Safe and Sound and Homeward Bound: Optimizing Hospital to Home Transitions

David Cooperberg, MD
Courtney Nataraj, Chair, Family Advisory Council
Andrew F. Beck, MD MPH
Ann Carr, MD
Snezana Nena Osorio, MD MS

No financial relationships to disclose or Conflicts of Interest (COIs) to resolve.
Audience Response System
Test Question

Which of the following songs/albums were recorded in Nashville:

A. Elvis Presley “Heartbreak Hotel”
B. Roy Orbison “Oh, Pretty Woman”
C. Kansas “Dust in the Wind”
D. Vanessa Williams “Save the Best for Last”
E. Taylor Swift “Love Story”
F. All of the above
Objectives

Summarize the current state of the pediatric research in hospital to home transitions

Describe how qualitative and quantitative research has helped reshape QI discharge bundles

Apply the Medical Home principles to establish partnerships between inpatient and outpatient providers and patients and families
Most Dangerous Time at the Hospital? It May Be When You Leave

Transition from Hospital to Home: A Safety Risk

- Inadequate Parent/Caregiver Preparation for Post-Discharge Care
  - Failure to recognize and activate contingency plans
  - Non-adherence to follow-up appointments
  - High rates of medication errors

- Untimely and Incomplete Medical Provider Handoff
  - Unaware of hospitalization
  - New medication list
  - Pending Labs
  - Immunizations received

Increased hospital re-utilization and cost

Prioritizing the Hospital to Home Transition - STARNet Collaborative

STARNet Collaborative

Review the current knowledge of hospital-to-home transitions

Outline the challenges of measuring and reducing readmissions

Highlight research gaps and list potential measures for transition quality

Critical Components of Transitions

Communication
- Changes in medical management
- Follow-up arrangements
- Outstanding labs

Care Coordination/Contingency Planning
- Individual or team responsibility

Family Engagement
- Appropriate literacy and language

Children with Medical Complexity


Potential Hospital-Home Transition Measures

Health care utilization (*Readmissions, Returns to ED, Outpatient visits)

Medication (Rx filled, MedRec, Adverse Drug Events)

Caregiver (Readiness for discharge, Experience with transitions, feedback to health care teams)

Other
- (Response to outstanding labs and radiology tests)
- Home Health Plan
- Discharge Information rec’d by PCP

Key Driver Diagram

Global Aim

1° Driver

Improve Pediatric Patient-Centered Hospital-to-Home Care Transitions

2° Drivers

Execute Patient-Centered Handoff

Partnership between Patient/Family, PCP, and Inpatient Team

3° Drivers

Use Family's Preferred Language
Respect Patient/Family Personal and Cultural Perspectives
Parent/Caregiver Teaches Back Essential Home-Management Skills
Identify and Mitigate Social, Financial, and Logistical Barriers to Seamless Transition
Engage Parent/Caregiver in Establishing Shared Care Plan
Engage PCP in Establishing Shared Care Plan
Identify and Document Correct PCP
Transmit Essential Discharge Communication to PCP on Day of Discharge
Two-way Communication for Complex or Evolving Course

Execute Medical Provider-Centered Handoff

Family Perspective

Courtney Nataraj, Chair Family Advisory Council
The NICU Journey

Discharge and Readmissions
Ready for Discharge

Becoming a Parent of Medically Complex Child
Family Perspective Qualitative Research

Andrew F. Beck, MD MPH
Family Perspective on Transitions

To develop a comprehensive qualitative understanding of hospital-to-home care transitions from family perspective

Design and participants
Caregivers within 30 days of child’s discharge for acute condition
61 participated in 11 focus groups, 4 interviews stratified by neighborhood poverty
87% female and 46% non-white
Most common reasons for admissions included asthma and bronchiolitis
Themes identified – represented by illustrative, verbatim quotes

“You go into a fog when you come here. You forget what day it is, what time…”

What I wish I had
Desired information and suggestions for improvement

Am I ready to go home?
Discharge readiness

I’m home, now what?
Confidence and post-discharge care

In a fog: Barriers to processing and acting upon information
In a fog

Mental exhaustion: this is too much

“If we don’t get sleep, … You are totally non-functional and you could only survive on adrenaline for so long.”

Handling uncertainty

“How do I know when it’s a situation that’s really bad and how much time do I have? … ‘Where [might] I fail in the process?’”

In a fog

Information overload

“I came home with a stack of papers this big … Way too much!”

Usability of Information

“‘Can somebody explain what’s going on because you’re all saying two different things. I’m getting confused.’”

Additional key concepts

What I wish I had
“[If I check his temperature and it says] 101, do I run to the ER or just call my doctor and – great, it’s Saturday.”

Am I ready to go home?
“I thought my son was ready. I was more concerned whether or not we were ready.”

I’m home, now what?
“The scariest part when you go home is like, ‘how do I know she’s having like some episode in her room and can’t breathe?’ … So we just had someone sleep with her the first few nights.”


Severity & modifiability of the “fog”

Conceptual framework
“Toll” of the home-to-hospital and hospital-to-home transitions modified by poverty:
- Logistical factors
- Emotional factors
- Financial factors

Quotes by neighborhood poverty
LOW POVERTY
HIGH POVERTY
Logistical factors

Challenges maintaining normalcy

“They’re going to have to have Taco Bell [again].”
“My [other children] were out of school for 4 days.”

Accessibility of resources

“[Our doctor will] get us in the same day.”
“I don’t have transportation. I had to catch the bus everywhere, and it was really hot. By him having a breathing problem, I was scared to catch the bus.”

Emotional factors

Getting back on track

“Our son was discharged a month ago. He’s fine. My husband and I are still recovering. We are still processing the stress and the panic.”
“I’m trying to keep my outside life going to, you know, be OK for my children.”

Presence or absence of social supports

“We are very fortunate to have my mom come and help us … When we got home, the house was beautiful.”
“As soon as we walk in the door, we go right back to the schedule. There is no leeway at all.”
Financial factors

Dealing with missed school and work

“I wasn’t going to lose my job, but it was difficult missing a week.”

“It affects our economy because I’m here and he is watching the kids. Bills pile up and it hurts you.”

Costs of hospitalization (no low poverty quotes)

“I was in the hospital with no money with no one, no food, no gas. I was breastfeeding, and I’m eating nothing but cereal or a little scrap that she don’t eat that I could sneak in before the doctors come and see.”

“I don’t think the doctors realize the financial toll that the parents take. I think it’s just, ‘We’re going to send you home; you can always come back.’ Well, that’s another $150 deductible.”


Solutions

Generally focused on:

- Easing cost of care while in hospital (e.g., meal vouchers)
- Efficiency and predictability of discharge processes
- Providing transition supports that balance potential benefit of supports with hope to quickly return to normalcy
  - Calls or nurse visits (H2O)

“If [a nurse] really came [to my house], I think I would have kissed her... I just need to know if I’m doing something right.”
Children with Medical Complexity

Ann Carr, MD

CMC: A High-Need High-Cost Population

Less than 1% of all children\(^1\)

55% of all inpatient costs in children’s hospitals\(^3\)

30% of all pediatric healthcare costs\(^2\)

85% of all 30-day readmission costs\(^4\)

$650 billion annually\(^5\)

\(^1\)Kuo et al, Arch Ped Adol Med (2011); \(^2\)Cohen et al, Pediatrics (2012); \(^3\)Berry et al, JAMA Pediatrics (2013)
\(^4\)Bogetz et al, Pediatric Clinics North Amer (2014); \(^5\)Berry et al, Health Affairs (2014)
Caregiver Perspectives on Hospital to Home Transitions: Children with Medical Complexity


Conceptual Model/7 Domains

Susceptibility and Severity
- Prone to severe illness and needs to be treated differently
- Symptoms observed that are reminiscent of previous episodes with poor outcomes

Health System and Forces
- Accessibility influences decisions about where to seek higher level of care
- Distance from home and provider continuity influence where to seek help

Family Capacity and Resources
- Need plans to help decide when and how to seek help
- Want to connect with network of parents facing similar issues


---

**Family Perspective Summary**

<table>
<thead>
<tr>
<th>Stress &quot;In a Fog&quot;</th>
<th>&quot;Red Flags&quot;</th>
<th>Discharge Readiness</th>
<th>Timing of Discharge</th>
<th>Who to call?</th>
<th>Individualized Care Plan</th>
<th>Self-Efficacy</th>
<th>Care Coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solan et al.</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Leyenaar et al.</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Nelson et al.</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

---

Family Engagement
Audience Response System

Question

The various qualitative studies of family/caregiver perspectives on hospital-to-home transitions endorse which of the following priorities:

A. Discharge readiness
B. Individualized care plan
C. Identifying ‘red flags’ of what to look for at home with specific written contingency plans including whom to call
D. Self-efficacy
E. All of the above
Complex Transition Interventions

S. Nena Osorio, MD MS
<table>
<thead>
<tr>
<th>Collaborative effort</th>
<th>Organizer/Drivers</th>
<th>Participants</th>
<th>Aim</th>
<th>Methods</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| **Children’s Hospitals Solutions for Patient Safety**
Every parent, every day. | National Children’s Network | 88+ hospitals | 20% reduction in readmissions by 12/31/13, phase 1 hospitals, and 10% reduction by 12/31/13 for phase 2 | “All Teach all learn” hospitals receive monthly reports for comparison with the whole network | 7-D inpatient and observation readmissions |
| **Project IMPACT**
AAP Section on Hospital Medicine Subcommittee on Quality and Safety | Interested Member Hospitals and their hospitals 16+ | Reduce reutilization rates for technology-supported patients by 20% within 24 months | Multifactorial planned experimentation, Rapid Cycle Improvement | 3, 7, 15 and 30-day readmission rates | And 3-day return to ED, |
| **Pedi-Boost**
University of California Medical Center with SHM | 3 Pilot Hospitals to be followed by interested hospitals nationally | Pedi-Boost tools implemented for the site-specific target population | Pedi-Boost tools | Return to ED |
| **Children’s Hospital Association** | Interested Member Hospitals | Reduce discharge related failures by 50% | Rapid cycle improvement | Discharge-related care failures and patient/family readiness for discharge, and readmission |

Pediatric Discharge Bundles /Adapted from Auger K. at al.Summary STARNet: Seamless Transitions and (Re)admissions Network. Pediatrics 2015

---

**A Quality Improvement Collaborative to Improve the Discharge Process for Hospitalized Children**

Tertiary-care children’s hospitals chose

- Target population
- Change package elements
- Submitted data

Primary Aim: Reduce discharge-related failures by 50% in 12 months

### Most Commonly Used Change Strategies by Participating Sites

<table>
<thead>
<tr>
<th>Change Strategy</th>
<th>Change Ideas</th>
<th>Number of Sites Using Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proactive discharge planning throughout hospitalization</td>
<td>Educate the patient and family about disease, discharge plans</td>
<td>10</td>
</tr>
<tr>
<td>Arrange for post-discharge treatment</td>
<td>Identify correct medicine and the plan to obtain them</td>
<td>9</td>
</tr>
<tr>
<td>Communicate post-discharge plans to patients and families</td>
<td>Improve written discharge instructions for the patient and family</td>
<td>8</td>
</tr>
<tr>
<td>Post-discharge support by phone</td>
<td>Post-discharge phone call to reinforce plan</td>
<td>9</td>
</tr>
</tbody>
</table>


### Outcome Measures

**Discharge-Related Failures**
N = 8 SITES

**Family Readiness for Discharge**
N = 4 SITES
Readmissions

No improvement
-worsening of 30-day readmissions
(4.5%-6.3%)

Take Home Points

Discharge process is complex; Large scale change is challenging

Post-discharge Phone Calls are important, but need to determine their cost and benefit

Standardized framework and measures for evaluating discharge care quality (readmissions may not be an ideal measure)

The Collaborative Model has many benefits and challenges:
- Shared learning, innovative work, national expertise
- Interventions for which baseline data does not exist
- Local support for QI studies
Project IMPACT Pilot Report: Feasibility of Implementing a Hospital-to-Home Transition Bundle

Transition Checklist
 Teach Back
Timely and Complete Communication with PCP
Post-Discharge Phone Call


Patient Populations

<table>
<thead>
<tr>
<th>TECHNOLOGY-SUPPORTED</th>
<th>NON-TECHNOLOGY SUPPORTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>VP shunt</td>
<td>Asthma (ages 2-17 years)</td>
</tr>
<tr>
<td>Tracheostomy tube</td>
<td>Infants &lt;12 months of age</td>
</tr>
<tr>
<td>Central venous catheter</td>
<td>Children &lt; 2 years of age</td>
</tr>
<tr>
<td>Feeding tubes</td>
<td>All pediatric patients (ages &lt;18 years)</td>
</tr>
</tbody>
</table>

Pediatric Patient-Centered Transition Care Bundle

Outcome Measures

- Caregiver ability to teach-back key home management skills on post-discharge phone call
- 30-day reutilization


Parent/Caregivers’ Performance during Follow-up Telephone Call

Project IMPACT Pilot Report

Lessons learned
Local context
EHR integration
Sub-group analysis (asthmatics, technology supported)

Next steps
Revamp bundle “IMPACT 2.0”
Focus on medically complex, technology supported patients
Spread to additional sites

What do these efforts have in common?

Attempted to generate evidence for transition interventions

Utilized complex interventions
  - Family education
  - Transition readiness
  - Post-discharge phone call
  - Provider handoff

Studied reutilization as an outcome—none showed an effect

*Identified need for “improved” measures

---

Hospital-To-Home Outcomes Study

Preliminary data from H2O’s RCT assessing single post-discharge nurse visit to standard discharge

Primary outcome: 30-day urgent reutilization

Population: 1,500 hospitalized children

Intention-to-treat results (similar to per protocol):
  - Urgent reutilization rate intervention: 17.8%
  - Urgent reutilization rate control: 14%

Intervention caregivers had better recall of warning signs, similar rates of post-discharge difficulty coping
Hospital-To-Home Outcomes Study

Preliminary data from H2O’s RCT assessing single post-discharge nurse visit to standard discharge

Potential explanations for these results
- Lack of illness trajectory
- Improved access to hospital
- Improved awareness of warning signs
- Perceptions of illness
- Effect may differ depending on contextual factors including illness complexity

Audience Response System Question

Thus far quality improvement collaboratives and quality improvement researchers have demonstrated improvement in which of the following processes:

A. Parent/caregiver recall of warning signs
B. Parent/caregiver teach back of essential home management skills
C. Timely and complete medical provider handoff
D. Safety in ‘skydiving’ and ‘Rocky Mountain climbing’
E. Choices a, b, and c
Medical Home Principles and Primary Care Provider Perspectives on Hospital-to-Home Transitions

Ann Carr, MD
Hospitalist to PCP Handoff: Expanding the Medical Home to a Medical Neighborhood

Landscape of Complex Care Programs (2010)

Unpublished data courtesy of Carl Tapia, Texas Children’s
Various Models of the Medical Home(s)

<table>
<thead>
<tr>
<th>Survey Item</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>A primary care (vs subspecialty care) medical home should be the locus of care for the majority of children with special health care needs</td>
<td>21%</td>
<td>44%</td>
<td>24%</td>
<td>8%</td>
<td>3%</td>
</tr>
<tr>
<td>A subspecialty clinic at a tertiary care center is the best source of a medical home for children with complex or rare conditions</td>
<td>13%</td>
<td>30%</td>
<td>26%</td>
<td>24%</td>
<td>6%</td>
</tr>
</tbody>
</table>

65% prefer a primary care medical home for CMC¹

43% prefer a subspecialty care medical home for CMC¹

40% of CMC do not have an annual primary care visit²

¹Van Cleave et al, Academic Pediatrics (2016)
²Berry et al, Health Affairs (2014)

Key Driver Diagram

Aim

1° Driver

Improve Pediatric Patient-Centered Hospital-to-Home Care Transitions for Children with Special Needs

2° Drivers

- Execute Patient-Centered Handoff
- Partnership between Patient/Family, PCP, and Inpatient Team

3° Drivers

- Use Family’s Preferred Language
- Respect Patient/Family Personal and Cultural Perspectives
- Parent/Caregiver Teaches Back Essential Home-Management Skills
- Identify and Mitigate Social, Financial, and Logistical Barriers to Seamless Transition
- Two-way Communication for Complex or Evolving Course
- Engage Parent/Caregiver in Establishing Shared Care Plan
- Engage PCP in Establishing Shared Care Plan
- Transmit Essential Discharge Communication to PCP on Day of Discharge
- Identify and Document Correct PCP
Key Driver Diagram

Aim

1o Driver
Improve Pediatric Patient-Centered Hospital-to-Home Care Transitions for Children with Special Needs

2o Drivers
- Execute Patient-Centered Handoff
  Partnership between Patient/Family, PCP, and Inpatient Team

3o Drivers
- Use Family's Preferred Language
- Respect Patient/Family Personal and Cultural Perspectives
- Parent/Caregiver Teaches Back Essential Home-Management Skills
- Identify and Mitigate Social, Financial, and Logistical Barriers to Seamless Transition
- Engage Parent/Caregiver in Establishing Shared Care Plan
- Transmit Essential Discharge Communication to PCP on Day of Discharge
- Two-way Communication for Complex or Evolving Course

Communication Challenges:
A Qualitative Look at the Relationship Between Pediatric Hospitalists and Primary Care Providers

To gain an in-depth understanding of pediatric outpatient and inpatient perceptions of and concerns with communication surrounding patient care plans and discharge.

Major themes for improvement and targets for future interventions

2 sets of focus groups, 6 with primary care providers and 3 with hospitalists:
  Local pediatricians and one NP, n = 27
  Hospitalists/free standing pediatric institution, n = 15

5 Themes

"I only called when there was something ... that really affected the follow up"

Problematic Aspects of Communication

Perceptions of Providers Roles

Push/Pull

Post-discharge care

Proposed Solutions

“They [residents] are just so Hospital focused... Where they [patients] Might get “real” care For lack of a better Word”

“Oh I am just Covering...”

“Well they are not my Patient...”

“I would say until we See the patient... any labs ... Have to be followed with them” [hospitalist]

“I think there is still... a grieving that medicine has changed.”


Proposed Solutions

Formal Resident Training

Use of Untapped Technology

Improved Communication

Standardized Verbal and Written Communication Templates

Adjust Timing of Verbal Communication

Center for CYSHCN & Transitions of Care

- Inpatient Rounds with PCP Team
- Huddle Information Sharing Family Meetings
- Discharge F/U Phone Call & Visit
- Monthly Meetings with IMPACT & Inpatient Teams
- Collaborate DC Planning Community Partners Specialists

---

Policy Statement

Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems

PEDIATRICS Volume 135, Number 5, May 2014
Understanding One Another Through the Lens of Cognitive Maps

Effective communication among members of interprofessional teams is crucial but is often difficult to achieve.

Each discipline has a unique vocabulary, approach to problem solving, and a perceptual approach described by Petrie and others as the professional’s “cognitive map.”

Differences in these cognitive maps lead to varying approaches to patient care, clinical priorities, and communication styles.

CMCs: Compel us to develop potential bridging strategies that could improve interprofessional team functioning and lead to enhanced quality of care.


 Audience Response System Question

Important considerations in establishing partnerships between hospitalists and outpatient medical primary care providers include which of the following:

A. Communication prior to discharge to establish shared care plan
B. Differences in cognitive maps contribute to hospitalists and primary care providers having different approaches to patient care, clinical priorities, and communication styles
C. Lack of clarity in roles and responsibilities (‘push/pull’ of who should own what)
D. Hospitalists are ‘a little bit country,’ while primary care providers are ‘a little bit rock-n-roll’
E. Choices a, b, and c
Reshaping QI Discharge Bundles
Next Steps

DAVID COOPERBERG, MD
Quality Indicators for Pediatric Hospital to Home Transitions

Quality Measures to Assess Care Transitions for Hospitalized Children

Evidence review and Delphi to develop Pediatric-specific Transitions of Care Quality Measures

Hospital to home transitions record content

Timely communication between providers
(24 hours prior - 48 hours after discharge)
Pediatric Medical Complexity Algorithm: Implications for QI

Simon TD et al, Pediatrics 2014

Key Driver Diagram

Aim

1° Driver

Partnership between Patient/Family, PCP, and Inpatient Team

2° Drivers

- Execute Patient-Centered Handoff
- Execute Medical Provider-Centered Handoff

3° Drivers

- Use Family’s Preferred Language
- Respect Patient/Family Personal and Cultural Perspectives
- Parent/Caregiver Teaches Back Essential Home-Management Skills
- Identify and Mitigate Social, Financial, and Logistical Barriers to Seamless Transition
- Engage Parent/Caregiver in Establishing Shared Care Plan
- Engage PCP in Establishing Shared Care Plan
- Identify and Document Correct PCP
- Transmit Essential Discharge Communication to PCP on Day of Discharge
- Two-way Communication for Complex or Evolving Course

Improve Pediatric Patient-Centered Hospital-to-Home Care Transitions for Children with Special Needs
Key Driver Diagram

Aim

1° Driver

Improve Pediatric Patient-Centered Hospital-to-Home Care Transitions for Children with Special Needs

Partnership between Patient/Family, PCP, and Inpatient Team

Execute Patient-Centered Handoff

2° Drivers

Parent/Caregiver Teaches Back Essential Home-Management Skills

Identify and Mitigate Social, Financial, and Logistical Barriers to Seamless Transition

Transmit Essential Discharge Communication to PCP on Day of Discharge

Two-way Communication for Complex or Evolving Course

3° Drivers

Use Family's Preferred Language

Respect Patient/Family Personal and Cultural Perspectives

Engage Parent/Caregiver in Establishing Shared Care Plan

Engage PCP in Establishing Shared Care Plan

Identify and Document Correct PCP

Barriers
How do we design or enhance QI interventions to help families navigate through the fog?


Key Driver Diagram

**Aim**

Improve Pediatric Patient-Centered Hospital-to-Home Care Transitions for Children with Special Needs

**1° Driver**

Partnership between Patient/Family, PCP, and Inpatient Team

**2° Drivers**

Execute Patient-Centered Handoff

**3° Drivers**

- Use Family’s Preferred Language
- Respect Patient/Family Personal and Cultural Perspectives
- Parent/Caregiver Teaches Back Essential Home-Management Skills
- Identify and Mitigate Social, Financial, and Logistical Barriers to Seamless Transition
- Engage Parent/Caregiver in Establishing Shared Care Plan
- Engage PCP in Establishing Shared Care Plan
- Identify and Document Correct PCP
- Transmit Essential Discharge Communication to PCP on Day of Discharge
- Two-way Communication for Complex or Evolving Course
In Summary

Qualitative and QI research provided valuable insight into the roles, goals, and perspectives of critical stakeholders in pediatric transitions.

Complex problem such as pediatric transitions from hospital to home requires complex, flexible and dynamic interventions.

Partnership between hospitalists and primary care providers and patients and their parents/caregivers is key.

Use of HIPAA approved technology may prove to be the next “iteration” of Pediatric Discharge Bundles.

Practical Strategies for Establishing Patient-Centered Partnerships

PANEL DISCUSSION
Thank You!!!

Lauren Solan, MD
Kathy Auger MD MSc
Sandra Gage, MD PhD
Leah Mallory, MD
Jeffrey Simmons, MD MSc
Renee Turchi MD MPH

IMPACT Pilot Study Group

Monica Kondrad, RN, Care Coordinator
Center for Children with Special Needs

Katelyn Burke, MPH
William Wollock, MPH
Alana Cordeiro, MPH
Andrew Atanas, MPH
Alexa Darcaris, MPH
Megan MacNeil, MPH
Anita Runowski, MPH
Sharon Craig, Co-Chair, FAC
Karen Vogel, Director, SW
Dogg Thompson MD, WWMI, Section Chief
Hospital Medicine

Blair Dickinson, MD MS
Vanessa Duranti, DO
Nichole Kuzma, MD
Khayandra Lewis, MD
Kelly Myers, NP
Jeff Yaeger, MD MPH
Dara Fermo, MD
Nicola Brook, MD, PL-4
Barb Hicks, RN, Quality Coordinator

Patricia Lye, MD, MS
Emily Denenon, MD
Paula Song, MD
Brittany Payer, DO, MS
Diana Hahn, MD
Jennifer Halajian, MD
Sarah Vajrides, MD
Sara Leuch, MD
Cori Gibson, MSN, RN, CNL
Lot Siwczik, RN
Amanda Quinones, MSN, RN
Kim Zimmerman, MS, RN

Stephen Prato, MA, Data Management
Akhil Bhattacharyya, MD PhD, Research Assistant
Nicole Manchester, MS RN, Director of Nursing
Melanie Lord, RN, Nurse Manager
Michael Payne, RN, Clinical Nurse Educator
Susan Talbot, MD, Ambulatory Clinician
Teresa Morgan, RN, Ambulatory Clinician
Agatha Bellows, RN, Care Manager
Joel McMillan, MS, Analyst

Nancy Boydell, RN, Care Transitions Nurse
Jane Premple, RN, Care Transitions Nurse
Brand Robertson, Patient Ambassador
Michelle Ambrose, Information Services

Jennifer DiPace, MD
Cori Green, MD
Enka Albersen, MD MS
Brooke Spector, MD
Jennie Ozn, MD
Therese Joanavlinda, MD
Ranea Popola, MD
Lisa Schmutter, RN
Heather McCauley, Director, SW
Lindle Kanel, SW
Eddie Luft, Care Coordinator
Samarnath Shami, FAC
April Hendrick, FAC
Daniae Guerrero, IT Specialist
Amy Whitten, Department for PFCC
Jessie Lee, Data Analyst, RedCap/CTSC
IMPACT QI Team Leaders

Monica Joseph-Griffin, Northshore, Evanston, IL
Melanie Blackburn, Palmetto Children’s, Columbia, SC
Maya Maxym & Deena Ibrahim, St. Barnabas, Livingston, NJ
Natalia Paciorowski, Rochester Regional, Rochester, NY
Elizabeth Peck, Sanford Health, Sioux Falls, ND
Beth Kleweno, St. Luke’s, Boise, ID
Deb Whitney & Jessica Hart, CHOP, Philadelphia, PA
Tricia Hopkins, Albany Medical Center, Albany, NY
Christina Peacock, Children’s Mercy, Kansas City, MO
Meena Iyer, Dell Children’s, Austin, TX
Kayce Morton, CoxHealth, Springfield, MO
Dan Coghlin, Hasbro Children’s, Providence, RI
Akshata Hopkins, All Children’s, St. Petersburg, FL
Jeananne Pardue, E Tennessee Children’s, Knoxville, TN
David Zipes, Peyton Manning Children’s, Indianapolis, IN

AAP SOHM
Niccole Alexander
Monique Phillips

SOHM Executive Council

H2O Team

Study participants

H2O Study Team Members:
- Katherine A. Auger; JoAnne Bachus; Kat Bell; Monica L. Borell; Stephanie A. Brunswick; Lenisa Chang; Jennifer Gold; Judy A. Heilman; Joe Jabor; Jane C. Khoury; Logan Maag; Margo J. Moore; Cory Pfefferman; Rita H. Pickler; Hadley Sauers-Ford; Anita N. Shah; Samir S. Shah; Susan N. Sherman; Jeffrey M. Simmons; Lauren G. Solan; Angela M. Statile; Heidi J. Sucharew; Karen P. Sullivan; Heather L. Tubbs-Cooley; Susan Wade-Murphy; and Christine M. White

PCORI (IHS-1306-00811)
NIH (SK23AI11291602)

The Hospital-To-Home Outcomes Study (H2O)
Improving the Fluidity of Patient Transitions
Thank You!

References


References


