Robert E Burke

List of Publications by Year
in descending order

88 papers	2,045 citations	257101 24 h-index	276539 41 g-index
89 all docs	89 docs citations	89 times ranked	2343 citing authors

#	Article	IF	Citations
1	Postacute care outcomes in home health or skilled nursing facilities in patients with a diagnosis of dementia. Health Services Research, 2022, 57, 497-504.	1.0	7
2	Selecting implementation strategies to drive <scp>Ageâ€Friendly</scp> Health System Adoption. Journal of the American Geriatrics Society, 2022, 70, 313-318.	1.3	12
3	Use of Post-Acute Care by Medicare Beneficiaries With a Diagnosis of Dementia. Journal of the American Medical Directors Association, 2022, 23, 877-879.e3.	1.2	4
4	Early Career Outcomes following a Quality Improvement Leadership Track in Graduate Medical Education. Journal of General Internal Medicine, 2022, , 1.	1.3	0
5	Skilled Nursing Facility Performance and Readmission Rates Under Value-Based Purchasing. JAMA Network Open, 2022, 5, e220721.	2.8	6
6	Association of Medicare-Medicaid Dual Eligibility and Race and Ethnicity With Ischemic Stroke Severity. JAMA Network Open, 2022, 5, e224596.	2.8	9
7	<scp>Ageâ€friendly</scp> learning health systems: Opportunities for model synergy and care improvement. Journal of the American Geriatrics Society, 2022, 70, 2458-2461.	1.3	3
8	<scp>VA</scp> nursing home compare metrics as an indicator of skilled nursing facility quality for veterans. Journal of the American Geriatrics Society, 2022, 70, 2269-2279.	1.3	1
9	Differences in transitional care processes among high-performing and low-performing hospital-SNF pairs: a rapid ethnographic approach. BMJ Quality and Safety, 2021, 30, 648-657.	1.8	7
10	Association of Medicare Advantage Penetration With Per Capita Spending, Emergency Department Visits, and Readmission Rates Among Fee-for-Service Medicare Beneficiaries With High Comorbidity Burden. Medical Care Research and Review, 2021, 78, 703-712.	1.0	4
11	Systems Approach Is Needed for In-Hospital Mobility: A Qualitative Metasynthesis of Patient and Clinician Perspectives. Archives of Physical Medicine and Rehabilitation, 2021, 102, 984-998.	0.5	20
12	Gaps in Hospital and Skilled Nursing Facility Responsibilities During Transitions of Care: a Comparison of Hospital and SNF Cliniciansâ€™ Perspectives. Journal of General Internal Medicine, 2021, 36, 2251-2258.	1.3	7
13	A Cross-Sectional Survey of Internal Medicine Residentsâ€™ Knowledge, Attitudes, and Current Practices Regarding Patient Transitions to Post-Acute Care. Journal of the American Medical Directors Association, 2021, 22, 2344-2349.	1.2	2
14	Trends in Use of Low-Value Care in Traditional Fee-for-Service Medicare and Medicare Advantage. JAMA Network Open, 2021, 4, e211762.	2.8	29
15	Sustaining quality improvement efforts: emerging principles and practice. BMJ Quality and Safety, 2021, 30, 848-852.	1.8	14
16	Integration Activities Between Hospitals and Skilled Nursing Facilities: A National Survey. Journal of the American Medical Directors Association, 2021, 22, 2565-2570.e4.	1.2	12
17	Outcomes of postâ€acute care in skilled nursing facilities in Medicare beneficiaries with and without a diagnosis of dementia. Journal of the American Geriatrics Society, 2021, 69, 2899-2907.	1.3	15
18	How Context Influences Hospital Readmissions from Skilled Nursing Facilities: A Rapid Ethnographic Study. Journal of the American Medical Directors Association, 2021, 22, 1248-1254.e3.	1.2	4

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19	Telehealth Benefits Offered by Medicare Advantage Plans in 2020. Medical Care, 2021, 59, 53-57.	1.1	9
20	Ready to Go Home? Assessment of Shared Mental Models of the Patient and Discharging Team Regarding Readiness for Hospital Discharge. Journal of Hospital Medicine, 2021, 16, 326-332.	0.7	6
21	Variability in skilled nursing facility screening and admission processes: Implications for value-based purchasing. Health Care Management Review, 2020, 45, 353-363.	0.6	10
22	Social and Healthâ€Related Factors Associated with Enrollment in Medicare Advantage Plans in Older Adults. Journal of the American Geriatrics Society, 2020, 68, 313-320.	1.3	4
23	Improving end-of-rotation transitions of care among ICU patients. BMJ Quality and Safety, 2020, 29, 250-259.	1.8	4
24	Addressing the â€œTotal Taxpayerâ€•Problem to Translate Veterans Health Administration Innovations in Long-Term Supports. The Public Policy and Aging Report, 2020, 30, 24-28.	0.8	1
25	Annals for Hospitalists Inpatient Notes - The Role of Hospitalists in the Creation of Learning Healthcare Systems. Annals of Internal Medicine, 2020, 172, HO2.	2.0	2
26	â€œWhat Would It Take to Transform Post-Acute Care?â€•2019 Conference Proceedings on Re-envisioning Post-Acute Care. Journal of the American Medical Directors Association, 2020, 21, 1012-1014.	1.2	1
27	Association of Discharge to Home vs Institutional Postacute Care With Outcomes After Lower Extremity Joint Replacement. JAMA Network Open, 2020, 3, e2022382.	2.8	4
28	External Validation of the Skilled Nursing Facility Prognosis Score for Predicting Mortality, Hospital Readmission, and Community Discharge in Veterans. Journal of the American Geriatrics Society, 2020, 68, 2090-2094.	1.3	5
29	Variability in Transitional Care Outcomes Across Hospitals Discharging Veterans to Skilled Nursing Facilities. Medical Care, 2020, 58, 301-306.	1.1	7
30	Cognitive Biases Influence Decision-Making Regarding Postacute Care in a Skilled Nursing Facility. Journal of Hospital Medicine, 2020, 15, 22-27.	0.7	6
31	Cognitive Biases Influence Decisionâ€Making Regarding Postacute Care in a Skilled Nursing Facility. Journal of Hospital Medicine, 2020, 15, 22-27.	0.7	6
32	Perspectives of Clinicians, Staff, and Veterans in Transitioning Veterans from non-VA Hospitals to Primary Care in a Single VA Healthcare System. Journal of Hospital Medicine, 2020, 14, 133-139.	0.7	11
33	Transitional Care Outcomes in Veterans Receiving Postâ€Acute Care in a Skilled Nursing Facility. Journal of the American Geriatrics Society, 2019, 67, 1820-1826.	1.3	12
34	Perceived Costs of Care Influence Postâ€Acute Care Choices by Clinicians, Patients, and Caregivers. Journal of the American Geriatrics Society, 2019, 67, 703-710.	1.3	20
35	Identifying Patient Readmissions: Are Our Data Sources Misleading?. Journal of the American Medical Directors Association, 2019, 20, 1042-1044.	1.2	3
36	Using the Practical, Robust Implementation and Sustainability Model (PRISM) to qualitatively assess multilevel contextual factors to help plan, implement, evaluate, and disseminate health services programs. Translational Behavioral Medicine, 2019, 9, 1002-1011.	1.2	110

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37	Operationalizing an Implementation Framework to Disseminate a Care Coordination Program for Rural Veterans. Journal of General Internal Medicine, 2019, 34, 58-66.	1.3	20
38	Practical Use of Process Mapping to Guide Implementation of a Care Coordination Program for Rural Veterans. Journal of General Internal Medicine, 2019, 34, 67-74.	1.3	19
39	Coordinating Care Across VA Providers and Settings: Policy and Research Recommendations from VAâ€™s State of the Art Conference. Journal of General Internal Medicine, 2019, 34, 11-17.	1.3	13
40	Assessing First Visits By Physicians To Medicare Patients Discharged To Skilled Nursing Facilities. Health Affairs, 2019, 38, 528-536.	2.5	16
41	Quality measurement and nursing homes: measuring what matters. BMJ Quality and Safety, 2019, 28, 520-523.	1.8	18
42	Improving the Transition of Care Process for Veterans Hospitalized at Non-VHA Facilities. Journal for Healthcare Quality: Official Publication of the National Association for Healthcare Quality, 2019, 41, 68-74.	0.3	3
43	Brainwriting Premortem. Journal of Nursing Care Quality, 2019, 34, 94-100.	0.5	23
44	Impaired Physical Performance Predicts Hospitalization Risk for Participants in the Program of All-Inclusive Care for the Elderly. Physical Therapy, 2019, 99, 28-36.	1.1	12
45	Involvement of Acute Care Physical Therapists in Care Transitions for Older Adults Following Acute Hospitalization: A Cross-sectional National Survey. Journal of Geriatric Physical Therapy, 2019, 42, E73-E80.	0.6	15
46	Waiting for Godot: The Quest to Promote Scholarship in Hospital Medicine. Journal of Hospital Medicine, 2019, 14, 508-509.	0.7	0
47	Discharge Destination and Disparities in Postoperative Care. JAMA - Journal of the American Medical Association, 2018, 319, 1653.	3.8	16
48	Predicting Potential Adverse Events During a Skilled Nursing Facility Stay: A Skilled Nursing Facility Prognosis Score. Journal of the American Geriatrics Society, 2018, 66, 930-936.	1.3	22
49	Evaluating the Quality of Patient Decision-Making Regarding Post-Acute Care. Journal of General Internal Medicine, 2018, 33, 678-684.	1.3	29
50	Influence of Nonindex Hospital Readmission on Length of Stay and Mortality. Medical Care, 2018, 56, 85-90.	1.1	38
51	Hospital Readmission From the Perspective of Medicaid and Uninsured Patients. Journal for Healthcare Quality: Official Publication of the National Association for Healthcare Quality, 2018, 40, 44-50.	0.3	10
52	Home-Health-Care Physical Therapy Improves Early Functional Recovery of Medicare Beneficiaries After Total Knee Arthroplasty. Journal of Bone and Joint Surgery - Series A, 2018, 100, 1728-1734.	1.4	30
53	Improving Transitions of Care for Veterans Transferred to Tertiary VA Medical Centers. American Journal of Medical Quality, 2018, 33, 147-153.	0.2	16
54	Within-Hospital Variation in 30-Day Adverse Events: Implications for Measuring Quality. Journal for Healthcare Quality: Official Publication of the National Association for Healthcare Quality, 2018, 40, 147-154.	0.3	1

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55	Systematic, Multimethod Assessment of Adaptations Across Four Diverse Health Systems Interventions. Frontiers in Public Health, 2018, 6, 102.	1.3	89
56	Rigorous evaluations of evolving interventions: can we have our cake and eat it too?. BMJ Quality and Safety, 2018, 27, 254-257.	1.8	16
57	Annals for Hospitalists Inpatient Notes - Getting Past the â€œBlack Boxâ€â€”Opportunities for Hospitalists to Improve Postacute Care Transitions. Annals of Internal Medicine, 2018, 168, HO2.	2.0	1
58	Reducing SNF Readmissions: At What Cost?. Journal of Hospital Medicine, 2018, 13, 285-286.	0.7	7
59	Characteristics Associated with Home Health Care Referrals at Hospital Discharge: Results from the 2012 National Inpatient Sample. Health Services Research, 2017, 52, 879-894.	1.0	40
60	Factors Associated With Early Readmission Among Patients Discharged to Postâ€Acute Care Facilities. Journal of the American Geriatrics Society, 2017, 65, 1199-1205.	1.3	34
61	Annals for Hospitalists Inpatient Notes - Research Highlights From Hospital Medicine 2017. Annals of Internal Medicine, 2017, 166, HO2.	2.0	1
62	The HOSPITAL Score Predicts Potentially Preventable 30-Day Readmissions in Conditions Targeted by the Hospital Readmissions Reduction Program. Medical Care, 2017, 55, 285-290.	1.1	34
63	How Hospital Clinicians Select Patients for Skilled Nursing Facilities. Journal of the American Geriatrics Society, 2017, 65, 2466-2472.	1.3	62
64	Study protocol: improving the transition of care from a non-network hospital back to the patientâ€™s medical home. BMC Health Services Research, 2017, 17, 123.	0.9	19
65	Hospital to Post-Acute Care Facility Transfers: Identifying Targets for Information Exchange Quality Improvement. Journal of the American Medical Directors Association, 2017, 18, 70-73.	1.2	39
66	Implementation and dissemination of a transition of care program for rural veterans: a controlled before and after study. Implementation Science, 2017, 12, 123.	2.5	30
67	Nurses' Role in Managing â€œThe Fitâ€•of Older Adults in Skilled Nursing Facilities. Journal of Gerontological Nursing, 2017, 43, 11-20.	0.3	11
68	Residents' Exposure to Educational Experiences in Facilitating Hospital Discharges. Journal of Graduate Medical Education, 2017, 9, 184-189.	0.6	10
69	Postâ€“Acute Care Reform: Implications and Opportunities for Hospitalists. Journal of Hospital Medicine, 2017, 12, 46-51.	0.7	24
70	Use of post-acute care after hospital discharge in urban and rural hospitals. American Journal of Accountable Care, 2017, 5, 16-22.	1.0	16
71	Can we engage caregiver spouses of patients with heart failure withÂa low-intensity, symptom-guided intervention?. Heart and Lung: Journal of Acute and Critical Care, 2016, 45, 114-120.	0.8	6
72	Facilityâ€Level Percutaneous Coronary Intervention Readmission Rates Are Not Associated With Facilityâ€Level Mortality: Insights From the VA Clinical Assessment, Reporting, and Tracking (CART) Program. Journal of the American Heart Association, 2016, 5, .	1.6	3

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73	Internal Medicine Residentsâ€™ Perceived Responsibility for Patients at Hospital Discharge: A National Survey. Journal of General Internal Medicine, 2016, 31, 1490-1495.	1.3	12
74	Hospital Readmission From Post-Acute Care Facilities: Risk Factors, Timing, and Outcomes. Journal of the American Medical Directors Association, 2016, 17, 249-255.	1.2	112
75	Role of Physical Therapists in Reducing Hospital Readmissions: Optimizing Outcomes for Older Adults During Care Transitions From Hospital to Community. Physical Therapy, 2016, 96, 1125-1134.	1.1	66
76	Increasing Home Healthcare Referrals upon Discharge from U.S. Hospitals: 2001â€“2012. Journal of the American Geriatrics Society, 2015, 63, 1265-1266.	1.3	33
77	Patient and Hospitalization Characteristics Associated With Increased Postacute Care Facility Discharges From US Hospitals. Medical Care, 2015, 53, 492-500.	1.1	69
78	Rise of Postâ€“Acute Care Facilities as a Discharge Destination of US Hospitalizations. JAMA Internal Medicine, 2015, 175, 295.	2.6	104
79	Physical Function and Hospital Readmissions. JAMA Internal Medicine, 2015, 175, 1722.	2.6	1
80	Identifying Potentially Preventable Emergency Department Visits byÂNursing Home Residents in the United States. Journal of the American Medical Directors Association, 2015, 16, 395-399.	1.2	77
81	Electronic Communication Capabilities of Residential Care Facilities at Times of Transition. Journal of the American Geriatrics Society, 2014, 62, 1381-1383.	1.3	2
82	Identifying keys to success in reducing readmissions using the ideal transitions in care framework. BMC Health Services Research, 2014, 14, 423.	0.9	110
83	Effect of a hospitalistâ€run postdischarge clinic on outcomes. Journal of Hospital Medicine, 2014, 9, 7-12.	0.7	16
84	Caregivers' Perceived Roles in Caring for Patients With Heart Failure: What Do Clinicians Need to Know?. Journal of Cardiac Failure, 2014, 20, 731-738.	0.7	34
85	Interventions to Decrease Hospital Readmissions. JAMA Internal Medicine, 2013, 173, 695.	2.6	101
86	Moving beyond readmission penalties: Creating an ideal process to improve transitional care. Journal of Hospital Medicine, 2013, 8, 102-109.	0.7	142
87	Contribution of psychiatric illness and substance abuse to 30â€day readmission risk. Journal of Hospital Medicine, 2013, 8, 450-455.	0.7	34
88	Postdischarge clinics: Hospitalist attitudes and experiences. Journal of Hospital Medicine, 2013, 8, 578-581.	0.7	11