

Lisa H Lubomski

List of Publications by Year in descending order

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46
papers

3,552
citations

279487

23
h-index

223531

46
g-index

46
all docs

46
docs citations

46
times ranked

2913
citing authors

#	ARTICLE	IF	CITATIONS
1	The RICH LIFE Project: A cluster randomized pragmatic trial comparing the effectiveness of health system only vs. health system Plus a collaborative/stepped care intervention to reduce hypertension disparities. <i>American Heart Journal</i> , 2020, 226, 94-113.	1.2	11
2	Barriers to and Facilitators of Implementing Enhanced Recovery Pathways Using an Implementation Framework. <i>JAMA Surgery</i> , 2018, 153, 270.	2.2	81
3	Statewide Collaborative to Reduce Surgical Site Infections: Results of the Hawaii Surgical Unit-Based Safety Program. <i>Journal of the American College of Surgeons</i> , 2018, 227, 189-197e1.	0.2	10
4	Reducing preventable harm: observations on minimizing bloodstream infections. <i>Journal of Health Organization and Management</i> , 2017, 31, 2-9.	0.6	11
5	Assessing content validity and user perspectives on the Team Check-up Tool: expert survey and user focus groups. <i>BMJ Quality and Safety</i> , 2017, 26, 288-295.	1.8	5
6	Two-State Collaborative Study of a Multifaceted Intervention to Decrease Ventilator-Associated Events. <i>Critical Care Medicine</i> , 2017, 45, 1208-1215.	0.4	40
7	Measure accurately, Act rapidly, and Partner with patients: An intuitive and practical three-part framework to guide efforts to improve hypertension control. <i>Journal of Clinical Hypertension</i> , 2017, 19, 684-694.	1.0	18
8	CLABSI Conversations. <i>Quality Management in Health Care</i> , 2016, 25, 67-78.	0.4	11
9	Locating Errors Through Networked Surveillance. <i>Journal of Patient Safety</i> , 2015, 11, 143-151.	0.7	6
10	Eliminating Central Line-Associated Bloodstream Infections: A National Patient Safety Imperative. <i>Infection Control and Hospital Epidemiology</i> , 2014, 35, 56-62.	1.0	113
11	Technologies in the wild (TiW): human factors implications for patient safety in the cardiovascular operating room. <i>Ergonomics</i> , 2013, 56, 205-219.	1.1	40
12	Developing and Pilot Testing Practical Measures of Preanalytic Surgical Specimen Identification Defects. <i>American Journal of Medical Quality</i> , 2013, 28, 308-314.	0.2	18
13	Decreasing Central-Line-Associated Bloodstream Infections in Connecticut Intensive Care Units. <i>Journal for Healthcare Quality: Official Publication of the National Association for Healthcare Quality</i> , 2013, 35, 78-87.	0.3	19
14	Using human factors engineering to improve patient safety in the cardiovascular operating room. <i>Work</i> , 2012, 41, 1801-1804.	0.6	19
15	Identifying and categorising patient safety hazards in cardiovascular operating rooms using an interdisciplinary approach: a multisite study. <i>BMJ Quality and Safety</i> , 2012, 21, 810-818.	1.8	100
16	Toward Improving Patient Safety Through Voluntary Peer-to-Peer Assessment. <i>American Journal of Medical Quality</i> , 2012, 27, 201-209.	0.2	23
17	Eradicating Central Line-Associated Bloodstream Infections Statewide. <i>American Journal of Medical Quality</i> , 2012, 27, 124-129.	0.2	42
18	Using the Opportunity Estimator Tool to Improve Engagement in a Quality and Safety Intervention. <i>Joint Commission Journal on Quality and Patient Safety</i> , 2012, 38, 41-AP2.	0.4	1

#	ARTICLE	IF	CITATIONS
19	Collaborative Cohort Study of an Intervention to Reduce Ventilator-Associated Pneumonia in the Intensive Care Unit. <i>Infection Control and Hospital Epidemiology</i> , 2011, 32, 305-314.	1.0	187
20	The Ability of Intensive Care Units to Maintain Zero Central Line-Associated Bloodstream Infections. <i>Archives of Internal Medicine</i> , 2011, 171, 856.	4.3	23
21	Validity and usefulness of members reports of implementation progress in a quality improvement initiative: findings from the Team Check-up Tool (TCT). <i>Implementation Science</i> , 2011, 6, 115.	2.5	20
22	High Stakes and High Risk. <i>Anesthesia and Analgesia</i> , 2011, 112, 1061-1074.	1.1	45
23	The Society of Cardiovascular Anesthesiologists' FOCUS Initiative: Locating Errors Through Networked Surveillance (LENS) Project Vision. <i>Anesthesia and Analgesia</i> , 2010, 110, 307-311.	1.1	42
24	Using evidence, rigorous measurement, and collaboration to eliminate central catheter-associated bloodstream infections. <i>Critical Care Medicine</i> , 2010, 38, S292-S298.	0.4	82
25	Executive/Senior Leader Checklist to Improve Culture and Reduce Central Line-Associated Bloodstream Infections. <i>Joint Commission Journal on Quality and Patient Safety</i> , 2010, 36, 519-524.	0.4	6
26	Improving the Quality of Quality Improvement Projects. <i>Joint Commission Journal on Quality and Patient Safety</i> , 2010, 36, 468-473.	0.4	20
27	Sustaining reductions in catheter related bloodstream infections in Michigan intensive care units: observational study. <i>BMJ: British Medical Journal</i> , 2010, 340, c309-c309.	2.4	432
28	Improving patient safety in intensive care units in Michigan. <i>Journal of Critical Care</i> , 2008, 23, 207-221.	1.0	284
29	Developing Process-Support Tools for Patient Safety: Finding the Balance Between Validity and Feasibility. <i>Joint Commission Journal on Quality and Patient Safety</i> , 2008, 34, 604-607.	0.4	3
30	The Team Checkup Tool: Evaluating QI Team Activities and Giving Feedback to Senior Leaders. <i>Joint Commission Journal on Quality and Patient Safety</i> , 2008, 34, 619-623.	0.4	11
31	View the World Through a Different Lens: Shadowing Another Provider. <i>Joint Commission Journal on Quality and Patient Safety</i> , 2008, 34, 614-618.	0.4	14
32	Using Incident Reporting to Improve Patient Safety. <i>Journal of Patient Safety</i> , 2007, 3, 27-33.	0.7	20
33	Intensive care unit safety incidents for medical versus surgical patients: A prospective multicenter study. <i>Journal of Critical Care</i> , 2007, 22, 177-183.	1.0	24
34	Creating High Reliability in Health Care Organizations. <i>Health Services Research</i> , 2006, 41, 1599-1617.	1.0	353
35	Toward learning from patient safety reporting systems. <i>Journal of Critical Care</i> , 2006, 21, 305-315.	1.0	177
36	A system factors analysis of celine, tube, and drain incidents in the intensive care unit*. <i>Critical Care Medicine</i> , 2005, 33, 1701-1707.	0.4	92

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37	Development of the ICU Safety Reporting System. <i>Journal of Patient Safety</i> , 2005, 1, 23-32.	0.7	17
38	Defining and measuring patient safety. <i>Critical Care Clinics</i> , 2005, 21, 1-19.	1.0	126
39	Creating the Web-based Intensive Care Unit Safety Reporting System. <i>Journal of the American Medical Informatics Association: JAMIA</i> , 2004, 12, 130-139.	2.2	57
40	A system factors analysis of airway events from the Intensive Care Unit Safety Reporting System (ICUSRS)*. <i>Critical Care Medicine</i> , 2004, 32, 2227-2233.	0.4	87
41	Risks and benefits of anticoagulant and antiplatelet medication use before cataract surgery. <i>Ophthalmology</i> , 2003, 110, 1784-1788.	2.5	178
42	A decision analysis of anesthesia management for cataract surgery. <i>American Journal of Ophthalmology</i> , 2001, 132, 528-536.	1.7	22
43	Adverse intraoperative medical events and their association with anesthesia management strategies in cataract surgery ¹ 1The authors have no financial interests related to the article contents.. <i>Ophthalmology</i> , 2001, 108, 1721-1726.	2.5	114
44	The Value of Routine Preoperative Medical Testing before Cataract Surgery. <i>New England Journal of Medicine</i> , 2000, 342, 168-175.	13.9	494
45	Injectable versus topical anesthesia for cataract surgery. <i>Ophthalmology</i> , 2000, 107, 2054-2060.	2.5	44
46	Effects of randomizing second eyes in a trial to evaluate preoperative medical testing for cataract surgery. <i>Ophthalmic Epidemiology</i> , 1997, 4, 101-105.	0.8	10