Showcase for Hopkins Inquiry and Nursing Excellence

SHINE

Conference

Getting Started in Inquiry Work - Johns Hopkins Care at Home

Presented by Dawn Hohl, PhD, RN

JOHNS HOPKINS NURSING

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This educational activity has not received any form of commercial support.

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Overview

Who is Johns Hopkins Care at Home (JHCH)?

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- Examples of EBP, QI and Research
- Next Steps for JHCH

- Objectives - Getting Started in Inquiry Work:
  1) Define the three types of nursing inquiry
  2) Describe the inter-connectedness of the three types of inquiry and how one may lead to another
  3) Identify two preliminary steps for a nurse who is interested in engaging in inquiry work

Johns Hopkins Medicine

Corporate Structure

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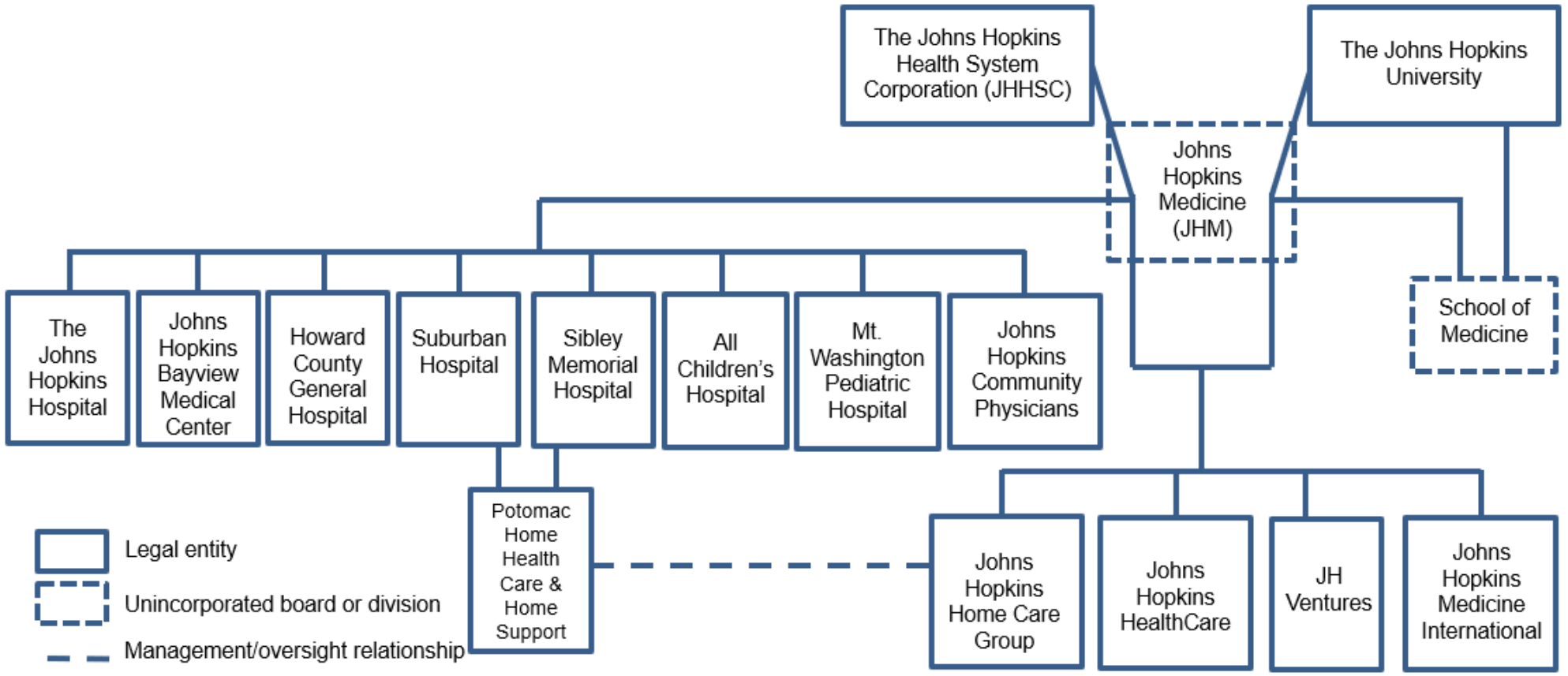

NOTE: Johns Hopkins Medicine is an unincorporated organization with delegated powers from JHU and JHHSC. Various trusts supporting JHU and JHHSC are not shown separately.

Simplifying How We Identify Ourselves

Unified Brand Name

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As of 6/1/2023, we launched our new brand name, Johns Hopkins Care at Home (JHCH) to refer to all of our services. This name replaced the name Johns Hopkins Home and Community-Based Services.

- Johns Hopkins Home Care Group, Inc. (JHHCG)
- Johns Hopkins Pharmaquip, Inc. (PQ)
- The Johns Hopkins Home Health Services, Inc. (HHS)
- Johns Hopkins Pediatrics at Home, Inc. (PAH)
- Sibley-Suburban Home Health Agency, Inc.
  D/B/A Potomac Home Health Care (PHHC)
- Potomac Home Support, Inc. (PHS)

Johns Hopkins Care at Home

Johns Hopkins Care at Home

Our Purpose

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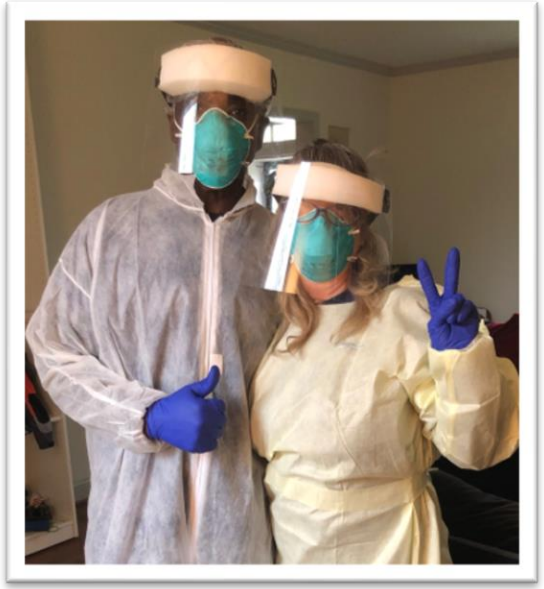
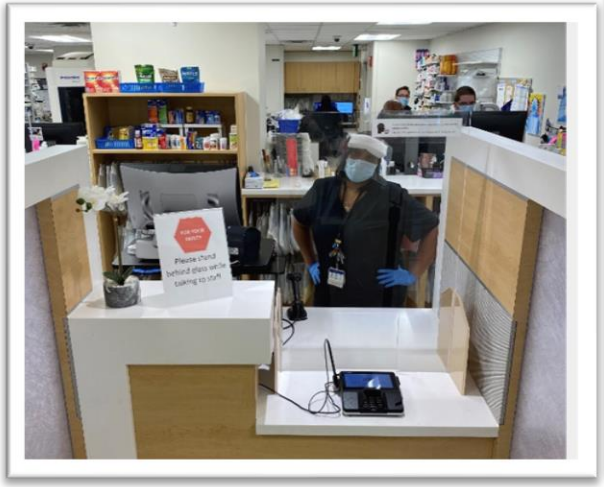
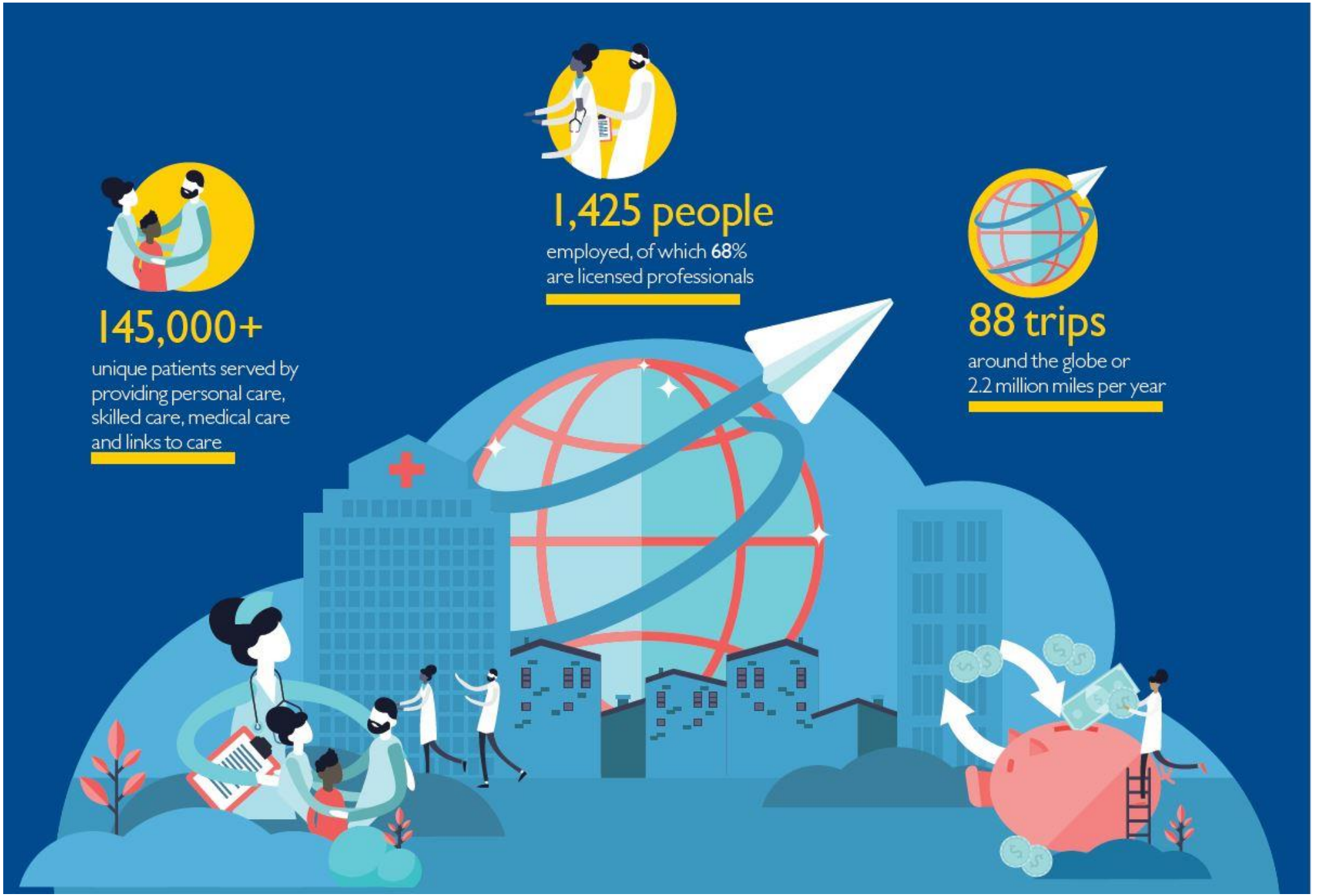
Johns Hopkins Care at Home provides safe, high quality, cost-effective care in the home and community. Our people link care across multiple sites for patients, families and colleagues in an effort to restore, maintain and promote health and reduce the effects of disease and disability.






145,000+
unique patients served by providing personal care, skilled care, medical care and links to care
1,425 people
employed, of which 68% are licensed professionals
88 trips
around the globe or 2.2 million miles per year

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The Spectrum of Services

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Personal Care

- Companion Care
- Daily Living Assistance
- Patient Safety Observer Services
- Transportation Services
- Memory Care
- Respite Care

Skilled Care

- Nursing
- Therapy (RT, OT, PT, Speech)
- Nutritional Counseling
- Infusion Services
- Wound / Ostomy Care
- Ventilator Mgt.
- Medication Mgt.
- Mgt. of Complex Conditions

Medical Care

- In-home Primary Care
- Pharmacy Services
- Home Medical Equipment
- Remote Patient Monitoring
- Hospital at Home (Future)

Link to Care

- Home Care Coordination / Discharge Planning
- Transition Guide (TG)
- Network Mgt.
- Social Work
- International Care
- Hospice Care

Pediatrics & Adults

The Three Forms of Nursing Inquiry

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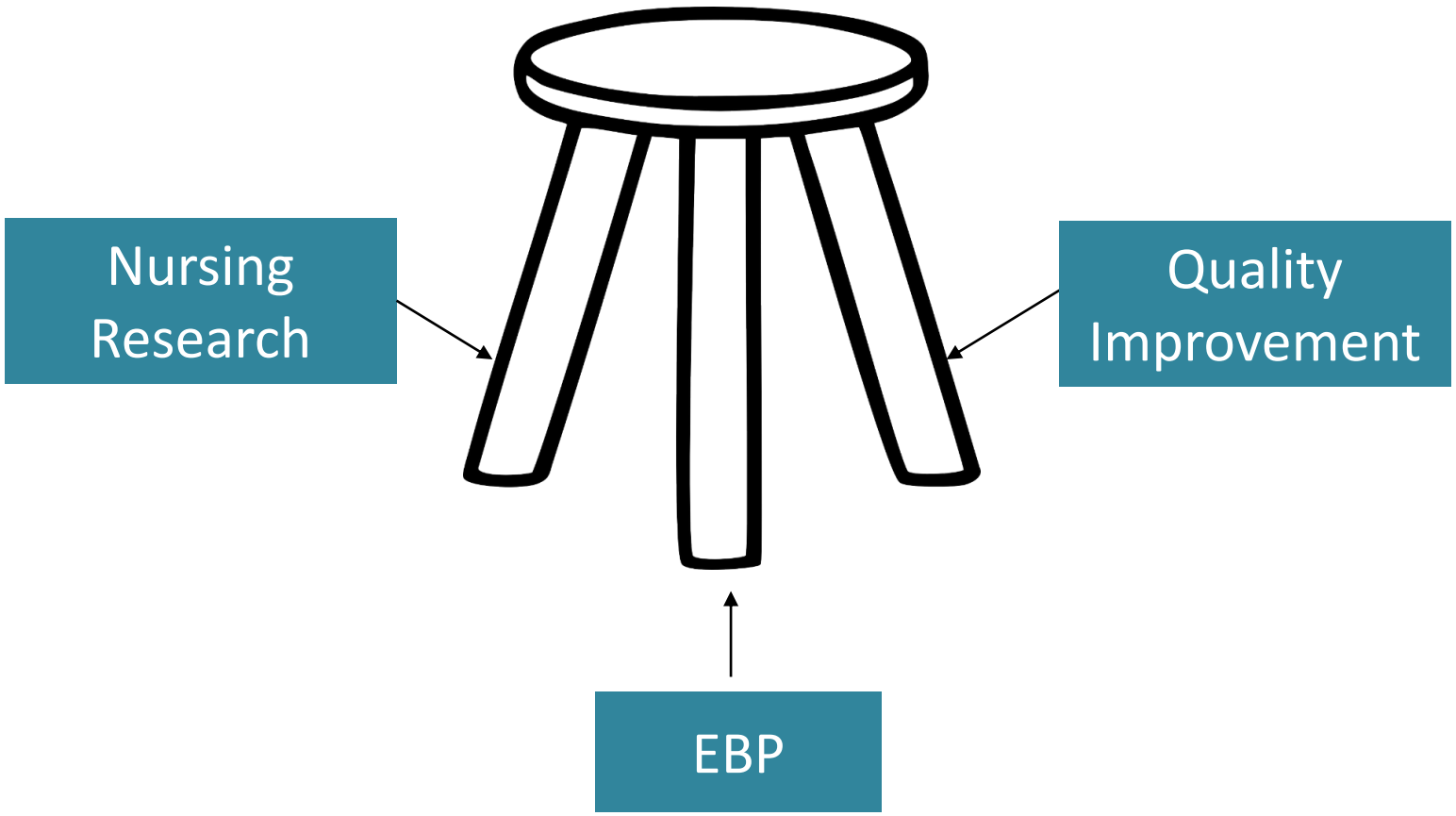

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The Future of Healthcare is in the Home

Evidence Best Practice

Triggers for Home Care

The Three Forms of Nursing Inquiry

Definitions

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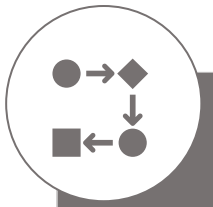
EBP

EBP is a **problem-solving approach** to clinical decision-making within a healthcare organization. EBP integrates the **best available scientific evidence** with the best available experiential (patient and practitioner) evidence.



QI

QI is a process to improve healthcare services, systems, and processes at the local level (i.e. unit, department, organization) with the intent to improve outcomes.

Research

Research is a systematic investigation (quantitative, qualitative, or mixed-methods) designed to develop, uncover, create, or contribute to new knowledge that can be generalized for broader application.

HCC/DCP Model:

Triggers to Identify Potential Home Care Patients

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Practice Question

- Interdisciplinary team
- Leader identified
- Held meetings
- Described the problem(s) and need
- Refined the EBP - "What is the best way to identify patients to be screened for home care?
- Identified stakeholders

Evidence

- Literature/evidence search
- Appraise and summarize the literature
- Synthesize the findings
- Develop recommendation

Translation

- Identify specific recommendations
- Draft action plan and secure support
- Implement the action plan
- Evaluate and continue to make improvements
- Report to stakeholders
- Disseminate findings

Current State

- Built into Epic
- HCC/DCPs use
- Continue to update as Epic evolved (IPV) and with stakeholder input

Next Steps

- Continue to refine
- Analytics to assist with outcomes
- Algorithm?
- Research

Using EBP to identify patients who may be in need of home care, combined with a unique model that uses the principles of a high reliability organization (HRO) by placing home care experts on the front line of the patient transition.

In Practice

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Home Care Triggers
Components

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- Patient Address (used to forecast any challenges to staff)
- Primary and Secondary Insurance (Medicare, Advantage)
- Length of Stay (I>E)
- Admission Diagnosis
- AM-PAC
- ESDP (Age, lives alone, Rankin score)
- Nutrition Risk/Weight (bariatric)
- PT disposition recommendation
- Expected Discharge Date (EDD)
- Home Care Order
- MVP (multi-visit patient); 30 day readmission within last 6 months
- Wound
- Pain
- Fall risk
- New anticoagulant
- Language (will a translator be needed?)
- IPV (part of SDOH screen; if positive screen for home safety)
- Other – Anecdotally that patient might refuse SAR and/or is refusing

HCC List of Triggers
EPIC

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Patient Address	Primary Ins.	Secondary Ins.	Length of Stay	Admission Diagnosis	Attending	AM-PAC IP Mob Raw	ESDP Score	PT D/C Recs	Exp Disch Date/Time	Home Care Orders

Utilization Level	D/T	StoCastic Discharge Prediction By	Fall Risk (Auto & Scored)	Nutrition Patient Risk	SDOH Interpersonal Violence Positive	SDOH Positive Screen	0-10 Pain Scale Score	Fall Risk (Auto & Scored)	Anticoag	Nutrition Risk Screenin	PT D/C Recs	Wound Order	Isolation	Langu

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The Future of Healthcare is in the Home

Quality Improvement

JHH/JHCH Transition Guide Program

The Three Forms of Nursing Inquiry

Definitions

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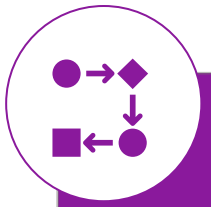

QI

QI is a **process to improve** healthcare services, systems, and processes at the **local** level (i.e. unit, department, organization) with the intent to improve **outcomes**.

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Transition Guide Program

Methodology

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Figure 1. In developing this program we followed a Define, Measure, Analyze, Improve and Control (DMAIC) Six Sigma Methodology. This methodology is used to optimize and stabilize processes, eliminate waste, decrease variation and sustain performance improvement

Transition Guide Referral Process

Define Phase: Screening Tools

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The Transition Guide Program embodies a culture of safety by using early screening tools to identify patients at risk and aiding in providing additional community support.

Screening Tools:

- The Early Screen for Discharge Planning (ESDP) screening
  - Identifies patients who need support upon discharge and are at higher risk for readmission
  - Scores greater than 10 on the ESDP identified those who need additional services post discharge
- 8 Ps Tool from Project BOOST (Better Outcomes by Optimizing Safe Transitions)
  - Assesses the risk for unsafe transitions and readmissions for patients with lower ESDP scores, using the 8 Ps Tool from Project BOOST
- Assessment of Social Determinates of Health (SDOH)
  - Identifies patient's psychosocial and socioeconomic needs that could be barriers to discharge

Transition Guide Program

Define Phase: Screening Tools

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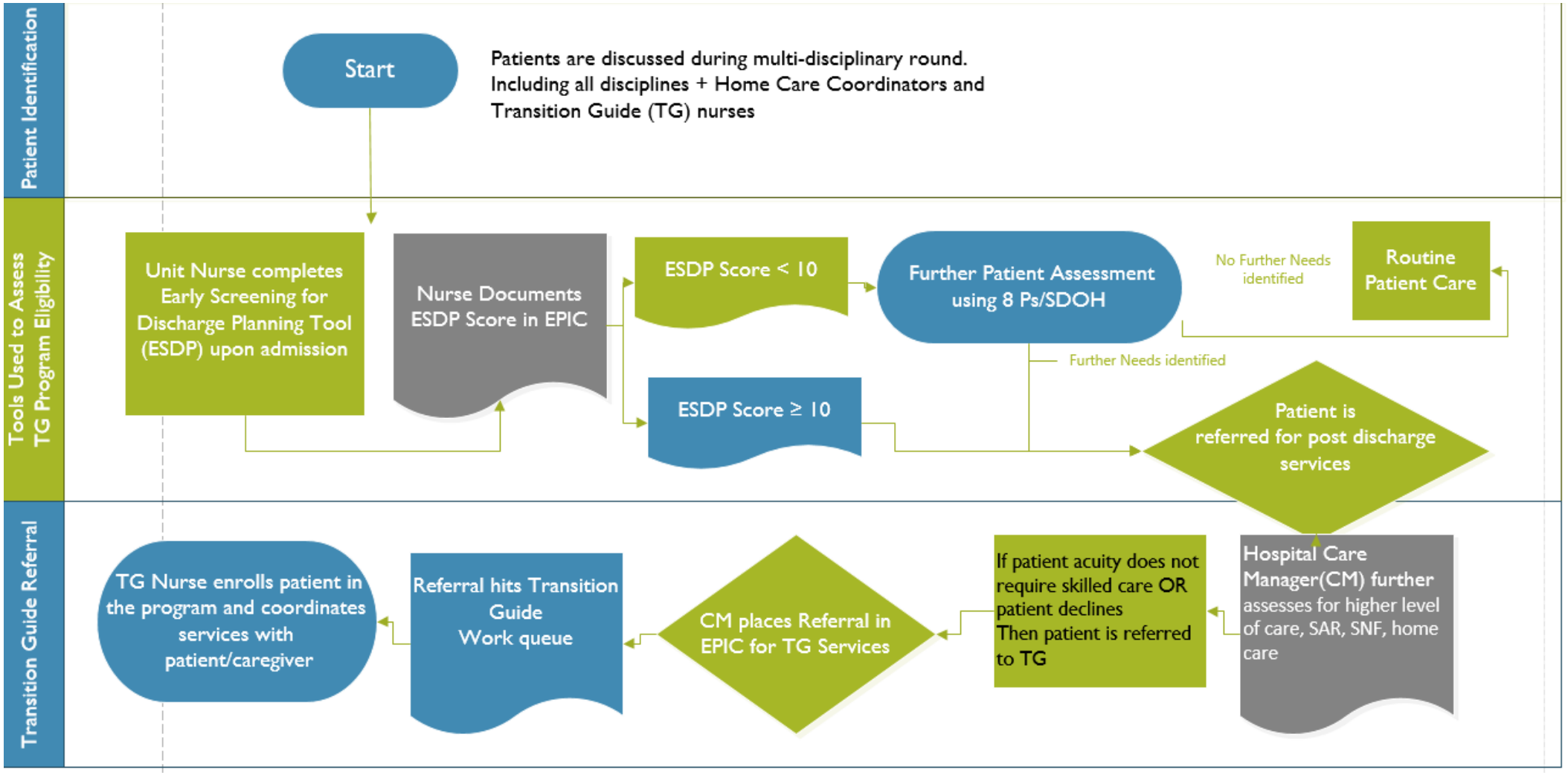

Transition Guide Program

Measure Phase

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Outcome measures

(1) Conversion Rate

The percentage of eligible referrals that ultimately result in transition guide services rendered. The target for the Transition Guide Program is 75%.

(2) Readmission Rate

The number of patients readmitted within 30 days of hospital discharge, comparing those who converted (received TG services) to those who did not convert (declined services or were unable to contact).

Transition Guide Interventions

Analysis Phase

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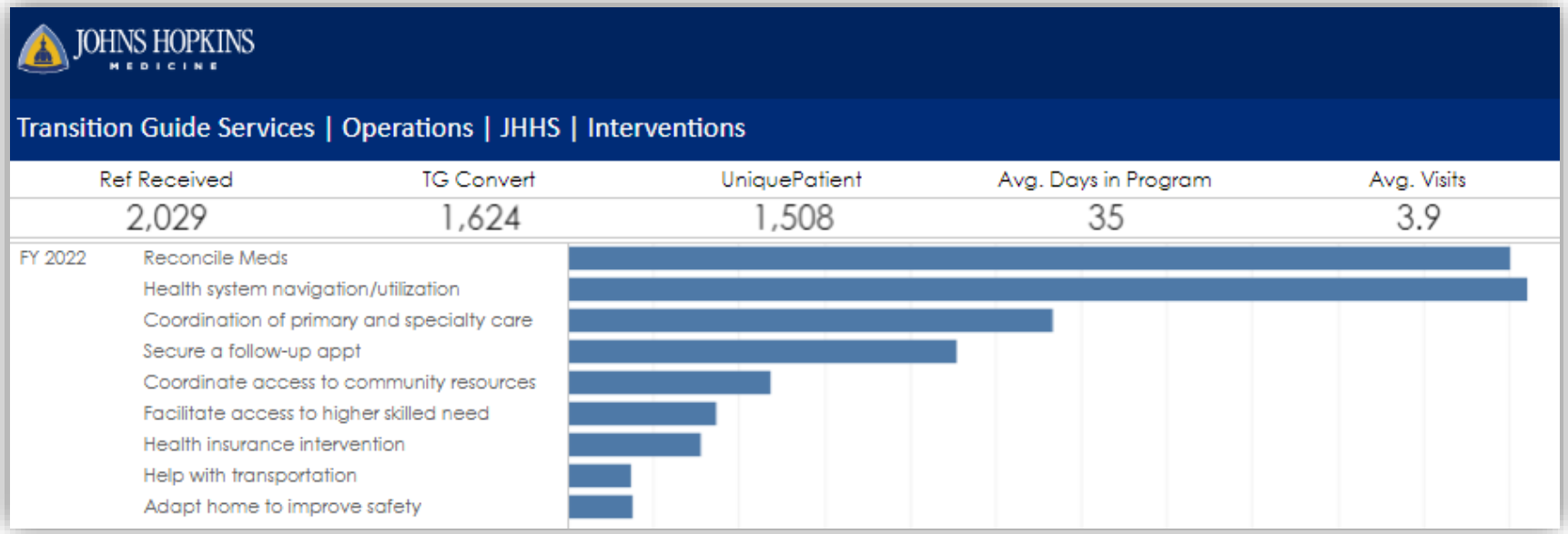

What interventions are the most beneficial?

- Education?
- Self-management?
- Symptom control?

Q: How many TG visits should it take to accomplish program aims?

Transition Guide Program

Improve Phase

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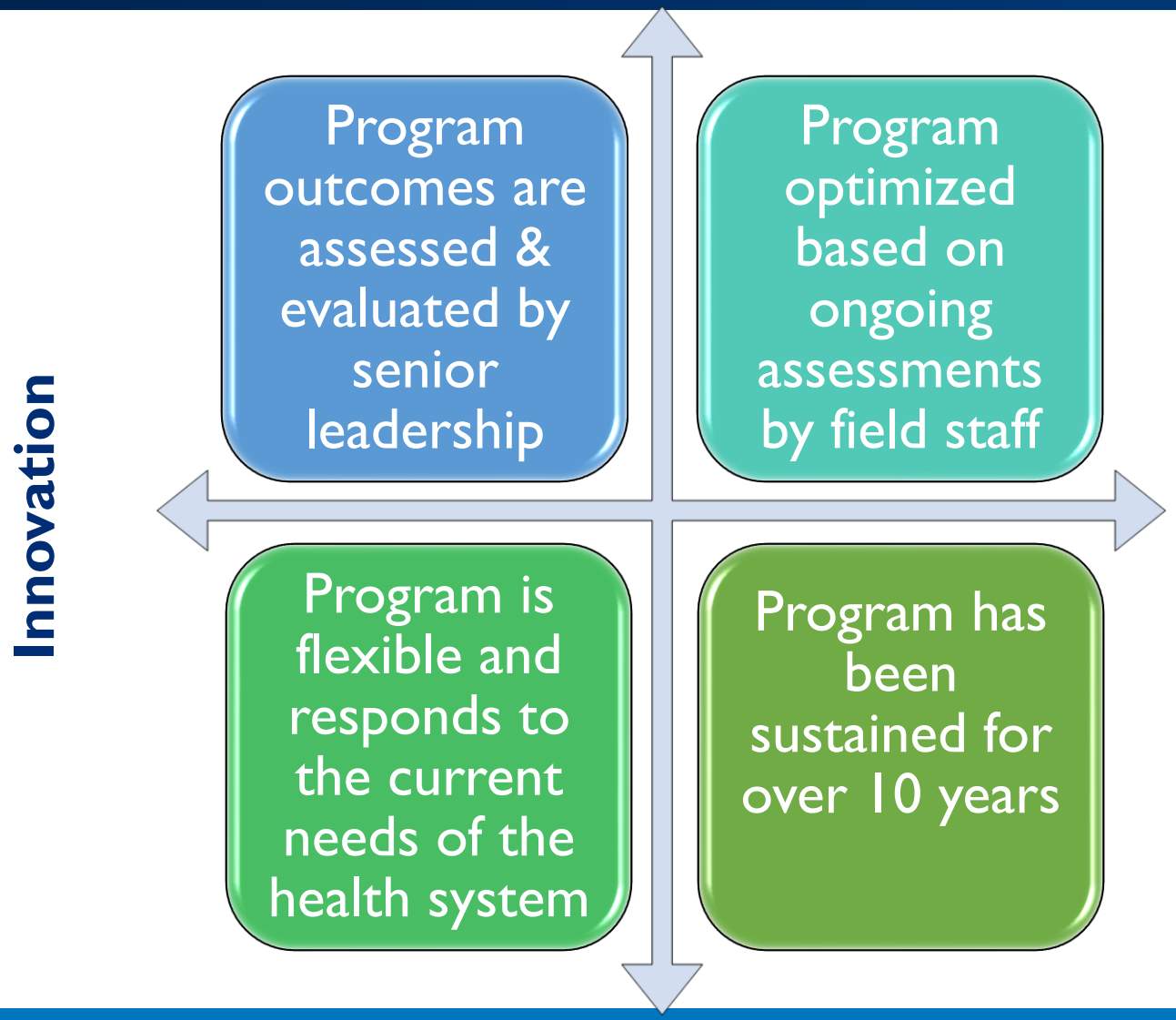
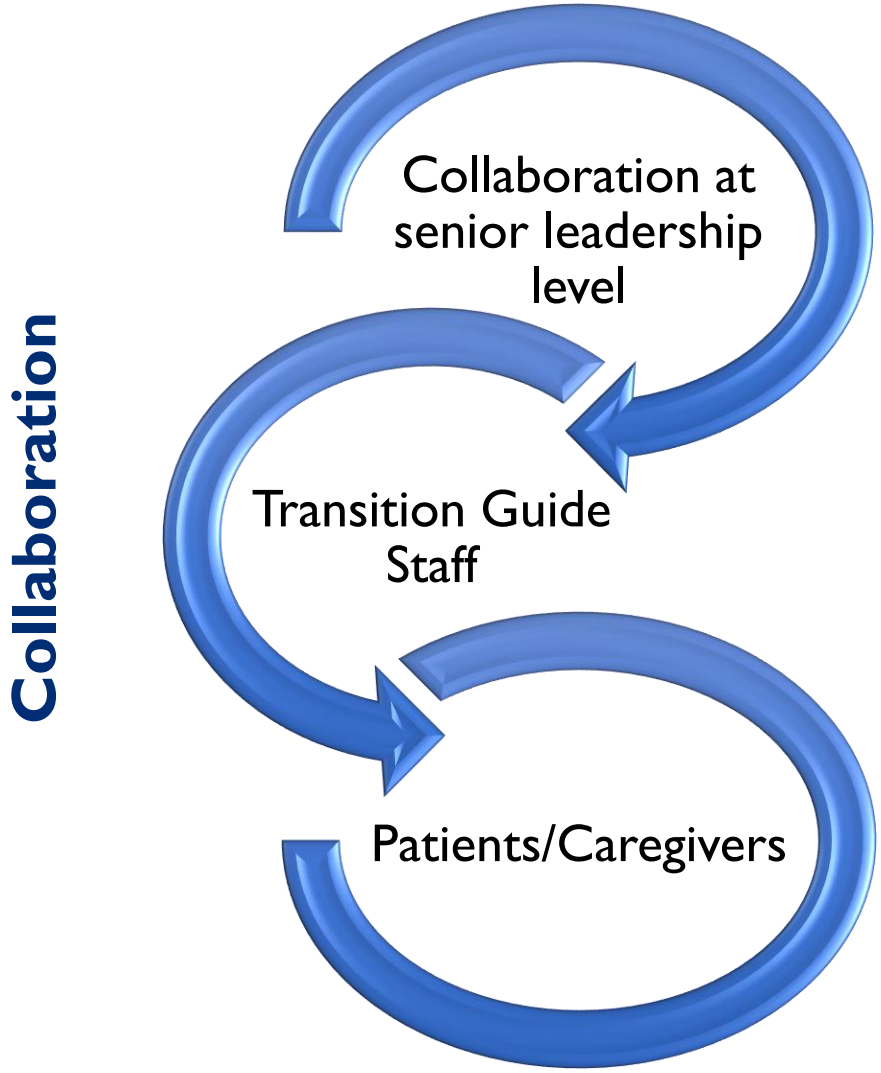
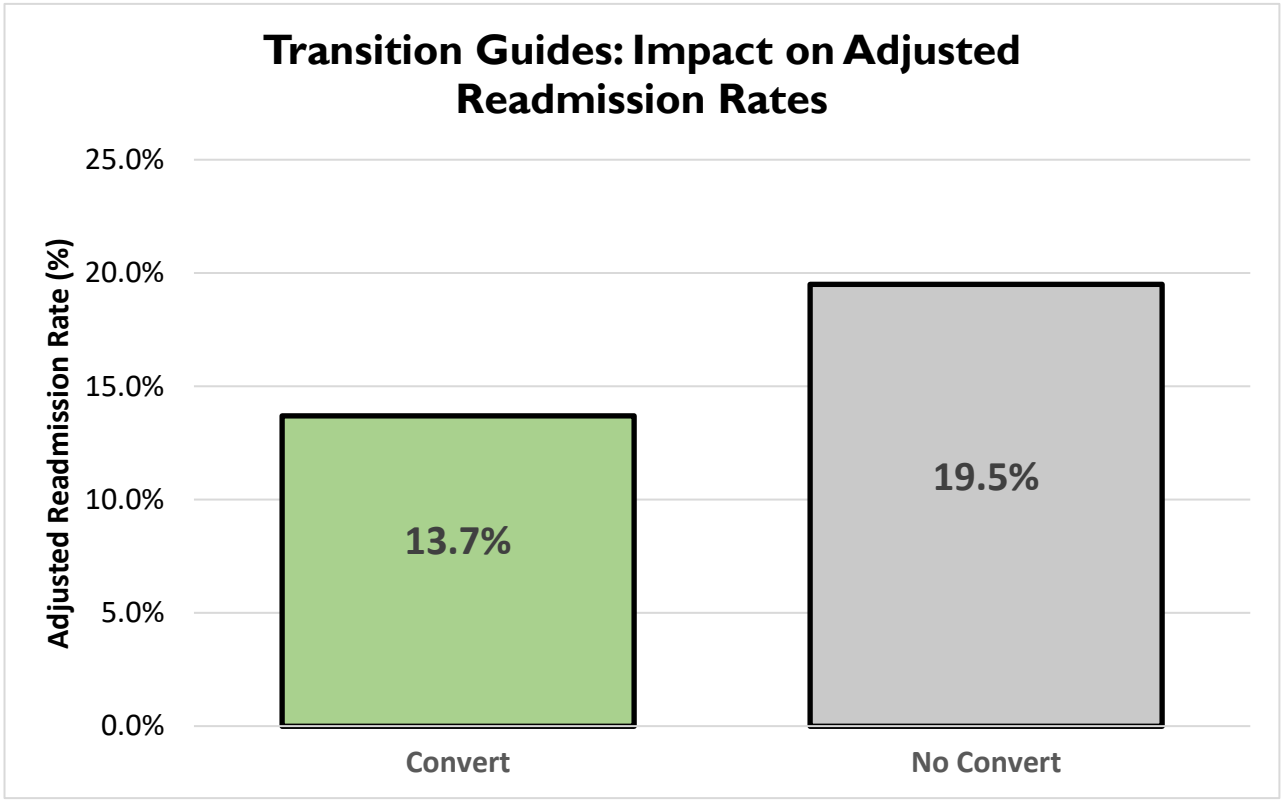




Transition Guide Program

Control Phase: Impact on Adjusted Readmission Rate



TG Convert	Q1 2018-2021 Adjusted Rates (95% CI)	Adjusted OR (95% CI)	p value
No	19.5% (16.0-23.7)	1.5 (1.2 to 2.0)	<0.001
Yes	13.7% (11.2-16.6)		

Source: Dr. Erik Hoyer

Other Quality Improvement

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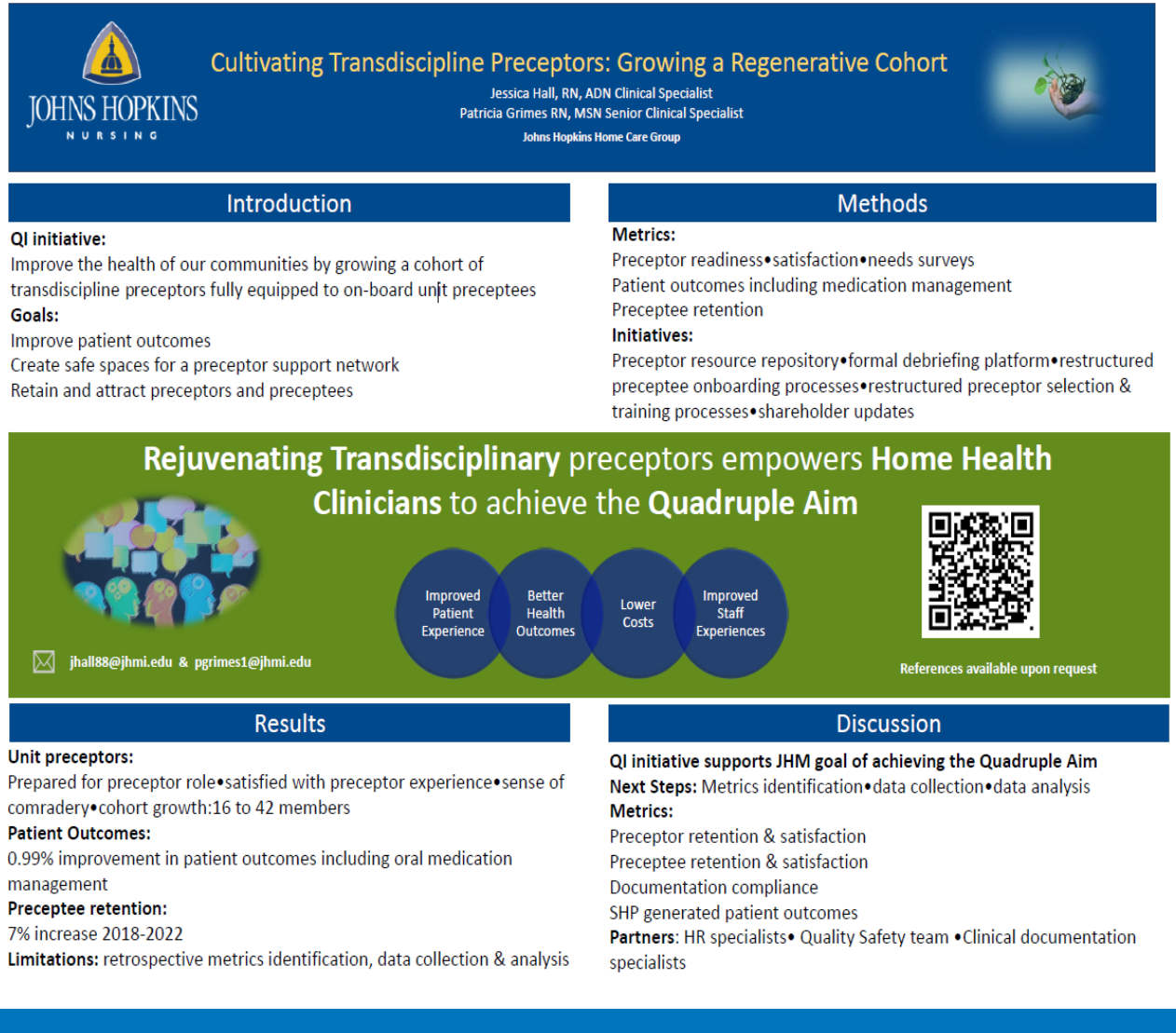
- Employee Safety with NAHC
- Practice Partner with the Johns Hopkins School of Nursing, Reimagining Nursing – Competency-Based Education to Include Home Care
- Congestive Heart Failure Pathway



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Cultivating Transdiscipline Preceptors: Growing a Regenerative Cohort

Jessica Hall, RN, ADN Clinical Specialist
Patricia Grimes RN, MSN Senior Clinical Specialist
Johns Hopkins Home Care Group

Introduction

QI initiative:
Improve the health of our communities by growing a cohort of transdiscipline preceptors fully equipped to on-board unit preceptees
Goals:
Improve patient outcomes
Create safe spaces for a preceptor support network
Retain and attract preceptors and preceptees

Methods

Metrics:
Preceptor readiness•satisfaction•needs surveys
Patient outcomes including medication management
Preceptee retention
Initiatives:
Preceptor resource repository•formal debriefing platform•restructured preceptee onboarding processes•restructured preceptor selection & training processes•shareholder updates

Rejuvenating Transdisciplinary preceptors empowers **Home Health Clinicians** to achieve the **Quadruple Aim**

Improved Patient Experience
Better Health Outcomes
Lower Costs
Improved Staff Experiences

jhall88@jhmi.edu & pgrimes1@jhmi.edu

References available upon request

Results

Unit preceptors:
Prepared for preceptor role•satisfied with preceptor experience•sense of comradery•cohort growth:16 to 42 members
Patient Outcomes:
0.99% improvement in patient outcomes including oral medication management
Preceptee retention:
7% increase 2018-2022
Limitations: retrospective metrics identification, data collection & analysis

Discussion

QI initiative supports JHM goal of achieving the Quadruple Aim
Next Steps: Metrics identification•data collection•data analysis
Metrics:
Preceptor retention & satisfaction
Preceptee retention & satisfaction
Documentation compliance
SHP generated patient outcomes
Partners: HR specialists• Quality Safety team •Clinical documentation specialists

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Research

Transitions Examples

The 3 Forms of Nursing Inquiry

Definitions

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Research is a **systematic** investigation (quantitative, qualitative, or mixed-methods) designed to develop, uncover, create, or contribute to **new knowledge** that can be **generalized** for broader application.

Examples of Involvement in Transitions Research

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With Dr. Arbaje and others.

- And Dr. Sterling (co-PI), *Improving Transitions And Outcomes for Heart FailurE Patients in Home Health CaRe (I-TRANSFER-HF)* with Weill Cornell Medicine and Visiting Nurse of New York; multi-site study funded by National Heart, Lung, and Blood Institute.
- Measuring safety threats to older adults receiving home health services after hospital discharge and relationship to patient outcomes; Baltimore, MD and New York City, NY. *2022 Annual Research Meeting*. Academy Health.
- Real-time Integration of Patient-Reported Safety Information during Older Adults' Hospital-to-Home Health Transitions. Agency for Healthcare Research and Quality(AHRQ); 2017-2021.
- Care transitions and medical management for dementia patients. AHRQ; 2019-2021.
- Older adult safety while receiving home health services after discharge; AHQR 2014-2019.

With Dr. Keller and others.

- Patient and Caregiver Provision of Outpatient Parenteral Antimicrobial Therapy (OPAT); OPAT complications; and evaluation at discharge and improving transitions; AHQR.
- A Qualitative Evaluation of Patient Experiences with Venous Catheters in the Home; 2015-2020.

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Next Steps

Next Steps and Key Takeaways

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JHCH Foundation

- Developing an Organizational Culture – leadership and resources
- CNI Participation
- Integrate into clinical leadership and strategic goals
- Networking

You are NOT Alone – Take the Nursing Inquiry Leap

- Network with your colleagues; others have the interest
- Explore resources: CNI, training, journal club, Welch Library

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Appendices

Questions?

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Appendices

Transition Guide Program

Early Screen for Discharge Planning (ESDP)

Early Screen For Discharge Planning (ESDP) Tool	
Self-rated walking limitation	Yes = (3 Points)
Age (in years)	18-44 years = (0 points) 45-64 years = (4 points) 65-79 years = (6 points) 80+ years = (8 points)
Prior Living Status	ALONE: IN OWN HOME (house or apartment) = (3 points)
Rankin Disability Score This is an assessment question, not self-reported from the patient	(Check one)
	------ No significant disability (0 points)
	------ Slight disability (3 points)
	------ Moderate or greater disability (9 points)
	TOTAL POINTS ----------

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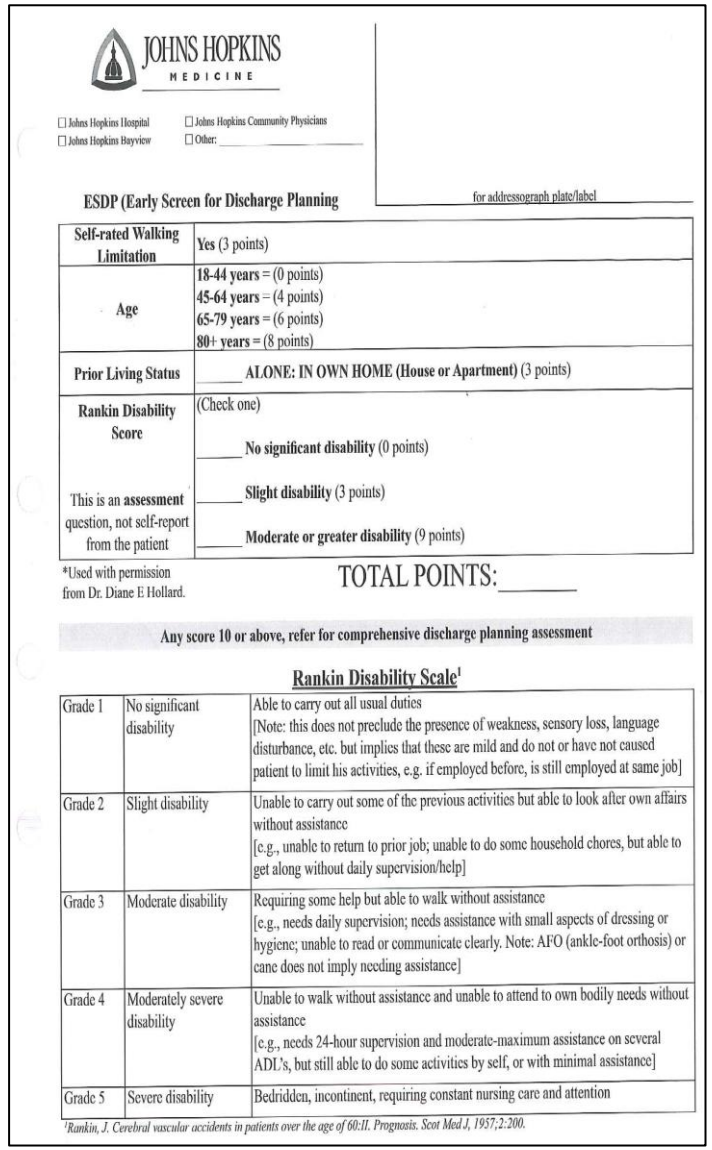

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☐ Johns Hopkins Hospital ☐ Johns Hopkins Community Physicians
☐ Johns Hopkins Bayview ☐ Other: _____

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ESDP (Early Screen for Discharge Planning

Self-rated Walking Limitation	**Yes** (3 points)
Age	**18-44 years** = (0 points) **45-64 years** = (4 points) **65-79 years** = (6 points) **80+ years** = (8 points)
Prior Living Status	_____ **ALONE: IN OWN HOME (House or Apartment)** (3 points)
Rankin Disability Score This is an **assessment** question, not self-report from the patient	(Check one) _____ **No significant disability** (0 points) _____ **Slight disability** (3 points) _____ **Moderate or greater disability** (9 points)

*Used with permission from Dr. Diane E Hollard.

TOTAL POINTS: _____

Any score 10 or above, refer for comprehensive discharge planning assessment

Rankin Disability Scale[1]

Grade 1	No significant disability	Able to carry out all usual duties [Note: this does not preclude the presence of weakness, sensory loss, language disturbance, etc. but implies that these are mild and do not or have not caused patient to limit his activities, e.g. if employed before, is still employed at same job]
Grade 2	Slight disability	Unable to carry out some of the previous activities but able to look after own affairs without assistance [e.g., unable to return to prior job; unable to do some household chores, but able to get along without daily supervision/help]
Grade 3	Moderate disability	Requiring some help but able to walk without assistance [e.g., needs daily supervision; needs assistance with small aspects of dressing or hygiene; unable to read or communicate clearly. Note: AFO (ankle-foot orthosis) or cane does not imply needing assistance]
Grade 4	Moderately severe disability	Unable to walk without assistance and unable to attend to own bodily needs without assistance [e.g., needs 24-hour supervision and moderate-maximum assistance on several ADL's, but still able to do some activities by self, or with minimal assistance]
Grade 5	Severe disability	Bedridden, incontinent, requiring constant nursing care and attention

[1]*Rankin, J. Cerebral vascular accidents in patients over the age of 60:II. Prognosis. Scot Med J, 1957;2:200.*

Transition Guide Program

The 8 Ps Tool from Project BOOST

8 Ps Risk Assessment Tool:

- Screens patients for specific risk factors known to be associated with adverse post-discharge events:

  - Poly-pharmacy
  - Poor health literacy
  - Palliative care
  - Prior hospitalization within past 6 months
  - Problem medications
  - Patient support
  - Psychological
  - Principle diagnosis

State of the Science…Literature review

TRANSITIONAL CARE: COMPARISON OF PROGRAMS

Transitional Care Model Components	Transitional Care Model *	JHH/JHHCG Transitions Program **
Setting	Hospital to home	Hospital to home
Staffing	Advanced Practice Nurses	Registered Nurses
Screening ✓	Older adults Hospitalized within the past 30 days or multiple times within past six months Physical function, cognitive function, emotional function deficits	Adults Inpatient/ED encounter ESDP Score ≥ 10 and/or 8 Ps (Project BOOST) All payors- Focus: Medicare- Fee for Service patients Focus – Multi-Visit Patient- Readmission Residing in Primary service area (21202, 21205, 21206, 21213, 21215, 21217, 21218, 21222, 21224, 21229, 21231, 21239)
Maintaining relationships ✓	Establishes and maintains a trusting relationship with the patient and family caregivers involved in the patients' care • Makes one or more visits or calls to at least two locations: hospital, next site of care (e.g., SNF), home • Motivational interviewing • Patient and family/caregiver goal setting	Inpatient contact Post discharge in-person visits (home and/or community, clinic) Phone calls Available for calls initiated by patient 7 days per week Type and frequency of encounters set by care plan • Patient Engagement Training, motivational interviewing and teach back **Patient-centered care planning/Advocacy**
Engaging patients and caregivers ✓	Engages older adults in design and implementation of the plan of care aligned with their preferences, values and goals • Engages patients and family caregivers in decision making	Elicit patient values, preferences, and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. Assessment of patient and family strengths. *Patient-centered Care Planning, Nursing Process, Education and* **Engagement of Patients and Families, Advocacy**
Managing Symptoms and Other Risks ✓	Identifies and addresses patients' priority risk factors and symptoms • Addresses each patient's and caregiver's needs • Uses medication and symptom management • Develops a comprehensive care plan	Teaching and coaching the management of Red Flags and when to call provider. Medication Management. Assess patient's readiness to engage in behavior change using the Knowledge, Behavior, Status (KBS) tool (Omaha score). *Coaching and Counseling of Patients and Families,* **Goal-directed support of Self-Management**
Education/Promoting Self-Management ✓	Prepares older adults and family caregivers to identify and respond quickly to worsening symptoms.	Teaching and coaching the management of Red Flags and when to call provider. Medication Management. Assessing patient's readiness to engage in behavior change using the Knowledge, Behavior, Status (KBS) tool (Omaha score). Assessment of needs and barriers to health care goals. **Coaching, Counseling of Patients and Families and Evaluation**

State of the Science…Part two

TRANSITIONAL CARE: COMPARISON OF PROGRAMS

Transitional Care Model Components	Transitional Care Model *	JHH/JHHCG Transitions Program **
Collaborating with Patients, Caregivers, & Team ✓	Promotes consensus on plan of care between older adults, family caregivers, and members of the care team. • Collaborates with care team across sites	Ensuring patient's needs and preferences are known across care settings. Safe hand-off to community care managers and providers. **Teamwork and Collaboration, Cross-Setting Communications and Care Transitions**
Promoting Continuity ✓	Designed to prevent breakdowns in care from hospital to home by having same clinician involved across these sites.	Same Transition Guide will follow patient from inpatient to home. Safe hand-off to community care managers and providers. **Teamwork and Collaboration, Cross-Setting Communications and Care Transitions**
Coordinating Care ✓	Promotes communication and connections between health care and community-based practitioners	Communicating patient values, preferences, and needs to the health care team. Safe hand-off to community care managers and providers. Coordination of community resources. **Teamwork and Collaboration, Cross-Setting Communications and Care Transitions**

*TCM is recognized as a "top-tiered" evidence-based approach that could impact the outcomes of hospitalized older adults and reduce total health care costs. (Coalition for Evidence-Based Policy, 2010)

References

1. Continuity of Care: The Transitional Care Model. Hirschman, K, et al. https://doe.org/10.3912/OJIN.Vol20No03Man01
2. Components of the transition care model (TCM) to reduce readmission in geriatric patients: a system review. Morkish, N, et al. https://doi.org/10.1186/s12877-020-01747-w

**The Transition Guide Principals of Care are based on the American Academy of Ambulatory Care Nursing: *Care Coordination and Transition Management Model*. In italics are the principals associated with each TCM component.

A Mapping review of clinical nurse leader and nurse educator transitional care skills and competencies. Agomah, Ch, et al. https://doi.org/10.1016/j.outlook.2020.02.003

TG Impact…Omaha Scores

Omaha Scores- Heart Failure	FY 2021 N= 251	Net Change	FY 2022 N= 251	Net Change	FY 2023 N= 157	Net Change
Avg. **Behavior** Initial Visit	3.8		3.8		4.0	
Avg. **Behavior** Completion	4.1	9.2%	4.1	8.1%	4.2	5.2%
Avg. **Knowledge** Initial Visit	3.5		3.5		3.7	
Avg. **Knowledge** Completion	4.2	18.6%	4.0	13.2%	4.1	12.5%
Avg. **Symptom Control** Initial Visit	3.7		3.9		4.2	
Avg. **Symptom Control** Completion	4.1	11.9%	4.1	5.8%	4.4	4.3%

Omaha Scores- COPD	FY 2021 N= 34	Net Change	FY 2022 N= 58	Net Change	FY 2023 N= 42	Net Change
Avg. **Behavior** Initial Visit	3.6		3.4		3.5	
Avg. **Behavior** Completion	4.2	14.3%	3.8	11.3%	3.6	5.6%
Avg. **Knowledge** Initial Visit	3.6		3.4		3.3	
Avg. **Knowledge** Completion	4.1	14.2%	3.8	12.5%	3.6	11.0%
Avg. **Symptom Control** Initial Visit	3.6		3.8		3.6	
Avg. **Symptom Control** Completion	4.0	12.3%	4.0	5.0%	3.7	1.9%

Omaha Scores- Diabetes	FY 2021 N= 133	Net Change	FY 2022 N= 138	Net Change	FY 2023 N= 80	Net Change
Avg. **Behavior** Initial Visit	4.0		3.9		3.6	
Avg. **Behavior** Completion	4.3	8.1%	4.1	5.2%	3.7	1.7%
Avg. **Knowledge** Initial Visit	3.7		3.7		3.5	
Avg. **Knowledge** Completion	4.2	12.0%	3.9	5.5%	3.6	3.7%
Avg. **Symptom Control** Initial Visit	3.8		3.9		3.9	
Avg. **Symptom Control** Completion	4.0	7.7%	4.0	1.6%	3.9	0.8%

Omaha Scores- Post Surg	FY 2021 N= 522	Net Change	FY 2022 N= 425	Net Change	FY 2023 N= 352	Net Change
Avg. **Behavior** Initial Visit	4.6		4.7		4.5	
Avg. **Behavior** Completion	4.8	4.8%	4.9	3.7%	4.5	1.1%
Avg. **Knowledge** Initial Visit	3.9		4.0		3.9	
Avg. **Knowledge** Completion	4.5	15.0%	4.4	11.9%	4.2	8.0%
Avg. **Symptom Control** Initial Visit	3.7		3.8		3.9	
Avg. **Symptom Control** Completion	3.9	5.9%	3.9	4.8%	3.9	1.8%

Q's: How are you identifying patients eligible for Omaha testing? Is there opportunity for improvement ?

Scale: Likert 1-5- higher is better; data as of 4/1/23

SNF Transition Guide Program Data

Readmission Rate

8.4%

SG Readmission Rate

N=103 (77 MDPCP | 26 MA);

16.4%

Baseline Readmission Rate

Over 12 months, patient population post SG Intervention readmission rate is 8.4%.

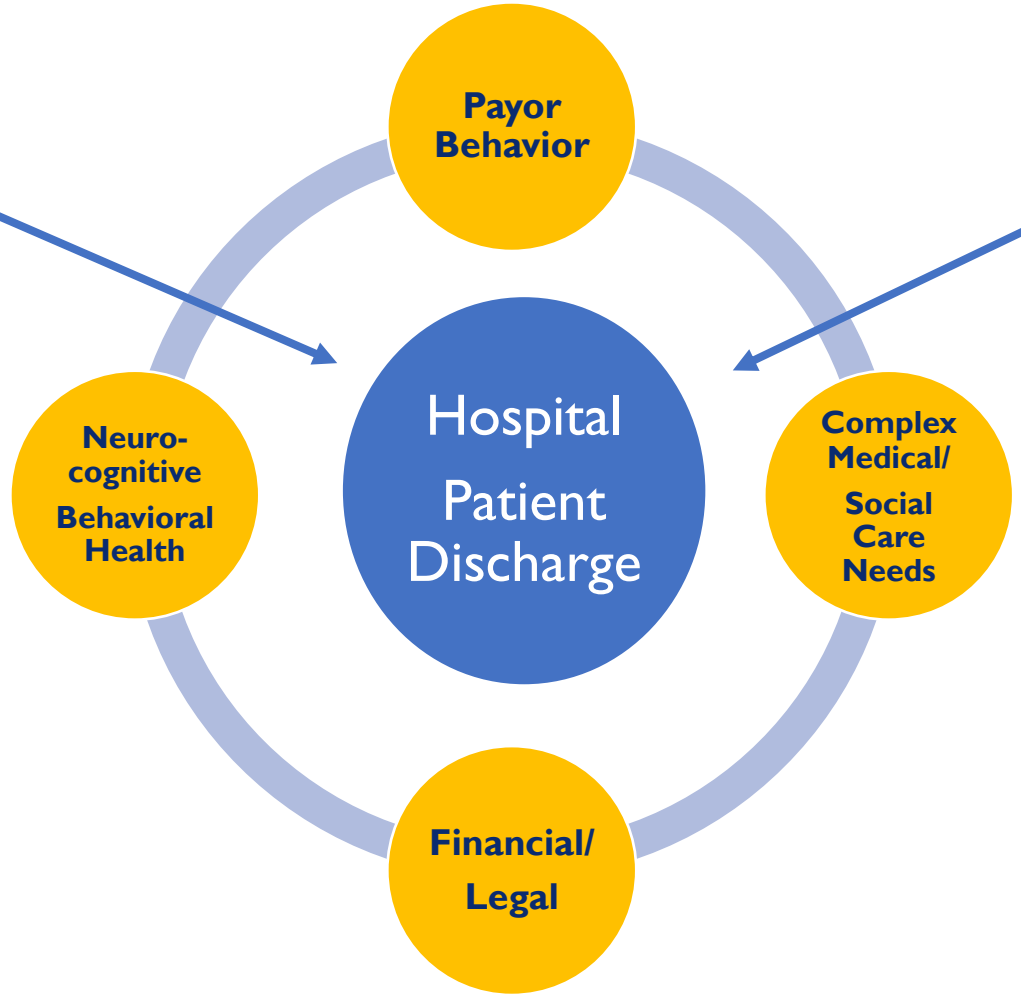
Over 12 months, patient population prior to the SG intervention readmission rate is 16.4.

Funding discontinued for this program but the data suggests that this is a successful strategy to reduce readmissions for future consideration.

Internal/External Challenges to Managing Care Transitions

Internal Barriers

- Workforce shortages
- Insurance coverage
- Fatigue/burnout
- Procedure/test delays
- Communication issues across departments
- Frequent changes in clinical teams
- Variation in practice and outdated workflows
- Documentation of patient acuity



External Barriers

- Workforce shortages
- Fatigue/burnout
- Payor behavior
- Fragmented care
- Community violence/trauma
- Homelessness
- Behavioral health needs
- Aging population
- Limited caregiver support
- Complex specialty care needs
- Lack of access to primary care
- Lack of access for immigrants

Transitions Publications - Dissemination

(2023). A qualitative study of midlevel nurse managers' perspectives of scholarly inquiry. JONA, 53(4), 214-219.

(2022). Implementing a toolkit to improve the education of patients on home-based outpatient parenteral antimicrobial therapy (OPAT). The Joint Commission Journal on Quality and Patient Safety 2022; 000:1–7 INNOVATION REPORT. https://doi.org/10.1016/j.jcjq.2022.05.008

(2021). Failure modes and effects analysis to improve transitions of care in patients discharged on outpatient parenteral antimicrobial therapy. American Journal Health System Pharmacies; doi: 10.1093/ajhp/zxab165. Online ahead of print. PMID: 33944904

(2019). Information management goals and process failures during home visits for middle-aged and older adults receiving skilled home healthcare services after hospital discharge: a multisite, qualitative study. *BMJ Qual Saf*, *28*(2), 111-120.

(2017). Clinical Infectious Disease. Rates and Risk Factors for Adverse Drug Events in Outpatient Parenteral Antimicrobial Therapy. *2*

(2017). Environmental Exposures and the Risk of Central Venous Cather Complications and Readmission in Home Infusion Therapy Patients. *Infection Control & Hospital Epidemiology*. https://doi.org/10.1017/ice.2016.223.

(2016). Older Adults and Management of Medical Devices in the Home: Five Requirements for Appropriate Use. *Population Health Management*. DOI: 10.1089/pop.2016.0070.

(2015). Identifying Challenges Associated with the Care Transition Workflow from Hospital to Skilled Home Health Care: Perspectives of Home Health Care Agency Providers. *Home Health Care Services Quarterly*. doi: 10.1080/01621424.2015.1092908.