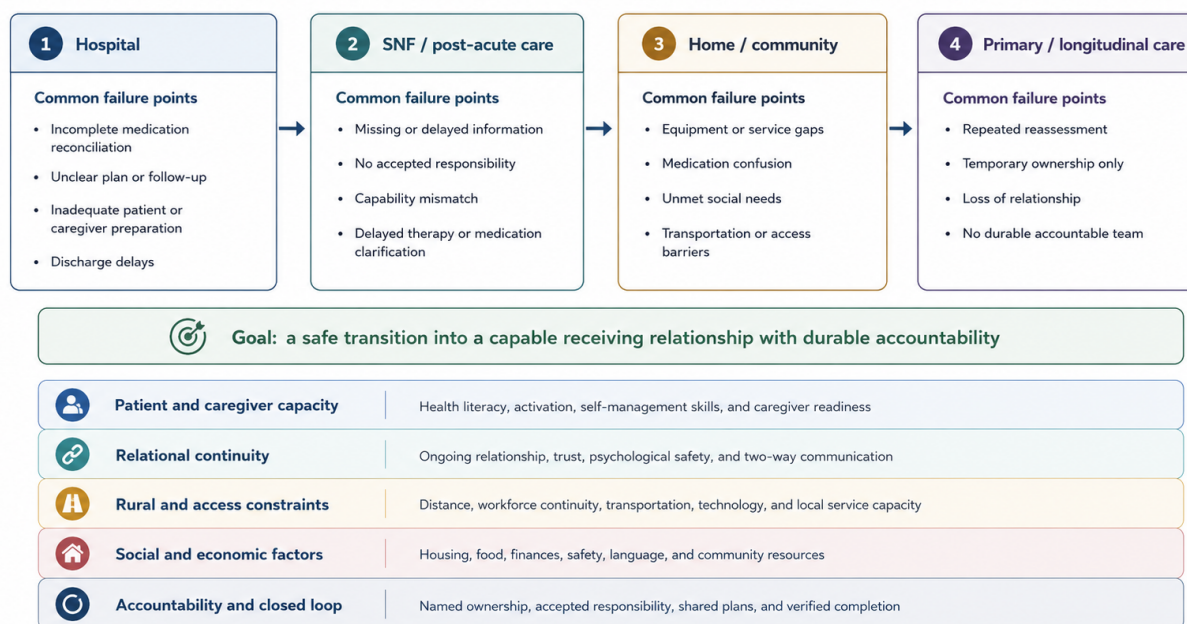
Post-acute pathways require the receiving organization to implement the plan. Hospital-to-SNF transitions depend on timely information, medication congruence, realistic knowledge of facility capability, rehabilitation goals, equipment, and explicit task ownership. Davidson et al. described variability across hospitals and SNFs, and Valverde et al. found responsibility gaps across most ideal-transition domains [5,6]. These findings suggest that information transfer alone may be insufficient when receiving capability is mismatched or a necessary task has no owner.

SNF-to-home is a second, distinct handoff. Patients may return with altered medications, new functional limitations, ongoing therapy needs, and caregivers assuming unfamiliar work. Patients and caregivers identified independence at home as central and described medication confusion, delayed therapy, and inadequate support as threats to recovery [15].

4.7 Rural transitions as an implementation stress test

Rural evidence shows that feasibility is not a property of the model alone. Byberg et al. identified distance and inaccessibility, professional competence and continuity, and organizational governance as interacting conditions [20]. These conditions shape whether home visits, virtual follow-up, medication and equipment access, record exchange, and escalation can be delivered at the intended dose. As a synthesis implication, rural adaptation should prospectively address travel, staffing, technology, regional partnerships, and financing rather than assume that an urban delivery model will transfer unchanged [20,28,29]. Mechanism identifies what should be done; pathway and geography determine whether it can be done reliably. Table 1 summarizes the models. Figure 2 maps the major failure points across the hospital-to-SNF-to-home-to-longitudinal-care pathway and the cross-cutting forms of continuity needed to bridge them.

Figure 2. Where transitions fail—and what continuity must bridge



Continuity must bridge every handoff; otherwise, task gaps, capability mismatch, and temporary ownership can reproduce fragmentation.

Common failure points and cross-cutting constraints synthesized from hospital-to-SNF, SNF-to-home, rural, patient and caregiver, and relationship-based evidence [5,6,15,20,24-26].

Table 1. Characteristics and clinical fit of major transitional-care models

Model / archetype	Mechanism and core functions	Lead workforce	Typical duration / intensity	Best-aligned risk	Principal limitation
BOOST / Project RED [2,3,21]	Hospital discharge redesign, standardized preparation, medication review, education, and information transfer	Hospital multidisciplinary team; discharge advocate; pharmacist follow-up in RED	Hospital-based to early follow-up; low-moderate	Unreliable discharge workflow or incomplete preparation	Variable local implementation and limited longitudinal clinical continuity
CTI / empowerment [2,3,22]	Coaching, medication self-management, warning-sign recognition, personal health information, and follow-up skills	Transition coach; patient-education team	Usually several weeks; low-moderate	Modifiable self-management or navigation deficit	Assumes adequate patient or caregiver cognitive and functional capacity
Transitional Care Model [2,16,17]	Advanced-practice-nurse continuity, home assessment, symptom management, caregiver engagement, and interdisciplinary coordination	Advanced practice nurse with multidisciplinary support	Hospital through home, often weeks to months; high	Multimorbidity, cognitive impairment, recurrent use, or continuing clinical instability	Greater workforce, home-visit, and cross-setting coordination requirements
Pharmacist-led care [23]	Medication reconciliation, comprehensive review, access and adherence assessment, education, and prescriber communication	Clinical pharmacist, usually linked to primary or transitional care	Targeted contacts over days to weeks; moderate	Polypharmacy, high-risk drugs, discrepancies, or medication-related admission	Medication-only approaches may not address clinical, functional, or social instability
Navigation / health-social support [13,18,19]	Resolution of access, transportation, housing, financial, behavioral-health, and community-service barriers	Navigator, social worker, community health worker, or multidisciplinary clinic	Variable; often 30-180 days	No durable follow-up source or major social and access barriers	Highly heterogeneous roles, authority, caseloads, and community resources
Disease- or setting-specific approaches [5,6,15,20,27]	Tailored bundle or pathway addressing predictable condition- or destination-specific failures	Disease-relevant or cross-setting team	Variable by pathway	COPD, ED-to-home, hospital-to-SNF, or SNF-to-home pathway risk	Limited generalizability; rurality and local infrastructure modify delivery across all models

5. Outcomes and effect modifiers

Readmission and emergency use dominate transitional-care research because they are observable and financially important, but they are incomplete. A model may improve medication safety, preparedness, function, or caregiver confidence without changing all-cause readmission, and a short follow-up window may obscure delayed or recurrent use. Studies should distinguish first from recurrent readmissions, condition-specific from all-cause events, emergency and observation use, inpatient days, and time between episodes [4,7-9,17,19].

Patient-centered outcomes are less consistently measured. Reviews show substantial variation in interventions and quality-of-life instruments; among patients with serious illness, transitional care produced small improvements in quality of life and symptoms but no clear mortality or functional benefit, with low or very low certainty [7,8]. After SNF care, patients emphasized mobility, therapy continuity, medication understanding, timely services, independence, and remaining safely at home [15]. Patients and caregivers also value continuity, clear accountability, caring relationships, and fewer unnecessary handoffs [24].

Caregivers are both an intervention resource and an outcome population. They often manage medication, transportation, appointments, mobility, and symptoms. Dyadic interventions may improve patient quality of life or function and reduce caregiver burden or depression, although utilization effects are inconsistent [9]. Programs should assess caregiver capability and willingness rather than assume unlimited unpaid labor.

Social conditions determine whether a technically correct plan is executable. Medication cost, transportation, housing, health literacy, access, behavioral-health needs, and unclear accountability are recurrent barriers [13]. Applying social-determinants domains within TCM offers a structure for repeated assessment, but evidence for active mitigation remains limited [14]. Screening should be judged by closed-loop resolution, not documentation alone [13,14,26].

Rurality is a delivery constraint as well as a patient characteristic. Distance and inaccessibility, workforce competence and continuity, and organizational governance can reduce the feasible dose or timeliness of care [20]. As implementation considerations, programs should also assess pharmacy and equipment access, digital connectivity, record exchange, and cross-organizational escalation rather than assume that geography alone determines feasibility.

Treatment effects are likely to vary by cognition, function, medication burden, literacy, caregiver capacity, social risk, rurality, prior use, outpatient access, and receiving setting. These factors should guide model selection and adaptation, not merely predict readmission [4,6-9,13-15,20]. Studies should also report fidelity, reach, attempted and completed

contacts, staff time, training, adaptation, caseload, technology dependence, sustainability, and outcomes across the full eligible population [2,4,7,9,20].

A common outcome framework should include utilization, transition-related harm, function, symptoms and quality of life, patient and caregiver preparedness, process completion, equity, economics, and implementation. Episode measures remain useful for immediate safety, but recurrent-event and longer-term outcomes are needed when vulnerability persists. Tables 2 and 3 summarize the evidence and delivery requirements [4,7-9,15].

Table 2. Comparative evidence profile by transitional-care model or archetype

Model / archetype	Utilization findings	Patient, caregiver, and safety outcomes	Economic findings	Evidence profile and interpretation
BOOST / Project RED [2,3,21]	Generally favorable short-term utilization findings, but effects vary with implementation and usual care	Improves discharge preparation, medication review, education, and communication; broader patient-centered outcomes are less consistently reported	Economic evidence is less developed than clinical-process evidence	Moderate evidence for improving discharge reliability; limited direct comparison and substantial fidelity variation
CTI / empowerment [12,22]	Reductions in some trials, with inconsistent effects across settings and populations	Strongest proximal effects involve activation, preparedness, warning-sign recognition, and navigation; health outcomes vary	Short-term cost-effectiveness is favorable in selected empowerment studies	Moderate but heterogeneous evidence; best fit when patient or caregiver can assume self-management tasks
Transitional Care Model [10,16,17]	Favorable readmission and resource-use findings in selected high-risk older populations	Supports clinical continuity and caregiver involvement; quality-of-life and functional effects are not uniformly measured	Lower downstream costs in selected trials; full cost-effectiveness evidence remains limited	Among the stronger model-specific evidence bases, but resource intensive and not automatically generalizable
Pharmacist-led care [11,23]	Mixed utilization effects; multifaceted programs appear more promising than reconciliation alone	Most direct benefits involve discrepancy resolution, medication understanding, adherence, and adverse-event prevention	Positive return and budget-impact estimates in selected studies, but results are design- and assumption-dependent	Low-moderate evidence for broad utilization effects; stronger mechanistic support for targeted medication risk
Navigation / health-social support [13,18,19,24-26]	Heterogeneous and sometimes subgroup-specific effects; may increase appropriate service use while addressing access gaps	Can improve access, engagement, continuity, and resolution of social barriers; caregiver and functional outcomes vary	Favorable findings in some multidisciplinary programs, but cost transfer and community-resource use are often incompletely measured	Low-moderate, highly context-dependent evidence; screening alone is insufficient without closed-loop mitigation
Disease- or setting-specific approaches [5,6,15,20,27]	Favorable findings in selected bundles and pathways, with limited transferability beyond the target condition or setting	May improve disease-specific preparation, medication safety, rehabilitation continuity, and independence at home	Selected COPD and pathway analyses are favorable, usually over short horizons	Low-moderate and intervention-specific evidence; receiving-setting capability and local infrastructure are central

Evidence profiles are qualitative syntheses of design strength, consistency, directness, and applicability; they are not formal certainty grades or numerical rankings.

Table 3. Context, infrastructure, and feasibility considerations

Model / archetype	Workforce and intensity	Infrastructure dependence	Social and rural adaptability	Key setting and accountability requirements
BOOST / Project RED [2,3,20,21]	Low-moderate; requires hospital champions, discharge personnel, and interdisciplinary participation	Moderate dependence on standardized workflow, timely records, and post-discharge contact	Adaptable locally, but social mitigation is not inherently comprehensive; rural feasibility depends on travel, communication access, and receiving services	Hospital leadership, reliable discharge processes, accepted handoff, and clear ownership of follow-up tasks
CTI / empowerment [12,20,22]	Low-moderate; coach or educator supports patient and caregiver activation	Moderate dependence on telephone access, records, and available outpatient services	Can be delivered remotely, but limited when cognition, literacy, digital access, or caregiver capacity is poor	A reachable patient or caregiver and an accessible receiving clinician are essential
Transitional Care Model [10,14,16,17,20]	High; advanced practice nurse, repeated contact, home assessment, and multidisciplinary coordination	High dependence on cross-setting records, clinical escalation pathways, and home-visit or virtual capacity	Can incorporate social assessment; rural delivery requires travel funding, flexible modalities, and regional partnerships	One clinically capable professional maintains continuity while task owners remain explicit across settings
Pharmacist-led care [11,20,23]	Moderate and targeted; depends on pharmacist availability and prescriber collaboration	High dependence on accurate medication data, pharmacy access, and timely communication	Can address affordability and access; rural feasibility depends on timely local or remote pharmacy services	Authority and closed-loop communication are needed to implement and verify medication changes
Navigation / health-social support [13,18-20,24-26]	Variable; caseload and effectiveness depend on training, authority, and community connections	Moderate-high dependence on referral networks, transportation, benefits, housing, and behavioral-health resources	Most directly adaptable to social risk; rural success depends on scarce local services and trusted community partnerships	The program must confirm that referrals were received and that a durable clinical owner exists
Disease- or setting-specific approaches [5,6,15,20,27]	Variable; requires condition-relevant and receiving-setting expertise	Often high dependence on specialized services, equipment, rehabilitation, and interorganizational data	Must be designed for local geography, workforce, destination capability, transportation, technology, and caregiver resources	Sending and receiving organizations must specify capability, medication, rehabilitation, monitoring, and escalation responsibilities

Feasibility is relative rather than fixed. Local staffing, travel distance, technology, community-service capacity, and payment can materially change the deliverability of each model [20,28,29].

6. Economic evidence and financing

Transitional-care programs require staff, data systems, outreach, home or virtual services, medication management, and cross-organizational coordination. Reported savings cannot be ranked directly because analyses differ in perspective, horizon, resources, population, health system, and method [4,10-12]. Cost analyses compare expenditures; cost-benefit analyses monetize costs and benefits; budget-impact analyses estimate affordability; and cost-effectiveness analyses relate costs to health outcomes. Kast et al. found few U.S. TCM economic studies, mostly partial analyses, and concluded that robust, transferable cost-effectiveness evidence was limited [10].

Economic findings are favorable but population specific. TCM nursing costs were offset by lower rehospitalization and post-acute use among cognitively impaired older adults [17]; a multidisciplinary practice for adults without usual care lowered costs at 180 days but not consistently at 90 or 365 days [19]. Pharmacist, COPD, and empowerment programs also report favorable selected or short-horizon results, without establishing general superiority [11,12,23,27]. Perspective is crucial: a payer may save while a hospital incurs costs or loses revenue, and programs may shift work to primary care, home health, social services, or caregivers [10-12,17,19]. Economic value should therefore be reported alongside the distribution of costs and benefits, because the organization financing transitional care may not be the organization that captures downstream savings [10-12,17,19].

Payment is a cross-cutting implementation mechanism, not a clinical model. Fee-for-service may underpay outreach and coordination; episode payment can fit time-limited care but may also create incentives for repeated enrollment or selection; prospective population payment can support capacity and continuity but requires risk adjustment and safeguards; and capacity payments can sustain staff, data systems, rural coverage, and rapid response [28,29]. Based on these considerations, we propose embedding universal safety functions in routine payment, using risk-adjusted case funding for targeted care, and providing prospective funding with event-responsive resources for longitudinal stabilization. Quality and shared-savings incentives should supplement adequate base payment and should be evaluated for delayed use, duplicated coordination, and cost shifting [28,29].

Economic evaluation should mirror the clinical architecture and report intervention costs; inpatient, outpatient, post-acute, home-health, pharmacy, and social-service use; patient and caregiver burden; and the distribution of costs and savings. Sensitivity analyses should test engagement, staffing, duration of effect, and whether improved access initially increases appropriate service use. A program can be cost-effective without being cost-saving [10-12,17,19].

7. Proposed layered framework

The comparison identifies three obligations: universal safety functions, additional services matched to a potentially resolvable risk, and persistent management when instability continues across events. We therefore propose a three-tier architecture. The complete framework is synthesis-derived and has not been tested as one integrated clinical and payment model [2,4,6,13,14,20,28,29].

7.1 Tier 1: Universal transition standard

Every transition should include a minimum set of safety and continuity functions regardless of diagnosis, payer, destination, or predicted readmission risk [2,6,13,24]:

- accurate medication reconciliation and explanation of changes;
- a current and actionable care plan;
- timely transfer of essential clinical and functional information;
- appropriate follow-up arrangements;
- patient and caregiver preparation, including warning signs and escalation instructions;
- identification of the clinician or team assuming responsibility;
- confirmation that the receiving setting can implement the plan; and
- initial assessment of clinical, functional, medication, caregiver, social, and geographic risk.

These functions require closed-loop completion: information must be received and accepted, follow-up must be feasible, and the receiving setting must have the required capability. Tier 1 should be embedded in routine care rather than sold as a premium product [2,6,13].

7.2 Tier 2: Risk-targeted transitional intervention

Additional time-limited services should match the dominant modifiable risk: BOOST or RED for process unreliability; CTI or empowerment for self-management; pharmacist care for medication risk; navigation for social and access barriers; TCM for continuing clinical instability; and tailored pathways for disease- or setting-specific risks [2-4,13,16,21-23,27].

Patients may require combinations—for example, TCM plus pharmacist support or RED plus navigation. When several mechanisms are needed, they should be integrated within one accountable plan rather than stacked as disconnected programs [2,4,13,14,23,26].

We propose that Tier 2 end when stability criteria are met rather than when a fixed period expires. Completion may require resolved medication discrepancies, established follow-up, accepted responsibility, stable symptoms, necessary services, a feasible social plan, and clear escalation contacts. Indirect assertive-community-treatment evidence identifies loss of relationships, fear of relapse, resistance to starting over, and inadequate receiving services as threats to step-down [30], while a small selected cohort sustained gains after discharge [31]. Intensive care need not continue indefinitely, but de-intensification should be readiness-based.

7.3 Tier 3: Persistent longitudinal stabilization

Some patients do not return to a stable baseline after one transition. Recurrent admissions, short intervals between events, failed prior interventions, multimorbidity, cognitive impairment with limited support, behavioral-health complexity, unstable housing, persistent medication instability, or absent outpatient care may indicate longitudinal need [1,13,14,17,19].

For these patients, another isolated episode may add coordination without changing fragmentation. We propose that one team remain accountable across settings, with lower-intensity monitoring during stable periods, rapid reassessment with deterioration, inpatient coordination during hospitalization, intensive post-discharge stabilization, and root-cause review after recurrence. This recommendation is consistent with evidence on persistent clinical and social risk, relational continuity, and step-down vulnerability, but it has not been tested as a complete delivery model [1,13,14,17,19,24-26,30,31]. Hospitalization should change care intensity, not automatically change care ownership.

7.4 Accountability, outcomes, and financing by tier

The framework requires person-level and task-level accountability: one team integrates the longitudinal plan, while each transition activity has a named owner, deadline, and verification process [6].

Outcomes should match the tier. Tier 1 emphasizes reliability and safety; Tier 2, resolution of the targeted risk, preparedness, early use, and completion; and Tier 3, recurrent events, acute-care days, time between hospitalizations, function, home time, continuity, caregiver sustainability, and long-term cost [7-10,15].

We propose that financing follow the same architecture: routine payment for Tier 1, risk-adjusted case funding for Tier 2, and prospective population or capacity funding with event-responsive resources for Tier 3. Table 4 summarizes the framework, and Figure 1 illustrates model selection and reassessment after acute events [28,29].

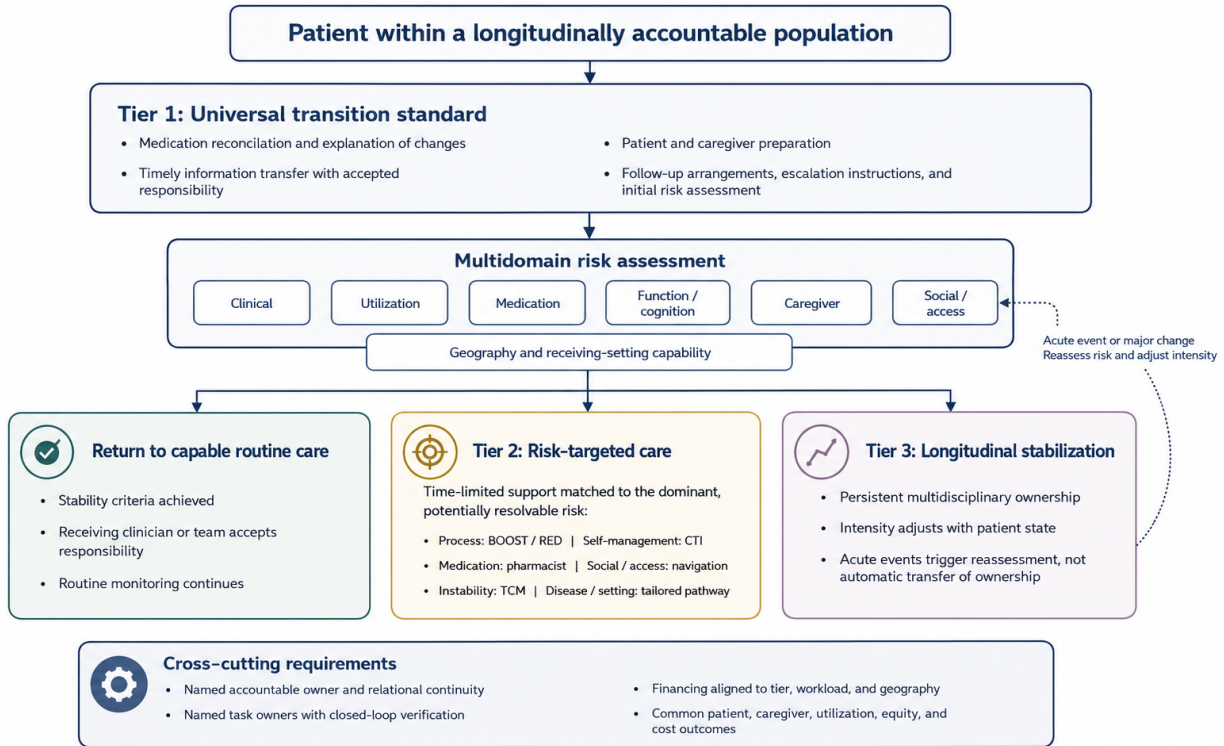
Table 4. Three-tier transitional-care framework

Feature	Tier 1: Universal standard	Tier 2: Targeted intervention	Tier 3: Longitudinal stabilization
Population	Every patient undergoing a transition	Patients with identifiable, potentially resolvable risks	Patients with persistent or recurrent multidomain instability
Purpose	Reliable safety and accepted handoff	Resolve a defined vulnerability	Improve the longitudinal trajectory across events
Duration	Until transition tasks are verified	Time-limited, based on stability criteria	Ongoing, with variable intensity
Representative approaches	Core discharge functions; BOOST/RED infrastructure	CTI, pharmacy, navigation, TCM, bundles, setting-specific care	Persistent multidisciplinary accountable team

Feature	Tier 1: Universal standard	Tier 2: Targeted intervention	Tier 3: Longitudinal stabilization
Ownership	Explicit sending and receiving task owners	Designated transitional team with a defined handoff	One team retains person-level accountability across settings
Payment	Embedded routine payment	Risk-adjusted case or episode funding	Prospective risk-adjusted capacity/population funding with event-responsive resources
Primary outcomes	Process reliability and safety	Resolution of target risk and early outcomes	Function, home time, recurrent use, continuity, and total cost

The three-tier framework is a synthesis-derived proposal. Its component functions, contextual modifiers, relational-continuity principles, and accountability requirements are grounded in the reviewed evidence [2,4,6,13-15,20,24-26,28,29], but the complete architecture has not been tested as one integrated clinical and payment model.

Figure 1. Risk-matched architecture for transitional care



Evidence-supported mechanisms are organized within a synthesis-derived three-tier architecture. Acute events trigger reassessment of risk and intensity without automatically changing accountable ownership.

8. Discussion

The evidence supports a mechanism- and context-based interpretation of transitional care. Model value lies not in intensity itself but in whether the intervention addresses a meaningful risk and can be delivered with fidelity [2-4]. Across models, continuity is more than structure: patient, caregiver, and case-management studies suggest that clear accountability and a trusted relationship can support engagement, motivation, and execution of the plan [24-26].

Readmission is important but insufficient. Transitional care may improve safety, understanding, function, symptoms, caregiver preparedness, and time at home without changing 30-day utilization. Evaluation should combine recurrent use with patient, caregiver, safety, equity, implementation, and total-cost outcomes [7-9,15].

SNF and rural studies indicate that context functions as part of the intervention. Hospital-to-SNF transitions can fail through unclear task ownership or inaccurate assumptions about facility capability; SNF-to-home transitions reintroduce medication, rehabilitation, caregiver, and functional needs in a new environment [5,6,15]. In rural care, distance, workforce continuity, access, and governance influence the dose and timeliness that can be delivered [20]. Model selection should therefore account for receiving-system capacity and the resources needed to bridge identified gaps.

This context-sensitive view exposes the limits of episodic care. Time-limited support is appropriate when it creates a stable handoff to a capable receiving relationship; it is less appropriate when repeated admissions reflect persistent multidomain instability. Model mismatch may therefore be more than ineffective. For patients whose stabilization depends partly on relational continuity, repeated enrollment in time-limited programs could create a form of iatrogenic discontinuity through recurrent assessment, trust formation, partial stabilization, and termination before a durable receiving relationship is established. Patient, caregiver, care-management, and behavioral-health evidence indirectly supports the plausibility of this pathway, including concerns about relationship loss, relapse, starting over, and inadequate receiving services; however, selected stable patients may sustain gains after intensive care ends. This hypothesis requires prospective testing [24-26,30,31]. A financing structure aligned with this framework would combine

episode funding for time-limited care, prospective funding for continuous responsibility, rural capacity support, and supplemental quality incentives [28,29].

The proposed architecture exceeds current evidence. The literature supports distinct mechanisms, risk heterogeneity, contextual and relational effects, readiness concerns during step-down, and the limits of readmission as a sole outcome, but it does not prove that a three-tier national model, persistent ownership, or a particular blended payment formula will outperform existing arrangements [2,4,7-9,13,14,20,24-26,28-31]. The framework is a testable synthesis, not a settled conclusion.

9. Limitations

This targeted review began with an author-curated source set and gap-directed searching; it did not include duplicate screening or a uniform risk-of-bias assessment. Interventions, populations, comparators, outcomes, and follow-up are heterogeneous, and identical labels may conceal different implementation. Economic studies often omit intervention, caregiver, community, or infrastructure costs [10-12]. Much of the evidence concerns older, high-risk, urban, and U.S. populations, while rural, equity-focused, and direct head-to-head studies remain limited [4,7-10,20]. The three-tier architecture has not been evaluated as an integrated model.

10. Research agenda

Research should address six questions: Which mechanisms perform best under common eligibility and outcome definitions? Which patients need low-, moderate-, or high-intensity care? Does active social-risk mitigation improve outcomes beyond screening and referral? How should SNF capability and rural infrastructure alter staffing, dose, and payment? Which stability, relationship, and receiving-system criteria should govern longitudinal conversion or safe step-down? Which payment structures support fidelity, reach, and accountability without selection or duplication? Studies should report workforce, dose, fidelity, reach, adaptations, caregiver and social interventions, travel and technology requirements, and incomplete delivery [5,6,20,24-26,30,31].

Head-to-head trials will not answer every policy question. Pragmatic cluster trials, stepped-wedge studies, interrupted time-series analyses, and natural experiments may be more feasible. Designs should prespecify subgroup analyses, measure contamination and concurrent programs, and use common outcomes spanning recurrent use, safety, function, home time, patient and caregiver preparedness, equity, cost, and sustainability.

Longer follow-up and recurrent-event methods are essential. Thirty-day outcomes remain useful for immediate safety, but six- to twelve-month measures such as time between hospitalizations, acute-care days per person-year, and days alive in the community better reflect persistent stabilization [7-9,15,17,19].

11. Conclusion

Transitional care is not a uniform post-discharge product. Its value depends on matching mechanism, intensity, duration, workforce, and receiving-system capacity to the patient's clinical, medication, self-management, caregiver, social, geographic, and setting-related risks. Transition-safety functions should be universal; additional services should be targeted; and recurrent multidomain instability may require a persistent accountable team rather than repeated temporary episodes.

Effective transitional care therefore requires the right mechanism, for the right patient, in a receiving environment able to carry it out, for the right duration. For patients with persistent multidomain instability, continuity of accountable ownership may itself be part of the intervention; based on the indirect evidence reviewed, premature or repeated program termination may recreate the fragmentation transitional care is intended to correct. Financing should support stability, readiness-based de-intensification, and durable accountability rather than repeated movement between temporary silos.

Disclosures

Funding: This work was funded by Presidium Health Corp., the authors' employer.

Conflicts of interest: All authors are employees and executive officers of Presidium Health Corp. Presidium Health holds multiple contracts to provide transitions-of-care and related care-management services. These professional and financial interests could be perceived as influencing the interpretation of the evidence and the proposed framework.

Ethics statement: Not applicable. This white paper reviews published literature and did not involve human participants or identifiable participant data.

Data availability: No new datasets were generated. The evidence base consists of the published sources listed in the references.

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