

Hardeep Singh

List of Publications by Citations

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The third column is the impact factor (IF) of the journal, and the fourth column is the number of citations of the article.

173
papers

5,909
citations

41
h-index

71
g-index

189
ext. papers

7,562
ext. citations

5.8
avg, IF

6.51
L-index

#	Paper	IF	Citations
173	A new sociotechnical model for studying health information technology in complex adaptive healthcare systems. <i>Quality and Safety in Health Care</i> , 2010 , 19 Suppl 3, i68-74		357
172	Types and origins of diagnostic errors in primary care settings. <i>JAMA Internal Medicine</i> , 2013 , 173, 418-25	11.5	276
171	Cognitive interventions to reduce diagnostic error: a narrative review. <i>BMJ Quality and Safety</i> , 2012 , 21, 535-57	5.4	274
170	The frequency of diagnostic errors in outpatient care: estimations from three large observational studies involving US adult populations. <i>BMJ Quality and Safety</i> , 2014 , 23, 727-31	5.4	265
169	Timely follow-up of abnormal diagnostic imaging test results in an outpatient setting: are electronic medical records achieving their potential?. <i>Archives of Internal Medicine</i> , 2009 , 169, 1578-86		141
168	Physicians' diagnostic accuracy, confidence, and resource requests: a vignette study. <i>JAMA Internal Medicine</i> , 2013 , 173, 1952-8	11.5	132
167	Information overload and missed test results in electronic health record-based settings. <i>JAMA Internal Medicine</i> , 2013 , 173, 702-4	11.5	130
166	The global burden of diagnostic errors in primary care. <i>BMJ Quality and Safety</i> , 2017 , 26, 484-494	5.4	123
165	Communication outcomes of critical imaging results in a computerized notification system. <i>Journal of the American Medical Informatics Association: JAMIA</i> , 2007 , 14, 459-66	8.6	118
164	Notification of abnormal lab test results in an electronic medical record: do any safety concerns remain?. <i>American Journal of Medicine</i> , 2010 , 123, 238-44	2.4	116
163	An analysis of electronic health record-related patient safety concerns. <i>Journal of the American Medical Informatics Association: JAMIA</i> , 2014 , 21, 1053-9	8.6	114
162	Two Decades Since To Err Is Human: An Assessment Of Progress And Emerging Priorities In Patient Safety. <i>Health Affairs</i> , 2018 , 37, 1736-1743	7	111
161	Defining and Measuring Diagnostic Uncertainty in Medicine: A Systematic Review. <i>Journal of General Internal Medicine</i> , 2018 , 33, 103-115	4	98
160	Advancing the science of measurement of diagnostic errors in healthcare: the Safer Dx framework. <i>BMJ Quality and Safety</i> , 2015 , 24, 103-10	5.4	88
159	Improving Diagnosis in Health Care--The Next Imperative for Patient Safety. <i>New England Journal of Medicine</i> , 2015 , 373, 2493-5	59.2	88
158	Missed opportunities to initiate endoscopic evaluation for colorectal cancer diagnosis. <i>American Journal of Gastroenterology</i> , 2009 , 104, 2543-54	0.7	86
157	Measuring and improving patient safety through health information technology: The Health IT Safety Framework. <i>BMJ Quality and Safety</i> , 2016 , 25, 226-32	5.4	84

156	System-related interventions to reduce diagnostic errors: a narrative review. <i>BMJ Quality and Safety</i> , 2012 , 21, 160-70	5.4	83
155	Characteristics and predictors of missed opportunities in lung cancer diagnosis: an electronic health record-based study. <i>Journal of Clinical Oncology</i> , 2010 , 28, 3307-15	2.2	82
154	The challenges in defining and measuring diagnostic error. <i>Diagnosis</i> , 2015 , 2, 97-103	4.2	81
153	Patient access to medical records and healthcare outcomes: a systematic review. <i>Journal of the American Medical Informatics Association: JAMIA</i> , 2014 , 21, 737-41	8.6	81
152	Notifications received by primary care practitioners in electronic health records: a taxonomy and time analysis. <i>American Journal of Medicine</i> , 2012 , 125, 209.e1-7	2.4	80
151	Electronic Health Record Alert-Related Workload as a Predictor of Burnout in Primary Care Providers. <i>Applied Clinical Informatics</i> , 2017 , 8, 686-697	3.1	78
150	Patient portals and health apps: Pitfalls, promises, and what one might learn from the other. <i>Healthcare</i> , 2017 , 5, 81-85	1.8	76
149	Electronic health record-based triggers to detect potential delays in cancer diagnosis. <i>BMJ Quality and Safety</i> , 2014 , 23, 8-16	5.4	75
148	Identifying diagnostic errors in primary care using an electronic screening algorithm. <i>Archives of Internal Medicine</i> , 2007 , 167, 302-8		74
147	Electronic health record-based surveillance of diagnostic errors in primary care. <i>BMJ Quality and Safety</i> , 2012 , 21, 93-100	5.4	71
146	The Burden of Inbox Notifications in Commercial Electronic Health Records. <i>JAMA Internal Medicine</i> , 2016 , 176, 559-60	11.5	68
145	Exploring situational awareness in diagnostic errors in primary care. <i>BMJ Quality and Safety</i> , 2012 , 21, 30-8	5.4	65
144	Primary care practitioners' views on test result management in EHR-enabled health systems: a national survey. <i>Journal of the American Medical Informatics Association: JAMIA</i> , 2013 , 20, 727-35	8.6	61
143	Electronic Trigger-Based Intervention to Reduce Delays in Diagnostic Evaluation for Cancer: A Cluster Randomized Controlled Trial. <i>Journal of Clinical Oncology</i> , 2015 , 33, 3560-7	2.2	55
142	Underdiagnosis of Lynch syndrome involves more than family history criteria. <i>Clinical Gastroenterology and Hepatology</i> , 2010 , 8, 523-9	6.9	55
141	Eight recommendations for policies for communicating abnormal test results. <i>Joint Commission Journal on Quality and Patient Safety</i> , 2010 , 36, 226-32	1.4	54
140	A Socio-Technical Approach to Preventing, Mitigating, and Recovering from Ransomware Attacks. <i>Applied Clinical Informatics</i> , 2016 , 7, 624-32	3.1	50
139	Patient-initiated second opinions: systematic review of characteristics and impact on diagnosis, treatment, and satisfaction. <i>Mayo Clinic Proceedings</i> , 2014 , 89, 687-96	6.4	50

138	A Decade of Health Information Technology Usability Challenges and the Path Forward. <i>JAMA - Journal of the American Medical Association</i> , 2019 , 321, 743-744	27.4	47
137	Follow-up actions on electronic referral communication in a multispecialty outpatient setting. <i>Journal of General Internal Medicine</i> , 2011 , 26, 64-9	4	47
136	Older patients' enthusiasm to use electronic mail to communicate with their physicians: cross-sectional survey. <i>Journal of Medical Internet Research</i> , 2009 , 11, e18	7.6	46
135	Improving the safety of health information technology requires shared responsibility: It is time we all step up. <i>Healthcare</i> , 2018 , 6, 7-12	1.8	43
134	Improving follow-up of abnormal cancer screens using electronic health records: trust but verify test result communication. <i>BMC Medical Informatics and Decision Making</i> , 2009 , 9, 49	3.6	42
133	Patient perspectives on how physicians communicate diagnostic uncertainty: An experimental vignette study. <i>International Journal for Quality in Health Care</i> , 2018 , 30, 2-8	1.9	40
132	The SAFER guides: empowering organizations to improve the safety and effectiveness of electronic health records. <i>American Journal of Managed Care</i> , 2014 , 20, 418-23	2.1	39
131	COVID-19 and the Need for a National Health Information Technology Infrastructure. <i>JAMA - Journal of the American Medical Association</i> , 2020 , 323, 2373-2374	27.4	38
130	Diagnostic errors related to acute abdominal pain in the emergency department. <i>Emergency Medicine Journal</i> , 2016 , 33, 253-9	1.5	38
129	Ebola US Patient Zero: lessons on misdiagnosis and effective use of electronic health records. <i>Diagnosis</i> , 2014 , 1, 283-287	4.2	38
128	Contingency planning for electronic health record-based care continuity: a survey of recommended practices. <i>International Journal of Medical Informatics</i> , 2014 , 83, 797-804	5.3	37
127	Graphical display of diagnostic test results in electronic health records: a comparison of 8 systems. <i>Journal of the American Medical Informatics Association: JAMIA</i> , 2015 , 22, 900-4	8.6	37
126	Analysis of Human Performance Deficiencies Associated With Surgical Adverse Events. <i>JAMA Network Open</i> , 2019 , 2, e198067	10.4	36
125	Advancing the research agenda for diagnostic error reduction. <i>BMJ Quality and Safety</i> , 2013 , 22 Suppl 2, ii52-ii57	5.4	36
124	Application of electronic trigger tools to identify targets for improving diagnostic safety. <i>BMJ Quality and Safety</i> , 2019 , 28, 151-159	5.4	35
123	Electronic health record-based messages to primary care providers: valuable information or just noise?. <i>Archives of Internal Medicine</i> , 2012 , 172, 283-5		32
122	The Path to Diagnostic Excellence Includes Feedback to Calibrate How Clinicians Think. <i>JAMA - Journal of the American Medical Association</i> , 2019 , 321, 737-738	27.4	31
121	Evaluation of outcomes from a national patient-initiated second-opinion program. <i>American Journal of Medicine</i> , 2015 , 128, 1138.e25-33	2.4	31

120	Using voluntary reports from physicians to learn from diagnostic errors in emergency medicine. <i>Emergency Medicine Journal</i> , 2016 , 33, 245-52	1.5	31
119	Reducing diagnostic error through medical home-based primary care reform. <i>JAMA - Journal of the American Medical Association</i> , 2010 , 304, 463-4	27.4	31
118	Patient Perspectives on the Usefulness of an Artificial Intelligence-Assisted Symptom Checker: Cross-Sectional Survey Study. <i>Journal of Medical Internet Research</i> , 2020 , 22, e14679	7.6	31
117	Accuracy of the Safer Dx Instrument to Identify Diagnostic Errors in Primary Care. <i>Journal of General Internal Medicine</i> , 2016 , 31, 602-8	4	30
116	Beyond Dr. Google: the evidence on consumer-facing digital tools for diagnosis. <i>Diagnosis</i> , 2018 , 5, 95-105	2.5	29
115	Errors in Diagnosis of Spinal Epidural Abscesses in the Era of Electronic Health Records. <i>American Journal of Medicine</i> , 2017 , 130, 975-981	2.4	29
114	Developing checklists to prevent diagnostic error in Emergency Room settings. <i>Diagnosis</i> , 2014 , 1, 223-231	2.1	29
113	The patient portal and abnormal test results: An exploratory study of patient experiences. <i>Patient Experience Journal</i> , 2015 , 2, 148-154	2.7	29
112	Crowdsourcing Diagnosis for Patients With Undiagnosed Illnesses: An Evaluation of CrowdMed. <i>Journal of Medical Internet Research</i> , 2016 , 18, e12	7.6	29
111	Learning From Patients' Experiences Related To Diagnostic Errors Is Essential For Progress In Patient Safety. <i>Health Affairs</i> , 2018 , 37, 1821-1827	7	28
110	Finding Diagnostic Errors in Children Admitted to the PICU. <i>Pediatric Critical Care Medicine</i> , 2017 , 18, 265-271	3	27
109	Should patients get direct access to their laboratory test results? An answer with many questions. <i>JAMA - Journal of the American Medical Association</i> , 2011 , 306, 2502-3	27.4	27
108	Development and Validation of Electronic Health Record-based Triggers to Detect Delays in Follow-up of Abnormal Lung Imaging Findings. <i>Radiology</i> , 2015 , 277, 81-7	20.5	26
107	How context affects electronic health record-based test result follow-up: a mixed-methods evaluation. <i>BMJ Open</i> , 2014 , 4, e005985	3	26
106	Workarounds and Test Results Follow-up in Electronic Health Record-Based Primary Care. <i>Applied Clinical Informatics</i> , 2016 , 7, 543-59	3.1	25
105	Safety huddles to proactively identify and address electronic health record safety. <i>Journal of the American Medical Informatics Association: JAMIA</i> , 2017 , 24, 261-267	8.6	24
104	Safety Assurance Factors for Electronic Health Record Resilience (SAFER): study protocol. <i>BMC Medical Informatics and Decision Making</i> , 2013 , 13, 46	3.6	24
103	Emergency physicians' views of direct notification of laboratory and radiology results to patients using the Internet: a multisite survey. <i>Journal of Medical Internet Research</i> , 2015 , 17, e60	7.6	24

102	Computerized Triggers of Big Data to Detect Delays in Follow-up of Chest Imaging Results. <i>Chest</i> , 2016 , 150, 613-20	5.3	24
101	Measures to Improve Diagnostic Safety in Clinical Practice. <i>Journal of Patient Safety</i> , 2019 , 15, 311-316	1.9	24
100	Reducing the Risk of Diagnostic Error in the COVID-19 Era. <i>Journal of Hospital Medicine</i> , 2020 , 15, 363-366	6.7	23
99	Reducing the Risk of Diagnostic Error in the COVID-19 Era. <i>Journal of Hospital Medicine</i> , 2020 , 15, 363-366	6.7	22
98	Evaluating diagnostic strategies for early detection of cancer: the CanTest framework. <i>BMC Cancer</i> , 2019 , 19, 586	4.8	21
97	Factors Associated With Potentially Missed Diagnosis of Appendicitis in the Emergency Department. <i>JAMA Network Open</i> , 2020 , 3, e200612	10.4	21
96	Releasing test results directly to patients: A multisite survey of physician perspectives. <i>Patient Education and Counseling</i> , 2015 , 98, 788-96	3.1	20
95	Patient-Reported Attributions for Missed Colonoscopy Appointments in Two Large Healthcare Systems. <i>Digestive Diseases and Sciences</i> , 2016 , 61, 1853-61	4	20
94	Analysis of Prescriber Notes in Electronic Prescriptions in Ambulatory Practice. <i>JAMA Internal Medicine</i> , 2016 , 176, 463-70	11.5	19
93	Patient safety goals for the proposed Federal Health Information Technology Safety Center. <i>Journal of the American Medical Informatics Association: JAMIA</i> , 2015 , 22, 472-8	8.6	19
92	Lack of timely follow-up of abnormal imaging results and radiologists' recommendations. <i>Journal of the American College of Radiology</i> , 2015 , 12, 385-9	3.5	18
91	Recommendations for using the Revised Safer Dx Instrument to help measure and improve diagnostic safety. <i>Diagnosis</i> , 2019 , 6, 315-323	4.2	18
90	Postreferral colonoscopy delays in diagnosis of colorectal cancer: a mixed-methods analysis. <i>Quality Management in Health Care</i> , 2012 , 21, 252-61	1	16
89	Challenges in patient safety improvement research in the era of electronic health records. <i>Healthcare</i> , 2016 , 4, 285-290	1.8	16
88	An Exploration of Barriers, Facilitators, and Suggestions for Improving Electronic Health Record Inbox-Related Usability: A Qualitative Analysis. <i>JAMA Network Open</i> , 2019 , 2, e1912638	10.4	15
87	Electronic Triggers to Identify Delays in Follow-Up of Mammography: Harnessing the Power of Big Data in Health Care. <i>Journal of the American College of Radiology</i> , 2018 , 15, 287-295	3.5	15
86	Diagnostic Errors in Primary Care Pediatrics: Project RedDE. <i>Academic Pediatrics</i> , 2018 , 18, 220-227	2.7	15
85	Tracking Progress in Improving Diagnosis: A Framework for Defining Undesirable Diagnostic Events. <i>Journal of General Internal Medicine</i> , 2018 , 33, 1187-1191	4	14

84	A Sociotechnical Framework for Safety-Related Electronic Health Record Research Reporting: The SAFER Reporting Framework. <i>Annals of Internal Medicine</i> , 2020 , 172, S92-S100	8	14
83	Resilient Practices in Maintaining Safety of Health Information Technologies. <i>Journal of Cognitive Engineering and Decision Making</i> , 2014 , 8, 265-282	2.5	13
82	Primary care pediatricians' Interest in diagnostic error reduction. <i>Diagnosis</i> , 2016 , 3, 65-69	4.2	13
81	Application of Electronic Algorithms to Improve Diagnostic Evaluation for Bladder Cancer. <i>Applied Clinical Informatics</i> , 2017 , 8, 279-290	3.1	12
80	Exploring new avenues to assess the sharp end of patient safety: an analysis of nationally aggregated peer review data. <i>BMJ Quality and Safety</i> , 2014 , 23, 1023-30	5.4	12
79	Development and Validation of Trigger Algorithms to Identify Delays in Diagnostic Evaluation of Gastroenterological Cancer. <i>Clinical Gastroenterology and Hepatology</i> , 2018 , 16, 90-98	6.9	12
78	Electronic health record reviews to measure diagnostic uncertainty in primary care. <i>Journal of Evaluation in Clinical Practice</i> , 2018 , 24, 545-551	2.5	11
77	Practicing Clinicians' Recommendations to Reduce Burden from the Electronic Health Record Inbox: a Mixed-Methods Study. <i>Journal of General Internal Medicine</i> , 2019 , 34, 1825-1832	4	11
76	Breakdowns in communication of radiological findings: an ethical and medico-legal conundrum. <i>Diagnosis</i> , 2014 , 1, 263-268	4.2	11
75	Toward More Proactive Approaches to Safety in the Electronic Health Record Era. <i>Joint Commission Journal on Quality and Patient Safety</i> , 2017 , 43, 540-547	1.4	11
74	Postradiation squamous cell cancer of the breast. <i>Cancer Investigation</i> , 2000 , 18, 343-6	2.1	11
73	Operational measurement of diagnostic safety: state of the science. <i>Diagnosis</i> , 2021 , 8, 51-65	4.2	11
72	Influence of doctor-patient conversations on behaviours of patients presenting to primary care with new or persistent symptoms: a video observation study. <i>BMJ Quality and Safety</i> , 2020 , 29, 198-208	5.4	11
71	Diagnostic Decision-Making in the Emergency Department. <i>Pediatric Clinics of North America</i> , 2018 , 65, 1097-1105	3.6	11
70	Methods for Patient-Centered Interface Design of Test Result Display in Online Portals. <i>EGEMS (Washington, DC)</i> , 2018 , 6, 15	2.2	10
69	Web Exclusives. Annals for Hospitalists Inpatient Notes - Reducing Diagnostic Error-A New Horizon of Opportunities for Hospital Medicine. <i>Annals of Internal Medicine</i> , 2016 , 165, HO2-HO4	8	10
68	Building the evidence-base to reduce electronic health record-related clinician burden. <i>Journal of the American Medical Informatics Association: JAMIA</i> , 2021 , 28, 1057-1061	8.6	10
67	Evaluating a mobile application for improving clinical laboratory test ordering and diagnosis. <i>Journal of the American Medical Informatics Association: JAMIA</i> , 2018 , 25, 841-847	8.6	10

66	Associations between diagnostic activity and measures of patient experience in primary care: a cross-sectional ecological study of English general practices. <i>British Journal of General Practice</i> , 2018 , 68, e9-e17	1.6	9
65	Assigning responsibility to close the loop on radiology test results. <i>Diagnosis</i> , 2017 , 4, 173-177	4.2	9
64	Artificial Intelligence Techniques That May Be Applied to Primary Care Data to Facilitate Earlier Diagnosis of Cancer: Systematic Review. <i>Journal of Medical Internet Research</i> , 2021 , 23, e23483	7.6	9
63	Missed Diagnosis of New-Onset Systolic Heart Failure at First Presentation in Children with No Known Heart Disease. <i>Journal of Pediatrics</i> , 2019 , 208, 258-264.e3	3.6	8
62	Imaging activity possibly signalling missed diagnostic opportunities in bladder and kidney cancer: A longitudinal data-linkage study using primary care electronic health records. <i>Cancer Epidemiology</i> , 2020 , 66, 101703	2.8	8
61	Missed diagnostic opportunities and English general practice: a study to determine their incidence, confounding and contributing factors and potential impact on patients through retrospective review of electronic medical records. <i>Implementation Science</i> , 2015 , 10, 105	8.4	8
60	Barriers and facilitators impacting reliability of the electronic health record-facilitated total testing process. <i>International Journal of Medical Informatics</i> , 2019 , 127, 102-108	5.3	7
59	Adherence to recommended electronic health record safety practices across eight health care organizations. <i>Journal of the American Medical Informatics Association: JAMIA</i> , 2018 , 25, 913-918	8.6	7
58	Developing Health Care Organizations That Pursue Learning and Exploration of Diagnostic Excellence: An Action Plan. <i>Academic Medicine</i> , 2020 , 95, 1172-1178	3.9	7
57	Assessment of Health Information Technology-Related Outpatient Diagnostic Delays in the US Veterans Affairs Health Care System: A Qualitative Study of Aggregated Root Cause Analysis Data. <i>JAMA Network Open</i> , 2020 , 3, e206752	10.4	7
56	A Program to Provide Clinicians with Feedback on Their Diagnostic Performance in a Learning Health System. <i>Joint Commission Journal on Quality and Patient Safety</i> , 2021 , 47, 120-126	1.4	7
55	Advancing Diagnostic Safety Research: Results of a Systematic Research Priority Setting Exercise. <i>Journal of General Internal Medicine</i> , 2021 , 36, 2943-2951	4	7
54	Communicating Findings of Delayed Diagnostic Evaluation to Primary Care Providers. <i>Journal of the American Board of Family Medicine</i> , 2016 , 29, 469-73	1.6	6
53	Follow-up of Abnormal Estimated GFR Results Within a Large Integrated Health Care Delivery System: A Mixed-Methods Study. <i>American Journal of Kidney Diseases</i> , 2019 , 74, 589-600	7.4	6
52	Factors Associated With Delay of Diagnosis of Hepatocellular Carcinoma in Patients With Cirrhosis. <i>Clinical Gastroenterology and Hepatology</i> , 2021 , 19, 1679-1687	6.9	6
51	Diagnostic Errors in Pediatric Critical Care: A Systematic Review. <i>Pediatric Critical Care Medicine</i> , 2021 , 22, 701-712	3	6
50	Electronic Detection of Delayed Test Result Follow-Up in Patients with Hypothyroidism. <i>Journal of General Internal Medicine</i> , 2017 , 32, 753-759	4	5
49	Measuring diagnostic safety of inpatients: time to set sail in uncharted waters. <i>Diagnosis</i> , 2015 , 2, 1-2	4.2	5

48	Reviving the Autopsy as a Diagnostic Error Reduction Tool. <i>Laboratory Medicine</i> , 2013 , 44, 186-190	1.6	5
47	Prolonged Diagnostic Intervals as Marker of Missed Diagnostic Opportunities in Bladder and Kidney Cancer Patients with Alarm Features: A Longitudinal Linked Data Study. <i>Cancers</i> , 2021 , 13,	6.6	5
46	Diagnostic evaluation of patients presenting with hematuria: An electronic health record-based study. <i>Urologic Oncology: Seminars and Original Investigations</i> , 2018 , 36, 88.e19-88.e25	2.8	5
45	Payment Innovations To Improve Diagnostic Accuracy And Reduce Diagnostic Error. <i>Health Affairs</i> , 2018 , 37, 1828-1835	7	5
44	Setting the record straight on measuring diagnostic errors. Reply to: Bad assumptions on primary care diagnostic errors by Dr Richard Young. <i>BMJ Quality and Safety</i> , 2015 , 24, 345-8	5.4	4
43	Incidence, origins and avoidable harm of missed opportunities in diagnosis: longitudinal patient record review in 21 English general practices. <i>BMJ Quality and Safety</i> , 2021 , 30, 977-985	5.4	4
42	Increasing Recognition and Diagnosis of Adolescent Depression: Project RedDE: A Cluster Randomized Trial. <i>Pediatric Quality & Safety</i> , 2019 , 4, e217	1	4
41	Cluster Randomized Trial Reducing Missed Elevated Blood Pressure in Pediatric Primary Care: Project RedDE. <i>Pediatric Quality & Safety</i> , 2019 , 4, e187	1	4
40	Essential activities for electronic health record safety: A qualitative study. <i>Health Informatics Journal</i> , 2020 , 26, 3140-3151	3	4
39	Fighting a common enemy: a catalyst to close intractable safety gaps. <i>BMJ Quality and Safety</i> , 2021 , 30, 141-145	5.4	4
38	Use of patient complaints to identify diagnosis-related safety concerns: a mixed-method evaluation. <i>BMJ Quality and Safety</i> , 2021 , 30, 996-1001	5.4	4
37	Five strategies for clinicians to advance diagnostic excellence.. <i>BMJ, The</i> , 2022 , 376, e068044	5.9	4
36	How can we partner with electronic health record vendors on the complex journey to safer health care?. <i>Journal of Healthcare Risk Management: the Journal of the American Society for Healthcare Risk Management</i> , 2020 , 40, 34-43	0.9	3
35	Patient and clinician experiences of uncertainty in the diagnostic process: Current understanding and future directions. <i>Patient Education and Counseling</i> , 2021 , 104, 2606-2615	3.1	3
34	Improving diagnostic performance through feedback: the Diagnosis Learning Cycle. <i>BMJ Quality and Safety</i> , 2021 , 30, 1002-1009	5.4	3
33	Patient safety counterpoint: systems approaches and multidisciplinary strategies at the centerpiece of error prevention. <i>Clinical Gastroenterology and Hepatology</i> , 2015 , 13, 824-6	6.9	2
32	Online public reactions to frequency of diagnostic errors in US outpatient care. <i>Diagnosis</i> , 2016 , 3, 17-22.4.2		2
31	Toward electronic medical record alerts that consume less physician time--reply. <i>JAMA Internal Medicine</i> , 2013 , 173, 1756	11.5	2

30	Guideline adherence for diagnosis of liver cancer in veterans.. <i>Journal of Clinical Oncology</i> , 2013 , 31, 89-892	2
29	A vision for using online portals for surveillance of patient-centered communication in cancer care. <i>Patient Experience Journal</i> , 2015 , 2, 125-131	2.7 2
28	Application of Human Factors Methods to Understand Missed Follow-up of Abnormal Test Results. <i>Applied Clinical Informatics</i> , 2020 , 11, 692-698	3.1 2
27	Validation of an electronic trigger to measure missed diagnosis of stroke in emergency departments. <i>Journal of the American Medical Informatics Association: JAMIA</i> , 2021 , 28, 2202-2211	8.6 2
26	Diagnosis Documentation of Critically Ill Children at Admission to a PICU. <i>Pediatric Critical Care Medicine</i> , 2021 ,	3 2
25	A Roadmap to Advance Patient Safety in Ambulatory Care. <i>JAMA - Journal of the American Medical Association</i> , 2020 , 324, 2481-2482	27.4 2
24	Inviting patients to identify diagnostic concerns through structured evaluation of their online visit notes.. <i>Journal of the American Medical Informatics Association: JAMIA</i> , 2022 ,	8.6 2
23	Origins of diagnostic error--reply. <i>JAMA Internal Medicine</i> , 2013 , 173, 1926-7	11.5 1
22	Applying requisite imagination to safeguard electronic health record transitions.. <i>Journal of the American Medical Informatics Association: JAMIA</i> , 2022 ,	8.6 1
21	Identifying trigger concepts to screen emergency department visits for diagnostic errors. <i>Diagnosis</i> , 2021 , 8, 340-346	4.2 1
20	Challenges in Communication from Referring Clinicians to Pathologists in the Electronic Health Record Era. <i>Journal of Pathology Informatics</i> , 2018 , 9, 8	4.4 1
19	Variation in surgical management of primary hyperparathyroidism in the US Department of Veterans Affairs healthcare system: A 15-year observational study. <i>Surgery</i> , 2020 , 168, 838-844	3.6 1
18	Why Test Results Are Still Getting "Lost" to Follow-up: a Qualitative Study of Implementation Gaps. <i>Journal of General Internal Medicine</i> , 2021 , 1	4 1
17	Monitoring Diagnostic Safety Risks in Emergency Departments: Protocol for a Machine Learning Study. <i>JMIR Research Protocols</i> , 2021 , 10, e24642	2 1
16	Project RedDE: Cluster Randomized Trial to Reduce Missed or Delayed Abnormal Laboratory Value Actions. <i>Pediatric Quality & Safety</i> , 2019 , 4, e218	1 1
15	Referral communication for pediatric intensive care unit admission and the diagnosis of critically ill children: A pilot ethnography. <i>Journal of Critical Care</i> , 2021 , 63, 246-249	4 1
14	Policies to Promote Shared Responsibility for Safer Electronic Health Records. <i>JAMA - Journal of the American Medical Association</i> , 2021 , 326, 1477-1478	27.4 1
13	Detection and Remediation of Misidentification Errors in Radiology Examination Ordering. <i>Applied Clinical Informatics</i> , 2020 , 11, 79-87	3.1 0

12	Identifying opportunities for timely diagnosis of bladder and renal cancer via abnormal blood tests: a longitudinal linked data study.. <i>British Journal of General Practice</i> , 2022 , 72, e19-e25	1.6	0
11	Contributing Factors for Pediatric Ambulatory Diagnostic Process Errors: Project RedDE. <i>Pediatric Quality & Safety</i> , 2020 , 5, e299	1	0
10	Harnessing Event Report Data to Identify Diagnostic Error During the COVID-19 Pandemic. <i>Joint Commission Journal on Quality and Patient Safety</i> , 2021 , 48, 71-71	1.4	0
9	Missed Opportunities to Promptly Diagnose and Treat Adrenal Tumors.. <i>Journal of Surgical Research</i> , 2022 , 276, 174-181	2.5	0
8	Adherence to National Guidelines for Timeliness of Test Results Communication to Patients in the Veterans Affairs Health Care System.. <i>JAMA Network Open</i> , 2022 , 5, e228568	10.4	0
7	Electronic Health Records Quantify Previously Existing Phenomenon-Physicians Spend Hours Coordinating Care-Reply. <i>JAMA Internal Medicine</i> , 2016 , 176, 1235-6	11.5	
6	Virtual Patient Simulation: A Method to Study Diagnostic Process as an Emergent Aspect of Information Sampling Behavior. <i>Proceedings of the Human Factors and Ergonomics Society</i> , 2016 , 60, 533-537	0.4	
5	Letter to the Editor. <i>Journal of General Internal Medicine</i> , 2019 , 34, 1960	4	
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