



RESEARCH SPOTLIGHT ON

Care Transitions

Care transitions occur when patients move between different healthcare settings, such as from a hospital to home care or between different practitioners. Poorly executed transitions can harm patients and lead to unnecessary hospital visits.

Suboptimal transitions occur relatively frequently. Medicare alone spent **\$17.8 billion** on avoidable readmissions in 2013, the Centers for Medicare and Medicaid Services reports. A study in the *Annals of Internal Medicine* found that on discharge from the hospital, **30 percent** of patients have at least one discrepancy between their discharge list of medications and the medications they actually take at home.

20% of all patients experience a preventable health problem within three weeks of leaving the hospital.

Source: Medicare Payment Advisory Commission

In recognition of the need to improve transitional care, PCORI is funding **comparative clinical effectiveness research (CER)** to determine which approaches to transitional care are most effective in lowering the rate of avoidable hospital readmissions, preventing adverse events, and promoting patient safety, satisfaction, and quality of life.

Research Addressing Questions That Matter

PCORI funds **comparative clinical effectiveness research (CER)** to determine which healthcare options work best for which patients, based on their needs and preferences. CER produces evidence that helps people make better-informed healthcare choices.



PATIENT

I'm recovering from heart surgery, and the nearest hospital is more than 100 miles away. I want to do everything necessary to avoid any complications or relapses. How do I work with my doctor to make sure I have all the resources I need?



CLINICIAN

I work at a large metropolitan hospital, and I want to know if a patient navigator helping discharged patients connect with community resources can actually reduce readmission rates.

STUDY SPOTLIGHTS

Improving Care Transitions From Hospital to Home

Poorly executed transitions between healthcare settings—for example, from hospital to home or a nursing facility—can harm patients and lead to additional hospital visits. This project is identifying the transitional care services that are most effective in ensuring a safe transition from one healthcare site to another. The first phase of the study determined that patients and their caregivers facing a transition from a hospital to their home want to feel prepared and capable of applying care plans, to receive unambiguous accountability from the healthcare system, and to feel that medical providers care for and about them. More details about this project are at www.pcori.org/Williams097.

As of August 2019, PCORI has awarded

\$119 MILLION TO FUND 26

comparative clinical effectiveness research studies and methods projects related to care transitions.

STUDY SPOTLIGHTS

Improving Older Adults' Transitions from Emergency Departments to Home

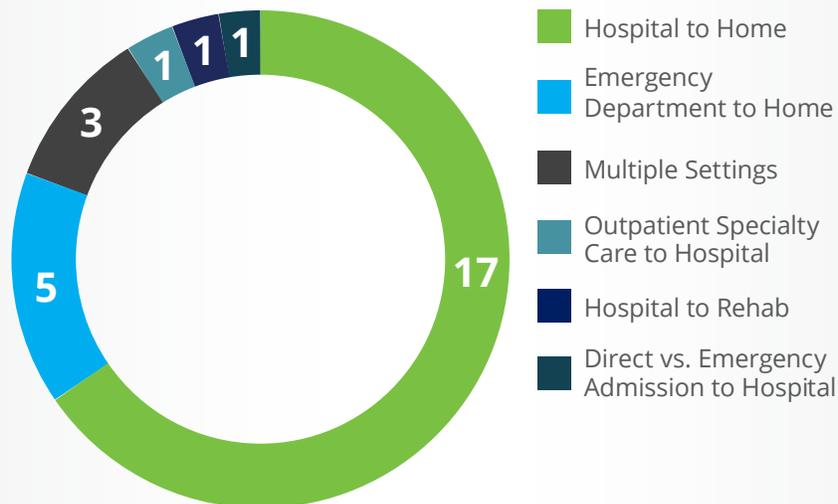
When patients with chronic medical conditions are discharged after an emergency department visit, uncertainty about where to get follow-up care and what to expect from it can often lead to hospital readmission. This study is comparing a system of community-based social support and follow-up care to the usual practice of providing verbal and written instructions to patients upon discharge. The study explores which approach is more likely to improve patients' quality of life and lessens the likelihood of hospital readmissions. More details about this project are at www.pcori.org/Carden018.

Improving Transitions for Patients with Traumatic Brain Injury

This study is comparing two approaches for transitioning patients who have had a traumatic brain injury from the hospital to outpatient care. Patients will receive either standard discharge care alone or standard care plus care coordination and follow-up via telehealth. The study will assess the patients' ability to function and quality of life. More details about this project are at www.pcori.org/Hoffman093.

BY THE NUMBER OF PROJECTS

Awards by Patient Transition Setting



*By number of projects.
A project may study more than one transition setting.*