PSNet
PATIENT SAFETY NETWORK

Support from hospital to home for elders: a randomized trial.

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Goldman E, Sarkar U, Kessell E, et al. Support from hospital to home for elders: a randomized trial. Ann Intern Med. 2014;161(7):472-81. doi:10.7326/M14-0094.
https://psnet.ahrq.gov/issue/support-hospital-home-elders-randomized-trial

Readmissions and adverse events after discharge are a continued patient safety problem, as evidenced by the fact that more than 2500 hospitals have been penalized by the Centers for Medicare and Medicaid Services due to excessive readmission rates. Comprehensive programs such as Project RED and the Care Transitions Intervention have successfully prevented readmissions by using a dedicated transition provider (usually a nurse) who contacts the patient before and after discharge and helps coordinate care. This randomized controlled trial, conducted in an urban safety net hospital, found that such an approach did not reduce 30-day readmission rates—and may have increased postdischarge emergency department visits—compared with usual discharge care for a group of elderly, ethnically, and linguistically diverse patients with low health literacy. The study findings reinforce the importance of customized, patient-centered discharge approaches and highlight barriers to generalizing interventions to improve safety across sites of care and patient populations. These challenges are explored further in an AHRQ WebM&M interview with Dr. Eric Coleman, a pioneer in the field of care transitions and a recipient of a MacArthur Award.