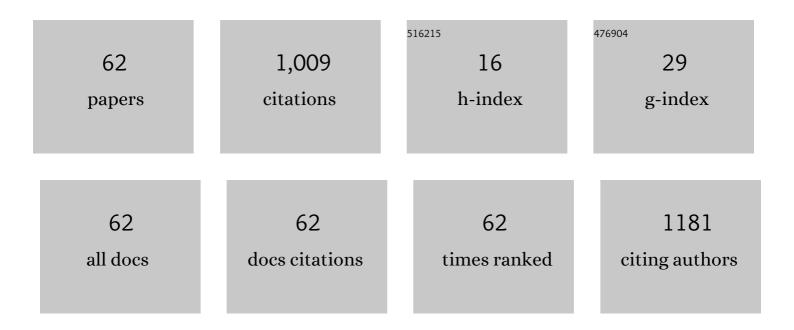
Hillary J Mull, Mpp

List of Publications by Year in descending order

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HILLADY MILLE MDD

#	Article	IF	CITATIONS
1	Validity of Selected AHRQ Patient Safety Indicators Based on VA National Surgical Quality Improvement Program Data. Health Services Research, 2009, 44, 182-204.	1.0	146
2	Validity of Selected Patient Safety Indicators: Opportunities and Concerns. Journal of the American College of Surgeons, 2011, 212, 924-934.	0.2	112
3	Access to Health Care and Nonemergency Medical Transportation. Transportation Research Record, 2005, 1924, 76-84.	1.0	76
4	Postoperative 30-day Readmission. Annals of Surgery, 2016, 264, 621-631.	2.1	56
5	Homeless Status, Postdischarge Health Care Utilization, and Readmission After Surgery. Medical Care, 2018, 56, 460-469.	1.1	34
6	Medical and Surgical Readmissions in the Veterans Health Administration. Medical Care, 2014, 52, 243-249.	1.1	32
7	Access to Health Care and Nonemergency Medical Transportation: Two Missing Links. , 0, .		29
8	Association Between Preoperative Proteinuria and Postoperative Acute Kidney Injury and Readmission. JAMA Surgery, 2018, 153, e182009.	2.2	28
9	Comparing 2 Methods of Assessing 30-Day Readmissions. Medical Care, 2013, 51, 589-596.	1.1	27
10	Detecting adverse events in surgery: comparing events detected by the Veterans Health Administration Surgical Quality Improvement Program and the Patient Safety Indicators. American Journal of Surgery, 2014, 207, 584-595.	0.9	25
11	Development of trigger tools for surveillance of adverse events in ambulatory surgery. BMJ Quality and Safety, 2010, 19, 425-429.	1.8	24
12	Association of Postoperative Readmissions With Surgical Quality Using a Delphi Consensus Process to Identify Relevant Diagnosis Codes. JAMA Surgery, 2018, 153, 728.	2.2	24
13	Does Use of a Hospital-wide Readmission Measure Versus Condition-specific Readmission Measures Make a Difference for Hospital Profiling and Payment Penalties?. Medical Care, 2016, 54, 155-161.	1.1	20
14	Applying Trigger Tools to Detect Adverse Events Associated With Outpatient Surgery. Journal of Patient Safety, 2011, 7, 45-59.	0.7	19
15	Development and Testing of Tools to Detect Ambulatory Surgical Adverse Events. Journal of Patient Safety, 2013, 9, 96-102.	0.7	19
16	Comparison of a Potential Hospital Quality Metric With Existing Metrics for Surgical Quality–Associated Readmission. JAMA Network Open, 2019, 2, e191313.	2.8	18
17	Preoperative opioid use and postoperative pain associated with surgical readmissions. American Journal of Surgery, 2019, 218, 828-835.	0.9	18
18	Prolonged antimicrobial prophylaxis following cardiac device procedures increases preventable harm: insights from the VA CART program. Infection Control and Hospital Epidemiology, 2018, 39, 1030-1036.	1.0	17

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19	Novel Method to Flag Cardiac Implantable Device Infections by Integrating Text Mining With Structured Data in the Veterans Health Administration's Electronic Medical Record. JAMA Network Open, 2020, 3, e2012264.	2.8	17
20	What Is the Value of Adding Medicare Data in Estimating VA Hospital Readmission Rates?. Health Services Research, 2015, 50, 40-57.	1.0	16
21	Do pneumonia readmissions flagged as potentially preventable by the 3M PPR software have more process of care problems? A cross-sectional observational study. BMJ Quality and Safety, 2015, 24, 753-763.	1.8	16
22	Consensus Building for Development of Outpatient Adverse Drug Event Triggers. Journal of Patient Safety, 2011, 7, 66-71.	0.7	15
23	Real-world effectiveness of infection prevention interventions for reducing procedure-related cardiac device infections: Insights from the veterans affairs clinical assessment reporting and tracking program. Infection Control and Hospital Epidemiology, 2019, 40, 855-862.	1.0	15
24	Hospital Readmissions after Surgery: How Important Are Hospital and Specialty Factors?. Journal of the American College of Surgeons, 2017, 224, 515-523.	0.2	14
25	A study to reduce readmissions after surgery in the Veterans Health Administration: design and methodology. BMC Health Services Research, 2017, 17, 198.	0.9	14
26	Factors Associated with Hospital Admission after Outpatient Surgery in the Veterans Health Administration. Health Services Research, 2018, 53, 3855-3880.	1.0	12
27	Facility type and surgical specialty are associated with suboptimal surgical antimicrobial prophylaxis practice patterns: a multi-center, retrospective cohort study. Antimicrobial Resistance and Infection Control, 2019, 8, 49.	1.5	12
28	Identifying Previously Undetected Harm. Quality Management in Health Care, 2015, 24, 140-146.	0.4	11
29	Cost-Effectiveness of Access to Nonemergency Medical Transportation: Comparison of Transportation and Health Care Costs and Benefits. , 0, .		10
30	Cost-Effectiveness of Access to Nonemergency Medical Transportation. Transportation Research Record, 2006, 1956, 86-93.	1.0	9
31	Improving the identification of Postoperative Wound Dehiscence missed by the Patient Safety Indicator algorithm. American Journal of Surgery, 2013, 205, 674-680.	0.9	8
32	Using AHRQ Patient Safety Indicators to Detect Postdischarge Adverse Events in the Veterans Health Administration. American Journal of Medical Quality, 2014, 29, 213-219.	0.2	8
33	Measuring readmissions after surgery: do different methods tell the same story?. American Journal of Surgery, 2016, 212, 24-33.	0.9	7
34	Development of an Adverse Event Surveillance Model for Outpatient Surgery in the Veterans Health Administration. Health Services Research, 2018, 53, 4507-4528.	1.0	7
35	Using a Composite Readmission Measure to Assess Surgical Quality in the Veterans Health Administration. JAMA Surgery, 2014, 149, 1206.	2.2	6
36	Measuring Surgical Quality. JAMA Surgery, 2014, 149, 1210.	2.2	6

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#	Article	IF	CITATIONS
37	Association Between Postoperative Admission and Location of Hernia Surgery. JAMA Surgery, 2016, 151, 1187.	2.2	6
38	Development and Validation of a Semi-Automated Surveillance Algorithm for Cardiac Device Infections: Insights from the VA CART program. Scientific Reports, 2020, 10, 5276.	1.6	6
39	Comparison of the Agency for Healthcare Research and Quality Patient Safety Indicator Rates Among Veteran Dual Users. American Journal of Medical Quality, 2014, 29, 335-343.	0.2	5
40	Identifying adverse events after outpatient surgery: improving measurement of patient safety. BMJ Quality and Safety, 2016, 25, 3-5.	1.8	5
41	Do Acute Myocardial Infarction and Heart Failure Readmissions Flagged as Potentially Preventable by the 3M Potentially Preventable Readmissions Software Have More Process-of-Care Problems?. Circulation: Cardiovascular Quality and Outcomes, 2016, 9, 532-541.	0.9	5
42	The Nature and Severity of Adverse Events in Select Outpatient Surgical Procedures in the Veterans Health Administration. Quality Management in Health Care, 2018, 27, 136-144.	0.4	5
43	Identifying Risks and Opportunities in Outpatient Surgical Patient Safety: A Qualitative Analysis of Veterans Health Administration Staff Perceptions. Journal of Patient Safety, 2021, 17, e177-e185.	0.7	5
44	Assessing the Potential Adoption and Usefulness of Concurrent, Action-Oriented, Electronic Adverse Drug Event Triggers Designed for the Outpatient Setting. EGEMS (Washington, DC), 2017, 3, 10.	2.0	5
45	Informatics tools for the development of action-oriented triggers for outpatient adverse drug events. AMIA Annual Symposium proceedings, 2008, , 505-9.	0.2	4
46	Promoting de-implementation of inappropriate antimicrobial use in cardiac device procedures by expanding audit and feedback: protocol for hybrid III type effectiveness/implementation quasi-experimental study. Implementation Science, 2022, 17, 12.	2.5	4
47	Comparing definitions of outpatient surgery: Implications for quality measurement. American Journal of Surgery, 2017, 214, 186-192.	0.9	3
48	Detection and potential consequences of intraoperative adverse events: A pilot study in the veterans health administration. American Journal of Surgery, 2017, 214, 786-791.	0.9	3
49	Factors Associated With Emergency Department Visits and Hospital Admissions After Invasive Outpatient Procedures in the Veterans Health Administration. JAMA Surgery, 2018, 153, 774.	2.2	3
50	Association between postoperative opioid use and outpatient surgical adverse events. American Journal of Surgery, 2019, 217, 605-612.	0.9	3
51	<p>Veterans Perceptions of Satisfaction and Convenience with Anticoagulants for Atrial Fibrillation: Warfarin versus Direct Oral Anticoagulants</p> . Patient Preference and Adherence, 2020, Volume 14, 1911-1922.	0.8	3
52	Comparing total medical expenditure between patients receiving direct oral anticoagulants vs warfarin for the treatment of atrial fibrillation: evidence from VA-Medicare dual enrollees. Journal of Managed Care & Specialty Pharmacy, 2021, 27, 1056-1066.	0.5	3
53	Assessing the sustainability of compliance with surgical site infection prophylaxis after discontinuation of mandatory active reporting: study protocol. Implementation Science Communications, 2022, 3, 47.	0.8	3
54	Defining Outpatient Surgery: Perspectives of Surgical Staff in the Veterans Health Administration. American Surgeon, 2016, 82, 1142-1145.	0.4	2

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#	Article	IF	CITATIONS
55	Surgical site infections in outpatient surgeries: Less invasive procedures contribute substantially to the overall burden. Infection Control and Hospital Epidemiology, 2019, 40, 1191-1193.	1.0	2
56	Emergency Department Use After Outpatient Surgery Among Dually Enrolled VA and Medicare Patients. Quality Management in Health Care, 2019, 28, 191-199.	0.4	2
57	Novel methodology to measure pre-procedure antimicrobial prophylaxis: integrating text searches with structured data from the Veterans Health Administration's electronic medical record. BMC Medical Informatics and Decision Making, 2020, 20, 15.	1.5	2
58	Association Between Diabetic Foot Infection Wound Culture Positivity and 1-Year Admission for Invasive Infection: A Multicenter Cohort Study. Open Forum Infectious Diseases, 2021, 8, ofab172.	0.4	1
59	Defining Outpatient Surgery: Perspectives of Surgical Staff in the Veterans Health Administration. American Surgeon, 2016, 82, 1142-1145.	0.4	1
60	Novel Methodology to Measure Preprocedure Antimicrobial Prophylaxis: Integrating Text Mining With Structured Data. Infection Control and Hospital Epidemiology, 2020, 41, s12-s13.	1.0	1
61	Response to: â€~Misinterpretation of meaning and intended use of potentially preventable readmissions' by Goldfieldet al. BMJ Quality and Safety, 2016, 25, 208-209.	1.8	0
62	Novel Method to Detect Cardiac Device Infections by Integrating Electronic Medical Record Text with Structured Data in the Veterans Affairs Health System. Infection Control and Hospital Epidemiology, 2020, 41, s332-s332.	1.0	0