The Care Transitions Intervention

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Citation Report

#	Article	IF	Citations
1	Improving Medication Adherence. Archives of Internal Medicine, 2006, 166, 1802.	4.3	78
4	Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians. JAMA - Journal of the American Medical Association, 2007, 297, 831.	3.8	1,608
5	Cardiovascular Health Disparities. Medical Care Research and Review, 2007, 64, 29S-100S.	1.0	183
6	ReACH National Demonstration Collaborative: Early Results of Implementation. Home Health Care Services Quarterly, 2007, 26, 105-120.	0.3	6
7	Discharge Dilemmas as System Failures. American Journal of Bioethics, 2007, 7, 29-31.	0.5	7
8	Communication During Patient Hand-Overs. Joint Commission Journal on Quality and Patient Safety, 2007, 33, 439-442.	0.4	30
9	A Systematic Review of Nurse-Assisted Case Management to Improve Hospital Discharge Transition Outcomes for the Elderly. Professional Case Management, 2007, 12, 330-336.	0.2	55
10	The Hospital Discharge. Journal of Patient Safety, 2007, 3, 97-106.	0.7	128
11	MANAGING TRANSITIONS IN CARE. American Journal of Nursing, 2007, 107, 72C-72D.	0.2	1
12	Inpatient and follow-up cardiology care and mortality for acute coronary syndrome patients in the Veterans Health Administration. American Heart Journal, 2007, 154, 489-494.	1.2	19
13	What Critical Care Nurses Need to Know About Health Care Access When Caring for Elders in Acute Care Settings. Critical Care Nursing Clinics of North America, 2007, 19, 253-261.	0.4	1
14	Promoting effective transitions of care at hospital discharge: A review of key issues for hospitalists. Journal of Hospital Medicine, 2007, 2, 314-323.	0.7	665
15	When the Patient Suffers: Optimization of Transitions between Care Facilities. Geriatric Nursing, 2007, 28, 298-300.	0.9	8
16	Patterns and predictors of statin use after coronary artery bypass graft surgery. Journal of Thoracic and Cardiovascular Surgery, 2007, 134, 932-938.	0.4	52
17	Transitions to palliation: Two solitudes or inevitable integration?. Current Oncology Reports, 2007, 9, 285-289.	1.8	11
18	Survey of medication documentation at hospital discharge: implications for patient safety and continuity of care. Irish Journal of Medical Science, 2008, 177, 93-97.	0.8	40
19	Redefining and Redesigning Hospital Discharge to Enhance Patient Care: A Randomized Controlled Study. Journal of General Internal Medicine, 2008, 23, 1228-1233.	1.3	165
20	The Price of Bouncing Back: Oneâ€Year Mortality and Payments for Acute Stroke Patients with 30â€Day Bounceâ€Backs. Journal of the American Geriatrics Society, 2008, 56, 999-1005.	1.3	45

#	Article	IF	Citations
21	Addressing delays in medication administration for patients transferred from the hospital to the nursing home: A pilot quality improvement project. American Journal of Geriatric Pharmacotherapy, 2008, 6, 205-211.	3.0	19
22	Canadian Cardiovascular Society Consensus Conference guidelines on heart failure â€“ 2008 update: Best practices for the transition of care of heart failure patients, and the recognition, investigation and treatment of cardiomyopathies. Canadian Journal of Cardiology, 2008, 24, 21-40.	0.8	93
23	Care Transitions for Hospitalized Patients. Medical Clinics of North America, 2008, 92, 315-324.	1.1	35
24	Exploring Diabetic Care Deficiencies and Adverse Events in Home Healthcare. Journal for Healthcare Quality: Official Publication of the National Association for Healthcare Quality, 2008, 30, 5-12.	0.3	10
25	Perspective: Transforming Chronic Care for Older Persons. Academic Medicine, 2008, 83, 627-631.	0.8	33
26	Seeking What's Best During the Transition to Adult Day Health Services. Qualitative Health Research, 2008, 18, 597-605.	1.0	18
27	Postdischarge Environmental and Socioeconomic Factors and the Likelihood of Early Hospital Readmission Among Community-Dwelling Medicare Beneficiaries. Gerontologist, The, 2008, 48, 495-504.	2.3	274
28	Coping Difficulties After Hospitalization. Clinical Nursing Research, 2008, 17, 278-296.	0.7	38
29	Coordinating Care â€" A Perilous Journey through the Health Care System. New England Journal of Medicine, 2008, 358, 1064-1071.	13.9	822
30	Palliative Care's Challenge: Facilitating Transitions of Care. Journal of Palliative Medicine, 2008, 11, 416-421.	0.6	33
31	Transitional Care. American Journal of Nursing, 2008, 108, 58-63.	0.2	214
32	Evidence for Improving Palliative Care at the End of Life: A Systematic Review. Annals of Internal Medicine, 2008, 148, 147.	2.0	483
33	TRANSITIONAL CARE. Journal of Social Work Education, 2008, 44, 65-73.	0.5	35
34	Addressing Postdischarge Adverse Events: A Neglected Area. Joint Commission Journal on Quality and Patient Safety, 2008, 34, 85-97.	0.4	73
35	Influencing Support for Caregivers. American Journal of Nursing, 2008, 108, 78-82.	0.2	1
36	Supporting Safe Transitions From Home to Healthcare Settings for Individuals With Intellectual Disabilities. Topics in Geriatric Rehabilitation, 2008, 24, 74-82.	0.2	5
37	Medicare Home Health Patientsâ€™ Transitions Through Acute And Post-Acute Care Settings. Medical Care, 2008, 46, 1188-1193.	1.1	32
38	INFLUENCING SUPPORT FOR CAREGIVERS. Journal of Social Work Education, 2008, 44, 97-103.	0.5	6

#	Article	IF	Citations
39	Better Transitions: Improving Comprehension of Discharge Instructions. Frontiers of Health Services Management, 2009, 25, 11-32.	0.1	84
40	Effectiveness of strategies to promote safe transition of elderly people across care settings. JBI Library of Systematic Reviews, 2009, 7, 1036-1090.	0.1	10
41	Linking Joint Commission Inpatient Core Measures and National Patient Safety Goals with Evidence. Baylor University Medical Center Proceedings, 2009, 22, 103-111.	0.2	14
42	Palliative Care Seeks its Home in National Health Care Reform. Journal of Palliative Medicine, 2009, 12, 593-597.	0.6	5
43	Further Application of the Care Transitions Intervention: Results of a Randomized Controlled Trial Conducted in a Fee-For-Service Setting. Home Health Care Services Quarterly, 2009, 28, 84-99.	0.3	98
44	The Growth of Hospitalists and the Changing Face of Primary Care. New England Journal of Medicine, 2009, 360, 1141-1143.	13.9	26
45	Follow the Money â€" Controlling Expenditures by Improving Care for Patients Needing Costly Services. New England Journal of Medicine, 2009, 361, 1521-1523.	13.9	107
46	Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries. JAMA - Journal of the American Medical Association, 2009, 301, 603.	3.8	642
47	A Review of Discharge Planning Research of Older Adults 1990-2008. Western Journal of Nursing Research, 2009, 31, 923-947.	0.6	45
48	Rehospitalizations among Patients in the Medicare Fee-for-Service Program. New England Journal of Medicine, 2009, 360, 1418-1428.	13.9	4,507
49	Reduction of 30â€day postdischarge hospital readmission or emergency department (ED) visit rates in highâ€risk elderly medical patients through delivery of a targeted care bundle. Journal of Hospital Medicine, 2009, 4, 211-218.	0.7	304
50	BOOSTing the hospital discharge. Journal of Hospital Medicine, 2009, 4, 209-210.	0.7	23
51	Prometheus Payment Model: Application to Hip and Knee Replacement Surgery. Clinical Orthopaedics and Related Research, 2009, 467, 2587-2597.	0.7	15
52	Identifying Patients with Post-discharge Care Problems Using an Interactive Voice Response System. Journal of General Internal Medicine, 2009, 24, 520-525.	1.3	26
53	Physicianâ€"Physician Communication: Whatâ€™s the Hang-up?. Journal of General Internal Medicine, 2009, 24, 437-439.	1.3	28
54	Tackling Care Transitions: Mom and Apple Pie vs. the Devil in the Details. Journal of General Internal Medicine, 2009, 24, 985-987.	1.3	7
55	Effects of a postdischarge transitional care programme for patients with coronary heart disease in China: a randomised controlled trial. Journal of Clinical Nursing, 2009, 18, 2444-2455.	1.4	54
56	Fast Forward Rounds: An Effective Method for Teaching Medical Students to Transition Patients Safely Across Care Settings. Journal of the American Geriatrics Society, 2009, 57, 910-917.	1.3	33

#	Article	IF	Citations
57	Optimizing Patient and Family Involvement in Geriatric Home Care. Journal for Healthcare Quality: Official Publication of the National Association for Healthcare Quality, 2009, 31, 24-33.	0.3	13
58	The Individual and Family Self-Management Theory: Background and perspectives on context, process, and outcomes. Nursing Outlook, 2009, 57, 217-225.e6.	1.5	527
59	A Reengineered Hospital Discharge Program to Decrease Rehospitalization. Annals of Internal Medicine, 2009, 150, 178.	2.0	1,267
60	Senescent Swallowing: Impact, Strategies, and Interventions. Nutrition in Clinical Practice, 2009, 24, 395-413.	1.1	330
61	Predictors of New Onset Depression in Medically Ill, Disabled Older Adults at 1 Year Follow-Up. American Journal of Geriatric Psychiatry, 2009, 17, 802-809.	0.6	45
62	Certified Nursing Assistants' Perceptions of Nursing Home Patient Safety Culture: Is There a Relationship to Clinical Outcomes?. Journal of the American Medical Directors Association, 2009, 10, 11-20.	1.2	70
63	Care Transitions and Home Health Care. Clinics in Geriatric Medicine, 2009, 25, 135-148.	1.0	92
64	Transitional Care. American Journal of Nursing, 2009, 109, 29-30.	0.2	1
65	Preventing the Preventable. Professional Case Management, 2009, 14, 135-140.	0.2	60
66	Progress in Prevention. Journal of Cardiovascular Nursing, 2009, 24, 249-251.	0.6	1
67	Physician Evaluation and Management of Medicare Home Health Patients. Medical Care, 2009, 47, 1147-1155.	1.1	9
68	Home Is Where the Health Is: Advancing Team-Based Care in Chronic Disease Management. Archives of Internal Medicine, 2009, 169, 1945.	4.3	19
69	The Hidden Patient: Addressing the Caregiver. American Journal of the Medical Sciences, 2009, 337, 199-204.	0.4	39
71	Implementation of the Care Transitions Intervention. Professional Case Management, 2009, 14, 282-293.	0.2	82
72	Postdischarge Adverse Events in the Elderly. Journal of Patient Safety, 2009, 5, 201-204.	0.7	6
73	Systematic review: interventions intended to reduce admission to hospital of older people. International Journal of Therapy and Rehabilitation, 2010, 17, 310-322.	0.1	11
74	Revenue-Based Cost Assignment: A Potent but Hidden Threat to the Survival of the Multispecialty Medical Practice. Academic Medicine, 2010, 85, 538-547.	0.8	6
75	Preventing the rebound: improving care transition in hospital discharge processes. Australian Health Review, 2010, 34, 445.	0.5	72

#	Article	IF	Citations
76	Nurse and Patient Perceptions of Discharge Readiness in Relation to Postdischarge Utilization. Medical Care, 2010, 48, 482-486.	1.1	98
77	Rehospitalization among Elderly Patients with Thyroid Cancer after Thyroidectomy are Prevalent and Costly. Annals of Surgical Oncology, 2010, 17, 2816-2823.	0.7	62
78	The Effects of Guided Care on the Perceived Quality of Health Care for Multi-morbid Older Persons: 18-Month Outcomes from a Cluster-Randomized Controlled Trial. Journal of General Internal Medicine, 2010, 25, 235-242.	1.3	139
79	Family Caregivers, Patients and Physicians: Ethical Guidance to Optimize Relationships. Journal of General Internal Medicine, 2010, 25, 255-260.	1.3	147
80	Toward Safe Hospital Discharge: A Transitions in Care Curriculum for Medical Students. Journal of General Internal Medicine, 2010, 25, 878-881.	1.3	47
81	A randomised clinical trial on a comprehensive geriatric assessment and intensive home follow-up after hospital discharge: the Transitional Care Bridge. BMC Health Services Research, 2010, 10, 296.	0.9	48
82	Use of an electronic administrative database to identify older community dwelling adults at high-risk for hospitalization or emergency department visits: The elders risk assessment index. BMC Health Services Research, 2010, 10, 338.	0.9	114
83	Age-Related Differences inÂPerception of Quality ofÂDischarge Teaching and Readiness for Hospital Discharge. Geriatric Nursing, 2010, 31, 178-187.	0.9	72
84	Nurse Identified Hospital to Home Medication Discrepancies: Implications for Improving Transitional Care. Geriatric Nursing, 2010, 31, 188-196.	0.9	65
85	Attitudes and Practices of Resident Physicians Regarding Hypertension in the Inpatient Setting. Journal of Clinical Hypertension, 2010, 12, 698-705.	1.0	25
86	The ethics of the hospitalist model. Journal of Hospital Medicine, 2010, 5, 183-188.	0.7	12
87	Postâ€hospitalization transitions: Examining the effects of timing of primary care provider followâ€up. Journal of Hospital Medicine, 2010, 5, 392-397.	0.7	220
88	Improving care transitions: Hospitalists partnering with primary care. Journal of Hospital Medicine, 2010, 5, 375-377.	0.7	15
89	Interventions to Improve Transitional Care Between Nursing Homes and Hospitals: A Systematic Review. Journal of the American Geriatrics Society, 2010, 58, 777-782.	1.3	146
90	The association between continuity of care and outcomes: a systematic and critical review. Journal of Evaluation in Clinical Practice, 2010, 16, 947-956.	0.9	427
91	Persistent cognitive decline in older hospitalized patients in Taiwan. Journal of Advanced Nursing, 2010, 66, 1991-2001.	1.5	10
92	Using A Quality Framework to Assess Rural Palliative Care. Journal of Palliative Care, 2010, 26, 141-150.	0.4	22
94	Prior Hospitalization and the Risk of Heart Attack in Older Adults: A 12-Year Prospective Study of Medicare Beneficiaries. Journals of Gerontology - Series A Biological Sciences and Medical Sciences, 2010, 65A, 769-777.	1.7	9

#	Article	IF	Citations
95	Delays in Filling Clopidogrel Prescription After Hospital Discharge and Adverse Outcomes After Drug-Eluting Stent Implantation. Circulation: Cardiovascular Quality and Outcomes, 2010, 3, 261-266.	0.9	61
96	Lessons For The New CMS Innovation Center From The Medicare Health Support Program. Health Affairs, 2010, 29, 1305-1309.	2.5	10
97	Transitional Case Management: A Method for Establishing Self-Advocacy and Reducing Hospital Readmissions in COPD Patients. Home Health Care Management and Practice, 2010, 22, 435-438.	0.4	0
98	Moving beyond the notion of â€˜selfâ€™ care. Chronic Illness, 2010, 6, 3-6.	0.6	16
99	The Revolving Door Of Rehospitalization From Skilled Nursing Facilities. Health Affairs, 2010, 29, 57-64.	2.5	412
100	Rationale and Design of the Pharmacist Intervention for Low Literacy in Cardiovascular Disease (PILL-CVD) Study. Circulation: Cardiovascular Quality and Outcomes, 2010, 3, 212-219.	0.9	58
101	Medicare Readmissions Policies and Racial and Ethnic Health Disparities: A Cautionary Tale. Policy, Politics, and Nursing Practice, 2010, 11, 309-316.	0.8	39
102	Care Management's Challenges and Opportunities to Reduce the Rapid Rehospitalization of Frail Community-Dwelling Older Adults. Gerontologist, The, 2010, 50, 451-458.	2.3	79
103	Outpatient Follow-up Visit and 30-Day Emergency Department Visit and Readmission in Patients Hospitalized for Chronic Obstructive Pulmonary Disease. Archives of Internal Medicine, 2010, 170, 1664-70.	4.3	222
104	National Patterns of Risk-Standardized Mortality and Readmission for Acute Myocardial Infarction and Heart Failure. Circulation: Cardiovascular Quality and Outcomes, 2010, 3, 459-467.	0.9	158
105	Stroke survivors with aphasia: personal experiences of coming home. British Journal of Community Nursing, 2010, 15, 241-247.	0.2	19
106	Community Navigation for Stroke Survivors and Their Care Partners: Description and Evaluation. Topics in Stroke Rehabilitation, 2010, 17, 183-190.	1.0	27
107	<scp>analysis & commentary</scp> The Foundation That Health Reform Lays For Improved Payment, Care Coordination, And Prevention. Health Affairs, 2010, 29, 1183-1187.	2.5	31
108	Effect of Hospital Follow-up Appointment on Clinical Event Outcomes and Mortality. Archives of Internal Medicine, 2010, 170, 955.	4.3	66
109	Health Care Providers' Opinions onÂCommunication Between Nursing Homes and Emergency Departments. Journal of the American Medical Directors Association, 2010, 11, 204-210.	1.2	45
110	Can principles of the Chronic Care Model be used to improve care of the older person in the acute care sector?. Collegian, 2010, 17, 63-69.	0.6	13
111	Derivation and validation of an index to predict early death or unplanned readmission after discharge from hospital to the community. Cmaj, 2010, 182, 551-557.	0.9	726
112	Inpatient medication reconciliation at admission and discharge: A retrospective cohort study of age and other risk factors for medication discrepancies. American Journal of Geriatric Pharmacotherapy, 2010, 8, 115-126.	3.0	147

#	Article	IF	Citations
113	Promoting Continuity for Patients Experiencing transitions in Care. Australian Critical Care, 2010, 23, 51-52.	0.6	9
114	Assessing Multiple Hospitalizations for Health-Plan-Managed Medicaid Diabetic Members. Journal for Healthcare Quality: Official Publication of the National Association for Healthcare Quality, 2010, 32, 7-14.	0.3	13
115	Social Work and Transitions of Care: Observations from an Intervention for Older Adults. Journal of Gerontological Social Work, 2011, 54, 615-626.	0.6	36
116	Review: Health Care Utilization and Costs of Elderly Persons With Multiple Chronic Conditions. Medical Care Research and Review, 2011, 68, 387-420.	1.0	572
117	Transitional Care of the Long-Term Care Patient. Clinics in Geriatric Medicine, 2011, 27, 259-271.	1.0	16
118	Consumer-oriented interventions for evidence-based prescribing and medicines use: an overview of systematic reviews. , 2011, , CD007768.		63
119	Palliative Care for Patients With Dementia in Long-Term Care. Clinics in Geriatric Medicine, 2011, 27, 153-170.	1.0	21
120	Hospital Readmission as an Accountability Measure. JAMA - Journal of the American Medical Association, 2011, 305, 504.	3.8	331
121	Interventions to Decrease Hospital Readmission Rates. Archives of Internal Medicine, 2011, 171, 1230.	4.3	10
122	Opportunities to improve healthcare outcomes for elderly people and reduce re-hospitalization. Aging Clinical and Experimental Research, 2011, 23, 427-430.	1.4	5
123	Linking Electronic Health Record-Extracted Psychosocial Data in Real-Time to Risk of Readmission for Heart Failure. Psychosomatics, 2011, 52, 319-327.	2.5	47
124	Effectiveness of discharge-coordinator intervention in patients with chronic obstructive pulmonary disease: study protocol of a randomized controlled clinical trial. Respiratory Medicine, 2011, 105, S26-S30.	1.3	22
125	Social Networks Enabled Coordination Model for Cost Management of Patient Hospital Admissions. Journal for Healthcare Quality: Official Publication of the National Association for Healthcare Quality, 2011, 33, 37-48.	0.3	23
126	Implementing a Transitional Care Program for High-Risk Heart Failure Patients: Findings from a Community-Based Partnership Between a Certified Home Healthcare Agency and Regional Hospital. Journal for Healthcare Quality: Official Publication of the National Association for Healthcare Quality, 2011, 33, 17-24.	0.3	21
127	Risk Prediction Models for Hospital Readmission. JAMA - Journal of the American Medical Association, 2011, 306, 1688.	3.8	1,394
128	2011 Prescott Lecture: The pharmacy profession and health care reform: Opportunities and challenges during the next decade. Journal of the American Pharmacists Association: JAPhA, 2011, 51, 477-480.	0.7	3
129	Evaluation of Care Management for the Uninsured. Medical Care, 2011, 49, 166-171.	1.1	37
130	Decreasing 30-Day Readmission Rates. American Journal of Nursing, 2011, 111, 65-69.	0.2	4

#	Article	IF	Citations
131	A Systematic Review of Curricular Interventions Teaching Transitional Care to Physicians-in-Training and Physicians. Academic Medicine, 2011, 86, 628-639.	0.8	32
132	Interventions to Reduce 30-Day Rehospitalization: A Systematic Review. Annals of Internal Medicine, 2011, 155, 520.	2.0	964
133	Paying for Outcomes, Not Performance: Lessons from the Medicare Inpatient Prospective Payment System. Joint Commission Journal on Quality and Patient Safety, 2011, 37, 184-192.	0.4	16
134	A systematic review of the effectiveness of nurse coordinated transitioning of care on readmission rates for patients with heart failure. JBI Library of Systematic Reviews, 2011, 9, 464-490.	0.1	12
135	An integrated review of the literature on challenges confronting the acute care staff nurse in discharge planning. Journal of Clinical Nursing, 2011, 20, 754-774.	1.4	69
136	Interventions to reduce hospital readmissions in the elderly: in-hospital or home care. A systematic review. Journal of Evaluation in Clinical Practice, 2011, 17, 1167-1175.	0.9	64
137	Perceptions of Hospital Safety Climate and Incidence of Readmission. Health Services Research, 2011, 46, 596-616.	1.0	110
138	Following the Money: Factors Associated with the Cost of Treating High-Cost Medicare Beneficiaries. Health Services Research, 2011, 46, 997-1021.	1.0	51
139	Quality and Cost Analysis of Nurse Staffing, Discharge Preparation, and Postdischarge Utilization. Health Services Research, 2011, 46, 1473-1494.	1.0	104
140	A Clinical Index to Stratify Hospitalized Older Adults According to Risk for Newâ€Onset Disability. Journal of the American Geriatrics Society, 2011, 59, 1206-1216.	1.3	63
141	Beyond the Prescription: Medication Monitoring and Adverse Drug Events in Older Adults. Journal of the American Geriatrics Society, 2011, 59, 1513-1520.	1.3	128
142	A New Multimodal Geriatric Discharge-Planning Intervention to Prevent Emergency Visits and Rehospitalizations of Older Adults: The Optimization of Medication in AGEd Multicenter Randomized Controlled Trial. Journal of the American Geriatrics Society, 2011, 59, 2017-2028.	1.3	105
143	Selfâ€management of chronic disease and hospital readmission: a care transition strategy. Journal of Nursing and Healthcare of Chronic Illness, 2011, 3, 4-11.	0.5	10
144	Effects of a health-social partnership transitional program on hospital readmission: A randomized controlled trial. Social Science and Medicine, 2011, 73, 960-969.	1.8	46
145	Development of a taxonomy of interventions to organise the evidence on consumersâ€™ medicines use. Patient Education and Counseling, 2011, 85, e101-e107.	1.0	26
146	Self-management: Enabling and empowering patients living with cancer as a chronic illness. Ca-A Cancer Journal for Clinicians, 2011, 61, 50-62.	157.7	726
147	Consultation psychiatry in the medical home and accountable care organizations: achieving the triple aim. General Hospital Psychiatry, 2011, 33, 305-310.	1.2	65
148	Review of the cost-effectiveness of interventions to improve seamless care focusing on medication. International Journal of Clinical Pharmacy, 2011, 33, 909-917.	1.0	13

#	Article	IF	Citations
149	Omission of Dysphagia Therapies in Hospital Discharge Communications. Dysphagia, 2011, 26, 49-61.	1.0	32
150	Improving chronic illness care for veterans within the framework of the Patient-Centered Medical Home: experiences from the Ann Arbor Patient-Aligned Care Team Laboratory. Translational Behavioral Medicine, 2011, 1, 615-623.	1.2	33
151	The Impact of Resident Duty Hour Reform on Hospital Readmission Rates Among Medicare Beneficiaries. Journal of General Internal Medicine, 2011, 26, 405-411.	1.3	26
152	Filling the Black Hole of Hospital Discharge (Editorial in Response to Article by Walz et al., J Gen) Tj ETQq1 1 0.784314 rgBT /Overlock	1.3	3
153	Inability of Providers to Predict Unplanned Readmissions. Journal of General Internal Medicine, 2011, 26, 771-776.	1.3	148
154	Effect of Standardized Electronic Discharge Instructions on Post-Discharge Hospital Utilization. Journal of General Internal Medicine, 2011, 26, 718-723.	1.3	29
155	Long-term declines in ADLs, IADLs, and mobility among older Medicare beneficiaries. BMC Geriatrics, 2011, 11, 43.	1.1	54
156	Health information management and perceptions of the quality of care for children with tracheotomy: A qualitative study. BMC Health Services Research, 2011, 11, 117.	0.9	42
157	Unplanned readmission rates, length of hospital stay, mortality, and medical costs of ten common medical conditions: a retrospective analysis of Hong Kong hospital data. BMC Health Services Research, 2011, 11, 149.	0.9	63
158	Integrated postdischarge transitional care in a hospitalist system to improve discharge outcome: an experimental study. BMC Medicine, 2011, 9, 96.	2.3	28
159	Redefining readmission risk factors for general medicine patients. Journal of Hospital Medicine, 2011, 6, 54-60.	0.7	189
160	Operational and quality outcomes of a mobile acute care for the elderly service. Journal of Hospital Medicine, 2011, 6, 358-363.	0.7	19
161	Development, validation, and results of a measure of 30â€day readmission following hospitalization for pneumonia. Journal of Hospital Medicine, 2011, 6, 142-150.	0.7	136
162	Ten ways to improve the care of elderly patients in the hospital. Journal of Hospital Medicine, 2011, 6, 351-357.	0.7	16
163	Improving the discharge process by embedding a discharge facilitator in a resident team. Journal of Hospital Medicine, 2011, 6, 494-500.	0.7	35
165	Effectiveness and Cost of a Transitional Care Program for Heart Failure. Archives of Internal Medicine, 2011, 171, 1238.	4.3	114
166	Thirty-Day Readmission Rates for Medicare Beneficiaries by Race and Site of Care. JAMA - Journal of the American Medical Association, 2011, 305, 675.	3.8	637
167	Care Transitions From Inpatient to Outpatient Settings: Ongoing Challenges and Emerging Best Practices. Hospital Practice (1995), 2011, 39, 128-139.	0.5	12

#	Article	IF	Citations
168	Strategies for Venous Thromboembolism Prophylaxis Programs. Postgraduate Medicine, 2011, 123, 91-101.	0.9	4
169	Impacting Readmission Rates and Patient Satisfaction: Results of a Discharge Pharmacist Pilot Program. Hospital Pharmacy, 2011, 46, 876-883.	0.4	27
170	Does Telephone Follow-up Predict Patient Satisfaction and Readmission?. Population Health Management, 2011, 14, 249-255.	0.8	24
171	Discharge Planning for Palliative Care Patients: A Qualitative Analysis. Journal of Palliative Medicine, 2011, 14, 65-69.	0.6	45
172	Finding the Right Level of Posthospital Care. JAMA - Journal of the American Medical Association, 2011, 305, 284.	3.8	95
173	The Effect of an Inpatient Transition Intervention on Attendance at the First Appointment Postdischarge From a Psychiatric Hospitalization. Journal of the American Psychiatric Nurses Association, 2011, 17, 330-338.	0.4	12
174	An Administrative Claims Measure Suitable for Profiling Hospital Performance Based on 30-Day All-Cause Readmission Rates Among Patients With Acute Myocardial Infarction. Circulation: Cardiovascular Quality and Outcomes, 2011, 4, 243-252.	0.9	276
175	Assisting Patients to Age in Place. Home Health Care Management and Practice, 2011, 23, 446-453.	0.4	7
176	Policy Options to Improve Discharge Planning and Reduce Rehospitalization. JAMA - Journal of the American Medical Association, 2011, 305, 302.	3.8	35
177	Improving Improvement for Childhood Asthma. JAMA - Journal of the American Medical Association, 2011, 306, 1487.	3.8	5
178	The Care Transitions Intervention. Archives of Internal Medicine, 2011, 171, 1232.	4.3	166
179	Working Without a Net: Leukemia and Lymphoma Survivorsâ€™ Perspectives on Care Delivery at End-of-Treatment and Beyond. Journal of Psychosocial Oncology, 2011, 29, 175-198.	0.6	59
180	Using Patients to Promote Evidence-Based Prescribing. Archives of Internal Medicine, 2011, 171, 1468.	4.3	2
181	The Community-Based Transitions Model. Home Healthcare Nurse, 2011, 29, 218-230.	0.4	28
182	One Home Health Agency's Quality Improvement Project to Decrease Rehospitalizations. Home Healthcare Nurse, 2011, 29, 180-193.	0.4	7
183	Supporting Family Caregivers: Teaching Essential Skills to Family Caregivers. American Journal of Nursing, 2011, 111, 52-58.	0.2	9
184	A Regional Health Collaborative Formed By NewYork-Presbyterian Aims To Improve The Health Of A Largely Hispanic Community. Health Affairs, 2011, 30, 1955-1964.	2.5	13
185	Age-Based Differences in Care Setting Transitions over the Last Year of Life. Current Gerontology and Geriatrics Research, 2011, 2011, 1-7.	1.6	9

#	Article	IF	Citations
186	The Relationship Between Intervening Hospitalizations and Transitions Between Frailty States. Journals of Gerontology - Series A Biological Sciences and Medical Sciences, 2011, 66A, 1238-1243.	1.7	107
187	Readmission after stroke in a hospital-based registry. Neurology, 2011, 76, 438-443.	1.5	77
188	Complexity of Family Caregiving and Discharge Planning. Journal of Family Nursing, 2011, 17, 61-81.	1.0	31
189	Hospital to Home Health Care Transition: Patient, Caregiver, and Clinician Perspectives. Western Journal of Nursing Research, 2012, 34, 194-212.	0.6	60
190	Prevalence of Potentially Preventable Unplanned Hospitalizations Caused by Therapeutic Failures and Adverse Drug Withdrawal Events Among Older Veterans. Journals of Gerontology - Series A Biological Sciences and Medical Sciences, 2012, 67, 867-874.	1.7	53
191	Adjuvant Trastuzumab in HER2-Positive Breast Cancer. New England Journal of Medicine, 2012, 366, 663-666.	13.9	2
192	Predicting readmissions: poor performance of the LACE index in an older UK population. Age and Ageing, 2012, 41, 784-789.	0.7	106
193	Effect of a Community-Based Nursing Intervention on Mortality in Chronically Ill Older Adults: A Randomized Controlled Trial. PLoS Medicine, 2012, 9, e1001265.	3.9	46
194	Safety threats and opportunities to improve interfacility care transitions: insights from patients and family members. Patient Preference and Adherence, 2012, 6, 711.	0.8	23
195	Do Timely Outpatient Follow-up Visits Decrease Hospital Readmission Rates?. American Journal of Medical Quality, 2012, 27, 11-15.	0.2	29
196	Improving Care Transitions: The Patient Perspective. Journal of Health Communication, 2012, 17, 312-324.	1.2	64
197	Coaching Older Adults and Carers to have their preferences. Heard COACH:A randomised controlled trial in an intermediate care setting study protocol. Australasian Medical Journal, 2012, 5, 444-454.	0.1	8
198	Does the "Office Nurse" Level of Training Matter in the Family Medicine Office?. Journal of the American Board of Family Medicine, 2012, 25, 854-861.	0.8	9
199	Medication errors in the ambulatory elderly. Aging Health, 2012, 8, 127-135.	0.3	5
200	Patient-Centered Adherence Intervention After Acute Coronary Syndrome Hospitalization. Circulation: Cardiovascular Quality and Outcomes, 2012, 5, 571-576.	0.9	24
201	Care Transitions. Advances in Nursing Science, 2012, 35, 236-248.	0.6	43
202	The Intersection of Long-Term Care and End-of-Life Care. Medical Care Research and Review, 2012, 69, 3-44.	1.0	31
203	Staff Interaction Strategies That Optimize Delivery of Transitional Care in a Skilled Nursing Facility. Family and Community Health, 2012, 35, 334-344.	0.5	12

#	Article	IF	Citations
204	Coordinating the Medical Home With Hospitalist Care. Hospital Pediatrics, 2012, 2, 105-108.	0.6	3
205	Forced relocation between nursing homes: residents' health outcomes and potential moderators. Reviews in Clinical Gerontology, 2012, 22, 301-319.	0.5	26
206	Medicare Health Support Pilot Program. New England Journal of Medicine, 2012, 366, 666-668.	13.9	1
207	Medical Patients' Experiences of Inreach Occupational Therapy: Continuity between Hospital and Home. British Journal of Occupational Therapy, 2012, 75, 330-336.	0.5	5
208	SMARTSync: Towards patient-driven medication reconciliation. , 2012, , .		1
209	A Qualitative Analysis of an Advanced Practice Nurse-Directed Transitional Care Model Intervention. Gerontologist, The, 2012, 52, 394-407.	2.3	71
210	Transition from Home Care to Nursing Home: Unmet Needs in a Home- and Community-Based Program for Older Adults. Journal of Aging and Social Policy, 2012, 24, 251-270.	0.9	54
211	The European HANDOVER project: the role of nursing. BMJ Quality and Safety, 2012, 21, i6-i8.	1.8	7
212	Low-Cost Transitional Care With Nurse Managers Making Mostly Phone Contact With Patients Cut Rehospitalization At A VA Hospital. Health Affairs, 2012, 31, 2659-2668.	2.5	90
213	The Feasibility of Caregiver-Assisted Home Nocturnal Hemodialysis. Nephron Clinical Practice, 2013, 122, 17-23.	2.3	12
214	Improving Transitions. American Journal of Medical Quality, 2012, 27, 291-296.	0.2	17
215	Describing Variation in Home Health Care Episodes for Patients With Heart Failure. Home Health Care Management and Practice, 2012, 24, 146-152.	0.4	4
216	How Changes In Washington Universityâ€™s Medicare Coordinated Care Demonstration Pilot Ultimately Achieved Savings. Health Affairs, 2012, 31, 1216-1226.	2.5	40
217	Innovations in Care Delivery to Slow Growth of US Health Spending. JAMA - Journal of the American Medical Association, 2012, 308, 1439.	3.8	18
218	What should we do about hospital readmissions?. Age and Ageing, 2012, 41, 702-704.	0.7	13
219	Six Features Of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions Of High-Risk Patients. Health Affairs, 2012, 31, 1156-1166.	2.5	205
220	Trying to cope with everyday lifeâ€"Emotional support in municipal elderly care setting. International Journal of Qualitative Studies on Health and Well-being, 2012, 7, 19613.	0.6	12
221	Acute Care Hospital Utilization Among Medical Inpatients Discharged With a Substance Use Disorder Diagnosis. Journal of Addiction Medicine, 2012, 6, 50-56.	1.4	115

#	Article	IF	Citations
222	Improving care transitions: Optimizing medication reconciliation. Journal of the American Pharmacists Association: JAPhA, 2012, 52, e43-e52.	0.7	44
223	The key actor: a qualitative study of patient participation in the handover process in Europe. BMJ Quality and Safety, 2012, 21, i89-i96.	1.8	52
224	â€œIt's like two worlds apartâ€• an analysis of vulnerable patient handover practices at discharge from hospital. BMJ Quality and Safety, 2012, 21, i67-i75.	1.8	68
225	Beliefs and experiences can influence patient participation in handover between primary and secondary careâ€”a qualitative study of patient perspectives. BMJ Quality and Safety, 2012, 21, i76-i83.	1.8	53
226	Best Practices for Heart Failure. Home Healthcare Nurse, 2012, 30, 394-405.	0.4	5
227	Reducing Unnecessary Hospital Readmissions: The Pharmacist's Role in Care Transitions. The Consultant Pharmacist, 2012, 27, 174-179.	0.4	30
228	Evidence-Based Practices in Home Care. Home Healthcare Nurse, 2012, 30, 615-616.	0.4	1
229	Factors Associated With 30-Day Hospital Readmissions Among Participants in a Care Transition Quality Improvement Program. Journal of the Society for Social Work and Research, 2012, 3, 308-328.	0.9	8
230	Thirty-Day, All-cause Readmissions for Elderly Patients Who Have an Injury-related Inpatient Stay. Medical Care, 2012, 50, 863-869.	1.1	24
231	Lessons Learned From Implementation of Postdischarge Telephone Calls at Baylor Health Care System. Journal of Nursing Administration, 2012, 42, 40-46.	0.7	13
232	Care transition interventions in mental health. Current Opinion in Psychiatry, 2012, 25, 551-558.	3.1	44
233	Transitional Care. Home Healthcare Nurse, 2012, 30, 19-26.	0.4	59
234	Scientific and Clinical Abstracts From the WOCNÂ® Society's 44th Annual Conference. Journal of Wound, Ostomy and Continence Nursing, 2012, 39, S1-S91.	0.6	1
235	Associations Between Reduced Hospital Length of Stay and 30-Day Readmission Rate and Mortality: 14-Year Experience in 129 Veterans Affairs Hospitals. Annals of Internal Medicine, 2012, 157, 837.	2.0	259
236	Transitional Care After Hospitalization for Acute Stroke or Myocardial Infarction. Annals of Internal Medicine, 2012, 157, 407.	2.0	109
237	Editorial. Contemporary Nurse, 2012, 40, 142-146.	0.4	1
238	Effect of a Restorative Model of Posthospital Home Care on Hospital Readmissions. Journal of the American Geriatrics Society, 2012, 60, 1521-1526.	1.3	42
239	Improving Transitions of Care From Hospital to Home: What Works?. Mount Sinai Journal of Medicine, 2012, 79, 535-544.	1.9	34

#	Article	IF	Citations
240	Improving Care Transitions: Current Practice and Future Opportunities for Pharmacists. Pharmacotherapy, 2012, 32, e326-37.	1.2	134
241	The E-Coach transition support computer telephony implementation study: Protocol of a randomized trial. Contemporary Clinical Trials, 2012, 33, 1172-1179.	0.8	15
242	Postoperative Complications and Long-Term Survival Among Patients Treated Surgically for Renal Cell Carcinoma. Journal of Urology, 2012, 187, 60-67.	0.2	15
243	Climbing Out of the Black Hole of Subacute Care. Journal of the American Medical Directors Association, 2012, 13, 493-494.	1.2	2
244	Identifying Risk of Hospital Readmission Among Medicare Aged Patients: An Approach Using Routinely Collected Data. Home Health Care Services Quarterly, 2012, 31, 181-195.	0.3	8
245	Patient Safety at Handoff in Rehabilitation Medicine. Physical Medicine and Rehabilitation Clinics of North America, 2012, 23, 241-257.	0.7	6
246	Prevalence, Predictors, and Patient Outcomes Associated with Physician Coâ€management: Findings from the Los Angeles Women's Health Study. Health Services Research, 2012, 47, 1091-1116.	1.0	15
247	Complementary Telephone Strategies to Improve Postdischarge Communication. American Journal of Medicine, 2012, 125, 28-30.	0.6	8
248	Pediatric Hospital Medicine and Children with Medical Complexity: Past, Present, and Future. Current Problems in Pediatric and Adolescent Health Care, 2012, 42, 113-119.	0.8	48
249	Predictive model of readmission to internal medicine wards. European Journal of Internal Medicine, 2012, 23, 451-456.	1.0	56
250	Acute Care For Elders Units Produced Shorter Hospital Stays At Lower Cost While Maintaining Patientsâ€™ Functional Status. Health Affairs, 2012, 31, 1227-1236.	2.5	90
251	Medication coaching program for patients with minor stroke or TIA: A pilot study. BMC Public Health, 2012, 12, 549.	1.2	16
252	Contemporary Evidence About Hospital Strategies for Reducing 30-Day Readmissions. Journal of the American College of Cardiology, 2012, 60, 607-614.	1.2	194
253	Incidence and Predictors of 30-Day Hospital Readmission Rate Following Percutaneous Coronary Intervention (from the National Heart, Lung, and Blood Institute Dynamic Registry). American Journal of Cardiology, 2012, 110, 1389-1396.	0.7	27
254	Telephone Follow-up as a Primary Care Intervention for Postdischarge Outcomes Improvement: A Systematic Review. American Journal of Medicine, 2012, 125, 915-921.	0.6	55
255	Bridging the Gap in Transitional Care: A Closer Look at Medication Reconciliation. Geriatric Nursing, 2012, 33, 401-409.	0.9	6
256	The imperative for patient-, family-, and population-centered interprofessional approaches to care coordination and transitional care: A policy brief by the American Academy of Nursingâ€™s Care Coordination Task Force. Nursing Outlook, 2012, 60, 330-333.	1.5	17
257	A Randomized Controlled Trial of a Goals-of-Care Video for Elderly Patients Admitted to Skilled Nursing Facilities. Journal of Palliative Medicine, 2012, 15, 805-811.	0.6	74

#	Article	IF	Citations
258	The Successful Development of a Subacute Care Service Associated With a Large Academic Health System. Journal of the American Medical Directors Association, 2012, 13, 564-567.	1.2	10
259	â€œDid I Do as Best as the System Would Let Me?â€•Healthcare Professional Views on Hospital to Home Care Transitions. Journal of General Internal Medicine, 2012, 27, 1649-1656.	1.3	79
260	â€œLearning by Doingâ€â€”Resident Perspectives on Developing Competency in High-Quality Discharge Care. Journal of General Internal Medicine, 2012, 27, 1188-1194.	1.3	38
261	Hip Fracture Management. JAMA - Journal of the American Medical Association, 2012, 307, 2185-94.	3.8	165
262	Readmission Risk Factors after Hospital Discharge Among the Elderly. Population Health Management, 2012, 15, 338-351.	0.8	37
263	Transitions in Care among Older Adults Receiving Long-Term Services and Supports. Journal of Gerontological Nursing, 2012, 38, 40-47.	0.3	31
264	From Hospital to Home: A Brief Nurse Practitioner Intervention for Vulnerable Older Adults. Journal of Gerontological Nursing, 2012, 38, 40-50.	0.3	48
265	Development of a real-time general medicine 30-day readmissions notification system. Journal of Hospital Administration, 2012, 2, 28.	0.0	1
266	Effectiveness of structured discharge process in reducing hospital readmission of adult patients with community acquired pneumonia: A systematic review. JBI Library of Systematic Reviews, 2012, 10, 1086-1121.	0.1	9
267	Care Transitions from the Hospital to Home for Patients with Mobility Impairments: Patient and Family Caregiver Experiences. Rehabilitation Nursing, 2012, 37, 277-285.	0.3	50
268	Planning and designing the care transitions innovation (Câ€Train) for uninsured and Medicaid patients. Journal of Hospital Medicine, 2012, 7, 524-529.	0.7	19
270	Effect of Patient- and Medication-Related Factors on Inpatient Medication Reconciliation Errors. Journal of General Internal Medicine, 2012, 27, 924-932.	1.3	60
271	Navigation roles support chronically ill older adults through healthcare transitions: a systematic review of the literature. Health and Social Care in the Community, 2012, 20, 113-127.	0.7	144
272	An Effectiveness and Costâ€Benefit Analysis of a Hospitalâ€Based Discharge Transition Program for Elderly Medicare Recipients. Journal of the American Geriatrics Society, 2012, 60, 1051-1056.	1.3	38
273	Medication reconciliation during the transition to and from long-term care settings: A systematic review. Research in Social and Administrative Pharmacy, 2012, 8, 60-75.	1.5	72
274	Economic Analysis of Secondary Trial Data. Progress in Cardiovascular Diseases, 2012, 54, 351-356.	1.6	6
275	Risk factors for 30â€day readmission in general medical patients admitted from the emergency department: a single centre study. Internal Medicine Journal, 2012, 42, 677-682.	0.5	30
276	The impact of hospital utilization on patient readmission rate. Health Care Management Science, 2012, 15, 29-36.	1.5	39

#	Article	IF	Citations
277	Delirium and transition to a nursing home of hospitalized older adults: A controlled trial of assessing the interdisciplinary teamâ€based â€œgeriatricâ€•care and care coordination by nonâ€geriatrics specialist physicians. Geriatrics and Gerontology International, 2013, 13, 342-350.	0.7	12
278	Interventions for reducing readmissions â€“ are we barking up the right tree?. Israel Journal of Health Policy Research, 2013, 2, 2.	1.4	11
279	2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction: Executive Summary. Journal of the American College of Cardiology, 2013, 61, 485-510.	1.2	905
280	Heart Failure Readmissions. Current Treatment Options in Cardiovascular Medicine, 2013, 15, 437-449.	0.4	5
281	How Can Health Literacy Influence Outcomes in Heart Failure Patients? Mechanisms and Interventions. Current Heart Failure Reports, 2013, 10, 232-243.	1.3	38
282	Potentially Avoidable 30-Day Hospital Readmissions in Medical Patients. JAMA Internal Medicine, 2013, 173, 632.	2.6	434
283	Impact of target-specific oral anticoagulants on transitions of care and outpatient care models. Journal of Thrombosis and Thrombolysis, 2013, 35, 304-311.	1.0	7
284	Completing the Play or Dropping the Ball?. JAMA Internal Medicine, 2013, 173, 1723-4.	2.6	9
285	The value of nursing care coordination: A white paper of the American Nurses Association. Nursing Outlook, 2013, 61, 490-501.	1.5	39
286	Quality of transitions in older medical patients with frequent readmissions: Opportunities for improvement. European Journal of Internal Medicine, 2013, 24, 779-783.	1.0	24
287	Hospitals With Higher Nurse Staffing Had Lower Odds Of Readmissions Penalties Than Hospitals With Lower Staffing. Health Affairs, 2013, 32, 1740-1747.	2.5	92
288	Interaction Between Cognitive Impairment and Discharge Destination and Its Effect on Rehospitalization. Journal of the American Geriatrics Society, 2013, 61, 1958-1963.	1.3	17
289	Evaluation of a modified community based care transitions model to reduce costs and improve outcomes. BMC Geriatrics, 2013, 13, 94.	1.1	11
290	Cliniciansâ€™ views on improving inter-organizational care transitions. BMC Health Services Research, 2013, 13, 289.	0.9	35
291	Disseminating Evidence-Based Care into Practice. Population Health Management, 2013, 16, 227-234.	0.8	24
294	Closing the loop: best practices for cross-setting communication at ED discharge. American Journal of Emergency Medicine, 2013, 31, 1297-1301.	0.7	21
295	Value Drivers: An Approach for Estimating Health and Disease Management Program Savings. Population Health Management, 2013, 16, 356-363.	0.8	1
296	The Influence of a Postdischarge Intervention on Reducing Hospital Readmissions in a Medicare Population. Population Health Management, 2013, 16, 310-316.	0.8	62

#	Article	IF	Citations
299	2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction. Journal of the American College of Cardiology, 2013, 61, e78-e140.	1.2	2,612
300	Developing an Integrated System of Care for Frail Seniors. Healthcare Management Forum, 2013, 26, 200-208.	0.6	21
301	Prevalence and correlates of self-reported medication non-adherence among older adults with coronary heart disease, diabetes mellitus, and/or hypertension. Research in Social and Administrative Pharmacy, 2013, 9, 817-827.	1.5	89
302	Predictors of 30-Day Readmission and Association with Primary Care Follow-Up Plans. Journal of Pediatrics, 2013, 163, 1027-1033.	0.9	38
303	Readmission After Abdominal Aortic Aneurysm Repair. Advances in Surgery, 2013, 47, 141-152.	0.6	5
304	Access to heart failure care post emergency department visit: Do we meet established benchmarks and does it matter?. American Heart Journal, 2013, 165, 725-732.	1.2	17
305	Chronic Obstructive Pulmonary Disease Readmissions at Minority-serving Institutions. Annals of the American Thoracic Society, 2013, 10, 680-684.	1.5	26
306	Forecasting the Impact of Heart Failure in the United States. Circulation: Heart Failure, 2013, 6, 606-619.	1.6	2,206
307	Health reform and the Affordable Care Act: The importance of mental health treatment to achieving the triple aim. Journal of Psychosomatic Research, 2013, 74, 533-537.	1.2	70
308	Recruitment and retention rates in behavioral trials involving patients and a support person: A systematic review. Contemporary Clinical Trials, 2013, 36, 307-318.	0.8	39
309	Transitions of Care for the Geriatric Patient in the Emergency Department. Clinics in Geriatric Medicine, 2013, 29, 49-69.	1.0	73
310	Extending Physician ReACH: Influencing patient activation and behavior through multichannel physician communication. Patient Education and Counseling, 2013, 91, 72-78.	1.0	15
311	A Patient-Centered Early Warning System to Prevent Readmission after Colorectal Surgery: A National Consensus Using the Delphi Method. Journal of the American College of Surgeons, 2013, 216, 210-216e6.	0.2	22
312	Management of hospital readmissions in internal medicine. Revista Clínica Espanõla, 2013, 213, 203-207.	0.3	2
313	GestiÃ³n de los reingresos en Medicina Interna. Revista Clinica Espanola, 2013, 213, 203-207.	0.2	3
314	Hospital-Based, Acute Care Use Among Patients Within 30 Days of Discharge After Coronary Artery Bypass Surgery. Annals of Thoracic Surgery, 2013, 96, 96-104.	0.7	37
315	Influence of a Transitional Care Clinic on Subsequent 30â€Day Hospitalizations and Emergency Department Visits in Individuals Discharged from a Skilled Nursing Facility. Journal of the American Geriatrics Society, 2013, 61, 137-142.	1.3	31
316	Innovative Geriatric Practice Models: Preliminary Data. Journal of the American Geriatrics Society, 2013, 61, 2-3.	1.3	3

#	Article	IF	Citations
317	Risk factors for hospital readmission of elderly patients. European Journal of Internal Medicine, 2013, 24, 45-51.	1.0	72
318	Big data solutions for predicting risk-of-readmission for congestive heart failure patients. , 2013, , .		58
319	Hospital readmission and parent perceptions of their child's hospital discharge. International Journal for Quality in Health Care, 2013, 25, 573-581.	0.9	104
320	Conceptualization of a Toolkit to Evaluate Everyday Competence in Planning Transitions From Nursing Homes to the Community. Journal of the American Medical Directors Association, 2013, 14, 626.e1-626.e7.	1.2	7
321	Hospital readmission among elderly patients. European Journal of Health Economics, 2013, 14, 809-820.	1.4	20
322	Association Between Quality Improvement for Care Transitions in Communities and Rehospitalizations Among Medicare Beneficiaries. JAMA - Journal of the American Medical Association, 2013, 309, 381.	3.8	125
323	Transitional Care: Looking for the Right Shoes to Fit Older Adult Patients. Care Management Journals: Journal of Case Management ; the Journal of Long Term Home Health Care, 2013, 14, 78-83.	0.5	10
324	Can a preflight checklist make hospital discharge safer?. Nursing Management, 2013, 44, 8-11.	0.2	3
325	Defining quality outcomes for complex-care patients transitioning across the continuum using a structured panel process. BMJ Quality and Safety, 2013, 22, 1014-1024.	1.8	30
326	User Experience of a Centralized Hyperacute Stroke Service. Stroke, 2013, 44, 2743-2747.	1.0	7
327	An approach to family-centered coordinated co-management for individuals with conditions identified through newborn screening. Genetics in Medicine, 2013, 15, 174-177.	1.1	18
328	Are readmission rates on a neurosurgical service indicators of quality of care?. Journal of Neurosurgery, 2013, 119, 1043-1049.	0.9	61
329	Health Care Utilization Prior to Loss to Care Among Veterans With Serious Mental Illness. Psychiatric Services, 2013, 64, 594-596.	1.1	2
330	Emergency Department Visits After Surgery Are Common For Medicare Patients, Suggesting Opportunities To Improve Care. Health Affairs, 2013, 32, 1600-1607.	2.5	72
331	Long-Term Acute Care Hospitals Have Low Impact on Medicare Readmissions to Short-Term Acute Care Hospitals. American Journal of Medical Quality, 2013, 28, 502-509.	0.2	3
332	Predictors of Thirty-Day Readmission Among Hospitalized Family Medicine Patients. Journal of the American Board of Family Medicine, 2013, 26, 71-77.	0.8	72
333	Hospital readmission performance and patterns of readmission: retrospective cohort study of Medicare admissions. BMJ, The, 2013, 347, f6571-f6571.	3.0	82
334	Exploring Care Transitions From Patient, Caregiver, and Health-Care Provider Perspectives. Clinical Nursing Research, 2013, 22, 258-274.	0.7	58

#	Article	IF	Citations
335	Postdischarge Environment Following Heart Failure Hospitalization: Expanding the View of Hospital Readmission. Journal of the American Heart Association, 2013, 2, e000116.	1.6	47
336	Approaches for improving continuity of care in medication management: a systematic review. International Journal for Quality in Health Care, 2013, 25, 403-417.	0.9	52
337	Can the Targeted Use of a Discharge Pharmacist Significantly Decrease 30-Day Readmissions?. Hospital Pharmacy, 2013, 48, 380-388.	0.4	49
338	Income inequality and 30 day outcomes after acute myocardial infarction, heart failure, and pneumonia: retrospective cohort study. BMJ, The, 2013, 346, f521-f521.	3.0	109
339	Care of the Older Adult in the Emergency Department: Nurses Views of the Pressing Issues. Gerontologist, The, 2013, 53, 441-453.	2.3	76
340	Thinking Outside the Box. Home Healthcare Nurse, 2013, 31, 338-339.	0.4	1
341	Mobility After Hospital Discharge as a Marker for 30-Day Readmission. Journals of Gerontology - Series A Biological Sciences and Medical Sciences, 2013, 68, 805-810.	1.7	87
342	Effect of Modest Pay-for-Performance Financial Incentive on Time-to-Discharge Summary Dictation Among Medical Residents. Quality Management in Health Care, 2013, 22, 272-275.	0.4	5
343	Transitions of Care in Patients Receiving Oral Anticoagulants. Journal of Cardiovascular Nursing, 2013, 28, 54-65.	0.6	4
344	Effects of Enterostomal Nurse Telephone Follow-up on Postoperative Adjustment of Discharged Colostomy Patients. Cancer Nursing, 2013, 36, 419-428.	0.7	80
345	Nurse Care Coordination and Technology Effects on Health Status of Frail Older Adults via Enhanced Self-Management of Medication. Nursing Research, 2013, 62, 269-278.	0.8	61
346	New Systems of Care Can Leverage the Health Care Workforce. Academic Medicine, 2013, 88, 1817-1821.	0.8	11
347	The Evolution of Banner Health's Case Management Program. Professional Case Management, 2013, 18, 138-141.	0.2	0
348	Hospital Nursing and 30-Day Readmissions Among Medicare Patients With Heart Failure, Acute Myocardial Infarction, and Pneumonia. Journal of Nursing Administration, 2013, 43, S11-S18.	0.7	7
349	Association of Early Physician Follow-Up and 30-Day Readmission After Nonâ€“ST-Segmentâ€“Elevation Myocardial Infarction Among Older Patients. Circulation, 2013, 128, 1206-1213.	1.6	43
350	Hospital Strategies Associated With 30-Day Readmission Rates for Patients With Heart Failure. Circulation: Cardiovascular Quality and Outcomes, 2013, 6, 444-450.	0.9	293
351	Measuring Hospital Quality Using Pediatric Readmission and Revisit Rates. Pediatrics, 2013, 132, 429-436.	1.0	121
352	Diagnoses and Timing of 30-Day Readmissions After Hospitalization for Heart Failure, Acute Myocardial Infarction, or Pneumonia. JAMA - Journal of the American Medical Association, 2013, 309, 355.	3.8	831

#	Article	IF	Citations
353	Reaching Out to Patients to Identify Adverse Drug Reactions and Nonadherence. JAMA Internal Medicine, 2013, 173, 384.	2.6	0
354	Use of Hospital-Based Acute Care Among Patients Recently Discharged From the Hospital. JAMA - Journal of the American Medical Association, 2013, 309, 364.	3.8	155
355	Limits Of Readmission Rates In Measuring Hospital Quality Suggest The Need For Added Metrics. Health Affairs, 2013, 32, 1083-1091.	2.5	63
356	Interventions to Decrease Hospital Readmissions. JAMA Internal Medicine, 2013, 173, 695.	2.6	101
357	2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction: Executive Summary. Circulation, 2013, 127, 529-555.	1.6	2,051
358	2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction. Circulation, 2013, 127, e362-425.	1.6	2,639
359	Racial and Ethnic Differences in Outcomes in Older Patients With Acute Ischemic Stroke. Circulation: Cardiovascular Quality and Outcomes, 2013, 6, 284-292.	0.9	67
360	Lean methodology. Nurse Practitioner, 2013, 38, 1-7.	0.2	12
361	Readmission After Colorectal Surgery Is Related to Preoperative Clinical Conditions and Major Complications. Diseases of the Colon and Rectum, 2013, 56, 1087-1092.	0.7	38
362	Clinician Roles and Responsibilities During Care Transitions of Older Adults. Journal of the American Geriatrics Society, 2013, 61, 231-236.	1.3	26
363	Implementation of a Care Transitions Model for Low-Income Older Adults: A High-Risk, Vulnerable Population. Journal of the American Geriatrics Society, 2013, 61, 987-992.	1.3	22
364	Causes and <scp>P</scp>revalence of <scp>U</scp>nplanned <scp>R</scp>eadmissions After <scp>C</scp>olorectal <scp>S</scp>urgery: <scp>A S</scp>ystematic <scp>R</scp>eview and <scp>M</scp>etaâ€<scp>A</scp>nalysis. Journal of the American Geriatrics Society, 2013, 61, 1175-1181.	1.3	72
365	The Importance of Clinical Severity in the Measurement of Hospital Readmission Rates for Medicare Beneficiaries, 1997-2007. Medical Care Research and Review, 2013, 70, 653-665.	1.0	11
366	Risk of Hospital Readmission for Older Adults Discharged on Friday. Journal of the American Geriatrics Society, 2013, 61, 300-301.	1.3	7
367	What's cost got to do with it? Association between hospital costs and frequency of admissions among â€œhigh usersâ€•of hospital care. Journal of Hospital Medicine, 2013, 8, 665-671.	0.7	20
368	Turning Readmission Reduction Policies into Results: Some Lessons from a Multistate Initiative to Reduce Readmissions. Population Health Management, 2013, 16, 255-260.	0.8	20
369	Transitional Care Challenges of Rehospitalized Veterans: Listening to Patients and Providers. Population Health Management, 2013, 16, 326-331.	0.8	16
370	Implications of Metric Choice for Common Applications of Readmission Metrics. Health Services Research, 2013, 48, 1978-1995.	1.0	13

#	Article	IF	Citations
371	Moving beyond readmission penalties: Creating an ideal process to improve transitional care. Journal of Hospital Medicine, 2013, 8, 102-109.	0.7	142
372	Recruiting hospitalized patients for research: How do participants differ from eligible nonparticipants?. Journal of Hospital Medicine, 2013, 8, 208-214.	0.7	10
373	Research Priorities in Geriatric Palliative Care: Policy Initiatives. Journal of Palliative Medicine, 2013, 16, 1503-1508.	0.6	26
374	Implementing a Care Coordination Program for Children with Special Healthcare Needs: Partnering with Families and Providers. Journal for Healthcare Quality: Official Publication of the National Association for Healthcare Quality, 2013, 35, 70-77.	0.3	20
375	Implementation of geriatric acute care best practices: Initial results of the <scp>NICHE SITE</scp> selfâ€evaluation. Australian Journal of Cancer Nursing, 2013, 15, 518-524.	0.8	26
376	Effect of Hospitalâ€“<scp>SNF</scp> Referral Linkages on Rehospitalization. Health Services Research, 2013, 48, 1898-1919.	1.0	85
377	Development of a checklist of safe discharge practices for hospital patients. Journal of Hospital Medicine, 2013, 8, 444-449.	0.7	65
378	Factors Contributing to Readmission of Seniors into Acute Care Hospitals. Educational Gerontology, 2013, 39, 878-887.	0.7	8
379	2013 ACCF/AHA Guideline for the Management of STâ€Elevation Myocardial Infarction: Executive Summary: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. Catheterization and Cardiovascular Interventions, 2013, 82, E1-27.	0.7	368
380	Transitional Care Cut Hospital Readmissions For North Carolina Medicaid Patients With Complex Chronic Conditions. Health Affairs, 2013, 32, 1407-1415.	2.5	81
381	Effects of an Enhanced Discharge Planning Intervention for Hospitalized Older Adults: A Randomized Trial. Gerontologist, The, 2013, 53, 430-440.	2.3	102
382	Minimizing Geriatric Rehospitalizations. American Journal of Medical Quality, 2013, 28, 8-15.	0.2	2
383	Predicting re-hospitalisations using intelligent systems: an exploratory study. International Journal of Business Information Systems, 2013, 13, 151.	0.2	2
384	Strategies to Improve Patient Safety: The Evidence Base Matures. Annals of Internal Medicine, 2013, 158, 350.	2.0	38
385	Hospital-Initiated Transitional Care Interventions as a Patient Safety Strategy. Annals of Internal Medicine, 2013, 158, 433.	2.0	211
386	Doctor to Doctor Communication. , 2013, , 57-63.		0
387	Home care: more than just a visiting nurse. BMJ Quality and Safety, 2013, 22, 972-974.	1.8	36
388	The effectiveness of computer-based learning in hospitalized adults with heart failure on knowledge, re-admission, self-care, quality of life, and patient satisfaction: a systematic review protocol. JBI Database of Systematic Reviews and Implementation Reports, 2013, 11, 129-145.	1.7	3

#	Article	IF	Citations
389	Identifying Patients at Increased Risk for Unplanned Readmission. Medical Care, 2013, 51, 761-766.	1.1	65
390	Case managers for older persons with multi-morbidity and their everyday work â€“ a focused ethnography. BMC Health Services Research, 2013, 13, 496.	0.9	22
391	Thirty-day hospital readmission rate among adults living with HIV. Aids, 2013, 27, 2059-2068.	1.0	27
392	Hospital Nursing and 30-Day Readmissions Among Medicare Patients With Heart Failure, Acute Myocardial Infarction, and Pneumonia. Medical Care, 2013, 51, 52-59.	1.1	149
393	Examining the Impact of the AHRQ Patient Safety Indicators (PSIs) on the Veterans Health Administration. Medical Care, 2013, 51, 37-44.	1.1	50
394	Facilitators and Challenges to Conducting Interdisciplinary Research. Medical Care, 2013, 51, S23-S31.	1.1	9
395	COSTS ASSOCIATED WITH READMISSIONS IN BELGIAN ACUTE-CARE HOSPITALS. Acta Clinica Belgica, 2013, 68, 263-267.	0.5	4
396	Handoff Communication Between Hospital and Outpatient Dialysis Units at Patient Discharge: A Qualitative Study. Joint Commission Journal on Quality and Patient Safety, 2013, 39, 70-76.	0.4	20
397	Disability During the Last Two Years of Life. JAMA Internal Medicine, 2013, 173, 1506.	2.6	76
398	Administration of care to older patients in transition from hospital to home care services: home nursing leaders' experiences. Journal of Multidisciplinary Healthcare, 2013, 6, 379.	1.1	10
400	Advancing Research in Transitional Care: Challenges of Culture, Language and Health Literacy in Asian American and Native Hawaiian Elders. Journal of Health Care for the Poor and Underserved, 2013, 24, 404-418.	0.4	13
401	Hip-Fracture Care in Rural Southwestern Ontario: An Ethnographic Study of Patient Transitions and Physiotherapy Handoffs. Physiotherapy Canada Physiotherapie Canada, 2013, 65, 266-275.	0.3	10
402	Transitional Care Management Services: Optimizing Medication Reconciliation to Improve the Care of Older Adults. Journal of Gerontological Nursing, 2013, 39, 10-15.	0.3	13
403	Hospital Readmissions Reduction Program: An Economic and Operational Analysis. SSRN Electronic Journal, 0, , .	0.4	1
404	A Public-Private Partnership Develops and Externally Validates a 30-Day Hospital Readmission Risk Prediction Model. Online Journal of Public Health Informatics, 2013, 5, 219.	0.4	48
405	Transitions of Care: Putting the Pieces Together. AMA Journal of Ethics, 2013, 15, 145-149.	0.4	1
406	Improving the Quality of Discharge Care for the Homeless: A Patient-centered Approach. Journal of Health Care for the Poor and Underserved, 2013, 24, 444-455.	0.4	30
407	Readmissions at a Public Safety Net Hospital. PLoS ONE, 2014, 9, e91244.	1.1	6

#	Article	IF	Citations
409	Comprehension deficits among older patients in a quick diagnostic unit. Clinical Interventions in Aging, 2014, 9, 705.	1.3	6
410	Facilitating safe patient transition of care: A qualitative systematic review. Journal of Nursing Education and Practice, 2014, 4, .	0.1	2
411	Post-acute integration strategies in an era of accountability. Journal of Hospital Administration, 2014, 3, 103.	0.0	4
412	SeguranÃ§a do paciente no uso de medicamentos apÃ³s a alta hospitalar: estudo exploratÃ³rio1. Saude E Sociedade, 2014, 23, 1431-1444.	0.1	8
413	Is audit and feedback associated with increased hospital adherence to standards for communication during patient care transitions?. Journal of Hospital Administration, 2014, 3, 1.	0.0	1
414	Perspectives of Older Adults of Low Socioeconomic Status on the Post-hospital Transition. Journal of Health Care for the Poor and Underserved, 2014, 25, 746-756.	0.4	18
415	EstratÃ©gias para a seguranÃ§a do paciente no processo de uso de medicamentos apÃ³s alta hospitalar. Physis, 2014, 24, 401-420.	0.1	7
416	Community Health Workers and the Patient Protection and Affordable Care Act: An Opportunity for a Research, Advocacy, and Policy Agenda. Journal of Health Care for the Poor and Underserved, 2014, 25, 17-24.	0.4	38
417	Transitional Care Interventions Prevent Hospital Readmissions For Adults With Chronic Illnesses. Health Affairs, 2014, 33, 1531-1539.	2.5	199
418	Exploring Best Practices in Home Health Care. Home Health Care Management and Practice, 2014, 26, 17-33.	0.4	18
419	Perspectives in Primary Care: Implementing Patient-Centered Care Coordination for Individuals with Multiple Chronic Medical Conditions. Annals of Family Medicine, 2014, 12, 500-503.	0.9	26
420	Dementia considered? Safety-relevant communication between health care settings: a systematic review. Zeitschrift Fur Gesundheitswissenschaften, 2014, 22, 383-393.	0.8	8
421	Improving patient discharge and reducing hospital readmissions by using Intervention Mapping. BMC Health Services Research, 2014, 14, 389.	0.9	123
422	Assessing the Impact of Nurse Post-Discharge Telephone Calls on 30-Day Hospital Readmission Rates. Journal of General Internal Medicine, 2014, 29, 1519-1525.	1.3	61
423	Better Health, Less Spending. Stroke, 2014, 45, 3105-3111.	1.0	14
424	Feasibility and evaluation of a pilot community health worker intervention to reduce hospital readmissions. International Journal for Quality in Health Care, 2014, 26, 358-365.	0.9	35
425	Heart failure assessment at the community pharmacy level: A feasibility pilot study. Journal of the American Pharmacists Association: JAPhA, 2014, 54, 634-641.	0.7	7
426	Development and Use of an Administrative Claims Measure for Profiling Hospital-wide Performance on 30-Day Unplanned Readmission. Annals of Internal Medicine, 2014, 161, S66.	2.0	74

#	Article	IF	Citations
427	Analysis of 30-day readmissions among neurosurgical patients: surgical complication avoidance as key to quality improvement. Journal of Neurosurgery, 2014, 121, 170-175.	0.9	54
428	Integrated Medical Processes: Redesigning Transitions of Care. Hospital Practice (1995), 2014, 42, 92-98.	0.5	0
429	Ability of Nurse Clinicians to Predict Unplanned Returns to Hospital Within Thirty Days of Discharge. Hospital Practice (1995), 2014, 42, 62-68.	0.5	5
430	Return to system within 30 days of discharge following pediatric shunt surgery. Journal of Neurosurgery: Pediatrics, 2014, 13, 525-531.	0.8	27
431	Transitional Care Clinic for Uninsured and Medicaid-Covered Patients With Diabetes Mellitus Discharged From the Hospital: A Pilot Quality Improvement Study. Hospital Practice (1995), 2014, 42, 46-51.	0.5	17
432	Where's the beef? Progress on reducing readmissions. Journal of Hospital Medicine, 2014, 9, 266-268.	0.7	0
433	The Empirical Foundations of Telemedicine Interventions for Chronic Disease Management. Telemedicine Journal and E-Health, 2014, 20, 769-800.	1.6	259
434	Indications, Hospital Course, and Complexity of Patients Undergoing Tracheostomy at a Tertiary Care Pediatric Hospital. Otolaryngology - Head and Neck Surgery, 2014, 151, 232-239.	1.1	55
435	Hospital Length of Stay and Readmission. Medical Care Research and Review, 2014, 71, 99-111.	1.0	48
436	Preventing Hospitalizations in Children With Medical Complexity: A Systematic Review. Pediatrics, 2014, 134, e1628-e1647.	1.0	119
437	Exploratory analysis of the relationship between home health agency engagement in a national campaign and reduction in acute care hospitalization in <scp>US</scp> home care patients. Journal of Evaluation in Clinical Practice, 2014, 20, 664-670.	0.9	3
438	Guidance statement on appropriate medical services for the elderly. Geriatrics and Gerontology International, 2014, 14, 518-525.	0.7	5
439	A Randomized Trial Exploring the Effect of a Telephone Call Followâ€up on Care Plan Compliance Among Older Adults Discharged Home From the Emergency Department. Academic Emergency Medicine, 2014, 21, 188-195.	0.8	74
440	Burden in Caregivers of Cognitively Impaired Elderly Adults at Time of Hospitalization: A Crossâ€Sectional Analysis. Journal of the American Geriatrics Society, 2014, 62, 276-284.	1.3	65
441	Hospitalization of Elderly Medicaid Longâ€Term Care Users Who Transition from Nursing Homes. Journal of the American Geriatrics Society, 2014, 62, 71-78.	1.3	26
442	Quality of care factors associated with unplanned readmissions of older medical patients: a caseâ€“control study. Internal Medicine Journal, 2014, 44, 161-170.	0.5	23
443	A transitional care model for low-income older adults does not reduce readmission rates or emergency department visits during care transitions. Evidence-based Nursing, 2014, 17, 98-98.	0.1	0
444	The successes and challenges of hospital to home transitions. Journal of Hospital Medicine, 2014, 9, 271-273.	0.7	4

#	Article	IF	Citations
445	Tablet computers for hospitalized patients: A pilot study to improve inpatient engagement. Journal of Hospital Medicine, 2014, 9, 396-399.	0.7	81
446	Making the Case for the Nurse as the Leader of Care Coordination. Nursing Forum, 2014, 49, 167-170.	1.0	10
447	The care of older adults in hospital: if it's common sense why isn't it common practice?. Journal of Clinical Nursing, 2014, 23, 1573-1582.	1.4	40
448	2014 AHA/ACC Guideline for the Management of Patients With Nonâ€“ST-Elevation Acute Coronary Syndromes. Circulation, 2014, 130, e344-426.	1.6	928
449	Interventions to Reduce Rehospitalizations after Chronic Obstructive Pulmonary Disease Exacerbations. A Systematic Review. Annals of the American Thoracic Society, 2014, 11, 417-424.	1.5	91
450	Sustained Care Intervention and Postdischarge Smoking Cessation Among Hospitalized Adults. JAMA - Journal of the American Medical Association, 2014, 312, 719.	3.8	114
451	A Framework of Pediatric Hospital Discharge Care Informed by Legislation, Research, and Practice. JAMA Pediatrics, 2014, 168, 955.	3.3	95
452	What Will It Take to Move the Needle on Hospital Readmissions?. American Journal of Medical Quality, 2014, 29, 357-359.	0.2	2
453	Strategies to Reduce 30-Day Readmissions in Older Patients Hospitalized with Heart Failure and Acute Myocardial Infarction. Current Geriatrics Reports, 2014, 3, 306-315.	1.1	41
454	Identifying keys to success in reducing readmissions using the ideal transitions in care framework. BMC Health Services Research, 2014, 14, 423.	0.9	110
455	The Patient-Centered Medical Neighborhood. American Journal of Medical Quality, 2014, 29, 344-349.	0.2	17
456	Optimizing Person-Centered Transitions In The Dementia Journey: A Comparison Of National Dementia Strategies. Health Affairs, 2014, 33, 566-573.	2.5	61
457	Disparities in Surgical 30-Day Readmission Rates for Medicare Beneficiaries by Race and Site of Care. Annals of Surgery, 2014, 259, 1086-1090.	2.1	171
458	Innovative and Successful Approaches to Improving Care Transitions From Hospital to Home. Home Healthcare Nurse, 2014, Publish Ahead of Print, 88-95.	0.4	8
459	Outpatient Interventions for Hepatology Patients With Fluid Retention. Gastroenterology Nursing, 2014, 37, 236-244.	0.2	5
460	The journey of the frail older adult with heart failure: implications for management and health care systems. Reviews in Clinical Gerontology, 2014, 24, 269-289.	0.5	13
461	A composite index for predicting readmission following emergency general surgery. Journal of Trauma and Acute Care Surgery, 2014, 76, 1467-1472.	1.1	30
462	Reducing Hospital Readmissions Among Medicaid Patients. Quality Management in Health Care, 2014, 23, 20-42.	0.4	15

#	Article	IF	Citations
463	Reducing Hospital Readmissions Among Medicaid Patients. Quality Management in Health Care, 2014, 23, 203-225.	0.4	30
464	Impact of Discharge Planning Decision Support on Time to Readmission Among Older Adult Medical Patients. Professional Case Management, 2014, 19, 29-38.	0.2	50
465	Advancing the Evolution of Healthcare. Journal of Nursing Administration, 2014, 44, 381-387.	0.7	1
466	2014 AHA/ACC Guideline for the Management of Patients With Nonâ€“ST-Elevation Acute Coronary Syndromes: Executive Summary. Circulation, 2014, 130, 2354-2394.	1.6	938
467	Preventing 30-Day Hospital Readmissions. JAMA Internal Medicine, 2014, 174, 1095.	2.6	595
468	Derivation and validation of a formula to estimate risk for 30-day readmission in medical patients. International Journal for Quality in Health Care, 2014, 26, 271-277.	0.9	27
469	Improving Patientsâ€™ Postdischarge Communication. Circulation, 2014, 130, 1091-1094.	1.6	5
470	Effect of a Postdischarge Virtual Ward on Readmission or Death for High-Risk Patients. JAMA - Journal of the American Medical Association, 2014, 312, 1305.	3.8	110
471	A Systematic Review of the Cost-Effectiveness of Nurse Practitioners and Clinical Nurse Specialists: What Is the Quality of the Evidence?. Nursing Research and Practice, 2014, 2014, 1-28.	0.4	40
472	Using Health Literacy Guidelines to Improve Discharge Education and the Post-Hospital Transition. American Journal of Medical Quality, 2014, 29, 86-86.	0.2	6
473	Cost Analysis of a Homeâ€Based Nurse Care Coordination Program. Journal of the American Geriatrics Society, 2014, 62, 2369-2376.	1.3	18
474	The Affordable Care Act. Journal of Occupational and Environmental Medicine, 2014, 56, 809-813.	0.9	13
475	Using Appreciative Inquiry During Care Transitions. Journal of Nursing Care Quality, 2014, 29, 44-50.	0.5	4
476	A System-Wide Innovation in Transition Services. Home Healthcare Nurse, 2014, 32, 78-86.	0.4	2
477	Comprehensive Longitudinal Health Care in the Home for Highâ€Cost Beneficiaries: A Critical Strategy for Population Health Management. Journal of the American Geriatrics Society, 2014, 62, 1974-1976.	1.3	15
478	Testing a Familyâ€Centered Intervention to Promote Functional and Cognitive Recovery in Hospitalized Older Adults. Journal of the American Geriatrics Society, 2014, 62, 2398-2407.	1.3	65
479	Association of dementia with early rehospitalization among Medicare beneficiaries. Archives of Gerontology and Geriatrics, 2014, 59, 162-168.	1.4	64
480	The Effect of Serious Mental Illness on the Risk of Rehospitalization Among Patients With Diabetes. Psychosomatics, 2014, 55, 134-143.	2.5	58

#	Article	IF	Citations
481	Cardiac Surgery Nurse Practitioner Home VisitsÂPrevent Coronary Artery Bypass GraftÂReadmissions. Annals of Thoracic Surgery, 2014, 97, 1488-1495.	0.7	54
482	The Ninety-Nine Percent: Focusing on the Patient to Reduce Readmissions. Journal of General Internal Medicine, 2014, 29, 556-557.	1.3	3
483	Cardiovascular Admissions, Readmissions, and Transitions of Care. Current Emergency and Hospital Medicine Reports, 2014, 2, 45-51.	0.6	5
484	Interplay between sepsis and chronic health. Trends in Molecular Medicine, 2014, 20, 234-238.	3.5	44
485	Interventions for Heart Failure Readmissions: Successes and Failures. Current Heart Failure Reports, 2014, 11, 178-187.	1.3	12
486	Rationale for a home dialysis virtual ward: design and implementation. BMC Nephrology, 2014, 15, 33.	0.8	14
487	Implementing Community-Based Diabetes Programs: The Scripps Whittier Diabetes Institute Experience. Current Diabetes Reports, 2014, 14, 462.	1.7	18
488	Randomized clinical trial of the timing it right stroke family support program: research protocol. BMC Health Services Research, 2014, 14, 18.	0.9	27
489	Transitions of Care and Rehabilitation After Fragility Fractures. Clinics in Geriatric Medicine, 2014, 30, 303-315.	1.0	7
490	Integrated Literature Review of Postdischarge Telephone Calls. Western Journal of Nursing Research, 2014, 36, 84-104.	0.6	37
491	Transitional Care Models. Critical Care Nursing Clinics of North America, 2014, 26, 589-597.	0.4	7
492	Early readmission among patients with diabetes: A qualitative assessment of contributing factors. Journal of Diabetes and its Complications, 2014, 28, 869-873.	1.2	62
493	Restarting the Cycle: Incidence and Predictors of First Acute Care Use After Nursing Home Discharge. Journal of the American Geriatrics Society, 2014, 62, 79-85.	1.3	52
494	Effectiveness of a National Transitional Care Program in Reducing Acute Care Use. Journal of the American Geriatrics Society, 2014, 62, 747-753.	1.3	55
495	â€œMissing Piecesâ€â€”Functional, Social, and Environmental Barriers to Recovery for Vulnerable Older Adults Transitioning from Hospital to Home. Journal of the American Geriatrics Society, 2014, 62, 1556-1561.	1.3	82
496	The Association between EHRs and Care Coordination Varies by Team Cohesion. Health Services Research, 2014, 49, 438-452.	1.0	35
498	Thirtyâ€Day Hospital Readmissions in Systemic Lupus Erythematosus: Predictors and Hospitalâ€•and Stateâ€Level Variation. Arthritis and Rheumatology, 2014, 66, 2828-2836.	2.9	54
499	2014 AHA/ACC Guideline for theÂManagement of Patients With Nonâ€“ST-Elevation Acute Coronary Syndromes: Executive Summary. Journal of the American College of Cardiology, 2014, 64, 2645-2687.	1.2	424

#	Article	IF	Citations
500	Redesigning Care For Patients At Increased Hospitalization Risk: The Comprehensive Care Physician Model. Health Affairs, 2014, 33, 770-777.	2.5	61
501	American Academy of Nursing: Improving health and health care systems with advanced practice registered nurse practice in acute and critical care settings. Nursing Outlook, 2014, 62, 366-370.	1.5	1
502	Reducing Hospital Readmission Rates: Current Strategies and Future Directions. Annual Review of Medicine, 2014, 65, 471-485.	5.0	436
503	Quality care outcomes following transitional care interventions for older people from hospital to home: a systematic review. BMC Health Services Research, 2014, 14, 346.	0.9	155
504	Transitions from hospital to community care: the role of patientâ€“provider language concordance. Israel Journal of Health Policy Research, 2014, 3, 24.	1.4	15
505	Managing Posthospital Care Transitions for Older Adults. JAMA - Journal of the American Medical Association, 2014, 312, 1303.	3.8	6
506	Readmissions After Treatment of Distal Radius Fractures. Journal of Hand Surgery, 2014, 39, 1926-1932.	0.7	35
507	2014 AHA/ACC Guideline for theÂManagement of Patients WithÂNonâ€“ST-Elevation Acute Coronary Syndromes. Journal of the American College of Cardiology, 2014, 64, e139-e228.	1.2	2,746
508	Readmissions Among Children Previously Hospitalized With Pneumonia. Pediatrics, 2014, 134, 100-109.	1.0	57
509	Is Implementation of the Care Transitions Intervention Associated with Cost Avoidance After Hospital Discharge?. Journal of General Internal Medicine, 2014, 29, 878-884.	1.3	59
510	Implementation Science Workshop: Primary Care-Based Multidisciplinary Readmission Prevention Program. Journal of General Internal Medicine, 2014, 29, 798-804.	1.3	29
511	The Care Transitions Innovation (C-TraIn) for Socioeconomically Disadvantaged Adults: Results of a Cluster Randomized Controlled Trial. Journal of General Internal Medicine, 2014, 29, 1460-1467.	1.3	56
512	Neuropsychiatric Disorders and Potentially Preventable Hospitalizations in a Prospective Cohort Study of Older Americans. Journal of General Internal Medicine, 2014, 29, 1362-1371.	1.3	45
513	Decreasing Heart Failure Revisits. Current Emergency and Hospital Medicine Reports, 2014, 2, 120-125.	0.6	1
514	A remote monitoring and telephone nurse coaching intervention to reduce readmissions among patients with heart failure: study protocol for the Better Effectiveness After Transition - Heart Failure (BEAT-HF) randomized controlled trial. Trials, 2014, 15, 124.	0.7	86
515	Hospitalist Perspective on the Treatment of Skin and Soft Tissue Infections. Mayo Clinic Proceedings, 2014, 89, 1436-1451.	1.4	43
516	Measuring Pediatric Hospital Readmission RatesÂto Drive Quality Improvement. Academic Pediatrics, 2014, 14, S39-S46.	1.0	66
517	Early hospital readmission in the trauma population: Are the risk factors different?. Injury, 2014, 45, 56-60.	0.7	69

#	Article	IF	Citations
518	Improvement of pain-related self-management for cancer patients through a modular transitional nursing intervention: A cluster-randomized multicenter trial. Pain, 2014, 155, 746-754.	2.0	55
519	Reliability of hospital readmission rates in vascular surgery. Journal of Vascular Surgery, 2014, 59, 1638-1643.	0.6	30
520	The Model of Care Partner Engagement: Use in delirium management. Geriatric Nursing, 2014, 35, 272-278.	0.9	8
521	Hospital-based Quality Improvement Initiatives. Hospital Medicine Clinics, 2014, 3, e441-e456.	0.2	0
522	Hospitalization, depression and dementia in community-dwelling older Americans: findings from the National Health and Aging Trends Study. General Hospital Psychiatry, 2014, 36, 135-141.	1.2	27
524	Interventions to improve safe and effective medicines use by consumers: an overview of systematic reviews. The Cochrane Library, 2022, 2022, CD007768.	1.5	140
525	General and Vascular Surgery Readmissions: A Systematic Review. Journal of the American College of Surgeons, 2014, 219, 552-569e2.	0.2	69
526	Decreasing bariatric surgery: Readmissions with preoperative education. Surgery for Obesity and Related Diseases, 2014, 10, 387-388.	1.0	3
527	Video-Assisted Thoracic Surgery Lobectomy Cost Variability: Implications for a Bundled Payment Era. Annals of Thoracic Surgery, 2014, 97, 1686-1693.	0.7	27
528	Improving the Quality of Care and Communication During Patient Transitions: Best Practices for Urgent Care Centers. Joint Commission Journal on Quality and Patient Safety, 2014, 40, 319-324.	0.4	18
529	Reducing Avoidable Hospital Readmissions Effectively: A Statewide Campaign. Joint Commission Journal on Quality and Patient Safety, 2014, 40, 198-AP2.	0.4	9
530	Development and Sustainability of an Inpatient-to-Outpatient Discharge Handoff Tool: A Quality Improvement Project. Joint Commission Journal on Quality and Patient Safety, 2014, 40, 219-227.	0.4	15
531	Support From Hospital to Home for Elders. Annals of Internal Medicine, 2014, 161, 472.	2.0	58
532	The effectiveness of computer-based learning in hospitalized adults with heart failure on knowledge, re-admission, self-care, quality of life and patient satisfaction: a systematic review. JBI Database of Systematic Reviews and Implementation Reports, 2014, 12, 430-465.	1.7	3
533	Derivation and validation of a quality indicator for 30-day unplanned hospital readmission to evaluate trauma care. Journal of Trauma and Acute Care Surgery, 2014, 76, 1310-1316.	1.1	31
534	Collaboration between Two Restructured Hospitals' Family Physician-Led Transitional Home Care Teams in the Provision of Home Ventilation Respiratory Support. Proceedings of Singapore Healthcare, 2014, 23, 173-176.	0.2	2
535	Rates, Patterns, and Determinants of Unplanned Readmission After Traumatic Injury. Annals of Surgery, 2014, 259, 374-380.	2.1	88
536	Impact of the care coordination program â€œPartners in Dementia Careâ€•onÂveterans' hospital admissions and emergency department visits. Alzheimer's and Dementia: Translational Research and Clinical Interventions, 2015, 1, 13-22.	1.8	28

#	Article	IF	Citations
537	Re-admission after gastro-intestinal surgery. Journal of Visceral Surgery, 2015, 152, S97-S104.	0.4	3
538	Effectiveness of community-based integrated care in frail COPD patients: a randomised controlled trial. Npj Primary Care Respiratory Medicine, 2015, 25, 15022.	1.1	53
539	TransitionRx: Impact of community pharmacy postdischarge medication therapy management on hospital readmission rate. Journal of the American Pharmacists Association: JAPhA, 2015, 55, 246-254.	0.7	76
540	Pharmacy transitions of care services in Wisconsin. Journal of the American Pharmacists Association: JAPhA, 2015, 55, 468-469.	0.7	0
541	Preventing Chronic Pain: A Human Systems Approachâ€"Results from a Massive Open Online Course. Global Advances in Health and Medicine, 2015, 4, 23-32.	0.7	28
542	Readmission Patterns and Effectiveness of Transitional Care Among Medicaid Patients With Schizophrenia and Medical Comorbidity. North Carolina Medical Journal, 2015, 76, 219-226.	0.1	9
544	Depression and risk of hospitalisations and rehospitalisations for ambulatory care-sensitive conditions in Denmark: a population-based cohort study. BMJ Open, 2015, 5, e009878.	0.8	27
545	Role of context in care transition interventions for medically complex older adults: a realist synthesis protocol. BMJ Open, 2015, 5, e008686.	0.8	9
546	Transitions of care and long-term surveillance after vascular surgery. Seminars in Vascular Surgery, 2015, 28, 134-140.	1.1	5
547	Integrating new practices: a qualitative study of how hospital innovations become routine. Implementation Science, 2015, 10, 168.	2.5	54
548	Seniors managing multiple medications: using mixed methods to view the home care safety lens. BMC Health Services Research, 2015, 15, 548.	0.9	30
549	Impact of an innovative inpatient patient navigator program on length of stay and 30â€day readmission. Journal of Hospital Medicine, 2015, 10, 799-803.	0.7	19
550	The work of case managers as experienced by older persons (75+) with multi-morbidity â€“ a focused ethnography. BMC Geriatrics, 2015, 15, 168.	1.1	15
551	A Virtual Ward for Home Hemodialysis Patients â€“ A Pilot Trial. Canadian Journal of Kidney Health and Disease, 2015, 2, 72.	0.6	10
552	Improving transitional patient safety: research protocol of the Transitional Incident Prevention Programme. Safety in Health, 2015, 1, .	0.7	6
553	A Patient-Centered Transitions Framework for Persons With Complex Chronic Conditions. Care Management Journals: Journal of Case Management ; the Journal of Long Term Home Health Care, 2015, 16, 159-169.	0.5	3
554	Elder Self-Neglect Is Associated with an Increased Rate of 30-Day Hospital Readmission: Findings from the Chicago Health and Aging Project. Gerontology, 2015, 61, 41-50.	1.4	42
555	Promising Practices for Achieving Patient-centered Hospital Care. Medical Care, 2015, 53, 758-767.	1.1	43

#	Article	IF	Citations
556	Leveraging Resources to Improve Clinical Outcomes and Teach Transitional Care Through Development of Academic-Clinical Partnerships. Nurse Educator, 2015, 40, 303-307.	0.6	12
557	Integrating Health Information Technology to Achieve Seamless Care Transitions. Journal of Patient Safety, 2015, 11, 185-190.	0.7	18
558	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
559	An evaluation of physician predictions of discharge on a general medicine service. Journal of Hospital Medicine, 2015, 10, 808-810.	0.7	10
560	A Model Program of Communityâ€Based Supports for Older Adults at Risk of Nursing Facility Placement. Journal of the American Geriatrics Society, 2015, 63, 2601-2609.	1.3	5
561	The Enthusiasm: Evidence Ratio for Comprehensive Chronic Disease Care?. Journal of the American Geriatrics Society, 2015, 63, 1940-1943.	1.3	6
562	Can Large Database Studies Help Us Decrease Readmissions After Colorectal Surgery?. Diseases of the Colon and Rectum, 2015, 58, 1121-1122.	0.7	3
563	Care transitions in a changing healthcare environment. JAAPA: Official Journal of the American Academy of Physician Assistants, 2015, 28, 29-35.	0.1	1
564	Implementation of a Bag Medication Reconciliation Initiative to Decrease Posthospitalization Medication Discrepancies. Journal of Nursing Care Quality, 2015, 30, 220-225.	0.5	2
565	Title III: Improving the Quality and Efficiency of Health Care. , 0, , 167-189.		0
566	Are we teaching our hospitalized patients self-management skills? Opportunities lost. Journal of Hospital Administration, 2015, 4, 30.	0.0	2
567	Improving Post-Hospitalization Transition Outcomes through Accessible Health Information Technology and Caregiver Support: Protocol for a Randomized Controlled Trial. Journal of Clinical Trials, 2015, 05, .	0.1	3
568	Exploring older adults’ perceptions of a patient-centered education manual for hip fracture recovery: “everything in one place”. Patient Preference and Adherence, 2015, 9, 1637.	0.8	4
569	Transitional Care for Older Adults with Chronic Illnesses as a Vulnerable Population: Theoretical Framework and Future Directions in Nursing. Journal of Korean Academy of Nursing, 2015, 45, 919.	0.3	9
570	Pharmacy-Initiated Transitions of Care Services: An Opportunity to Impact Patient Satisfaction. Hospital Pharmacy, 2015, 50, 911-917.	0.4	5
571	Evaluation of a Pharmacist-Specific Intervention on 30-Day Readmission Rates for High-Risk Patients with Pneumonia. Hospital Pharmacy, 2015, 50, 700-709.	0.4	10
572	Timing of Discharge Follow-up for Acute Pulmonary Embolism: Retrospective Cohort Study. Western Journal of Emergency Medicine, 2015, 16, 55-61.	0.6	17
573	The Need for Preventing Chronic Pain: The â€œBig Elephant in the roomâ€•of Healthcare. Global Advances in Health and Medicine, 2015, 4, 6-7.	0.7	15

#	Article	IF	Citations
574	Reasons for 30-day Postoperative Readmissions for Medicare Patients at a Community-based Teaching Hospital. American Surgeon, 2015, 81, 381-386.	0.4	2
575	Bridging the gap between acute and postacute care. Nursing Management, 2015, 46, 8-10.	0.2	0
576	The Association of Acute Kidney Injury in the Critically Ill and Postdischarge Outcomes. Critical Care Medicine, 2015, 43, 354-364.	0.4	81
577	Chronic Illness Trends and the Challenges to Family Caregivers. , 2015, , 79-103.		6
578	Reducing COPD Readmissions. Chest, 2015, 147, 1199-1201.	0.4	16
579	The role of intervening hospital admissions on trajectories of disability in the last year of life: prospective cohort study of older people. BMJ, The, 2015, 350, h2361-h2361.	3.0	84
580	Clinical Effectiveness of Integrating Depression Care Management Into Medicare Home Health. JAMA Internal Medicine, 2015, 175, 55.	2.6	45
581	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, 2015, 34, 185-203.	0.3	22
582	The Affordable Care Act, Accountable Care Organizations, and Mental Health Care for Older Adults. Harvard Review of Psychiatry, 2015, 23, 304-319.	0.9	31
583	Family meetings for older adults in intermediate care settings: the impact of patient cognitive impairment and other characteristics on shared decision making. Health Expectations, 2015, 18, 1030-1040.	1.1	29
584	Does Transitional Care Prevent Older Adults from Rehospitalization? A Review. Journal of Evidence-informed Social Work, 2015, 12, 261-271.	0.8	19
585	Understanding and Improving Older People's Experiences of Service Transitions: Implications for Social Work. British Journal of Social Work, 2015, 45, 2056-2071.	0.9	13
586	The Family Perspective on Hospital to Home Transitions: A Qualitative Study. Pediatrics, 2015, 136, e1539-e1549.	1.0	88
587	Quantifying care coordination using natural language processing and domain-specific ontology. Journal of the American Medical Informatics Association: JAMIA, 2015, 22, e93-e103.	2.2	32
588	Patient Safety Coalition. Critical Care Nursing Clinics of North America, 2015, 27, 523-535.	0.4	2
589	Nursing discharge planning for older medical inpatients in Switzerland: A cross-sectional study. Geriatric Nursing, 2015, 36, 451-457.	0.9	20
590	Transitional Care Strategies From Hospital to Home. Neurohospitalist, The, 2015, 5, 35-42.	0.3	62
591	Geriatric Syndromes and Geriatric Assessment for the Generalist. Medical Clinics of North America, 2015, 99, 263-279.	1.1	57

#	Article	IF	Citations
592	Trajectories of risk after hospitalization for heart failure, acute myocardial infarction, or pneumonia: retrospective cohort study. BMJ, The, 2015, 350, h411-h411.	3.0	158
593	Tackling the growing diabetes burden in Sub-Saharan Africa: A framework for enhancing outcomes in stroke patients. Journal of the Neurological Sciences, 2015, 348, 136-141.	0.3	12
594	Transitions of Care in Heart Failure. Circulation: Heart Failure, 2015, 8, 384-409.	1.6	206
595	Hospital readmission after hip fracture. Archives of Orthopaedic and Trauma Surgery, 2015, 135, 329-337.	1.3	72
596	Association of hospital volume with readmission rates: a retrospective cross-sectional study. BMJ, The, 2015, 350, h447-h447.	3.0	49
597	Understanding the occupational and organizational boundaries to safe hospital discharge. Journal of Health Services Research and Policy, 2015, 20, 35-44.	0.8	55
598	Utilization of Acute Care among Patients with ESRD Discharged Home from Skilled Nursing Facilities. Clinical Journal of the American Society of Nephrology: CJASN, 2015, 10, 428-434.	2.2	23
599	Potentials of Internet-Based Patient Engagement and Education Programs to Reduce Hospital Readmissions. Nursing Clinics of North America, 2015, 50, 283-291.	0.7	4
600	Care Transitions Intervention and Other Non-nursing Home Transitions Models. , 2015, , 97-114.		1
601	The changing roles of registered nurses in Pioneer Accountable Care Organizations. Nursing Outlook, 2015, 63, 554-565.	1.5	21
602	A Role for Social Workers in Improving Care Setting Transitions: A Case Study. Social Work in Health Care, 2015, 54, 177-192.	0.8	24
603	Why Do Patients Keep Coming Back? Results of a Readmitted Patient Survey. Social Work in Health Care, 2015, 54, 1-15.	0.8	41
604	Predictors of surgical site infection after hospital discharge in patients undergoing major vascular surgery. Journal of Vascular Surgery, 2015, 62, 1023-1031.e5.	0.6	82
605	Team-Based Transitions of Care in Heart Failure. Heart Failure Clinics, 2015, 11, 371-378.	1.0	9
606	â€œAs Neededâ€•Case Management Across Aging Services in Response to Depression. Journal of Gerontological Social Work, 2015, 58, 272-288.	0.6	3
607	Hospital Readmission Rates and Emergency Department Visits for Mental Health and Substance Abuse Conditions. Community Mental Health Journal, 2015, 51, 190-197.	1.1	64
608	Hospital Strategy Uptake and Reductions in Unplanned Readmission Rates for Patients with Heart Failure: A Prospective Study. Journal of General Internal Medicine, 2015, 30, 605-611.	1.3	38
609	Association of Early Post-Discharge Follow-Up by a Primary Care Physician and 30-Day Rehospitalization Among Older Adults. Journal of General Internal Medicine, 2015, 30, 565-571.	1.3	53

#	Article	IF	Citations
610	A Patient Navigator Intervention to Reduce Hospital Readmissions among High-Risk Safety-Net Patients: A Randomized Controlled Trial. Journal of General Internal Medicine, 2015, 30, 907-915.	1.3	99
611	Hospital Readmission of Patients with Diabetes. Current Diabetes Reports, 2015, 15, 17.	1.7	112
612	Effectiveness of a transitional home care program in reducing acute hospital utilization: a quasi-experimental study. BMC Health Services Research, 2015, 15, 100.	0.9	49
613	The Community In-Reach and Care Transition (CIRACT) clinical and cost-effectiveness study: study protocol for a randomised controlled trial. Trials, 2015, 16, 41.	0.7	3
614	Experiences of Older Adults in Transition from Hospital to Community. Canadian Journal on Aging, 2015, 34, 90-99.	0.6	58
615	Personalised care planning for adults with chronic or long-term health conditions. The Cochrane Library, 2015, , CD010523.	1.5	329
616	Understanding Why Patients With COPD Get Readmitted. Chest, 2015, 147, 1219-1226.	0.4	179
617	Predischarge Bundle for Patients With Acute Exacerbations of COPD to Reduce Readmissions and ED Visits. Chest, 2015, 147, 1227-1234.	0.4	78
618	Thirty-day readmission rates after PCI in a metropolitan center in Europe. Journal of Cardiovascular Medicine, 2015, 16, 238-245.	0.6	31
619	Predicting 30-Day Readmissions With Preadmission Electronic Health Record Data. Medical Care, 2015, 53, 283-289.	1.1	101
620	Implementing a Transitional Care Program to Reduce Hospital Readmissions Among Older Adults. Journal of Nursing Care Quality, 2015, 30, 121-129.	0.5	10
621	Using Human Factors and Systems Engineering to Evaluate Readmission after Complex Surgery. Journal of the American College of Surgeons, 2015, 221, 810-820.	0.2	34
622	Effects of a Psychosocial Transitional Care Model on Hospitalizations and Cost of Care for High Utilizers. Social Work in Health Care, 2015, 54, 485-498.	0.8	23
623	Interprofessional Communication Patterns During Patient Discharges: A Social Network Analysis. Journal of General Internal Medicine, 2015, 30, 1299-1306.	1.3	18
624	RÃ©admission aprÃ¨s chirurgie digestive. Journal De Chirurgie ViscÃ©rale, 2015, 152, S42-S49.	0.0	0
625	Staying Home After Discharge: Nurse-Led Versus Physician-Led Transitional Care Models. Nurse Leader, 2015, 13, 66-65.	0.4	0
626	Financial Implications of Hospital Readmission After Hip Fracture. Geriatric Orthopaedic Surgery and Rehabilitation, 2015, 6, 140-146.	0.6	33
627	A complex transition: lessons learned as three young adults with complex care needs transition from an inpatient paediatric hospital to adult community residences. Child: Care, Health and Development, 2015, 41, 397-407.	0.8	12

#	Article	IF	Citations
628	A conceptual framework for evaluating the conceptualization, implementation and performance of transitional care programmes. Journal of Evaluation in Clinical Practice, 2015, 21, 221-228.	0.9	16
629	The Role of Intervening Illnesses and Injuries in Prolonging the Disabling Process. Journal of the American Geriatrics Society, 2015, 63, 447-452.	1.3	7
630	Pediatric solid organ transplant recipients: Transition to home and chronic illness care. Pediatric Transplantation, 2015, 19, 118-129.	0.5	54
631	STAAR: improving the reliability of care coordination and reducing hospital readmissions in an academic medical centre. BMJ Innovations, 2015, 1, 75-80.	1.0	17
632	The Effect of a Care Transition Intervention on the Patient Experience of Older Multi-Lingual Adults in the Safety Net: Results of a Randomized Controlled Trial. Journal of General Internal Medicine, 2015, 30, 1788-1794.	1.3	31
633	Reducing hospital readmissions in patients with end-stage kidney disease. Kidney International, 2015, 88, 1250-1260.	2.6	49
634	Functional Impairment and Hospital Readmission in Medicare Seniors. JAMA Internal Medicine, 2015, 175, 559.	2.6	224
635	Conflicting Readmission Rate Trends in a High-Risk Population: Implications for Performance Measurement. Population Health Management, 2015, 18, 351-357.	0.8	3
636	Achieving patientâ€centred care: the potential and challenge of the patientâ€asâ€professional role. Health Expectations, 2015, 18, 2616-2628.	1.1	34
637	Hospice Enrollment, Local Hospice Utilization Patterns, and Rehospitalization in Medicare Patients. Journal of Palliative Medicine, 2015, 18, 601-612.	0.6	15
638	Systematic review of planned care transitions for persons with dementia. Neurodegenerative Disease Management, 2015, 5, 317-331.	1.2	23
639	Rethinking Hospital-Associated Deconditioning: Proposed Paradigm Shift. Physical Therapy, 2015, 95, 1307-1315.	1.1	93
641	The Effectiveness of Family-Centered Transition Processes From Hospital Settings to Home: A Review of the Literature. Hospital Pediatrics, 2015, 5, 219-231.	0.6	51
642	Summary of STARNet: Seamless Transitions and (Re)admissions Network. Pediatrics, 2015, 135, 164-175.	1.0	59
643	Hospital to community transitional care by nurse practitioners: A systematic review of cost-effectiveness. International Journal of Nursing Studies, 2015, 52, 436-451.	2.5	47
644	Evaluation of a High-Risk Case Management Pilot Program for Medicare Beneficiaries with Medigap Coverage. Population Health Management, 2015, 18, 93-103.	0.8	17
645	Utilizing information technology to improve transition of care from hospital to home. Journal of Nursing Education and Practice, 2016, 6, .	0.1	2
646	What Factors Predict Hospital Readmission after Colorectal Surgery?. American Surgeon, 2016, 82, 433-438.	0.4	11

#	Article	IF	Citations
647	Hospital Readmission after Post-acute Care at Different Settings: Estimation using the Propensity Score Matching Method. , 2016, 06, .		0
648	Use of motivational and educational techniques in behavioral health patients to impact self-care and emergency department visit rates. Journal of Nursing Education and Practice, 2016, 6, .	0.1	1
649	Development and Validation of a Novel Tool to Predict Hospital Readmission Risk Among Patients with Diabetes. Endocrine Practice, 2016, 22, 1204-1215.	1.1	50
650	Enhancing informal patient education in nursing practice: A review of literature. Journal of Nursing Education and Practice, 2016, 7, .	0.1	3
651	Clinical pharmacist-led program on medication reconciliation implementation at hospital admission: experience of a single university hospital in Croatia. Croatian Medical Journal, 2016, 57, 572-581.	0.2	21
652	Reducing Hospital Re-Admissions in Patients with Diabetes: Developing Better Strategies. Endocrine Practice, 2016, 22, 1134-1136.	1.1	3
653	The Community In-reach Rehabilitation and Care Transition (CIRACT) clinical and cost-effectiveness randomisation controlled trial in older people admitted to hospital as an acute medical emergency. Age and Ageing, 2016, 46, 26-32.	0.7	15
654	Coordination at the Point of Need. , 2016, , 81-100.		6
655	Factors associated with emergency department visit within 30 days after discharge. BMC Health Services Research, 2016, 16, 190.	0.9	10
656	Patterns of community follow-up, subsequent health service use and survival among young and mid-life adults discharged from chronic care hospitals: a retrospective cohort study. BMC Health Services Research, 2016, 16, 382.	0.9	0
657	Using Telehealth to Reduce All-Cause 30-Day Hospital Readmissions among Heart Failure Patients Receiving Skilled Home Health Services. Applied Clinical Informatics, 2016, 07, 238-247.	0.8	56
659	Engaging Patients and Caregivers to Design Transitional Care Management Services at a Minority Serving Institution. Journal of Health Care for the Poor and Underserved, 2016, 27, 352-365.	0.4	13
660	Innovations in Long-Term Care. , 2016, , 419-439.		14
661	What Works in Readmissions Reduction. Medical Care, 2016, 54, 600-607.	1.1	44
662	Coordinating Care. Nursing Administration Quarterly, 2016, 40, 122-129.	0.9	0
664	Admission Data Predict High Hospital Readmission Risk. Journal of the American Board of Family Medicine, 2016, 29, 50-59.	0.8	29
665	Variability in Implementation of Interventions Aimed at Reducing Readmissions Among Patients With Heart Failure. Academic Medicine, 2016, 91, 522-529.	0.8	14
666	From discharge to readmission: Understanding the process from the patient perspective. Journal of Hospital Medicine, 2016, 11, 407-412.	0.7	55

#	Article	IF	Citations
667	A framework for the frontline: How hospitalists can improve healthcare value. Journal of Hospital Medicine, 2016, 11, 297-302.	0.7	10
668	So many options, where do we start? An overview of the care transitions literature. Journal of Hospital Medicine, 2016, 11, 221-230.	0.7	62
669	Thirtyâ€day hospital readmissions for adults with and without <scp>HIV</scp> infection. HIV Medicine, 2016, 17, 167-177.	1.0	26
670	Incremental Benefit of a Home Visit Following Discharge for Patients with Multiple Chronic Conditions Receiving Transitional Care. Population Health Management, 2016, 19, 163-170.	0.8	25
671	Hospital Revisits Within 30 Days After Conventional and Robotically Assisted Hysterectomy. Medical Care, 2016, 54, 311-318.	1.1	6
672	Hepatic encephalopathy for the hospitalist. Journal of Hospital Medicine, 2016, 11, 591-594.	0.7	0
673	Not ready, not setâ€¦discharge: Patientâ€reported barriers to discharge readiness at an academic medical center. Journal of Hospital Medicine, 2016, 11, 610-614.	0.7	27
674	Transitional care interventions and hospital readmissions in surgical populations: a systematic review. American Journal of Surgery, 2016, 212, 327-335.	0.9	51
675	Identifying Care Coordination Interventions Provided to Community-Dwelling Older Adults Using Electronic Health Records. CIN - Computers Informatics Nursing, 2016, 34, 303-311.	0.3	4
676	Patient engagement in clinical communication: an exploratory study. Scandinavian Journal of Caring Sciences, 2016, 30, 565-573.	1.0	22
677	Reducing Pediatric Readmissions. Journal of Nursing Care Quality, 2016, 31, 224-232.	0.5	33
678	Association of 30-Day Readmission MetricÂfor Heart Failure Under the HospitalÂReadmissions Reduction ProgramÂWith Quality of Care andÂOutcomes. JACC: Heart Failure, 2016, 4, 935-946.	1.9	68
679	Insights Into Roles for Health-Care Professionals in Meeting the Needs of Older Adults and Unpaid Caregivers During Health-Care Transitions. Canadian Journal of Nursing Research, 2016, 48, 70-79.	0.6	5
680	A framework for administrative claim data to explore healthcare coordination and collaboration. Australian Health Review, 2016, 40, 500.	0.5	18
681	Perspectives: answering questions about quality improvement: suggestions for investigators. International Journal for Quality in Health Care, 2017, 29, 137-142.	0.9	6
682	Community-based long-term care for the elderly. , 2016, , 651-658.		0
683	Effectiveness of nursing discharge planning interventions on health-related outcomes in discharged elderly inpatients. JBI Database of Systematic Reviews and Implementation Reports, 2016, 14, 217-260.	1.7	21
684	Understanding Patient, Provider, and System Factors Related to Medicaid Readmissions. Joint Commission Journal on Quality and Patient Safety, 2016, 42, 115-121.	0.4	30

#	Article	IF	Citations
685	Rehabilitation Practitioners' Prioritized Care Processes in Hip Fracture Post-Acute Care. Physical and Occupational Therapy in Geriatrics, 2016, 34, 155-168.	0.2	1
686	Unplanned 30-day readmissions in orthopaedic trauma. Injury, 2016, 47, 1794-1797.	0.7	21
687	Comprehensive Strategies to Reduce Readmissions in Older Patients With Cardiovascular Disease. Canadian Journal of Cardiology, 2016, 32, 1306-1314.	0.8	12
688	Characteristics of Hospital and Emergency Care Super-utilizers with Multiple Chronic Conditions. Journal of Emergency Medicine, 2016, 50, e203-e214.	0.3	41
689	Early geriatric follow-up after discharge reduces readmissions â€“ A quasi-randomised controlled trial. European Geriatric Medicine, 2016, 7, 443-448.	1.2	26
690	A comparison study between two discharge planning tools. Applied Nursing Research, 2016, 32, 52-60.	1.0	3
691	Medication Adherence: Truth and Consequences. American Journal of the Medical Sciences, 2016, 351, 387-399.	0.4	250
692	Unmet Nursing Care Linked to Rehospitalizations Among Older Black AMI Patients. Medical Care, 2016, 54, 457-465.	1.1	21
693	Better health, less spending: Redesigning the transition from pediatric to adult healthcare for youth with chronic illness. Healthcare, 2016, 4, 57-68.	0.6	35
694	How Avoidable are Hospitalizations for Children With Medical Complexity? Understanding Parent Perspectives. Academic Pediatrics, 2016, 16, 579-586.	1.0	40
695	Quasi-Experimental Evaluation of the Effectiveness of a Large-Scale Readmission Reduction Program. JAMA Internal Medicine, 2016, 176, 681.	2.6	30
696	Readmission after major surgery: effect of the postdischarge environment. Journal of Surgical Research, 2016, 205, 318-326.	0.8	7
697	Interprofessional Collaboration to Improve Discharge from Skilled Nursing Facility to Home: Preliminary Data on Postdischarge Hospitalizations and Emergency Department Visits. Journal of the American Geriatrics Society, 2016, 64, 1895-1899.	1.3	24
698	Intensive care unit admission predicts hospital readmission in pediatric trauma. Journal of Surgical Research, 2016, 205, 456-463.	0.8	7
699	Inpatient Walking Activity to Predict Readmission in Older Adults. Archives of Physical Medicine and Rehabilitation, 2016, 97, S226-S231.	0.5	67
700	Quality Measures to Assess Care Transitions for Hospitalized Children. Pediatrics, 2016, 138, e20160906.	1.0	38
701	Predictors of 30-day readmission after aneurysmal subarachnoid hemorrhage: a case-control study. Journal of Neurosurgery, 2016, 126, 1847-1854.	0.9	10
702	For Hospital Readmissions, Hindsight is Not 20/20. Journal of General Internal Medicine, 2016, 31, 1270-1271.	1.3	0

#	Article	IF	Citations
703	Personâ€Centered Care for Older Adults with Chronic Conditions and Functional Impairment: A Systematic Literature Review. Journal of the American Geriatrics Society, 2016, 64, e1-7.	1.3	249
704	The Current Landscape of Transitions of Care Practice Models: A Scoping Review. Pharmacotherapy, 2016, 36, 117-133.	1.2	45
705	Changes in Payment Regulation and Acute Care Use for Total Hip Replacement: Trends in Length of Stay, Costs, and Discharge, 1997â€“2012. Rehabilitation Nursing, 2016, 41, 67-77.	0.3	7
706	Evidence Summary and Recommendations for Improved Communication during Care Transitions. Rehabilitation Nursing, 2016, 41, 135-148.	0.3	12
707	Engaging patients and families in communication across transitions ofÂcare: an integrative review protocol. Journal of Advanced Nursing, 2016, 72, 1689-1700.	1.5	19
708	Diagnosis and Disruption: Populationâ€Level Analysis Identifying Points of Care at Which Transitions Are Highest for People with Dementia and Factors That Contribute to Them. Journal of the American Geriatrics Society, 2016, 64, 569-577.	1.3	18
709	Evaluation of prediction strategy and care coordination for COPD readmissions. Hospital Practice (1995), 2016, 44, 123-128.	0.5	17
710	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
711	Mainstream or Extinction: Can Defining Who We Are Save Geriatrics?. Journal of the American Geriatrics Society, 2016, 64, 1400-1404.	1.3	77
712	Lessons From a Care Management Pilot Program for People With Acquired Brain Injury. Journal for Healthcare Quality: Official Publication of the National Association for Healthcare Quality, 2016, 38, 255-263.	0.3	2
713	Patientâ€centered support in the survivorship care transition: Outcomes from the Patientâ€Owned Survivorship Care Plan Intervention. Cancer, 2016, 122, 3232-3242.	2.0	76
714	The E-Coach technology-assisted care transition system: a pragmatic randomized trial. Translational Behavioral Medicine, 2016, 6, 428-437.	1.2	58
715	Drug therapy problems and medication discrepancies during care transitions in super-utilizers. Journal of the American Pharmacists Association: JAPhA, 2016, 56, 633-642.e1.	0.7	27
716	Post-Discharge Treatment Engagement Among Patients with an Opioid-Use Disorder. Journal of Substance Abuse Treatment, 2016, 69, 64-71.	1.5	69
717	Clinical Update on Nursing Home Medicine: 2016. Journal of the American Medical Directors Association, 2016, 17, 978-993.	1.2	9
718	A literature review of preventable hospital readmissions: Preceding the Readmissions Reduction Act. IIE Transactions on Healthcare Systems Engineering, 2016, 6, 193-211.	0.8	7
719	Using a complex adaptive system lens to understand family caregiving experiences navigating the stroke rehabilitation system. BMC Health Services Research, 2016, 16, 538.	0.9	25
720	Unrecognized Cognitive Impairment and Its Effect on Heart Failure Readmissions of Elderly Adults. Journal of the American Geriatrics Society, 2016, 64, 2296-2301.	1.3	57

#	Article	IF	Citations
721	The impact of transitional care programs on health services utilization among community-dwelling older adults and their caregivers. JBI Database of Systematic Reviews and Implementation Reports, 2016, 14, 26-34.	1.7	0
722	Prevention of hospital-acquired thrombosis from a primary care perspective: a qualitative study. British Journal of General Practice, 2016, 66, e593-e602.	0.7	3
723	Effectiveness of discharge interventions from hospital to home on hospital readmissions: a systematic review. JBI Database of Systematic Reviews and Implementation Reports, 2016, 14, 106-173.	1.7	98
724	Improving Care Transitions Across Healthcare Settings Through a Human Factors Approach. Journal for Healthcare Quality: Official Publication of the National Association for Healthcare Quality, 2016, 38, 328-343.	0.3	19
725	A qualitative study of professional and carer perceptions of the threats to safe hospital discharge for stroke and hip fracture patients in the English National Health Service. BMC Health Services Research, 2016, 16, 297.	0.9	25
726	Aiming to Improve Readmissions Through InteGrated Hospital Transitions (AIRTIGHT): study protocol for a randomized controlled trial. Trials, 2016, 17, 603.	0.7	3
728	Bridging the Gap. Journal of Ambulatory Care Management, 2016, 39, 209-219.	0.5	3
729	Testing a postâ€discharge nurseâ€led transitional home visit in acute care pediatrics: the Hospitalâ€Toâ€Home Outcomes (H2O) study protocol. Journal of Advanced Nursing, 2016, 72, 915-925.	1.5	18
730	Analysis of a Social Workâ€"Based Model of Transitional Care to Reduce Hospital Readmissions: Preliminary Data. Journal of the American Geriatrics Society, 2016, 64, 1104-1107.	1.3	24
731	Impact of a transition nurse program on the prevention of thirty-day hospital readmissions of elderly patients discharged from short-stay units: study protocol of the PROUST stepped-wedge cluster randomised trial. BMC Geriatrics, 2016, 16, 57.	1.1	21
732	Provider-to-Provider Communication during Transitions of Care from Outpatient to Acute Care: A Systematic Review. Journal of General Internal Medicine, 2016, 31, 417-425.	1.3	27
733	Implementation Science Workshop: a Novel Multidisciplinary Primary Care Program to Improve Care and Outcomes for Super-Utilizers. Journal of General Internal Medicine, 2016, 31, 797-802.	1.3	13
734	Pharmacist-Provided Medication Management in Interdisciplinary Transitions in a Community Hospital (PMIT). Annals of Pharmacotherapy, 2016, 50, 649-655.	0.9	17
735	Predicting Patients at Risk for 3-Day Postdischarge Readmissions, ED Visits, and Deaths. Medical Care, 2016, 54, 1017-1023.	1.1	7
736	Examining the impact of comorbid serious mental illness on rehospitalization among medical and surgical inpatients. General Hospital Psychiatry, 2016, 42, 36-40.	1.2	34
737	The Integrated Comprehensive Care Program: A Novel Home Care Initiative After Major Thoracic Surgery. Seminars in Thoracic and Cardiovascular Surgery, 2016, 28, 574-582.	0.4	13
738	Timely Post-discharge Telephone Follow-Up is a Useful Tool in Identifying Post-discharge Complications Patients After Congenital Heart Surgery. Pediatric Cardiology, 2016, 37, 1106-1110.	0.6	19
739	Handover between home and respite care concerning people with dementia: An online survey. Zeitschrift Fur Evidenz, Fortbildung Und Qualitat Im Gesundheitswesen, 2016, 112, 27-35.	0.7	0

#	Article	IF	Citations
740	Meeting the challenge of COPD care delivery in the USA: a multiprovider perspective. Lancet Respiratory Medicine,the, 2016, 4, 473-526.	5.2	80
741	Short-term and long-term effectiveness of a post-hospital care transitions program in an older, medically complex population. Healthcare, 2016, 4, 30-35.	0.6	29
742	Impact of an Enhanced Transition Process on Patient Readiness for Discharge. American Journal of Medical Quality, 2016, 31, 604-605.	0.2	1
743	Project ACHIEVE â€“ using implementation research to guide the evaluation of transitional care effectiveness. BMC Health Services Research, 2016, 16, 70.	0.9	27
744	Care coordination gaps due to lack of interoperability in the United States: a qualitative study and literature review. BMC Health Services Research, 2016, 16, 143.	0.9	75
745	Effects of a transitional palliative care model on patients with end-stage heart failure: study protocol for a randomized controlled trial. Trials, 2016, 17, 173.	0.7	9
746	Social workers as care coordinators: Leaders in ensuring effective, compassionate care. Social Work in Health Care, 2016, 55, 195-213.	0.8	8
747	Transitions From Hospitals to Skilled Nursing Facilities for Persons With Dementia: A Challenging Convergence of Patient and System-Level Needs. Gerontologist, The, 2017, 57, gnw085.	2.3	36
748	The Social Work Role in Reducing 30-Day Readmissions: The Effectiveness of the Bridge Model of Transitional Care. Journal of Gerontological Social Work, 2016, 59, 222-227.	0.6	28
749	Reducing suicidal ideation in home health care: results from the CAREPATH depression care management trial. International Journal of Geriatric Psychiatry, 2016, 31, 708-715.	1.3	18
750	Harnessing Protocolized Adaptation in Dissemination: Successful Implementation and Sustainment of the Veterans Affairs Coordinatedâ€Transitional Care Program in a Nonâ€Veterans Affairs Hospital. Journal of the American Geriatrics Society, 2016, 64, 409-416.	1.3	52
751	Pain and Satisfaction With Pain Management Among Older Patients During the Transition From Acute to Skilled Nursing Care. Gerontologist, The, 2016, 56, 1138-1145.	2.3	17
752	Polypharmacyâ€”Time to Get Beyond Numbers. JAMA Internal Medicine, 2016, 176, 482.	2.6	52
753	A Perfect Storm: Care Transitions for Vulnerable Older Adults Discharged Home From the Emergency Department Without a Hospital Admission. Gerontologist, The, 2016, 56, 326-334.	2.3	16
754	Patient perspective on care transitions after colorectal surgery. Journal of Surgical Research, 2016, 203, 103-112.	0.8	9
755	Developing an instrument to selfâ€evaluate the Discharge Planning of Ward Nurses. Nursing Open, 2016, 3, 30-40.	1.1	10
756	Comprehensive Geriatric Assessment and Transitional Care in Acutely Hospitalized Patients. JAMA Internal Medicine, 2016, 176, 302.	2.6	69
757	Diminished Cognitive Function Among Chronic Obstructive Pulmonary Disease Patients During Periods of Acute Illness Exacerbation: Table 1.. Journals of Gerontology - Series A Biological Sciences and Medical Sciences, 2016, 71, 279-280.	1.7	1

#	Article	IF	Citations
758	Effectiveness of Remote Patient Monitoring After Discharge of Hospitalized Patients With Heart Failure. JAMA Internal Medicine, 2016, 176, 310.	2.6	528
759	Unhealthy alcohol use in older adults: Association with readmissions and emergency department use in the 30 days after hospital discharge. Drug and Alcohol Dependence, 2016, 158, 94-101.	1.6	20
760	A systematic review of transitional-care strategies to reduce rehospitalization in patients with heart failure. Heart and Lung: Journal of Acute and Critical Care, 2016, 45, 100-113.	0.8	76
761	Hospital Readmissions Reduction Program: An Economic and Operational Analysis. Management Science, 2016, 62, 3351-3371.	2.4	72
762	Causes of hospital readmissions after urologic cancer surgery. Urologic Oncology: Seminars and Original Investigations, 2016, 34, 236.e1-236.e11.	0.8	36
763	SafeMed: Using pharmacy technicians in a novel role as community health workers to improve transitions of care. Journal of the American Pharmacists Association: JAPhA, 2016, 56, 73-81.	0.7	41
764	Effect of Pharmacist Counseling Intervention on Health Care Utilization Following Hospital Discharge: A Randomized Control Trial. Journal of General Internal Medicine, 2016, 31, 470-477.	1.3	58
765	When patients call their surgeon's office: an opportunity to improve the quality of surgical care and prevent readmissions. American Journal of Surgery, 2016, 211, 599-604.	0.9	9
766	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
767	Tackling 30-Day, All-Cause Readmissions with a Patient-Centered Transitional Care Bundle. Population Health Management, 2016, 19, 56-62.	0.8	20
768	30-Day readmission after bariatric surgery in a publicly funded regionalized center of excellence system. Surgical Endoscopy and Other Interventional Techniques, 2016, 30, 2066-2072.	1.3	27
769	Analysis of Causes and Risk Factors for Hospital Readmission After Roux-en-Y Gastric Bypass. Obesity Surgery, 2016, 26, 257-260.	1.1	16
770	The cost of hospital readmissions: evidence from the VA. Health Care Management Science, 2016, 19, 241-248.	1.5	24
771	Systematic Review of Ambulatory Transitional Care Management (TCM) Visits on Hospital 30-Day Readmission Rates. American Journal of Medical Quality, 2017, 32, 19-26.	0.2	12
772	The Contribution of Skilled Nursing Facilities to Hospitalsâ€™ Readmission Rate. Health Services Research, 2017, 52, 656-675.	1.0	35
773	The volunteer's dilemma and alternate solutions for ensuring responsibility within accountable care organizations. Engineering Economist, 2017, 62, 146-160.	0.3	0
774	Postacute Care and Recovery After Cancer Surgery. Annals of Surgery, 2017, 265, 993-999.	2.1	8
775	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

#	Article	IF	Citations
776	Strategies to Reduce Hospitalizations of Children With Medical Complexity Through Complex Care: Expert Perspectives. Academic Pediatrics, 2017, 17, 381-388.	1.0	37
777	Working in silos? â€“ Head & Neck cancer patients during and after treatment with or without early palliative care referral. European Journal of Oncology Nursing, 2017, 26, 56-62.	0.9	15
778	Predictors of 30-day hospital readmission after hip fracture: a systematic review. Injury, 2017, 48, 243-252.	0.7	63
779	Identifying Effective Nurseâ€Led Care Transition Interventions for Older Adults With Complex Needs Using a Structured Expert Panel. Worldviews on Evidence-Based Nursing, 2017, 14, 136-144.	1.2	71
780	Resource Use and Medicare Costs During Lay Navigation for Geriatric Patients With Cancer. JAMA Oncology, 2017, 3, 817.	3.4	126
781	Apples and Oranges: Four Definitions of Multiple Chronic Conditions and their Relationship to 30â€Day Hospital Readmission. Journal of the American Geriatrics Society, 2017, 65, 712-720.	1.3	23
782	Measuring health literate discharge practices. International Journal of Health Care Quality Assurance, 2017, 30, 67-78.	0.2	5
783	Project IMPACT Pilot Report: Feasibility of Implementing a Hospital-to-Home Transition Bundle. Pediatrics, 2017, 139, .	1.0	37
784	On the interdependence of ambulatory and hospital care in the German health system. Health Economics Review, 2017, 7, 2.	0.8	4
785	Experiences and preferences of patients visiting a head and neck oncology outpatient clinic: a qualitative study. European Archives of Oto-Rhino-Laryngology, 2017, 274, 2245-2252.	0.8	9
786	The PEARL score predicts 90-day readmission or death after hospitalisation for acute exacerbation of COPD. Thorax, 2017, 72, 686-693.	2.7	52
787	Transitioning the Adult with Type 2 Diabetes From the Acute to Chronic Care Setting: Strategies to Support Pragmatic Implementation Success. Current Diabetes Reports, 2017, 17, 6.	1.7	1
788	Early primary care follow-up after ED and hospital discharge â€“ does it affect readmissions?. Hospital Practice (1995), 2017, 45, 51-57.	0.5	8
789	Evolution of Geriatric Medicine: Midcareer Faculty Continuing the Dialogue. Journal of the American Geriatrics Society, 2017, 65, 1389-1391.	1.3	1
790	Nutritional follow-up after discharge prevents readmission to hospital - A randomized clinical trial. Journal of Nutrition, Health and Aging, 2017, 21, 75-82.	1.5	33
791	Thirty-day Readmission Rates in an HIV-infected Cohort From Rio de Janeiro, Brazil. Journal of Acquired Immune Deficiency Syndromes (1999), 2017, 75, e90-e98.	0.9	13
792	Impact of Transitional Care Services for Chronically Ill Older Patients: A Systematic Evidence Review. Journal of the American Geriatrics Society, 2017, 65, 1597-1608.	1.3	120
793	Cost-Effectiveness of a Care Transition Intervention Among Multimorbid Patients. Western Journal of Nursing Research, 2017, 39, 622-642.	0.6	8

#	Article	IF	Citations
794	Beyond Hospital Discharge Mechanics: Managing the Discharge Paradox and Bridging the Care Chasm. Qualitative Health Research, 2017, 27, 1225-1235.	1.0	13
795	User-centered design of discharge warnings tool for colorectal surgery patients. Journal of the American Medical Informatics Association: JAMIA, 2017, 24, 975-980.	2.2	10
796	Risk factors of adverse health outcomes after hospital discharge modifiable by clinical pharmacist interventions: a review with a systematic approach. British Journal of Clinical Pharmacology, 2017, 83, 2163-2178.	1.1	12
797	An Innovative Approach to Health Care Delivery for Patients with Chronic Conditions. Population Health Management, 2017, 20, 23-30.	0.8	121
798	Validation of New Quality Measures for Transitions Between Sites of Care. Pediatrics, 2017, 139, e20164178.	1.0	10
799	An exploratory study of healthcare professionalsâ€™ perceptions of interprofessional communication and collaboration. Journal of Interprofessional Care, 2017, 31, 397-400.	0.8	18
800	A Study of Role Expectations and Satisfaction With the Healthcare Coach Role. Journal of Nursing Administration, 2017, 47, 108-115.	0.7	1
801	Informed Consent to Research with Cognitively Impaired Adults: Transdisciplinary Challenges and Opportunities. Clinical Gerontologist, 2017, 40, 63-73.	1.2	67
802	Social Workers Uniquely Positioned to Create and Support Healthcare Systems for Older Adults with Complex Chronic Conditions. Journal of Gerontological Social Work, 2017, 60, 173-177.	0.6	1
803	â€œI have nine specialists. They need to swap notes!â€•Australian patientsâ€™ perspectives of medicationâ€related problems following discharge from hospital. Health Expectations, 2017, 20, 1114-1120.	1.1	12
804	Visit Entropy Associated with Hospital Readmission Rates. Journal of the American Board of Family Medicine, 2017, 30, 63-70.	0.8	18
805	Improving Patient-Centered Transitional Care after Complex Abdominal Surgery. Journal of the American College of Surgeons, 2017, 225, 259-265.	0.2	28
806	Patient Perspectives on Transitions of Surgical Care: Examining the Complexities and Interdependencies of Care. Qualitative Health Research, 2017, 27, 1856-1869.	1.0	6
807	The Experience of Transitional Care for Non-Medically Complex Older Adults and Their Family Caregivers. Global Qualitative Nursing Research, 2017, 4, 233393617769668.	0.7	14
808	Economic Evaluation of Quality Improvement Interventions Designed to Prevent Hospital Readmission. JAMA Internal Medicine, 2017, 177, 975.	2.6	75
809	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
810	Can Lawyers Improve Transitions of Care?. Journal of the American Medical Directors Association, 2017, 18, 207-210.	1.2	0
811	Endâ€ofâ€Life Care Transition Patterns of Medicare Beneficiaries. Journal of the American Geriatrics Society, 2017, 65, 1406-1413.	1.3	34

#	Article	IF	Citations
812	Independent Living Capacity Evaluation in Home-Based Primary Care: Considerations and Outcomes of a Quality Improvement Project. Clinical Gerontologist, 2017, 40, 51-62.	1.2	5
813	Discharge to a rehabilitation facility is associated with decreased 30-day readmission in elective spinal surgery. Journal of Clinical Neuroscience, 2017, 36, 37-42.	0.8	27
814	A structured review of chronic care model components supporting transition between healthcare service delivery types for older people with multiple chronic diseases. Health Information Management Journal, 2017, 46, 58-68.	0.9	12
815	What can five high cost patients teach us about healthcare spending?. Healthcare, 2017, 5, 204-213.	0.6	11
816	Improving the seniorsâ€™ transition from hospital to the community: a case for intensive geriatric service workers. International Psychogeriatrics, 2017, 29, 149-163.	0.6	11
817	Familiesâ€™ Priorities Regarding Hospital-to-Home Transitions for Children With Medical Complexity. Pediatrics, 2017, 139, .	1.0	82
818	From home to â€˜homeâ€™: Mapping the caregiver journey in the transition from home care into residential care. Journal of Aging Studies, 2017, 43, 32-39.	0.7	24
819	The Effectiveness of Transitions-of-Care Interventions in Reducing Hospital Readmissions and Mortality. Dimensions of Critical Care Nursing, 2017, 36, 311-316.	0.4	29
820	Chronic obstructive pulmonary disease in the long-term care setting. Current Opinion in Pulmonary Medicine, 2017, 23, S1-S28.	1.2	7
821	Reducing Readmissions: Nurseâ€Driven Interventions in the Transition of Care From the Hospital. Worldviews on Evidence-Based Nursing, 2017, 14, 432-439.	1.2	9
822	Improving Posthospital Discharge Telephone Reach Rates Through Prehospital Discharge Face-to-Face Meetings. Professional Case Management, 2017, 22, 275-283.	0.2	6
823	Changes in Statin Adherence Following an Acute Myocardial Infarction Among Older Adults: Patient Predictors and the Association With Followâ€Up With Primary Care Providers and/or Cardiologists. Journal of the American Heart Association, 2017, 6, .	1.6	26
824	A randomised controlled trial assessing the efficacy of an electronic discharge communication tool for preventing death or hospital readmission. BMJ Quality and Safety, 2017, 26, 993-1003.	1.8	14
825	Simulating the experience of home environments. , 2017, , .		5
826	Trends in readmission rates for safety net hospitals and non-safety net hospitals in the era of the US Hospital Readmission Reduction Program: a retrospective time series analysis using Medicare administrative claims data from 2008 to 2015. BMJ Open, 2017, 7, e016149.	0.8	36
827	Effectiveness of Intensive Primary Care Interventions: A Systematic Review. Journal of General Internal Medicine, 2017, 32, 1377-1386.	1.3	57
828	Patient Engagement Following Acute Myocardial Infarction and Its Influence on Outcomes. American Journal of Cardiology, 2017, 120, 1467-1471.	0.7	10
829	Ready to Go Home? Patientsâ€™ Experiences of the Discharge Process in an Enhanced Recovery After Surgery (ERAS) Program for Colorectal Surgery. Journal of Gastrointestinal Surgery, 2017, 21, 1865-1878.	0.9	39

#	Article	IF	Citations
830	On the Right Track: Implementing Interventions to Reduce Readmissions in Dialysis Patients. American Journal of Nephrology, 2017, 45, 549-551.	1.4	1
831	Provider Opinions and Experiences Regarding Development of a Social Support Assessment to Inform Hospital Discharge. Professional Case Management, 2017, 22, 214-227.	0.2	7
832	Right TraCâ„¢ Post-Hospitalization Care Transitions Program to Reduce Readmissions for Hemodialysis Patients. American Journal of Nephrology, 2017, 45, 532-539.	1.4	13
833	Exploring challenges in the patientâ€™s discharge process from the internal medicine service: A qualitative study of patientsâ€™ and providersâ€™ perceptions. Journal of Interprofessional Care, 2017, 31, 566-574.	0.8	25
834	Understanding Facilitators and Barriers to Care Transitions: Insights from Project ACHIEVE Site Visits. Joint Commission Journal on Quality and Patient Safety, 2017, 43, 433-447.	0.4	39
835	Association of Changing Hospital Readmission Rates With Mortality Rates After Hospital Discharge. JAMA - Journal of the American Medical Association, 2017, 318, 270.	3.8	176
836	Early geriatric follow-up after discharge reduces mortality among patients living in their own home. A randomised controlled trial. European Geriatric Medicine, 2017, 8, 330-336.	1.2	9
837	Implementation of a Patient Navigator Program to Reduce 30-day Heart Failure Readmission Rate. Progress in Cardiovascular Diseases, 2017, 60, 259-266.	1.6	47
838	A Moving Targetâ€"Medicare Beneficiaries Coming to the End of Long Lives. Journal of the American Geriatrics Society, 2017, 65, 1394-1395.	1.3	1
839	FiftyYears ofResearch inARDS.Long-Term Follow-up after Acute Respiratory Distress Syndrome. Insights for Managing Medical Complexity after Critical Illness. American Journal of Respiratory and Critical Care Medicine, 2017, 196, 1380-1384.	2.5	31
840	Being with a Person in Our Care: Person-Centered Social Work Practice that is Authentically Person-Centered. Journal of Gerontological Social Work, 2017, 60, 408-423.	0.6	14
841	The transition of care from hospital to home for patients with hypertension. Nurse Practitioner, 2017, 42, 12-18.	0.2	8
842	Enhanced Transitions of Care: Centralizing Discharge Phone Calls Improves Ability to Reach Patients and Reduces Hospital Readmissions. Journal for Healthcare Quality: Official Publication of the National Association for Healthcare Quality, 2017, 39, e10-e21.	0.3	6
843	Performance of the LACE index to identify elderly patients at high risk for hospital readmission in Singapore. Medicine (United States), 2017, 96, e6728.	0.4	22
844	Can Vertical Integration Reduce Hospital Readmissions? A Difference-in-Differences Approach. Medical Care, 2017, 55, 506-513.	1.1	10
845	The Association Between Unhealthy Alcohol Use and Acute Care Expenditures in the 30ÂDays Following Hospital Discharge Among Older Veterans Affairs Patients with a Medical Condition. Journal of Behavioral Health Services and Research, 2017, 44, 602-624.	0.6	6
846	Planning for Discharge. , 0, , 290-295.		0
847	Patient experience with discharge instructions in postdischarge recovery: a qualitative study. BMJ Open, 2017, 7, e014842.	0.8	33

#	Article	IF	Citations
848	Medication Use Leading to Hospital Readmission in Frail Elders. Journal for Nurse Practitioners, 2017, 13, 708-715.	0.4	5
849	Post discharge issues identified by a call-back program: identifying improvement opportunities. Hospital Practice (1995), 2017, 45, 201-208.	0.5	0
850	Hospital Readmission Following Thoracic Surgery. Thoracic Surgery Clinics, 2017, 27, 315-326.	0.4	2
851	Protocol for regional implementation of community-based collaborative management of complex chronic patients. Npj Primary Care Respiratory Medicine, 2017, 27, 44.	1.1	10
852	The Supporting Patient Activation in Transition to Home (sPATH) intervention: a study protocol of a randomised controlled trial using motivational interviewing to decrease re-hospitalisation for patients with COPD or heart failure. BMJ Open, 2017, 7, e014178.	0.8	14
853	Predicting Readmission at Early Hospitalization Using Electronic Clinical Data. Medical Care, 2017, 55, 267-275.	1.1	35
854	Development of Indicators to Measure Health Literate Discharge Practices. Journal of Nursing Care Quality, 2017, 32, 157-163.	0.5	7
855	Managing multiple chronic conditions in the community: a Canadian qualitative study of the experiences of older adults, family caregivers and healthcare providers. BMC Geriatrics, 2017, 17, 40.	1.1	135
856	Improving transitions in acute stroke patients discharged to home: the Michigan stroke transitions trial (MISTT) protocol. BMC Neurology, 2017, 17, 115.	0.8	36
857	Educational level and 30-day outcomes after hospitalization for acute myocardial infarction in Italy. BMC Health Services Research, 2017, 17, 18.	0.9	22
858	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
859	Implementation and adaptation of the Re-Engineered Discharge (RED) in five California hospitals: a qualitative research study. BMC Health Services Research, 2017, 17, 291.	0.9	17
860	Risk assessment tools to predict location of discharge and need for supportive services for medical patients after discharge from hospital: a systematic review protocol. Systematic Reviews, 2017, 6, 8.	2.5	4
861	A place to heal: a qualitative focus group study of respite care preferences among individuals experiencing homelessness. Journal of Social Distress and the Homeless, 2017, 26, 104-115.	0.7	3
862	â€œTheyâ€™re on the Fast Trackâ€: Older Blacks Describe Experiences of Nursing Care Quality During Hospitalization. Clinical Nursing Research, 2017, 26, 557-575.	0.7	5
863	Enablers and barriers of men with Duchenne muscular dystrophy transitioning from an adult clinic within a pediatric hospital. Disability and Health Journal, 2017, 10, 73-79.	1.6	26
864	User Experience and Care Integration in Transitional Care for Older People From Hospital to Home. Qualitative Health Research, 2017, 27, 24-36.	1.0	66
865	Improving Care Transitions Management: Examining the Role of Accountable Care Organization Participation and Expanded Electronic Health Record Functionality. Health Services Research, 2017, 52, 1494-1510.	1.0	12

#	Article	IF	Citations
866	The Insiders as Outsiders: Professionals Caring for an Aging Parent. Gerontologist, The, 2017, 57, 46-53.	2.3	10
867	Profiling Patient Characteristics Associated With the Intensity of Nurse Care Coordination. Western Journal of Nursing Research, 2017, 39, 186-203.	0.6	0
868	Comparing performance of 30â€day readmission risk classifiers among hospitalized primary care patients. Journal of Evaluation in Clinical Practice, 2017, 23, 524-529.	0.9	25
869	Stroke severity may predict causes of readmission within one year in patients with first ischemic stroke event. Journal of the Neurological Sciences, 2017, 372, 21-27.	0.3	28
870	Psychiatric Inpatient Discharge Planning Practices and Attendance at Aftercare Appointments. Psychiatric Services, 2017, 68, 92-95.	1.1	20
871	Bundle in the Bronx: Impact of a Transition-of-Care Outpatient Parenteral Antibiotic Therapy Bundle on All-Cause 30-Day Hospital Readmissions. Open Forum Infectious Diseases, 2017, 4, ofx097.	0.4	38
872	Scaling up improvements more quickly and effectively. International Journal for Quality in Health Care, 2017, 29, 1014-1019.	0.9	13
873	Senior services in US hospitals and readmission risk in the Medicare population. International Journal for Quality in Health Care, 2017, 29, 845-852.	0.9	6
874	Longâ€Term Impact of a Postdischarge Community Health Worker Intervention on Health Care Costs in a Safetyâ€Net System. Health Services Research, 2017, 52, 2061-2078.	1.0	18
875	IMPLEMENTING AÂPROCESS OF RISK-STRATIFIED CARE COORDINATION FOR OLDER ADULTS IN PRIMARY CARE. Innovation in Aging, 2017, 1, 159-159.	0.0	1
876	Outcomes of an Interdisciplinary Transitional Care Quality Improvement Project on Self-Management and Health Care Use in Patients With Heart Failure. Journal of Gerontological Nursing, 2017, 43, 23-31.	0.3	13
877	Feasibility of an ED-to-Home Intervention to Engage Patients: A Mixed-Methods Investigation. Western Journal of Emergency Medicine, 2017, 18, 743-751.	0.6	11
878	A community virtual ward model to support older persons with complex health care and social care needs. Clinical Interventions in Aging, 2017, Volume 12, 985-993.	1.3	28
879	The role of hospitals in bridging the care continuum: a systematic review of coordination of care and follow-up for adults with chronic conditions. BMC Health Services Research, 2017, 17, 550.	0.9	36
880	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
881	Service description and analysis for an interprofessional discharge clinic within a primary care practice. Journal of Interprofessional Care, 2017, 31, 771-773.	0.8	4
882	Dangers of Polypharmacy. , 2017, , .		7
883	Health-related quality of life among older patients following an emergency department visit and emergency department-to-home coaching intervention: A randomized controlled trial. International Journal of Care Coordination, 2017, 20, 162-170.	0.3	6

#	Article	IF	Citations
884	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
885	Bridging Transitions of Care From Hospital to Community on the Foundation of Integrated and Collaborative Care. Focus (American Psychiatric Publishing), 2017, 15, 306-315.	0.4	2
886	Seamless Transitions: Achieving Patient Safety Through Communication and Collaboration. Journal of Patient Safety, 2018, 14, e3-e5.	0.7	6
887	Care coordination: Identifying and connecting the most appropriate care to the patients. Research in Nursing and Health, 2018, 41, 49-56.	0.8	27
888	Acute Hospital Care. , 2018, , 221-231.		0
889	Implementing and sustaining evidence-based practice in health care: The Bridge Model experience. Journal of Gerontological Social Work, 2018, 61, 280-294.	0.6	10
890	A Multidisciplinary Discharge Timeout Checklist Improves Patient Education and Captures Discharge Process Errors. Quality Management in Health Care, 2018, 27, 63-68.	0.4	12
891	Correction to: Hospital Readmission of Patients with Diabetes. Current Diabetes Reports, 2018, 18, 21.	1.7	19
892	Paediatric hospital admission processes and outcomes: a qualitative study of parentsâ€™ experiences and priorities. BMJ Quality and Safety, 2018, 27, 790-798.	1.8	15
893	Qualitative Evaluation of the Coach Training within a Community Paramedicine Care Transitions Intervention. Prehospital Emergency Care, 2018, 22, 527-534.	1.0	12
894	The impact of transitional care programs on health services utilization in community-dwelling older adults: a systematic review. JBI Database of Systematic Reviews and Implementation Reports, 2018, 16, 345-384.	1.7	38
895	Implementation of a Workflow Initiative for Integrating Transitional Care Management Codes in a Geriatric Primary Care Practice. Journal of Nursing Care Quality, 2018, 33, 348-353.	0.5	1
896	An Initiative to Change Inpatient Practice: Leveraging the Patient Medical Home for Postdischarge Follow-Up. Joint Commission Journal on Quality and Patient Safety, 2018, 44, 101-106.	0.4	1
897	Sleep in Hospitalized Older Adults. Sleep Medicine Clinics, 2018, 13, 127-135.	1.2	65
898	Telephone Followâ€Up for Older Adults Discharged to Home from the Emergency Department: A Pragmatic Randomized Controlled Trial. Journal of the American Geriatrics Society, 2018, 66, 452-458.	1.3	44
899	Association of Delivery System Integration and Outcomes for Major Cancer Surgery. Annals of Surgical Oncology, 2018, 25, 856-863.	0.7	2
900	A pragmatic randomized comparative effectiveness trial of transitional care for a socioeconomically diverse population: Design, rationale and baseline characteristics. Contemporary Clinical Trials, 2018, 65, 53-60.	0.8	4
901	Improving Outcomes After Hospitalization: A Prospective Observational Multicenter Evaluation of Care Coordination Strategies for Reducing 30-Day Readmissions to Maryland Hospitals. Journal of General Internal Medicine, 2018, 33, 621-627.	1.3	24

#	Article	IF	Citations
902	A proactive outreach intervention that decreases readmission after hepatectomy. Surgery, 2018, 163, 703-708.	1.0	8
903	Management of care transition and hospital discharge. Aging Clinical and Experimental Research, 2018, 30, 263-270.	1.4	48
904	Older adults in jail: high rates and early onset of geriatric conditions. Health and Justice, 2018, 6, 3.	0.9	74
905	Risk factors for 90-day readmission in veterans with inflammatory bowel diseaseâ€"Does post-discharge follow-up matter?. Military Medical Research, 2018, 5, 5.	1.9	11
906	Implementing evidence-based interventions to prevent readmissions in the real world. Journal of General Internal Medicine, 2018, 33, 578-580.	1.3	3
907	Performance Improvement to Decrease Readmission Rates for Patients With a Left Ventricular Assist Device. Progress in Transplantation, 2018, 28, 184-188.	0.4	5
908	The Impact of a Transition of Care Program on Acute Myocardial Infarction Readmission Rates. American Journal of Medical Quality, 2018, 33, 481-486.	0.2	5
909	The effectiveness of remote monitoring of elderly patients after hospitalisation for heart failure: The renewing health European project. International Journal of Cardiology, 2018, 257, 137-142.	0.8	35
910	Effect of Grand-Aides Nurse Extenders on Readmissions and Emergency Department Visits in Medicare Patients With Heart Failure. American Journal of Cardiology, 2018, 121, 1336-1342.	0.7	4
911	Delivering high quality hip fracture rehabilitation: the perspective of occupational and physical therapy practitioners. Disability and Rehabilitation, 2018, 40, 646-654.	0.9	20
912	The Residential Long-Term Care Role in Health Care Transitions. Journal of Applied Gerontology, 2018, 37, 1472-1489.	1.0	6
913	Development and preliminary evaluation of the resident coordinated-transitional care (RC-TraC) program: A sustainable option for transitional care education. Gerontology and Geriatrics Education, 2018, 39, 160-169.	0.6	2
914	Evaluation of Early Versus Late Postdischarge Medication Reconciliation on Readmission Rates and Emergency Department Visits. Journal of Pharmacy Practice, 2018, 31, 279-283.	0.5	2
915	Accountable Care in Transitions (ACTion): A Team-Based Approach to Reducing Hospital Utilization in a Patient-Centered Medical Home. Journal of Pharmacy Practice, 2018, 31, 175-182.	0.5	16
916	Spaces of well-being among young adults with physical disabilities transitioning from pediatric to adult healthcare. Disability and Health Journal, 2018, 11, 149-154.	1.6	6
917	Patientâ€reported dietetic care post hospital for freeâ€living patients: a Canadian Malnutrition Task Force Study. Journal of Human Nutrition and Dietetics, 2018, 31, 33-40.	1.3	10
918	Perfil y resultados del paciente frÃ¡gil valorado por la Enfermera de PrÃ¡ctica Avanzada en un servicio de urgencias. EnfermerÃa ClÃnica, 2018, 28, 365-374.	0.1	3
919	Profile and results of frail patient assessed by advanced practice nursing in an Emergency Department. EnfermerÃa ClÃnica (English Edition), 2018, 28, 365-374.	0.1	1

#	Article	IF	Citations
920	Hospital Readmissions After Urological Surgical Procedures in France: A Nationwide Cohort Study over 3 Years. European Urology Focus, 2018, 4, 621-627.	1.6	2
921	Hospital-Community Partnerships to Aid Transitions for Older Adults. Journal of Nursing Care Quality, 2018, 33, 221-228.	0.5	7
922	Metaâ€analysis of the effectiveness of nursing discharge planning interventions for older inpatients discharged home. Journal of Advanced Nursing, 2018, 74, 788-799.	1.5	37
923	Association between Hospice Spending on Patient Care and Rates of Hospitalization and Medicare Expenditures of Hospice Enrollees. Journal of Palliative Medicine, 2018, 21, 55-61.	0.6	11
924	Intensive Outpatient Program Effects on High-need Patientsâ€™ Access, Continuity, Coordination, and Engagement. Medical Care, 2018, 56, 19-24.	1.1	9
925	Want to Champion Better Care for Vulnerable Older Americans? Start Here. Journal of the American Geriatrics Society, 2018, 66, 847-849.	1.3	0
926	Low-Income Senior Housing Residentsâ€™ Emergency Department Use and Care Transition Problems. Journal of Pharmacy Practice, 2018, 31, 610-616.	0.5	11
927	A community pharmacistâ€“led service to facilitate care transitions and reduce hospital readmissions. Journal of the American Pharmacists Association: JAPhA, 2018, 58, 36-43.	0.7	19
928	User experience and care for older people transitioning from hospital to home: Patientsâ€™ and carersâ€™ perspectives. Health Expectations, 2018, 21, 518-527.	1.1	59
929	Sooner or Later? Health Information Technology, Length of Stay, and Readmission Risk. Production and Operations Management, 2018, 27, 2038-2053.	2.1	37
930	Importance and Feasibility of Transitional Care for Children With Medical Complexity: Results of a Multistakeholder Delphi Process. Academic Pediatrics, 2018, 18, 94-101.	1.0	18
931	The Varying Roles of Nurses During Interfacility Care Transitions. Journal of Nursing Care Quality, 2018, 33, E1-E6.	0.5	6
932	Returnâ€onâ€Investment (ROI) Analyses of an Inpatient Lay Health Worker Model on 30â€Day Readmission Rates in a Rural Community Hospital. Journal of Rural Health, 2018, 34, 411-422.	1.6	1
933	Effects of Transitional Care Management Services From an Interprofessional Team on 30-Day Readmission Rates Among Medicare Beneficiaries. Topics in Geriatric Rehabilitation, 2018, 34, 182-184.	0.2	4
934	Which Readmissions May Be Preventable? Lessons Learned From a Posthospitalization Care Transitions Program for High-risk Elders. Medical Care, 2018, 56, 693-700.	1.1	7
935	The Best Practice for Increasing Telephone Outreach. Professional Case Management, 2018, 23, 307-317.	0.2	9
936	The Acute Care for Elders Unit Model of Care. Geriatrics (Switzerland), 2018, 3, 59.	0.6	64
937	A qualitative study of urban hospital transitional care. Qualitative Research in Medicine & Healthcare, 2018, 2, .	0.2	2

#	Article	IF	Citations
938	Intern Transitions of Care Curriculum Through Posthospital Home and Skilled Nursing Facility Visits. Journal of Graduate Medical Education, 2018, 10, 442-448.	0.6	6
939	Health System Affiliation and 30-Day Readmission After Heart Attack in Black Men. American Journal of Preventive Medicine, 2018, 55, S22-S30.	1.6	2
940	Using Virtual Reality to Study Health in the Home. , 2018, , .		0
941	Resident learning across the full range of core competencies through a transitions of care curriculum. Gerontology and Geriatrics Education, 2018, 39, 144-159.	0.6	7
942	Supporting Transitions in Care for Older Adults With Type 2 Diabetes Mellitus and Obesity. Research in Gerontological Nursing, 2018, 11, 71-81.	0.2	12
943	Evaluation of a Hospital. Professional Case Management, 2018, 23, 327-341.	0.2	5
944	The effectiveness of an integrated care pathway in geriatric rehabilitation among older patients with complex health problems and their informal caregivers: a prospective cohort study. BMC Geriatrics, 2018, 18, 285.	1.1	25
945	Improving Care Transitions in Healthcare: A Human Factors/Ergonomics (HFE) Approach. Proceedings of the Human Factors and Ergonomics Society, 2018, 62, 551-555.	0.2	3
946	Perioperative Surgical Home Models. Anesthesiology Clinics, 2018, 36, 677-687.	0.6	12
947	Thirtyâ€Day Readmission Rates, Timing, Causes, and Costs after STâ€Segmentâ€“Elevation Myocardial Infarction in the United States: A National Readmission Database Analysis 2010â€“2014. Journal of the American Heart Association, 2018, 7, e009863.	1.6	56
948	Muscled by the System: Informal Caregiversâ€™ Experiences of Transitioning an Older Adult into Long-term Care. Canadian Journal on Aging, 2018, 37, 464-473.	0.6	8
949	Care coordination for complex cancer survivors in an integrated safety-net system: a study protocol. BMC Cancer, 2018, 18, 1204.	1.1	17
950	Changes to Racial Disparities in Readmission Rates After Medicareâ€™s Hospital Readmissions Reduction Program Within Safety-Net and Nonâ€“Safety-Net Hospitals. JAMA Network Open, 2018, 1, e184154.	2.8	54
951	Modelo de seguimiento, organizaciÃ³n y gestiÃ³n de la infecciÃ³n por VIH. Enfermedades Infecciosas Y MicrobiologÃa ClÃnica, 2018, 36, 45-49.	0.3	5
952	Understanding experiences of patients and family caregivers in the Mayo Clinic Care Transitions program: a qualitative study. Clinical Interventions in Aging, 2019, Volume 14, 17-25.	1.3	7
953	Can Better Care Coordination Lower Health Care Costs?. JAMA Network Open, 2018, 1, e184295.	2.8	15
954	The SUMMIT ambulatory-ICU primary care model for medically and socially complex patients in an urban federally qualified health center: study design and rationale. Addiction Science & Clinical Practice, 2018, 13, 27.	1.2	12
955	University of Pittsburgh Medical Center Home Transitions Multidisciplinary Care Coordination Reduces Readmissions for Older Adults. Journal of the American Geriatrics Society, 2019, 67, 156-163.	1.3	43

#	Article	IF	Citations
956	Factors associated with attendance at primary care appointments after discharge from hospital: a retrospective cohort study. CMAJ Open, 2018, 6, E587-E593.	1.1	14
957	Health Literacy and 1-Year Mortality: Mechanisms of Association in Adults Hospitalized for Cardiovascular Disease. Mayo Clinic Proceedings, 2018, 93, 1728-1738.	1.4	26
958	Alcohol misuse and outpatient follow-up after hospital discharge: a retrospective cohort study. Addiction Science & Clinical Practice, 2018, 13, 24.	1.2	12
959	The Effect of a Personalized Approach to Patient Education on Heart Failure Self-Management. Journal of Personalized Medicine, 2018, 8, 39.	1.1	10
960	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
961	Pediatric rheumatology: addressing the transition to adult-orientated health care. Open Access Rheumatology: Research and Reviews, 2018, Volume 10, 83-95.	0.8	20
962	Depression and Coleman Care Transitions Intervention. Social Work in Health Care, 2018, 57, 750-761.	0.8	2
963	Are we â€œmissing the big pictureâ€•in transitions of care? Perspectives of healthcare providers managing patients with unplanned hospitalization. Applied Nursing Research, 2018, 44, 60-66.	1.0	15
964	Capsule Commentary on Grant et al., Which Complex Patients Should Be Referred for Intensive Care Management? A Mixed Methods Analysis. Journal of General Internal Medicine, 2018, 33, 1551-1551.	1.3	0
965	Family Medicine Hospitalists Three Years Out of Residency: Career Flexibility or a Threat to Office-Based Family Medicine?. Journal of the American Board of Family Medicine, 2018, 31, 677-679.	0.8	1
966	Cost impact of the transitional care model for hospitalized cognitively impaired older adults. Journal of Comparative Effectiveness Research, 2018, 7, 913-922.	0.6	9
967	Improving the EDâ€toâ€Home Transition: The Community Paramedicâ€“Delivered Care Transitions Interventionâ€”Preliminary Findings. Journal of the American Geriatrics Society, 2018, 66, 2213-2220.	1.3	31
968	Proprietary management and higher readmission rates: A correlation. PLoS ONE, 2018, 13, e0204272.	1.1	15
969	Tele-transitions of care. A 12-month, parallel-group, superiority randomized controlled trial protocol, evaluating the use of telehealth versus standard transitions of care in the prevention of avoidable hospital readmissions. Contemporary Clinical Trials Communications, 2018, 12, 9-16.	0.5	13
970	Geographic Variations in Physician Relationships Over Time: Implications for Care Coordination. Medical Care Research and Review, 2018, 75, 586-611.	1.0	13
972	Evidence-Based Interventions for Transitions in Care for Individuals Living With Dementia. Gerontologist, The, 2018, 58, S129-S140.	2.3	72
973	Improving Transitions of Care for Veterans Transferred to Tertiary VA Medical Centers. American Journal of Medical Quality, 2018, 33, 147-153.	0.2	16
974	Nursesâ€™ Perceptions of Patient Safety Culture in Three Hospitals in Saudi Arabia. Journal of Nursing Scholarship, 2018, 50, 422-431.	1.1	51

#	Article	IF	Citations
975	A Call to Bridge Across Silos during Care Transitions. Joint Commission Journal on Quality and Patient Safety, 2018, 44, 270-278.	0.4	12
976	Family caregiversâ€™ reports of hospitalizations and emergency department visits in community-dwelling individuals with dementia. Dementia, 2018, 17, 585-595.	1.0	17
977	Postdischarge Interventions to Prevent Pediatric Readmissions: Lost in Translation?. Pediatrics, 2018, 142, .	1.0	4
978	Are the Drivers of Healthcare Change Changing Healthcare Outcomes?. , 2018, , 33-47.		0
979	Delivering improved patient and system outcomes for hospitalized older adults through an Acute Care for Elders Strategy. Healthcare Management Forum, 2018, 31, 126-132.	0.6	9
980	Avoidable readmissions seem to be reduced by early follow-up visits for geriatric patients discharged from hospital. European Geriatric Medicine, 2018, 9, 613-621.	1.2	8
981	Risk factors for readmission following ileal pouchâ€“Anal anastomosis: an American College of Surgeons National Surgical Quality Improvement Program analysis. Journal of Surgical Research, 2018, 229, 324-331.	0.8	25
982	Postdischarge Nurse Home Visits and Reuse: The Hospital to Home Outcomes (H2O) Trial. Pediatrics, 2018, 142, .	1.0	38
983	Strategies to Prevent Readmission in High-Risk Patients with Diabetes: the Importance of an Interdisciplinary Approach. Current Diabetes Reports, 2018, 18, 54.	1.7	18
985	Improving Chronic Disease Self-Management by Older Home Health Patients through Community Health Coaching. International Journal of Environmental Research and Public Health, 2018, 15, 660.	1.2	25
986	Experiences of selfâ€management among young adults with Type 1 diabetes in the context of a structured education programme: a qualitative study. Diabetic Medicine, 2018, 35, 1531-1537.	1.2	11
987	A research agenda for care coordination for chronic conditions: aligning implementation, technology, and policy strategies. Translational Behavioral Medicine, 2018, 8, 515-521.	1.2	21
988	Risk assessment of the hospital discharge process of high-risk patients with diabetes. BMJ Open Quality, 2018, 7, e000224.	0.4	9
989	Complex Care Hospital Use and Postdischarge Coaching: A Randomized Controlled Trial. Pediatrics, 2018, 142, .	1.0	43
990	Late Transitions and Bereaved Family Member Perceptions of Quality of Endâ€ofâ€Life Care. Journal of the American Geriatrics Society, 2018, 66, 1730-1736.	1.3	44
991	Evaluation of a transitional care pharmacist intervention in a high-risk cardiovascular patient population. American Journal of Health-System Pharmacy, 2018, 75, S63-S71.	0.5	21
993	Continuity of Care among People Experiencing Homelessness and Mental Illness: Does Community Followâ€up Reduce Rehospitalization?. Health Services Research, 2018, 53, 3400-3415.	1.0	11
994	Communication Strategies for Better Care of Older Individuals in the Emergency Department. Clinics in Geriatric Medicine, 2018, 34, 387-397.	1.0	9

#	Article	IF	Citations
995	Adaptations of the evidence-based Transitional Care Model in the U.S.. Social Science and Medicine, 2018, 213, 28-36.	1.8	51
996	Early geriatric follow-up visits to nursing home residents reduce the number of readmissions: a quasi-randomised controlled trial. European Geriatric Medicine, 2018, 9, 329-337.	1.2	14
997	The effect of a gerontology nurse specialist for high needs older people in the community on healthcare utilisation: a controlled before-after study. BMC Geriatrics, 2018, 18, 22.	1.1	11
998	A randomized controlled trial testing the effectiveness of a paramedic-delivered care transitions intervention to reduce emergency department revisits. BMC Geriatrics, 2018, 18, 104.	1.1	27
999	Patientsâ€™ perceptions of interactions with hospital staff are associated with hospital readmissions: a national survey of 4535 hospitals. BMC Health Services Research, 2018, 18, 50.	0.9	14
1000	Impact of medication reconciliation and review and counselling, on adverse drug events and healthcare resource use. International Journal of Clinical Pharmacy, 2018, 40, 1154-1164.	1.0	48
1001	Reducing 30-day readmission rates in a high-risk population using a lay-health worker model in Appalachia Kentucky. Health Education Research, 2018, 33, 73-80.	1.0	13
1002	Adaptation and Implementation of a Transitional Care Protocol for Patients Undergoing Complex Abdominal Surgery. Joint Commission Journal on Quality and Patient Safety, 2018, 44, 741-750.	0.4	5
1003	Self-Identified Social Determinants of Health during Transitions of Care in the Medically Underserved: a Narrative Review. Journal of General Internal Medicine, 2018, 33, 1959-1967.	1.3	30
1004	Rates and causes of 30-day readmission and emergency room utilization following head and neck surgery. Journal of Otolaryngology - Head and Neck Surgery, 2018, 47, 36.	0.9	24
1005	Is Mental Illness a Risk Factor for Hospital Readmission?. Administration and Policy in Mental Health and Mental Health Services Research, 2018, 45, 933-943.	1.2	2
1006	An economic evaluation of an integrated care pathway in geriatric rehabilitation for older patients with complex health problems. PLoS ONE, 2018, 13, e0191851.	1.1	21
1007	Time-varying Readmission Diagnoses During 30 Days After Hospitalization for COPD Exacerbation. Medical Care, 2018, 56, 673-678.	1.1	10
1008	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 Quality and Safety, 2019, 28, 111-120.	1.8	40
1009	Association Between Community Social Capital and Hospital Readmission Rates. Population Health Management, 2019, 22, 40-47.	0.8	17
1010	Is Length of Stay Influenced by the Weekday On Which Lumbar Surgery is Performed?. Neurosurgery, 2019, 85, 494-499.	0.6	10
1011	The Role of Rehabilitation Professionals in Care Transitions for Older Adults: A Scoping Review. Physical and Occupational Therapy in Geriatrics, 2019, 37, 123-150.	0.2	16
1012	Medsâ€toâ€Beds: The impact of a bedside medication delivery program on 30â€day readmissions. JACCP Journal of the American College of Clinical Pharmacy, 2019, 2, 674-680.	0.5	19

#	Article	IF	Citations
1013	Association of US Dialysis Facility Staffing with Profiling of Hospital-Wide 30-Day Unplanned Readmission. Kidney Diseases (Basel, Switzerland), 2019, 5, 153-162.	1.2	16
1014	Regional data exchange to improve care for veterans after non-VA hospitalization: a randomized controlled trial. BMC Medical Informatics and Decision Making, 2019, 19, 125.	1.5	11
1015	A quality improvement curriculum for the neurology clerkship: A practice-based approach to discharge education. ENeurologicalSci, 2019, 16, 100196.	0.5	3
1016	The Discharge Companion Program: An Interprofessional Collaboration in Transitional Care Model Delivery. Pharmacy (Basel, Switzerland), 2019, 7, 68.	0.6	7
1017	Predictive risk score for unplanned 30-day rehospitalizations in the French universal health care system based on a medico-administrative database. PLoS ONE, 2019, 14, e0210714.	1.1	9
1018	Effects of a Transitional Care Practice for a Vulnerable Population: a Pragmatic, Randomized Comparative Effectiveness Trial. Journal of General Internal Medicine, 2019, 34, 1758-1765.	1.3	21
1019	Identifying patients at highest-risk: the best timing to apply a readmission predictive model. BMC Medical Informatics and Decision Making, 2019, 19, 118.	1.5	18
1020	Evaluation of Tailored Falls Education on Older Adults' Behavior Following Hospitalization. Journal of the American Geriatrics Society, 2019, 67, 2274-2281.	1.3	18
1021	Effect of Intensive Interdisciplinary Transitional Care for High-Need, High-Cost Patients on Quality, Outcomes, and Costs: a Quasi-Experimental Study. Journal of General Internal Medicine, 2019, 34, 1815-1824.	1.3	24
1022	Primary Care: the New Frontier for Reducing Readmissions. Journal of General Internal Medicine, 2019, 34, 2894-2897.	1.3	12
1023	Care Management Theories versus Realities in Health Care. Human Service Organizations Management, Leadership and Governance, 2019, 43, 407-420.	0.7	0
1024	Association Between Care Management and Outcomes Among Patients With Complex Needs in Medicare Accountable Care Organizations. JAMA Network Open, 2019, 2, e196939.	2.8	30
1025	Predicting Hospital Readmissions from Home Healthcare in Medicare Beneficiaries. Journal of the American Geriatrics Society, 2019, 67, 2505-2510.	1.3	21
1026	The effect of a pharmaceutical transitional care program on rehospitalisations in internal medicine patients: an interrupted-time-series study. BMC Health Services Research, 2019, 19, 717.	0.9	9
1027	Potentially Avoidable Hospital Readmissions in Patients With Advanced Cancer. Journal of Oncology Practice, 2019, 15, e420-e427.	2.5	27
1028	Pharmacists and Medicareâ€™s Annual Wellness Visit: implications for pharmacy education and interprofessional primary care. Pharmacy Practice, 2019, 17, 1672.	0.8	4
1029	Care trajectories of chronically ill older adult patients discharged from hospital: a quantitative cross-sectional study using health insurance claims data. BMC Geriatrics, 2019, 19, 266.	1.1	3
1030	Evaluation of a Multicomponent Care Transitions Program for Highâ€Risk Hospitalized Older Adults. Journal of the American Geriatrics Society, 2019, 67, 2634-2642.	1.3	6

#	Article	IF	Citations
1031	Michigan Stroke Transitions Trial. Circulation: Cardiovascular Quality and Outcomes, 2019, 12, e005493.	0.9	31
1032	Design of the patient navigator to Reduce Readmissions (PArTNER) study: A pragmatic clinical effectiveness trial. Contemporary Clinical Trials Communications, 2019, 15, 100420.	0.5	9
1033	Postdischarge Unplanned Care Events Among Commercially Insured Patients With an Observation Stay Versus Short Inpatient Admission. Annals of Emergency Medicine, 2019, 74, 334-344.	0.3	1
1034	Why patients decline participation in an intervention to reduce re-hospitalization through patient activation: whom are we missing?. Trials, 2019, 20, 82.	0.7	14
1035	Economic Impact of Chronic Heart Failure Management in Todayâ€™s Cost-Conscious Environment. Cardiac Electrophysiology Clinics, 2019, 11, 1-9.	0.7	15
1036	The developing role of community pharmacists in facilitating care transitions: A systematic review. Journal of the American Pharmacists Association: JAPhA, 2019, 59, 265-274.	0.7	13
1037	Association between transitional care factors and hospital readmission after transcatheter aortic valve replacement: a retrospective observational cohort study. BMC Cardiovascular Disorders, 2019, 19, 23.	0.7	9
1039	Getting Back to Normal: A Grounded Theory Study of Function in Post-hospitalized Older Adults. Gerontologist, The, 2019, 60, 704-714.	2.3	8
1040	Retrospective evaluation of healthcare utilisation and mortality of two post-discharge care programmes in Singapore. BMJ Open, 2019, 9, e027220.	0.8	9
1041	A Large-Scale Advanced Illness Intervention Informs Medicareâ€™s New Serious Illness Payment Model. Health Affairs, 2019, 38, 950-956.	2.5	5
1042	Readmissions Following Isolated Coronary Artery Bypass Graft Surgery in the United States (from the) Tj ETQq0 0 0 rgBT /Overlock 10 Tf	0.7	15
1043	Facilitating holistic continuity of care for older patients: Home care nursesâ€™ experiences using checklists. Journal of Clinical Nursing, 2019, 28, 3478-3491.	1.4	13
1044	Posthospital Fall Injuries and 30-Day Readmissions in Adults 65 Years and Older. JAMA Network Open, 2019, 2, e194276.	2.8	55
1045	High perceived social support and hospital readmissions in an older multi-ethnic, limited English proficiency, safety-net population. BMC Health Services Research, 2019, 19, 334.	0.9	23
1046	â€˜Eyes In The Homeâ€™: ACOs Use Home Visits To Improve Care Management, Identify Needs, And Reduce Hospital Use. Health Affairs, 2019, 38, 1021-1027.	2.5	24
1047	Coordinatedâ€Transitional Care for Veterans with Heart Failure and Chronic Lung Disease. Journal of the American Geriatrics Society, 2019, 67, 1502-1507.	1.3	18
1048	A transition care coordinator model reduces hospital readmissions and costs. Contemporary Clinical Trials, 2019, 81, 55-61.	0.8	25
1049	Improving care transitions through medication therapy management: A community partnership to reduce readmissions in multiple health-systems. Journal of the American Pharmacists Association: JAPhA, 2019, 59, 319-328.	0.7	23

#	Article	IF	Citations
1050	Cost-related medication underuse: Strategies to improve medication adherence at care transitions. American Journal of Health-System Pharmacy, 2019, 76, 560-565.	0.5	11
1051	Kidney Disease Awareness and Knowledge among Survivors ofAcute Kidney Injury. American Journal of Nephrology, 2019, 49, 449-459.	1.4	34
1052	Barriers and facilitators with medication use during the transition from hospital to home: a qualitative study among patients. BMC Health Services Research, 2019, 19, 204.	0.9	41
1053	Reduction in Hospitalsâ€™ Readmission Rates: Role of Hospital-Based Skilled Nursing Facilities. Inquiry (United States), 2019, 56, 004695801881799.	0.5	10
1054	Hospital admissions and emergency department visits among kidney transplant recipients. Clinical Transplantation, 2019, 33, e13522.	0.8	10
1055	e-Infrastructure and e-Services for Developing Countries. Lecture Notes of the Institute for Computer Sciences, Social-Informatics and Telecommunications Engineering, 2019, , .	0.2	1
1056	The Association Between Insulin Initiation and Adverse Outcomes After Hospital Discharge in Older Adults: a Population-Based Cohort Study. Journal of General Internal Medicine, 2019, 34, 575-582.	1.3	11
1057	Are Patients Frequently Readmitted to the Hospital Different from the Other Admitted Patients?. Journal of the American Board of Family Medicine, 2019, 32, 58-64.	0.8	8
1058	Development of an iterative validation process for a 30-day hospital readmission prediction index. American Journal of Health-System Pharmacy, 2019, 76, 444-452.	0.5	3
1059	A Framework for Supporting Post-acute Care Transitions of Older Patients With Hip Fracture. Journal of the American Medical Directors Association, 2019, 20, 414-419.e1.	1.2	23
1060	The Need to Realign Health System Processes for Patients Discharged From the Hospitalâ€"Getting Patients Home. JAMA Internal Medicine, 2019, 179, 614.	2.6	8
1061	Safe and effective person- and family-centered care practices during transitions from hospital to homeâ€"A web-based Delphi technique. PLoS ONE, 2019, 14, e0211024.	1.1	8
1062	Predictors of Hospital Reuse Among Publicly Insured Children Hospitalized for Status Asthmaticus. Hospital Pediatrics, 2019, 9, 194-200.	0.6	2
1063	The (Missing?) Role of Health Information Systems (HIS) in Patient Care Coordination and Continuity (PCCC): The Case of Uganda. Lecture Notes of the Institute for Computer Sciences, Social-Informatics and Telecommunications Engineering, 2019, , 142-151.	0.2	4
1064	Family involvement in managing medications of older patients across transitions of care: a systematic review. BMC Geriatrics, 2019, 19, 95.	1.1	45
1065	An analysis of randomized controlled trials underpinning ST-elevation myocardial infarction management guidelines. American Journal of Emergency Medicine, 2019, 37, 2229-2238.	0.7	2
1066	Patients' ratings of the in-hospital discharge briefing and post-discharge primary care follow-up: The association with 30-day readmissions. Patient Education and Counseling, 2019, 102, 1513-1519.	1.0	4
1067	The Three Rs for Preventing Heart Failure Readmission: Review, Reassess, and Reeducate. Critical Care Nurse, 2019, 39, 85-93.	0.5	13

#	Article	IF	Citations
1068	An Advanced Practice Practitionerâ€“Based Program to Reduce 30â€•and 90â€Day Readmissions After Liver Transplantation. Liver Transplantation, 2019, 25, 901-910.	1.3	20
1069	Predictors and Costs of 30â€Day Readmissions After Index Hospitalizations for Alcoholâ€Related Disorders in U.S. Adults. Alcoholism: Clinical and Experimental Research, 2019, 43, 857-868.	1.4	6
1070	Outcomes of a Citywide Campaign to Reduce Medicaid Hospital Readmissions With Connection to Primary Care Within 7 Days of Hospital Discharge. JAMA Network Open, 2019, 2, e187369.	2.8	27
1071	Concurrent validity and acceptability of health literacy measures of adults hospitalized with heart failure. Applied Nursing Research, 2019, 46, 50-56.	1.0	10
1072	Building patient capacity to participate in care during hospitalisation: a scoping review. BMJ Open, 2019, 9, e026551.	0.8	14
1073	Feasibility and performance of a patient-oriented discharge instruction tool for heart failure. BMJ Open Quality, 2019, 8, e000489.	0.4	1
1074	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
1075	Avoidable 30â€day readmissions in patients undergoing vascular surgery. BJS Open, 2019, 3, 759-766.	0.7	10
1076	Health Literacy and Medication Adherence in COPD Patients: When Caregiver Presence Is Not Sufficient. COPD: Journal of Chronic Obstructive Pulmonary Disease, 2019, 16, 362-367.	0.7	12
1077	Health Optimization Program for Elders. Journal of Nursing Care Quality, 2019, 34, 217-222.	0.5	6
1078	Improving Care Transitions to Drive Patient Outcomes. Professional Case Management, 2019, 24, 297-305.	0.2	8
1079	"I think we know more than our doctors". Proceedings of the ACM on Human-Computer Interaction, 2019, 3, 1-22.	2.5	14
1080	What All Case Managers Can Do to Help Improve Care Transitions. Professional Case Management, 2019, 24, 327-328.	0.2	0
1081	Aiming to Improve Readmissions Through InteGrated Hospital Transitions (AIRTIGHT): a Pragmatic Randomized Controlled Trial. Journal of General Internal Medicine, 2019, 34, 58-64.	1.3	26
1082	Clarifying model for continuity of care: A concept analysis. International Journal of Nursing Practice, 2019, 25, e12704.	0.8	28
1083	Social work-based transitional care intervention for super utilizers of medical care: a retrospective analysis of the bridge model for super utilizers. Social Work in Health Care, 2019, 58, 126-141.	0.8	14
1084	Patient readiness for hospital discharge and its relationship to discharge preparation and structural factors: A cross-sectional study. International Journal of Nursing Studies, 2019, 90, 13-20.	2.5	30
1085	Enhanced readability of discharge summaries decreases provider telephone calls and patient readmissions in the posthospital setting. Surgery, 2019, 165, 789-794.	1.0	17

#	Article	IF	Citations
1086	Factors for Self-Managing Care Following Older Adultsâ€™ Discharge from the Emergency Department: A Qualitative Study. Canadian Journal on Aging, 2019, 38, 76-89.	0.6	4
1087	Effect of Patient Care Coordination on Hospital Encounters and Related Costs. Population Health Management, 2019, 22, 406-414.	0.8	10
1088	From Hospital to Home to Participation: A Position Paper on Transition Planning Poststroke. Archives of Physical Medicine and Rehabilitation, 2019, 100, 1162-1175.	0.5	35
1089	What Are Strategies to Advance Policies Supporting Family Caregivers? Promising Approaches From a Statewide Task Force. Journal of Aging and Social Policy, 2019, 31, 66-84.	0.9	9
1090	Eliciting nursesâ€™ perspectives to improve health information exchange between hospital and home health care. Geriatric Nursing, 2019, 40, 277-283.	0.9	15
1091	Cost-Benefit Analysis of Transitional Care in Neurosurgery. Neurosurgery, 2019, 85, 672-679.	0.6	15
1092	The Course of Geriatric Syndromes in Acutely Hospitalized Older Adults: The Hospital-ADL Study. Journal of the American Medical Directors Association, 2019, 20, 152-158.e2.	1.2	41
1093	The Effectiveness of the Nurse Care Coordinator Role on Patient-Reported and Health Service Outcomes: A Systematic Review. Evaluation and the Health Professions, 2019, 42, 263-296.	0.9	37
1094	Market and organizational factors associated with hospital vertical integration into sub-acute care. Health Care Management Review, 2019, 44, 137-147.	0.6	7
1095	Tracking the Rise of Geriatric Emergency Departments in the United States. Journal of Applied Gerontology, 2020, 39, 871-879.	1.0	17
1096	90-Day Hospital Readmissions of Patients in a Geriatric Acute Care Ward in Singapore. Clinical Nursing Research, 2020, 29, 200-209.	0.7	0
1097	Incorporation of Clinical Pharmacy Into a Geriatric Transitional Care Management Program. Journal of Pharmacy Practice, 2020, 33, 661-665.	0.5	2
1098	Change Over Time in Caregiving Networks for Older Adults With and Without Dementia. Journals of Gerontology - Series B Psychological Sciences and Social Sciences, 2020, 75, 1563-1572.	2.4	45
1099	Patient and caregiver experiences on care transitions for adults with a hip fracture: a scoping review. Disability and Rehabilitation, 2020, 42, 3549-3558.	0.9	27
1100	The medication discrepancy taxonomy (MedTax): The development and validation of a classification system for medication discrepancies identified through medication reconciliation. Research in Social and Administrative Pharmacy, 2020, 16, 142-148.	1.5	32
1101	Does a Reduction in Readmissions Result in Net Savings for Most Hospitals? An Examination of Medicareâ€™s Hospital Readmissions Reduction Program. Medical Care Research and Review, 2020, 77, 334-344.	1.0	14
1102	Strategies older adults use in their work to get back to normal following hospitalization. Geriatric Nursing, 2020, 41, 132-138.	0.9	7
1103	Where are the family caregivers? Finding family caregiver-related content in foundational nursing documents. Journal of Professional Nursing, 2020, 36, 76-84.	1.4	10

#	Article	IF	Citations
1104	Face-to-Face Meetings with Neurosurgical Patients Before Hospital Discharge: Impact on Telephone Outreach, Emergency Department Visits, and Hospital Readmissions. Population Health Management, 2020, 23, 174-182.	0.8	5
1105	Care Transitions in the Psychiatric Hospital: Focus on Older Adults. American Journal of Geriatric Psychiatry, 2020, 28, 368-377.	0.6	7
1106	Patient expectations for recovery after elective surgery: a common-sense model approach. Journal of Behavioral Medicine, 2020, 43, 185-197.	1.1	10
1107	Continuity of care interventions for preventing hospital readmission of older people with chronic diseases: A meta-analysis. International Journal of Nursing Studies, 2020, 101, 103396.	2.5	79
1108	Health Care Hotspotting â€" A Randomized, Controlled Trial. New England Journal of Medicine, 2020, 382, 152-162.	13.9	206
1109	Associations of Hospital Discharge Services With Potentially Avoidable Readmissions Within 30 Days Among Older Adults After Rehabilitation in Acute Care Hospitals in Tokyo, Japan. Archives of Physical Medicine and Rehabilitation, 2020, 101, 832-840.	0.5	18
1110	Role of House Calls in the Care of Patients With Pulmonary Disease. Chest, 2020, 157, 1250-1255.	0.4	1
1111	Evidence of the Linkage Between Hospital-based Care Coordination Strategies and Hospital Overall (Star) Ratings. Medical Care, 2020, 58, 18-26.	1.1	2
1112	Early Readmission to Hospital in Patients With Cancer With Malignant Pleural Effusions. Chest, 2020, 157, 435-445.	0.4	16
1113	Transitions in Atrial Fibrillation Care: AÂSystematic Review. Heart Lung and Circulation, 2020, 29, 1000-1014.	0.2	3
1114	Planning for a Safe Discharge: More Than a Capacity Evaluation. Journal of the American Geriatrics Society, 2020, 68, 859-866.	1.3	19
1115	Using a Social Worker Transition Coach to Improve Hospital-to-Home Transitions for High-Risk Nonelderly Patients. Journal for Healthcare Quality: Official Publication of the National Association for Healthcare Quality, 2020, 42, 315-325.	0.3	3
1116	Impact of a transitions of care pilot service established by pharmacy residents within an academic medical center. Journal of the American Pharmacists Association: JAPhA, 2020, 60, 87-92.e2.	0.7	6
1117	Effects of Accessible Health Technology and Caregiver Support Posthospitalization on 30-Day Readmission Risk: A Randomized Trial. Joint Commission Journal on Quality and Patient Safety, 2020, 46, 109-117.	0.4	9
1118	Community pharmacy medication review, death and re-admission after hospital discharge: a propensity score-matched cohort study. BMJ Quality and Safety, 2020, 29, 41-51.	1.8	20
1119	Rates and Types of Medication-Related Problems in Patients Rehospitalized Within 30 Days of Discharge From a Community Hospital. Journal of Pharmacy Technology, 2020, 36, 47-53.	0.5	4
1120	Validation of the Elderly Risk Assessment Index in the Emergency Department. American Journal of Emergency Medicine, 2020, 38, 1441-1445.	0.7	5
1121	Social Factors and Patient Perceptions Associated With Preventable Hospital Readmissions. Journal of Patient Experience, 2020, 7, 19-26.	0.4	24

#	Article	IF	Citations
1122	Preventing Readmissions Through Effective Partnershipsâ€"Communication and Palliative Care (PREP-CPC): A Multisite Intervention for Encouraging Goals of Care Conversations for Hospitalized Patients Facing Serious Illness. American Journal of Hospice and Palliative Medicine, 2020, 37, 582-588.	0.8	3
1123	Nursing discharge teaching for hospitalized older people: A rapid realist review. Journal of Advanced Nursing, 2020, 76, 2885-2896.	1.5	13
1124	Utilization of a standardized discharge checklist to improve the transition of care for patients receiving parenteral nutrition. Nutrition in Clinical Practice, 2021, 36, 877-883.	1.1	2
1125	Crossing boundaries: Establishing a framework for researching quality and safety in care transitions. Applied Ergonomics, 2020, 89, 103228.	1.7	23
1126	Hospital to Community Transitions for Older Adults. Mayo Clinic Proceedings, 2020, 95, 2253-2262.	1.4	8
1127	Alzheimerâ€™s Caregiversâ€™ Experience With and Perceptions of the Affordable Care Act: Thematic Analysis of Online Discussion Forums. Journal of Applied Gerontology, 2020, 40, 073346482096408.	1.0	2
1128	â€œWonâ€™t You Be My Doctor?â€ Four Keys to a Satisfying Relationship in an Increasingly Virtual World. Journal of Patient Experience, 2020, 7, 851-855.	0.4	6
1129	Patientsâ€™ experiences of using an e-Health tool for self-management support after prostate cancer surgery: a deductive interview study explained through the FITT framework. BMJ Open, 2020, 10, e035024.	0.8	8
1130	Study protocol for a hospital-to-home transitional care intervention for older adults with multiple chronic conditions and depressive symptoms: a pragmatic effectiveness-implementation trial. BMC Geriatrics, 2020, 20, 240.	1.1	10
1131	A technology-enhanced model of care for transitional palliative care versus attention control for adult family caregivers in rural or medically underserved areas: study protocol for a randomized controlled trial. Trials, 2020, 21, 895.	0.7	7
1132	Stakeholder perceptions of components of a Parkinson disease care management intervention, care coordination for health promotion and activities in Parkinsonâ€™s disease (CHAPS). BMC Neurology, 2020, 20, 437.	0.8	5
1134	Parent Perceptions and Experiences Regarding Medication Education at Time of Hospital Discharge for Children With Medical Complexity. Hospital Pediatrics, 2020, 10, 00-00.	0.6	12
1135	Nurse Continuity at Discharge and Return to Hospital. Nursing Research, 2020, 69, 186-196.	0.8	11
1136	Geriatric-Specific Standards for Information Transfer BetweenÂNursing Homes and Acute Care Hospitals. Journal of the American Medical Directors Association, 2020, 21, 444-446.	1.2	4
1137	Intensified ambulatory cardiology care: effects on mortality and hospitalisationâ€"a comparative observational study. Scientific Reports, 2020, 10, 14695.	1.6	12
1138	Prehospital and Posthospital Fall Injuries in Older US Adults. JAMA Network Open, 2020, 3, e2013243.	2.8	9
1139	Components of the transitional care model (TCM) to reduce readmission in geriatric patients: a systematic review. BMC Geriatrics, 2020, 20, 345.	1.1	48
1140	Machine-learning prediction of unplanned 30-day rehospitalization using the French hospital medico-administrative database. Medicine (United States), 2020, 99, e22361.	0.4	7

#	Article	IF	Citations
1141	Variations in hospitalization rates across Parkinson's Foundation Centers of Excellence. Parkinsonism and Related Disorders, 2020, 81, 123-128.	1.1	9
1142	Organizational integration, practice capabilities, and outcomes in clinically complex medicare beneficiaries. Health Services Research, 2020, 55, 1085-1097.	1.0	15
1143	Designing and Adapting Services to Create Value Outside a Hospital Using Blockchain Architecture. International Journal of R&D Innovation Strategy, 2020, 2, 44-67.	1.0	2
1144	Teaching Geriatrics and Transitions of Care to Internal Medicine Resident Physicians. Geriatrics (Switzerland), 2020, 5, 72.	0.6	1
1145	Medicareâ€™s Care Management Codes Might Not SupportÂPrimary Care As Expected. Health Affairs, 2020, 39, 828-836.	2.5	10
1146	Readmission of older acutely admitted medical patients after short-term admissions in Denmark: a nationwide cohort study. BMC Geriatrics, 2020, 20, 203.	1.1	23
1147	Evaluation of the medication reconciliation process and classification of discrepancies at hospital admission and dischargeÂin Italy. International Journal of Clinical Pharmacy, 2020, 42, 1061-1072.	1.0	4
1148	Interdisciplinary communication and collaboration as key to improved nutritional care of malnourished older adults across healthâ€care settings â€“ A qualitative study. Health Expectations, 2020, 23, 1096-1107.	1.1	12
1149	A comparative effectiveness trial of an information technology enhanced peer-integrated collaborative care intervention versus enhanced usual care for US trauma care systems: Clinical study protocol. Contemporary Clinical Trials, 2020, 91, 105970.	0.8	10
1150	Design for self-care. , 2020, , 277-302.		5
1151	The Association Between Patient-reported Clinical Factors and 30-day Acute Care Utilization in Chronic Heart Failure. Medical Care, 2020, 58, 336-343.	1.1	9
1152	Mental illnesses among patients undergoing elective anterior cervical discectomy and fusion: Analysis from the National Readmissions Database. Clinical Neurology and Neurosurgery, 2020, 193, 105765.	0.6	6
1153	Extending Enhanced Recovery after Surgery Protocols to the Post-Discharge Setting: A Phone Call Intervention to Support Patients after Expedited Discharge after Pancreaticoduodenectomy. American Surgeon, 2020, 86, 42-48.	0.4	8
1154	Thirtyâ€Day Hospital Readmissions in a Care Transitions Program for Highâ€Risk Older Adults. Journal of the American Geriatrics Society, 2020, 68, 1307-1312.	1.3	8
1155	Engaging patients and families in communication across transitions of care: An integrative review. Patient Education and Counseling, 2020, 103, 1104-1117.	1.0	22
1156	Tele-transitions of care (TTOC): a 12-month, randomized controlled trial evaluating the use of Telehealth to achieve triple aim objectives. BMC Family Practice, 2020, 21, 27.	2.9	21
1157	Does Care Transition Matter? Exploring the Newly Published HCAHPS Measure. American Journal of Medical Quality, 2020, 35, 380-387.	0.2	4
1158	Successful care transitions for older people: a systematic review and meta-analysis of the effects of interventions that support medication continuity. Age and Ageing, 2020, 49, 558-569.	0.7	76

#	Article	IF	Citations
1159	A quasi-experiment assessing the six-months effects of a nurse care coordination program on patient care experiences and clinician teamwork in community health centers. BMC Health Services Research, 2020, 20, 137.	0.9	8
1160	Potentially Preventable Spending Among High-Cost Medicare Patients: Implications for Healthcare Delivery. Journal of General Internal Medicine, 2020, 35, 2845-2852.	1.3	8
1161	My Bridge (Mi Puente), a care transitions intervention for Hispanics/Latinos with multimorbidity and behavioral health concerns: protocol for a randomized controlled trial. Trials, 2020, 21, 174.	0.7	2
1162	2019 Update on Pediatric Medical Overuse. JAMA Pediatrics, 2020, 174, 375.	3.3	14
1163	Assess the Performance and Cost-Effectiveness of LACE and HOSPITAL Re-Admission Prediction Models as a Risk Management Tool for Home Care Patients: An Evaluation Study of a Medical Center Affiliated Home Care Unit in Taiwan. International Journal of Environmental Research and Public Health, 2020, 17, 927.	1.2	4
1164	Facilitating the identification of patients hospitalized for acute myocardial infarction and heart failure and the assessment of their readmission risk through the Patient Navigator Program. American Heart Journal, 2020, 224, 77-84.	1.2	1
1165	Readmissions among NICU graduates: Who, when and why?. Seminars in Perinatology, 2020, 44, 151245.	1.1	30
1166	Evaluation of the TRANSITION tool to improve communication during older patientsâ€™ care transitions: Healthcare practitionersâ€™ perspectives. Journal of Clinical Nursing, 2020, 29, 2275-2284.	1.4	5
1167	Decreasing Heart Failure Readmissions Among Older Patients With Cognitive Impairment by Engaging Caregivers. Journal of Cardiovascular Nursing, 2020, 35, 253-261.	0.6	9
1168	Collaborating with healthcare providers to understand their perspectives on a hospital-to-home warning signs intervention for rural transitional care: protocol of a multimethod descriptive study. BMJ Open, 2020, 10, e034698.	0.8	2
1169	Linking Health And Social Services Through Area Agencies On Aging Is Associated With Lower Health Care Use And Spending. Health Affairs, 2020, 39, 587-594.	2.5	24
1170	Relative contributions of hospital versus skilled nursing facility quality on patient outcomes. BMJ Quality and Safety, 2021, 30, 195-201.	1.8	1
1171	A System-Wide Population Health Value Approach to Reduce Hospitalization Among Chronic Kidney Disease Patients: an Observational Study. Journal of General Internal Medicine, 2021, 36, 1613-1621.	1.3	6
1172	Medication transitions: Vulnerable periods of change in need of human factors and ergonomics. Applied Ergonomics, 2021, 90, 103279.	1.7	17
1173	A Nurse-Led Bridging Program to Reduce 30-Day Readmissions of Older Patients Discharged From Acute Care Units. Journal of the American Medical Directors Association, 2021, 22, 1292-1299.e5.	1.2	6
1174	Evaluation of an interprofessional care coordination model: Benefits to health professions students and the community served. Nursing Outlook, 2021, 69, 322-332.	1.5	11
1175	A telephone-based surgical transitional care program with improved patient satisfaction scores and fiscal neutrality. Surgery, 2021, 169, 347-355.	1.0	4
1176	Optimizing Safety for Surgical Patients Undergoing Interhospital Transfer. Surgical Clinics of North America, 2021, 101, 57-69.	0.5	3

#	Article	IF	Citations
1177	An exploration of Canadian transitional care programs for older adults. Healthcare Management Forum, 2021, 34, 163-168.	0.6	9
1178	A Collaboration Among Primary Careâ€"Based Clinical Pharmacists and Communityâ€Based Health Coaches. Journal of the American Geriatrics Society, 2021, 69, 68-76.	1.3	11
1179	Highâ€need highâ€cost patients: A Concept Analysis. Nursing Forum, 2021, 56, 127-133.	1.0	6
1180	A multi-level stakeholder-centered approach to investigate unnecessary readmissions in emergency departments. IISE Transactions on Healthcare Systems Engineering, 2021, 11, 24-37.	1.2	1
1181	Predictors of Older Adult Adherence With Emergency Department Discharge Instructions. Academic Emergency Medicine, 2021, 28, 215-225.	0.8	11
1182	Impacts of Post-Hospitalization Accessible Health Technology and Caregiver Support on 90-Day Acute Care Use and Self-Care Assistance. American Journal of Medical Quality, 2021, 36, 145-155.	0.2	10
1183	Effectiveness of Discharge Education With the Teach-Back Method on 30-Day Readmission: A Systematic Review. Journal of Patient Safety, 2021, 17, 305-310.	0.7	40
1184	Improving evidence-based grouping of transitional care strategies in hospital implementation using statistical tools and expert review. BMC Health Services Research, 2021, 21, 35.	0.9	10
1185	Training pharmacy residents as transitions of care specialists: a United States perspective. International Journal of Clinical Pharmacy, 2021, 43, 756-758.	1.0	2
1186	Effectiveness of a community-based integrated care ward (CICW) on 90-day readmission among the elderly people: a retrospective cohort study of a rural area in Japan. Journal of Rural Medicine: JRM, 2021, 16, 236-244.	0.2	3
1187	Association of cognitive impairment severity with potentially avoidable readmissions: A retrospective cohort study of 8897 older patients. Alzheimer's and Dementia: Diagnosis, Assessment and Disease Monitoring, 2021, 13, e12147.	1.2	6
1188	Information Sharing Practices Between US Hospitals and Skilled Nursing Facilities to Support Care Transitions. JAMA Network Open, 2021, 4, e2033980.	2.8	31
1189	Bridging the Gap: A Mixed Methods Study Investigating Caregiver Integration for People with Geriatric Syndrome. International Journal of Integrated Care, 2021, 21, 14.	0.1	3
1190	Reducing Readmissions by Addressing the Social Determinants of Health. American Journal of Health Economics, 2021, 7, 1-40.	1.4	16
1191	Development of claimsâ€based measures of unplanned acute care with superior power for assessing the effectiveness of interventions following acute care. Health Services Research, 2021, 56, 550-557.	1.0	1
1192	Stakeholder impact on the implementation of integrated care: Opportunities to consider for patient-centered outcomes research. Contemporary Clinical Trials, 2021, 101, 106256.	0.8	5
1193	Who is Responsible for Discharge Education of Patients? A Multi-Institutional Survey of Internal Medicine Residents. Journal of General Internal Medicine, 2021, 36, 1568-1575.	1.3	6
1194	The effect of a telephone follow-up call for older patients, discharged home from the emergency department on health-related outcomes: a systematic review of controlled studies. International Journal of Emergency Medicine, 2021, 14, 13.	0.6	14

#	Article	IF	Citations
1195	Complications as a Mediator of the Perioperative Frailtyâ€“Mortality Association. Anesthesiology, 2021, 134, 577-587.	1.3	12
1196	Improvement of transitional care from hospital to home for older patients, the TIGER study: protocol of a randomised controlled trial. BMJ Open, 2021, 11, e037999.	0.8	9
1197	Pharmaceutical Discharge Management: Implementation in Swiss Hospitals Compared to International Guidelines. Pharmacy (Basel, Switzerland), 2021, 9, 33.	0.6	3
1198	A myriad of factors influencing the implementation of transitional care innovations: a scoping review. Implementation Science, 2021, 16, 21.	2.5	14
1199	Transitional care during COVID-19 pandemic in Japan: Calls for new strategies to integrate traditional approaches with information and communication technologies. BioScience Trends, 2021, 15, 55-57.	1.1	10
1201	Receipt of Posthospitalization Care Training Among Medicare Beneficiariesâ€™ Family Caregivers. JAMA Network Open, 2021, 4, e211806.	2.8	13
1202	Nursing Care Coordination for Patients with Complex Needs in Primary Healthcare: A Scoping Review. International Journal of Integrated Care, 2021, 21, 16.	0.1	39
1203	Evidence based processes to prevent readmissions: more is better, a ten-site observational study. BMC Health Services Research, 2021, 21, 189.	0.9	15
1204	Effect of continuous nursing on quality of life of hemodialysis patients. Medicine (United States), 2021, 100, e24942.	0.4	6
1205	Standardized Discharge Planning Tool Leads to Earlier Discharges and Fewer Readmissions. Journal of Nursing Care Quality, 2022, 37, 54-60.	0.5	5
1206	Implementation and preliminary testing of a theory-guided nursing discharge teaching intervention for adult inpatients aged 50 and over with multimorbidity: a pragmatic feasibility study protocol. Pilot and Feasibility Studies, 2021, 7, 71.	0.5	4
1207	Assessment of Care Handoffs Among Hospitalist Physicians and 30-Day Mortality in Hospitalized Medicare Beneficiaries. JAMA Network Open, 2021, 4, e213040.	2.8	8
1208	Association between social isolation and outpatient follow-up in older adults following emergency department discharge. Archives of Gerontology and Geriatrics, 2021, 93, 104298.	1.4	9
1209	Skilled Nursing Facilities Modify the Relationship Between Depressive Symptoms and Hospital Readmissions but Not Health Outcomes Among Older Adults. Journal of Aging and Health, 2021, 33, 817-827.	0.9	1
1210	Effect of a Medicaid Accountable Care Collaborative on 30-Day Hospital Readmission Rates. Population Health Management, 2021, 24, 190-197.	0.8	1
1211	Transitional Cancer Care Program from Hospital to Home in the Health Care System of Iran. Asian Pacific Journal of Cancer Prevention, 2021, 22, 1231-1237.	0.5	2
1212	Health care transitions for persons living with dementia and their caregivers. BMC Geriatrics, 2021, 21, 285.	1.1	18
1213	Enhancing physician care of vulnerable older adults. Journal of the American Geriatrics Society, 2021, 69, 1463-1465.	1.3	0

#	Article	IF	Citations
1214	Factors Associated With Discharge Planning Practices for Patients Receiving Inpatient Psychiatric Care. Psychiatric Services, 2021, 72, 498-506.	1.1	3
1215	Improving Patient Activation among Older Veterans: Results from a Social Worker-Led Care Transitions Intervention. Journal of Gerontological Social Work, 2022, 65, 63-77.	0.6	4
1216	Outcomes of a Nursing Home-to-Community Care Transition Program. Journal of the American Medical Directors Association, 2021, 22, 2440-2446.e2.	1.2	5
1217	Impact of an integrated medication reconciliation model led by a hospital clinical pharmacist on the reduction of postâ€discharge unintentional discrepancies. Journal of Clinical Pharmacy and Therapeutics, 2021, 46, 1326-1333.	0.7	9
1218	Personâ€centred communication with cancer survivors: Exploring the meaning of followâ€up coaching conversations. Scandinavian Journal of Caring Sciences, 2023, 37, 243-249.	1.0	2
1219	Cancer care reform in South Africa: A case for cancer care coordination: A narrative review. Palliative and Supportive Care, 2022, 20, 129-137.	0.6	3
1220	A scoping review of interventions for older adults transitioning from hospital to home. Journal of the American Geriatrics Society, 2021, 69, 2950-2962.	1.3	26
1221	Resident perspectives on the value of interdisciplinary conference calls for geriatric patients. BMC Medical Education, 2021, 21, 314.	1.0	2
1223	Reducing costs and improving care after hospitalization: Economic evaluation of a novel transitional care clinic. Health Services Management Research, 2021, , 095148482110287.	1.0	0
1224	Post-Discharge Mortality and Rehospitalization among Participants in a Comprehensive Acute Kidney Injury Rehabilitation Program. Kidney360, 2021, 2, 1424-1433.	0.9	16
1225	Opening Pandoraâ€™s Box. Medical Care, 2021, 59, S336-S343.	1.1	6
1226	The value of caregiver inclusive practices in geriatric transitions of care: A systematic review. Health Policy, 2021, 125, 888-898.	1.4	7
1227	How Do Care Transitions Work?. Medical Care, 2021, 59, S387-S397.	1.1	10
1228	An integrated model of care utilizing community health workers to promote safe transitions of care. Journal of the American Geriatrics Society, 2021, 69, 2638-2647.	1.3	2
1229	A scoping review of communication tools applicable to patients and their primary care providers after discharge from hospital. Patient Education and Counseling, 2021, 104, 1681-1703.	1.0	5
1230	Development of a Primary Care Transitions Clinic in an Academic Medical Center. Journal of General Internal Medicine, 2022, 37, 582-589.	1.3	4
1231	Effectiveness of a nurse-led hospital-to-home transitional care intervention for older adults with multimorbidity and depressive symptoms: A pragmatic randomized controlled trial. PLoS ONE, 2021, 16, e0254573.	1.1	14
1232	The Association of Readmission Reduction Activities with Primary Care Practice Readmission Rates. Journal of General Internal Medicine, 2021, , 1.	1.3	3

#	Article	IF	Citations
1233	Tools to evaluate medication management for caregivers of people living with dementia: A systematic review. Health Expectations, 2021, 24, 1570-1581.	1.1	7
1234	A Multi-Component Transition of Care Improvement Project to Reduce Hospital Readmissions Following Ischemic Stroke. Neurohospitalist, The, 2022, 12, 205-212.	0.3	3
1235	Discharge destination influences risks of readmission and complications after lumbar spine surgery in severely disabled patients. Clinical Neurology and Neurosurgery, 2021, 207, 106801.	0.6	4
1236	Effectiveness of a care transitions intervention for older adults discharged home from the emergency department: A randomized controlled trial. Academic Emergency Medicine, 2022, 29, 51-63.	0.8	12
1237	Care Coordination for Dialysis Patients During and After Hospitalization: A Pilot Study. Kidney Medicine, 2021, 3, 1109-1111.	1.0	0
1238	Thirty-Day Readmission Rates after Takotsubo Syndrome with or without Malignancy: A Nationwide Readmissions Database Analysis. Journal of Clinical Medicine, 2021, 10, 3701.	1.0	2
1239	Non-specific pain and 30-day readmission in acute coronary syndromes: findings from the TRACE-CORE prospective cohort. BMC Cardiovascular Disorders, 2021, 21, 383.	0.7	2
1240	Supporting medicines management for older people at care transitions â€“ a theory-based analysis of a systematic review of 24 interventions. BMC Health Services Research, 2021, 21, 890.	0.9	0
1241	Improving Care Transitions: An Initiative between the Emergency Department and Senior Care Facilities. Spartan Medical Research Journal, 2021, 6, 26862.	0.3	0
1242	Development and psychometric properties of surveys to assess patient and family caregiver experience with care transitions. BMC Health Services Research, 2021, 21, 785.	0.9	3
1243	A Nurse Practitioner-Led Multidisciplinary Diabetes Clinic for Adult Patients Discharged From Hospital. Canadian Journal of Diabetes, 2021, 45, 566-570.	0.4	2
1244	Factorial Analysis Quantifies the Effects of Pediatric Discharge Bundle on Hospital Readmission. Pediatrics, 2021, 148, .	1.0	2
1245	Diagnosis-group-specific transitional care program recommendations for 30-day rehospitalization reduction. Annals of Applied Statistics, 2021, 15, .	0.5	1
1246	Students' perceptions of a new transitions of care elective course in the pharmacy curriculum. Currents in Pharmacy Teaching and Learning, 2021, 13, 1215-1220.	0.4	1
1247	Facilitators and barriers to post-discharge pain assessment and triage: a qualitative study of nursesâ€™ and patientsâ€™ perspectives. BMC Health Services Research, 2021, 21, 1021.	0.9	1
1248	Transitions From Hospital to Home. , 2022, , 668-671.		0
1249	Update on the status of effective programs to help dementia family caregivers in the United States: Observations from the search for programs to include in Best Practice Caregiving. , 2021, , 247-300.		0
1250	The association of care transitions measure-15 score and outcomes after discharge from the NICU. BMC Pediatrics, 2021, 21, 7.	0.7	4

#	Article	IF	Citations
1251	Evaluation of a Transitional Care Program After Hospitalization for Heart Failure in an Integrated Health Care System. JAMA Network Open, 2020, 3, e2027410.	2.8	22
1255	Successful Aging and Resilience: Applications for Public Health and Health Care. , 2011, , 15-29.		17
1256	Geriatric Models of Care. , 2011, , 253-266.		3
1258	Targeting Enhanced Services Toward High-Cost, High-Need Medicare Patients. , 2016, , 13-30.		5
1259	Nursing Issues in Older Adult Surgery Patients. , 2020, , 431-449.		1
1260	Transitions of Care. , 2017, , 105-116.		1
1261	Nurse Practitioners and Primary Care for Older Adults. , 2018, , 159-172.		1
1262	Crossing Boundaries: Quality in Care Transitions. , 2017, , 3-29.		16
1263	Deconstructing Quality in Care Transitions. , 2017, , 283-293.		1
1264	Poor Adherence to Antipsychotic Medication in People with Schizophrenia: Diffusion, Consequences and Contributing Factors. , 2014, , 1-84.		1
1265	A Perfect Storm? The Future of Family Caregiving. , 2015, , 357-379.		13
1266	Exploring SEIPS 2.0 as a model for analyzing care transitions across work systems. Applied Ergonomics, 2020, 88, 103141.	1.7	21
1267	Machine Learning Prediction of Postoperative Emergency Department Hospital Readmission. Anesthesiology, 2020, 132, 968-980.	1.3	34
1268	An Analysis of Methodologies That Can Be Used to Validate if a Perioperative Surgical Home Improves the Patient-centeredness, Evidence-based Practice, Quality, Safety, and Value of Patient Care. Anesthesiology, 2013, 119, 1261-1274.	1.3	67
1269	Practices to support relational coordination in care transitions: Observations from the VA rural Transitions Nurse Program. Health Care Management Review, 2022, 47, 109-114.	0.6	12
1270	Implementation and Feasibility of the Re-Engineered Discharge for Surgery (RED-S) Intervention: A Pilot Study. Journal for Healthcare Quality: Official Publication of the National Association for Healthcare Quality, 2021, 43, 92-100.	0.3	3
1271	Impact of an Emergency Department-to-Home Transitional Care Intervention on Health Service Use in Medicare Beneficiaries. Medical Care, 2021, 59, 29-37.	1.1	10
1272	Cliniciansâ€™ Attitudes and System Capacity Regarding Transitional Care Practices Within a Health System. Journal of Patient Safety, 2020, Publish Ahead of Print, e727-e731.	0.7	2

#	Article	IF	Citations
1273	Where Are My Patients? It Is Time to Automate Notification of Hospital Use to Primary Care Practices. Southern Medical Journal, 2012, 105, 18-23.	0.3	8
1274	Effectiveness of strategies to promote safe transition of elderly people across care settings. JBI Database of Systematic Reviews and Implementation Reports, 2009, 7, 1036-1090.	1.7	11
1275	A systematic review of the effectiveness of nurse coordinated transitioning of care on readmission rates for patients with heart failure. JBI Database of Systematic Reviews and Implementation Reports, 2011, 9, 464-490.	1.7	5
1276	Effectiveness of nursing discharge planning interventions on health-related outcomes in elderly inpatients discharged home: a systematic review protocol. JBI Database of Systematic Reviews and Implementation Reports, 2013, 11, 1-12.	1.7	4
1278	Impact of Patientâ€Centered Discharge Tools: A Systematic Review. Journal of Hospital Medicine, 2017, 12, 110-117.	0.7	31
1279	Impact of a Connected Care Model on 30-Day Readmission Rates from Skilled Nursing Facilities. Journal of Hospital Medicine, 2017, 12, 238-244.	0.7	26
1280	Perspectives of Clinicians at Skilled Nursing Facilities on 30â€Day Hospital Readmissions: A Qualitative Study. Journal of Hospital Medicine, 2017, 12, 632-638.	0.7	15
1281	Low Health Literacy Is Associated with Increased Transitional Care Needs in Hospitalized Patients. Journal of Hospital Medicine, 2017, 12, 918-924.	0.7	28
1282	The Enhanced Care Program: Impact of a Care Transition Program on 30â€Day Hospital Readmissions for Patients Discharged From an Acute Care Facility to Skilled Nursing Facilities. Journal of Hospital Medicine, 2018, 13, 229-235.	0.7	21
1283	Does Scheduling a Postdischarge Visit with a Primary Care Physician Increase Rates of Follow-up and Decrease Readmissions?. Journal of Hospital Medicine, 2019, 14, e37-e42.	0.7	8
1284	The Effects of a Multifaceted Intervention to Improve Care Transitions Within an Accountable Care Organization: Results of a Stepped-Wedge Cluster-Randomized Trial. Journal of Hospital Medicine, 2020, 16, 15-22.	0.7	10
1285	Toward Safer Transitions: How Can We Reduce Post-Discharge Adverse Events?. Healthcare Quarterly, 2012, 15, 63-67.	0.7	19
1286	Integrating Social Determinants of Health into Primary Care Clinical and Informational Workflow during Care Transitions. EGEMS (Washington, DC), 2017, 5, 2.	2.0	20
1287	Data-Driven Decisions for Reducing Readmissions for Heart Failure: General Methodology and Case Study. PLoS ONE, 2014, 9, e109264.	1.1	94
1288	Applying the Integrated Practice Unit Concept to a Modified Virtual Ward Model of Care for Patients at Highest Risk of Readmission: A Randomized Controlled Trial. PLoS ONE, 2017, 12, e0168757.	1.1	46
1289	Technological resources and personnel costs required to implement an automated alert system for ambulatory physicians when patients are discharged from hospitals to home. Journal of Innovation in Health Informatics, 2013, 20, 87-93.	0.9	9
1290	Ninety-day readmissions after degenerative cervical spine surgery: A single-center administrative database study. International Journal of Spine Surgery, 2015, 9, 19.	0.7	22
1291	National COPD Readmissions Summit 2013: Integrating COPD into Patient-Centered Hospital Readmissions Reduction Programs. Chronic Obstructive Pulmonary Diseases (Miami, Fla), 2014, 2, 70-80.	0.5	25

#	Article	IF	Citations
1292	Preventing Breakdowns in Communication: Teaching Patient-Centered Posthospital Care Transitions to Medical Students. MedEdPORTAL: the Journal of Teaching and Learning Resources, 2016, 12, 10435.	0.5	6
1294	Alta hospitalar de pacientes idosos: necessidades e desafios do cuidado contÃ¬nuo. Estudos De Psicologia (Natal), 2014, 19, 227-236.	0.0	5
1295	Risk Factors for 30-Day Readmissions after Acute Myocardial Infarction. International Cardiovascular Forum Journal, 0, 4, 30.	1.1	9
1296	Improving Care Transitions Means More Than Reducing Hospital Readmissions. North Carolina Medical Journal, 2012, 73, 31-33.	0.1	4
1298	Development of a Path to Home Mobile App for the Geriatric Rehabilitation Program at BruyÃ¨re Continuing Care: Protocol for User-Centered Design and Feasibility Testing Studies. JMIR Research Protocols, 2018, 7, e11031.	0.5	7
1299	Learning Integrated Health System to Mobilize Context-Adapted Knowledge With a Wiki Platform to Improve the Transitions of Frail Seniors From Hospitals and Emergency Departments to the Community (LEARNING WISDOM): Protocol for a Mixed-Methods Implementation Study. JMIR Research Protocols, 2020, 9, e17363.	0.5	3
1300	Evaluating the Impact of a Risk Assessment System With Tailored Interventions in Germany: Protocol for a Prospective Study With Matched Controls. JMIR Research Protocols, 2020, 9, e17584.	0.5	1
1301	Older Adults with Multi-Morbidity: Medication Management Processes and Design Implications for Personal Health Applications. Journal of Medical Internet Research, 2011, 13, e44.	2.1	48
1302	Two Complementary Personal Medication Management Applications Developed on a Common Platform: Case Report. Journal of Medical Internet Research, 2011, 13, e45.	2.1	7
1303	The Personal Health Record Paradox: Health Care Professionalsâ€™ Perspectives and the Information Ecology of Personal Health Record Systems in Organizational and Clinical Settings. Journal of Medical Internet Research, 2013, 15, e70.	2.1	154
1304	How Can Research Keep Up With eHealth? Ten Strategies for Increasing the Timeliness and Usefulness of eHealth Research. Journal of Medical Internet Research, 2014, 16, e36.	2.1	197
1305	Using Tablet Computers to Increase Patient Engagement With Electronic Personal Health Records: Protocol For a Prospective, Randomized Interventional Study. JMIR Research Protocols, 2016, 5, e176.	0.5	11
1306	Feasibility of Implementing a Patient-Centered Postoperative Wound Monitoring Program Using Smartphone Images: A Pilot Protocol. JMIR Research Protocols, 2017, 6, e26.	0.5	24
1307	Enhancing mHealth Technology in the Patient-Centered Medical Home Environment to Activate Patients With Type 2 Diabetes: A Multisite Feasibility Study Protocol. JMIR Research Protocols, 2017, 6, e38.	0.5	14
1308	An ethnographic study of knowledge sharing across the boundaries between care processes, services and organisations: the contributions to â€˜safeâ€™ hospital discharge. Health Services and Delivery Research, 2014, 2, 1-160.	1.4	58
1309	Integration and continuity of primary care: polyclinics and alternatives â€“ a patient-centred analysis of how organisation constrains care co-ordination. Health Services and Delivery Research, 2015, 3, 1-148.	1.4	14
1310	Comparing the cost-effectiveness and clinical effectiveness of a new community in-reach rehabilitation service with the cost-effectiveness and clinical effectiveness of an established hospital-based rehabilitation service for older people: a pragmatic randomised controlled trial with microcost and qualitative analysis â€“ the Community In-reach Rehabilitation And Care Transition (CIRACT) study. Health Services and Delivery Research, 2016, 4, 1-90.	1.4	4
1312	Care of Nursing Home Residents by Advanced Practice Nurses. Research in Gerontological Nursing, 2008, 1, 177-185.	0.2	56

#	Article	IF	Citations
1313	Characteristics of Older Adults Rehospitalized Within 7 and 30 Days of Discharge: Implications for Nursing Practice. Journal of Gerontological Nursing, 2012, 38, 32-44.	0.3	10
1314	Older Adults' Perceptions of Their Fall Risk and Prevention Strategies After Transitioning from Hospital to Home. Journal of Gerontological Nursing, 2019, 45, 23-30.	0.3	17
1315	Differences in Transitional Care Provided to Patients With and Without Dementia. Journal of Gerontological Nursing, 2019, 45, 15-22.	0.3	6
1316	Aging in Community: Developing a More Holistic Approach to Enhance Older Adults' Well-Being. Research in Gerontological Nursing, 2016, 9, 6-13.	0.2	17
1317	Patient Preferences for Information on Post-Acute Care Services. Research in Gerontological Nursing, 2016, 9, 175-182.	0.2	17
1318	Home-based care for heart failure: Cleveland Clinicâ€™s â€œHeart Care at Homeâ€•transitional care program. Cleveland Clinic Journal of Medicine, 2013, 80, e-S20-e-S26.	0.6	12
1319	Optimizing transitions of care to reduce rehospitalizations. Cleveland Clinic Journal of Medicine, 2014, 81, 312-320.	0.6	28
1320	The aging nurse workforce and technology. Gerontechnology, 2011, 10, .	0.0	4
1321	The Effects of a Comprehensive Multidisciplinary Outpatient Diabetes Program on Hospital Readmission Rates in Patients with Diabetes: A Randomized Controlled Prospective Study. Endocrine Practice, 2020, 26, 1331-1336.	1.1	4
1322	The Transition from Hospital to Home: Older Peopleâ€™s Experiences. Open Journal of Nursing, 2015, 05, 622-631.	0.2	16
1323	Is the Risk-Standardized Readmission Rate Appropriate for a Generic Quality Indicator of Hospital Care?. Health Policy and Management, 2016, 26, 148-152.	0.3	2
1324	Can geriatric approaches support the care of old patients in emergency departments?. Swiss Medical Weekly, 2014, 144, w14040.	0.8	8
1325	Care Transition Processes to Achieve a Successful Community Discharge After Postacute Care: A Scoping Review. American Journal of Occupational Therapy, 2019, 73, 7301205140p1-7301205140p9.	0.1	20
1326	Occupational Therapyâ€™s Value in Provision of Quality Care to Prevent Readmissions. American Journal of Occupational Therapy, 2020, 74, 7403090010p1-7403090010p9.	0.1	9
1327	Measuring the Delivery of Complex Interventions through Electronic Medical Records: Challenges and Lessons Learned. EGEMS (Washington, DC), 2018, 6, 10.	2.0	9
1328	Patient-centeredness in Integrated healthcare delivery systems - Needs, expectations and priorities for organized healthcare systems. International Journal of Integrated Care, 2013, 13, .	0.1	13
1329	Quality in transitional care of the elderly: Key challenges and relevant improvement measures. International Journal of Integrated Care, 2014, 14, e013.	0.1	99
1330	Family members of older persons with multi-morbidity and their experiences of case managers in Sweden: an interpretive phenomenological approach. International Journal of Integrated Care, 2015, 15, e011.	0.1	7

#	Article	IF	Citations
1331	Transitional care for the highest risk patients: findings of a randomised control study. International Journal of Integrated Care, 2015, 15, e039.	0.1	32
1332	Implementation of Home Hospitalization and Early Discharge as an Integrated Care Service: A Ten Years Pragmatic Assessment. International Journal of Integrated Care, 2018, 18, 12.	0.1	43
1333	Care transitions for older patients with musculoskeletal disorders: continuity from the providersâ€™ perspective. International Journal of Integrated Care, 2011, 11, e014.	0.1	27
1334	Ten years of integrated care: backwards and forwards. The case of the province of QuÃ©bec, Canada. International Journal of Integrated Care, 2011, 11, e004.	0.1	46
1335	Transitional care programs: who is left behind? A systematic review. International Journal of Integrated Care, 2012, 12, e132.	0.1	33
1336	A collaborative chain out of phase. International Journal of Integrated Care, 2013, 13, e008.	0.1	24
1337	New nursing roles for the integrated management of complex chronic and palliative care patients in the region of Valencia/Nuevos perfiles enfermerÃa para el manejo integral de pacientes crÃ³nicos complejos y paliativos en la Comunidad Valenciana. International Journal of Integrated Care, 2012, 12, .	0.1	10
1338	Functional Impairment, Symptom Burden, and Clinical Outcomes Among Hospitalized Patients With Advanced Cancer. Journal of the National Comprehensive Cancer Network: JNCCN, 2020, 18, 747-754.	2.3	40
1339	A Multidisciplinary Approach to Transition Care: A Patient Safety Innovation Study. , 2007, 11, 4-9.		19
1340	Improving Chronic Care: The â€œGuided Careâ€•Model. , 2008, 12, 50-54.		58
1341	A Framework for Making Patient-Centered Care Front and Center. , 2012, 16, 49-53.		168
1342	Living With Advanced Illness: Longitudinal Study of Patient, Family, and Caregiver Needs. , 2012, 16, 28-35.		23
1343	Health changing conversations: cliniciansâ€™ experience of health coaching in the East of England. Future Hospital Journal, 2016, 3, 147-151.	0.2	7
1344	Pharmacist-led telemental health transitions of care clinic improves antidepressant medication continuity posthospitalization. Mental Health Clinician, 2020, 10, 381-384.	0.5	7
1345	Effect of nurse-led hospital-to-home transitional care interventions on mortality and psychosocial outcomes in adults with heart failure: a meta-analysis. European Journal of Cardiovascular Nursing, 2022, 21, 307-317.	0.4	6
1346	Allâ€Cause Unplanned Readmissions in the United States. Insights from the Nationwide Readmission Database. Internal Medicine Journal, 2021, , .	0.5	8
1347	Understanding the groups of care transition strategies used by U.S. hospitals: an application of factor analytic and latent class methods. BMC Medical Research Methodology, 2021, 21, 228.	1.4	4
1348	The critical role of care coordinators for persons with substance use disorder in rural settings: a case study. Social Work in Health Care, 2021, 60, 561-580.	0.8	1

#	Article	IF	Citations
1349	Effects of Different Transitional Care Strategies on Outcomes after Hospital Dischargeâ€"Trust Matters, Too. Joint Commission Journal on Quality and Patient Safety, 2022, 48, 40-52.	0.4	7
1350	Care Coordination Models and Toolsâ€"Systematic Review and Key Informant Interviews. Journal of General Internal Medicine, 2022, 37, 1367-1379.	1.3	13
1351	Predictors for Telephone Outreach Post-hospital Discharge. Professional Case Management, 2021, 26, 286-297.	0.2	3
1352	Care of Nursing Home Residents by Advanced Practice Nurses: A Review of the Literature. Research in Gerontological Nursing, 2008, 1, 177-185.	0.2	28
1353	The Frail Elderly Patient with Heart Disease. , 2010, , 295-299.		1
1354	Effect of post-discharge follow-up care on re-admissions among US veterans with congestive heart failure: a rural-urban comparison. Rural and Remote Health, 0, , .	0.4	14
1355	Managing multiple sclerosis. Independent Nurse, 2010, 2010, .	0.0	0
1356	Geriatric Models of Care. , 2011, , 43-56.		2
1357	Effectiveness of structured discharge process in reducing hospital readmission of adult patients with community acquired pneumonia: A systematic review. JBI Database of Systematic Reviews and Implementation Reports, 2011, 9, 1-11.	1.7	6
1358	Mettre en Å“uvre lâ€™amÃ©lioration de la valeur. , 2011, , 93-111.		0
1359	Effectiveness of structured discharge process in reducing hospital readmission of adult patients with community acquired pneumonia: A systematic review. JBI Library of Systematic Reviews, 2011, 9, 1-11.	0.1	0
1361	Transitional Care. , 2012, , 165-180.		0
1362	Effective Discharge Planning. Contemporary Cardiology, 2012, , 207-215.	0.0	0
1363	Effectiveness of structured discharge process in reducing hospital readmission of adult patients with community acquired pneumonia: A systematic review. JBI Database of Systematic Reviews and Implementation Reports, 2012, 10, 1086-1121.	1.7	6
1364	Cachexia (Wasting Syndrome). , 2013, , 281-282.		0
1371	This Is Your Life: Achieving a Comprehensive, Person-Centered Model of Care at the Intersection of Policy, Politics, and Private Sector Innovation. , 2014, , 47-58.		0
1372	Not Just Meaningful Data but Coordinated Data!. Advances in Healthcare Information Systems and Administration Book Series, 2014, , 19-34.	0.2	4
1374	TINKAMA SVEIKATOS PRIEÅ½IÅ¡RA: PAKARTOTINÄ– HOSPITALIZACIJA â€“ NORMA AR NEPAGEIDAUTINAS Ä®VYKIS. Health Sciences, 2014, 24, 92-99.	0.0	1

#	Article	IF	Citations
1375	Medicare and Medicaid Coordination: Special Case of the Dual Eligible Beneficiary. , 2015, , 117-131.		2
1376	Not Just Meaningful Data but Coordinated Data!. , 2015, , 1526-1541.		0
1378	Better Care and Better Value for Canadians: A Review of RCT Studies of Nurse Interventions. Canadian Journal of Nursing Research, 2015, 47, 41-60.	0.6	1
1380	Transitions in Care for the Person with Dementia. , 2016, , 233-245.		1
1381	Discharge Planning. Contemporary Cardiology, 2016, , 187-194.	0.0	1
1382	Transition Coach Program Implementation Associated with Thirty-Day Readmission Rates in a Community Hospital Setting. Archives of Community Medicine and Public Health, 2016, 2, 022-026.	0.1	0
1383	The transitional care program for older adults with disabilities. Japanese Journal of Geriatrics, 2017, 54, 41-49.	0.0	0
1384	Effective Discharge Planning. Contemporary Cardiology, 2017, , 233-242.	0.0	0
1385	Transformative Care for Orofacial Disorders. , 2017, , 301-315.		0
1386	Can an Elephant Crack a Nut with a Sledgehammer? How Physicians Cross Boundaries. , 2017, , 223-237.		0
1387	Low Health Literacy and Transitional Care Needs: Beyond Screening. Journal of Hospital Medicine, 2017, 12, 941-942.	0.7	0
1388	Managing Transitions in theÂTreatment of Eating Disorders. , 2018, , 215-223.		1
1389	Transitional Care for Seniors: What do Care Partners and Seniors Really Experience?. Journal of Nursing & Care, 2018, 07, .	0.1	0
1390	Ambulatory Care. , 2018, , 199-211.		0
1391	Eliminating â€œWasteâ€•in Health Care. , 2018, , 209-212.		2
1393	Drug-Related Problems in the transitional care of the elderly from hospital to home. Revista Brasileira De Enfermagem, 2019, 72, 345-353.	0.2	8
1394	Getting to Patient-Centered Care. , 2019, , 1-15.		1
1395	Post-acute Care. , 2019, , 1-3.		0

#	Article	IF	Citations
1396	Transitioning Care at Discharge. , 2019, , 1-22.		0
1397	Implications of Transitional Care Interventions on Hospital Readmissions in Patients With Destination Therapy Left Ventricular Assist Devices. Research and Theory for Nursing Practice, 2019, 33, 81-96.	0.2	1
1398	Patient-Centered Care for Persons with Multiple Conditions. , 2020, , 117-127.		0
1399	PH Professional Network: Bridging the Gap: A Multidisciplinary Approach to Transitions of Care. Advances in Pulmonary Hypertension, 2019, 18, 103-107.	0.1	0
1402	Reducing Hospitalizations and Emergency Department Visits in Patients With Venous Thromboembolism Using a Multicomponent Care Transition Intervention. Inquiry (United States), 2020, 57, 004695801990008.	0.5	0
1403	Clientsâ€™ outcomes from providersâ€™ networks: the role of relational exclusivity and complementary capabilities. Connections, 2020, 40, 31-46.	0.2	0
1406	Factors and experiences associated with unscheduled 30-day hospital readmission: A mixed method study. Annals of the Academy of Medicine, Singapore, 2021, 50, 751-764.	0.2	3
1407	Hospital to Home: Supporting the Transition From Hospital to Home for Older Adults. Canadian Journal of Nursing Research, 2022, 54, 483-496.	0.6	4
1408	Continuity of Care. , 2020, , 542-543.		0
1409	Improving Use of a Hospital Transitional Care Clinic. Joint Commission Journal on Quality and Patient Safety, 2020, 46, 673-681.	0.4	0
1410	Transition from hospital to home after elective colorectal surgery performed in an enhanced recovery program: An integrative review. Nursing Open, 2021, 8, 1550-1570.	1.1	5
1411	Discharge Communication: A Multi-Institutional Survey of Internal Medicine Residentsâ€™ Education and Practices. Academic Medicine, 2021, 96, 1043-1049.	0.8	4
1412	Missed Appointments by Hypertension Patients in Transitional Care: Race and Insurance Correlates. Journal of Public Health Issues and Practices, 2019, 3, .	0.2	0
1415	Transitioning Care at Discharge. , 2020, , 485-506.		1
1416	Communication and Coordination Processes Supporting Integrated Transitional Care: Australian Healthcare Practitionersâ€™ Perspectives. International Journal of Integrated Care, 2020, 20, 1.	0.1	18
1417	Implementation of a multi-interventional approach to improve medication safety in older hospitalized patients: feasibility and impact on 30-day rehospitalization rate. Annales Pharmaceutiques Francaises, 2021, , .	0.4	0
1418	Chapitre 3. La coordination et lâ€™intÃ©gration des services. , 0, , 35-69.		0
1419	Social Networks Enabled Coordination Model for Cost Management of Patient Hospital Admissions. Journal for Healthcare Quality: Official Publication of the National Association for Healthcare Quality, 2011, 33, no-no.	0.3	3

#	Article	IF	Citations
1421	Improving chronic care: the "guided care" model. , 2008, 12, 50-4.		24
1422	Unplanned readmissions after hospital discharge among patients identified as being at high risk for readmission using a validated predictive algorithm. Open Medicine, 2011, 5, e104-11.	1.5	53
1423	Coaching Older Adults and Carers to have their preferences Heard (COACH): A randomised controlled trial in an intermediate care setting (study protocol). Australasian Medical Journal, 2012, 5, 444-54.	0.1	2
1424	A framework for making patient-centered care front and center. , 2012, 16, 49-53.		49
1425	Medication use in the transition from hospital to home. Annals of the Academy of Medicine, Singapore, 2008, 37, 136-6.	0.2	37
1427	Discharge planning in chronic conditions: an evidence-based analysis. Ontario Health Technology Assessment Series, 2013, 13, 1-72.	3.0	9
1428	Patient-centredness in integrated healthcare delivery systems - needs, expectations and priorities for organised healthcare systems. International Journal of Integrated Care, 2013, 13, e051.	0.1	8
1429	Development and Implementation of the Coordinated-Transitional Care (C-TraC) Program. Federal Practitioner: for the Health Care Professionals of the VA, DoD, and PHS, 2014, 31, 30-34.	0.6	4
1430	Predicting 30- to 120-Day Readmission Risk among Medicare Fee-for-Service Patients Using Nonmedical Workers and Mobile Technology. Perspectives in Health Information Management / AHIMA, American Health Information Management Association, 2016, 13, 1e.	0.0	2
1431	Comparing Aging in Place to Home Health Care: Impact of Nurse Care Coordination On Utilization and Costs. Nursing Economics, 2015, 33, 306-13.	0.3	14
1432	Investigating the impact of intervention refusal on hospital readmission. American Journal of Managed Care, 2017, 23, e394-e401.	0.8	1
1433	Pharmacist-Led Drug Therapy Problem Management in an Interprofessional Geriatric Care Continuum: A Subset of the PIVOTS Group. American Health and Drug Benefits, 2018, 11, 469-478.	0.5	4
1434	A Systematic Review of Interventions to Improve Nursing Home to Emergency Department Care Transitions. Annals of Long-Term Care, 2020, 28, e12-e19.	0.2	3
1435	Validity and reliability of the Chinese version of the partners at care transitions measure. BMC Health Services Research, 2021, 21, 1284.	0.9	3
1436	Making sense of the French public hospital system: a network-based approach to hospital clustering using unsupervised learning methods. BMC Health Services Research, 2021, 21, 1244.	0.9	3
1439	Post-acute Care. , 2021, , 3907-3909.		0
1440	Protocol for the MobiMD trial: A randomized controlled trial to evaluate the effect of a self-monitoring mobile app on hospital readmissions for complex surgical patients. Contemporary Clinical Trials, 2022, 113, 106658.	0.8	2
1441	Understanding Patientsâ€™ Intention to Use Digital Health Apps That Support Postdischarge Symptom Monitoring by Providers Among Patients With Acute Coronary Syndrome: Survey Study. JMIR Human Factors, 2022, 9, e34452.	1.0	2

#	Article	IF	Citations
1442	Perceived Self-Efficacy, Confidence, and Skill Among Factors of Adult Patient Participation in Transitional Care: A Systematic Review of Quantitative Studies. SAGE Open Nursing, 2022, 8, 237796082210746.	0.5	2
1443	Effect of health information technology (HIT)-based discharge transition interventions on patient readmissions and emergency room visits: a systematic review. Journal of the American Medical Informatics Association: JAMIA, 2022, 29, 735-748.	2.2	2
1444	Telemedicine as a Means to an End, Not an End in Itself. Life, 2022, 12, 122.	1.1	4
1445	The Imperative to Reimagine Assisted Living. Journal of the American Medical Directors Association, 2022, 23, 225-234.	1.2	45
1446	Impact of the Registered Nurse Clinical Liaison Role in Ambulatory Care on Transitions of Care. Professional Case Management, 2022, 27, 58-66.	0.2	0
1447	Case Management Programs for Improving Integrated Care for Frequent Users of Healthcare Services: An Implementation Analysis. International Journal of Integrated Care, 2022, 22, 11.	0.1	4
1448	Predicting Hospital Readmissions from Health Insurance Claims Data: A Modeling Study Targeting Potentially Inappropriate Prescribing. Methods of Information in Medicine, 2022, 61, 055-060.	0.7	1
1449	Development of the Socioeconomic Screening, Active Engagement, Follow-up, Education, Discharge Readiness, and Consistency (SAFEDC) Model for Improving Transitions of Care: Participatory Design. JMIR Formative Research, 2022, 6, e31277.	0.7	1
1451	Extending Enhanced Recovery after Surgery Protocols to the Post-Discharge Setting: A Phone Call Intervention to Support Patients after Expedited Discharge after Pancreaticoduodenectomy. American Surgeon, 2020, 86, 42-48.	0.4	5
1452	Post-Discharge Transitional Care Program and Patient Compliance With Follow-Up Activities. Journal of Patient Experience, 2022, 9, 237437352210867.	0.4	2
1453	Reliability and validity of the Japanese version of readiness for hospital discharge scale. Japanese Journal of Health and Human Ecology, 2022, 88, 24-35.	0.0	0
1454	Defining Minimum Necessary Communication During Care Transitions for Patients on Antihyperglycemic Medication: Consensus of the Care Transitions Task Force of the IPRO Hypoglycemia Coalition. Diabetes Therapy, 2022, 13, 535-549.	1.2	0
1455	Effect of Health Information Exchange Plus a Care Transitions Intervention on Post-Hospital Outcomes Among VA Primary Care Patients: a Randomized Clinical Trial. Journal of General Internal Medicine, 2022, , 1.	1.3	2
1456	Evaluation of pharmacy intern-led transition of care service at an academic hospital in Saudi Arabia: A prospective pilot study. Saudi Pharmaceutical Journal, 2022, , .	1.2	0
1457	Components of hospital-to-home care interventions for patients with heart failure in Japan: An integrative review. , 2022, 1, e2021-0001-e2021-0001.		2
1458	Implementation of a telehealth videoconference to improve hospitalâ€toâ€skilled nursing care transitions: Preliminary data. Journal of the American Geriatrics Society, 2022, 70, 1828-1837.	1.3	5
1459	Effectiveness of the rural transitions nurse program for Veterans: A multicenter implementation study. Journal of Hospital Medicine, 2022, 17, 149-157.	0.7	12
1460	Pragmatic Clinical Trial to Improve Patient Experience Among Adults During Transitions from Hospital to Home: the PArTNER study. Journal of General Internal Medicine, 2022, , 1.	1.3	0

#	Article	IF	Citations
1461	Improving In-Hospital Care For Older Adults: A Mixed Methods Study Protocol to Evaluate a System-Wide Sub-Acute Care Intervention in Canada. International Journal of Integrated Care, 2022, 22, 25.	0.1	1
1462	Information exchange among providers and patient-centeredness in transitional care: A five-year retrospective analysis. Healthcare, 2022, 10, 100626.	0.6	1
1464	Design and Development of an eHealth Service for Collaborative Self-Management among Older Adults with Chronic Diseases: A Theory-Driven User-Centered Approach. International Journal of Environmental Research and Public Health, 2022, 19, 391.	1.2	12
1465	Age- and Diagnosis-Based Trends for Unplanned Pediatric Rehospitalizations in the United States. Cureus, 2021, 13, e20181.	0.2	1
1466	Evaluations of postoperative transitions in care for older adults: a scoping review. BMC Geriatrics, 2022, 22, 329.	1.1	7
1469	Sleep in Hospitalized Older Adults. Sleep Medicine Clinics, 2022, 17, 223-232.	1.2	5
1470	Complexities of care: Common components of models of care in geriatrics. Journal of the American Geriatrics Society, 2022, 70, 1960-1972.	1.3	16
1471	Readmission After ACS: Burden, Epidemiology, and Mitigation. Current Cardiology Reports, 2022, 24, 807-815.	1.3	2
1473	Improving transitional care communication for older Australians from hospital to home: Coâ€design of the TRANSITION tool. Health and Social Care in the Community, 2022, , .	0.7	2
1474	Head and neck cancer readmission reduction (HANCARRE) project: Reducing 30â€day readmissions. World Journal of Otorhinolaryngology - Head and Neck Surgery, 2022, 8, 158-166.	0.7	1
1475	Exploratory pilot study on resource allocation along the dementia continuum under constrained and unconstrained budget scenarios. BMC Geriatrics, 2022, 22, 437.	1.1	0
1476	Recommendations for the Design and Delivery of Transitions-Focused Digital Health Interventions: Rapid Review. JMIR Aging, 2022, 5, e35929.	1.4	4
1478	Does integrated care mean fewer hospitalizations? An evaluation of a French field experiment. Health Policy, 2022, 126, 786-794.	1.4	2
1479	Key Care Provision Aspects That Affect Care Transition in the Long-Term Care Systems: Preliminary Review Findings. International Journal of Environmental Research and Public Health, 2022, 19, 6402.	1.2	2
1480	Familial caregiving following stroke: findings from the comprehensive post-acute stroke services (COMPASS) pragmatic cluster-randomized transitional care study. Topics in Stroke Rehabilitation, 2023, 30, 436-447.	1.0	2
1481	Association of Early and Late Hospital Readmissions with a Novel Housing-Based Socioeconomic Measure. Health Services Research and Managerial Epidemiology, 2022, 9, 233339282211046.	0.5	0
1482	Articulation of postsurgical patient discharges: coordinating care transitions from hospital to home. Journal of the American Medical Informatics Association: JAMIA, 0, , .	2.2	0
1483	Multimethod Process Evaluation of a Community Paramedic Delivered Care Transitions Intervention for Older ED Patients. Prehospital Emergency Care, 0, , 1-19.	1.0	1

#	Article	IF	Citations
1484	Optimising transitions of care for acute kidney injury survivors: protocol for a mixed-methods study of nephrologist and primary care provider recommendations. BMJ Open, 2022, 12, e058613.	0.8	1
1485	Innovative Billing Practices for RNs and Social Work Under the Oregon Medicaid Structure: Billing for Services Without a Provider. Nurse Leader, 2022, 20, 485-489.	0.4	1
1486	Effectiveness of a Web-Based Provider Communications Platform in Reducing Hospital Readmissions Among Patients Receiving Dialysis: A Pilot Pre-Post Study. Kidney Medicine, 2022, 4, 100511.	1.0	0
1487	Effectiveness of integrating primary healthcare in aftercare for older patients after discharge from tertiary hospitalsâ€"a systematic review and meta-analysis. Age and Ageing, 2022, 51, .	0.7	6
1488	Integrated Care Components in Transitional Care Models from Hospital to Home for Frail Older Adults: A Systematic Review. International Journal of Integrated Care, 2022, 22, 28.	0.1	11
1489	Evidence-Based Programs to Improve Transitional Care of Older Adults. , 2022, , 132-160.		0
1490	The effect of a trAnSitional Pharmacist Intervention in geRiatric inpatients on hospital visits after dischargE (ASPIRE): Protocol for a randomized controlled trial. Contemporary Clinical Trials, 2022, 119, 106853.	0.8	5
1491	Operationalizing Whole-Person Postpartum Care: Health Care Provider-Level Strategies. Clinical Obstetrics and Gynecology, 2022, 65, 611-631.	0.6	1
1492	POISED: Protocol for a multi-site randomized controlled trial of the program of intensive support in emergency departments for care partners of cognitively impaired patients (Preprint). JMIR Research Protocols, 0, , .	0.5	0
1493	Home to stay: a randomized controlled trial protocol to assess use of a mobile app to reduce readmissions following colorectal surgery. Colorectal Disease, 0, , .	0.7	1
1494	Coaching older adults discharged home from the emergency department: The role of competence and emotion in following up with outpatient clinicians. Patient Education and Counseling, 2022, , .	1.0	0
1495	Feasibility of the Transport PLUS intervention to improve the transitions of care for patients transported home by ambulance: a non-randomized pilot study. Pilot and Feasibility Studies, 2022, 8, .	0.5	0
1496	Implementation of the Community Assets Supporting Transitions (CAST) transitional care intervention for older adults with multimorbidity and depressive symptoms: A qualitative descriptive study. PLoS ONE, 2022, 17, e0271500.	1.1	2
1497	Improving Quality and Safety for Patients After Hospital Discharge. Journal of Ambulatory Care Management, 2022, 45, 310-320.	0.5	0
1498	Avoiding revolving door and homelessness: The need to improve care transition interventions in psychiatry and mental health. Frontiers in Psychiatry, 0, 13, .	1.3	5
1499	Impacts of Omaha System-Based Continuing Care on the Medication Compliance, Quality of Life, and Prognosis of Coronary Heart Disease Patients After PCI. Brazilian Journal of Cardiovascular Surgery, 2022, 37, .	0.2	5
1500	The Influence of the Rural Transitions Nurse Program for Veterans on Healthcare Utilization Costs. Journal of General Internal Medicine, 2022, 37, 3529-3534.	1.3	2
1501	Family Structure Diversity and Youth Health Care Access and Interactions With Health Care Providers. Journal of Family Nursing, 2022, 28, 308-320.	1.0	2

#	Article	IF	Citations
1502	Informal carers' support needs, facilitators and barriers in the transitional care of older adults: A qualitative study. Health Expectations, 2022, 25, 2876-2892.	1.1	3
1503	Raising the bar for patient experience during care transitions in Canada: A repeated cross-sectional survey evaluating a patient-oriented discharge summary at Ontario hospitals. PLoS ONE, 2022, 17, e0268418.	1.1	0
1504	Quality, safety, and implementation science in acute kidney care. Current Opinion in Critical Care, 2022, 28, 613-621.	1.6	3
1505	Supporting Carers as Patients Move between Hospital and Home: A Systematic Review of Interventions to Support These Transitions in Care. Journal of Palliative Medicine, 0, , .	0.6	2
1506	Efficacy of acute care pathways for older patients: a systematic review and meta-analysis. European Journal of Ageing, 2022, 19, 1571-1585.	1.2	5
1507	Prevalence and Severity of Discharge Medication Discrepancies Resolved by Pharmacists at a Veterans Affairs Teaching Hospital. JACCP Journal of the American College of Clinical Pharmacy, 0, , .	0.5	0
1508	Social Circumstances and Behavioral Patterns: Impacts on Health and Initiatives to Mitigate These Impacts. , 2022, , 61-85.		0
1509	Perspectives of acute, post-acute, physician and community support providers on community collaborative efforts to improve transitions of care. Healthcare, 2023, 11, 100673.	0.6	0
1510	Can a mobile app technology reduce emergency department visits and readmissions after lung resection? A prospective cohort study. Canadian Journal of Surgery, 2022, 65, E798-E804.	0.5	3
1511	Cohort design to assess the association between post-hospital primary care physician follow-up visits and hospital readmissions. Medicine (United States), 2022, 101, e31830.	0.4	0
1512	Development and implementation of a nurse-based remote patient monitoring program for ambulatory disease management. Frontiers in Digital Health, 0, 4, .	1.5	6
1513	Acute Kidney Injury Survivor Care Following Hospital Discharge: A Mixed-Methods Study of Nephrologists and Primary Care Providers. Kidney Medicine, 2023, 5, 100586.	1.0	8
1514	A Qualitative Analysis of the Optimal Discharge Summary: Effective Communication of Medication Changes for Older Patients. Journal of Applied Gerontology, 0, , 073346482211458.	1.0	0
1515	Qualitative Study Assessing Factors for 30-day Readmissions: A Head and Neck Oncology Cohort. Annals of Otology, Rhinology and Laryngology, 0, , 000348942211478.	0.6	0
1516	No Longer Lost in Transition?. Annals of the Academy of Medicine, Singapore, 2012, 41, 479-482.	0.2	0
1517	â€œI Had Bills to Payâ€: a Mixed-Methods Study on the Role of Income on Care Transitions in a Public-Payer Healthcare System. Journal of General Internal Medicine, 0, , .	1.3	0
1518	Efficacy of the Home Continuity Care Unit in Toledo, Spain for Older Adults with Advanced Chronic Diseases. Home Healthcare Now, 2023, 41, 14-19.	0.1	0
1519	Health information exchangeâ€“enhanced care coordination: implementation and evaluation of event notification services in the Veterans Health Administration. , 2023, , 563-578.		0

#	Article	IF	Citations
1520	Medication Use in the Transition from Hospital to Home. Annals of the Academy of Medicine, Singapore, 2008, 37, 136-141.	0.2	62
1521	Approach to Acute Hospital Care. , 2023, , 1-19.		0
1522	Caregiversâ€™ experience with Tele-Savvy Caregiver Program post-hospitalization. Geriatric Nursing, 2023, 51, 156-166.	0.9	0
1523	Dementia and readmission risk in patients with heart failure participating in a transitional care program. Archives of Gerontology and Geriatrics, 2023, 110, 104973.	1.4	0
1524	Care Transition Interventions to Improve Stroke Outcomes: Evidence Gaps in Underserved and Minority Populations. Stroke, 2023, 54, 386-395.	1.0	3
1525	TransiÃ§Ã£o do cuidado de idosos do hospital para casa: vivÃªncia da enfermagem. ACTA Paulista De Enfermagem, 2022, 35, .	0.1	3
1526	The Role of Individual-Level Socioeconomic Status on Nursing Home Placement Accounting for Neighborhood Characteristics. Journal of the American Medical Directors Association, 2023, , .	1.2	0
1527	Interventions for the empowerment of older people and informal caregivers in transitional care decision-making: short report of a systematic review. BMC Geriatrics, 2023, 23, .	1.1	1
1529	â€œCommunity health workers bring value and deserve to be valued too:â€•Key considerations in improving CHW career advancement opportunities. Frontiers in Public Health, 0, 11, .	1.3	5
1530	Comprehensive Cardiac Care: How Much Does It Cost?. International Journal of Environmental Research and Public Health, 2023, 20, 4980.	1.2	0
1531	Effect of ED-based transitional care interventions by healthcare professionals providing transitional care in the emergency department on clinical, process and service use outcomes: a systematic review. BMJ Open, 2023, 13, e066030.	0.8	2
1532	Evaluation of a theoryâ€informed implementation of a nursing discharge teaching intervention for older adults. Journal of Advanced Nursing, 2023, 79, 3147-3159.	1.5	1
1533	Awareness of and subjective needs for post-discharge healthcare services among older adult patients. BMC Nursing, 2023, 22, .	0.9	3
1534	Impact of an Area Agency on Aging Pharmacist-led Community Care Transition Initiative. Journal of the American Pharmacists Association: JAPhA, 2023, , .	0.7	1
1535	Interventions to Reduce Repeat Presentations to Hospital Emergency Departments for Mental Health Concerns: A Scoping Review of the Literature. Healthcare (Switzerland), 2023, 11, 1161.	1.0	1
1538	Acute Hospital Care. , 2023, , 231-243.		0
1573	Approach to Acute Hospital Care. , 2024, , 1317-1335.		0