

# Emily S Patterson

## 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.

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|--------------------|-------------------------|----------------|-----------------|
| 166<br>papers      | 3,495<br>citations      | 28<br>h-index  | 57<br>g-index   |
| 185<br>ext. papers | 3,897<br>ext. citations | 2.3<br>avg, IF | 5.33<br>L-index |

| #   | Paper                                                                                                                                                                                                                    | IF   | Citations |
|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-----------|
| 166 | Handoff strategies in settings with high consequences for failure: lessons for health care operations. <i>International Journal for Quality in Health Care</i> , <b>2004</b> , 16, 125-32                                | 1.9  | 341       |
| 165 | Improving patient safety by identifying side effects from introducing bar coding in medication administration. <i>Journal of the American Medical Informatics Association: JAMIA</i> , <b>2002</b> , 9, 540-53           | 8.6  | 300       |
| 164 | Understanding the complexity of registered nurse work in acute care settings. <i>Journal of Nursing Administration</i> , <b>2003</b> , 33, 630-8                                                                         | 1.6  | 217       |
| 163 | Exploring barriers and facilitators to the use of computerized clinical reminders. <i>Journal of the American Medical Informatics Association: JAMIA</i> , <b>2005</b> , 12, 438-47                                      | 8.6  | 196       |
| 162 | Improving handoffs in the emergency department. <i>Annals of Emergency Medicine</i> , <b>2010</b> , 55, 171-80                                                                                                           | 2.1  | 171       |
| 161 | Patient handoffs: standardized and reliable measurement tools remain elusive. <i>Joint Commission Journal on Quality and Patient Safety</i> , <b>2010</b> , 36, 52-61                                                    | 1.4  | 170       |
| 160 | Compliance with intended use of Bar Code Medication Administration in acute and long-term care: an observational study. <i>Human Factors</i> , <b>2006</b> , 48, 15-22                                                   | 3.8  | 117       |
| 159 | Identifying barriers to the effective use of clinical reminders: bootstrapping multiple methods. <i>Journal of Biomedical Informatics</i> , <b>2005</b> , 38, 189-99                                                     | 10.2 | 99        |
| 158 | Human factors barriers to the effective use of ten HIV clinical reminders. <i>Journal of the American Medical Informatics Association: JAMIA</i> , <b>2004</b> , 11, 50-9                                                | 8.6  | 98        |
| 157 | Themes surrounding novice nurse near-miss and adverse-event situations. <i>Journal of Nursing Administration</i> , <b>2004</b> , 34, 531-8                                                                               | 1.6  | 94        |
| 156 | Collaborative cross-checking to enhance resilience. <i>Cognition, Technology and Work</i> , <b>2007</b> , 9, 155-162                                                                                                     | 2.9  | 83        |
| 155 | Shift changes, updates, and the on-call architecture in space shuttle mission control. <i>Computer Supported Cooperative Work</i> , <b>2001</b> , 10, 317-46                                                             | 2.4  | 78        |
| 154 | Voice loops as coordination aids in space shuttle mission control. <i>Computer Supported Cooperative Work</i> , <b>1999</b> , 8, 353-71                                                                                  | 2.4  | 76        |
| 153 | Impact of clinical reminder redesign on learnability, efficiency, usability, and workload for ambulatory clinic nurses. <i>Journal of the American Medical Informatics Association: JAMIA</i> , <b>2007</b> , 14, 632-40 | 8.6  | 67        |
| 152 | Information flow during crisis management: challenges to coordination in the emergency operations center. <i>Cognition, Technology and Work</i> , <b>2007</b> , 9, 25-31                                                 | 2.9  | 66        |
| 151 | Structuring flexibility: the potential good, bad and ugly in standardisation of handovers. <i>Quality and Safety in Health Care</i> , <b>2008</b> , 17, 4-5                                                              |      | 64        |
| 150 | Evaluation of a physician informatics tool to improve patient handoffs. <i>Journal of the American Medical Informatics Association: JAMIA</i> , <b>2009</b> , 16, 509-15                                                 | 8.6  | 62        |

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| 149 | A Multimodal Intervention Improves Postanesthesia Care Unit Handovers. <i>Anesthesia and Analgesia</i> , <b>2015</b> , 121, 957-971                                                                                                                      | 3.9  | 47 |
| 148 | Investigating stacking: How do registered nurses prioritize their activities in real-time?. <i>International Journal of Industrial Ergonomics</i> , <b>2011</b> , 41, 389-393                                                                            | 2.9  | 47 |
| 147 | Geminin promotes neural fate acquisition of embryonic stem cells by maintaining chromatin in an accessible and hyperacetylated state. <i>Proceedings of the National Academy of Sciences of the United States of America</i> , <b>2011</b> , 108, 3294-9 | 11.5 | 45 |
| 146 | Barriers and facilitators to adoption of soft copy interpretation from the user perspective: Lessons learned from filmless radiology for slideless pathology. <i>Journal of Pathology Informatics</i> , <b>2011</b> , 2, 1                               | 4.4  | 42 |
| 145 | Examining the complexity behind a medication error: generic patterns in communication. <i>IEEE Transactions on Systems, Man and Cybernetics, Part A: Systems and Humans</i> , <b>2004</b> , 34, 749-756                                                  |      | 42 |
| 144 | Improving interunit transitions of care between emergency physicians and hospital medicine physicians: a conceptual approach. <i>Academic Emergency Medicine</i> , <b>2012</b> , 19, 1188-95                                                             | 3.4  | 41 |
| 143 | Factors associated with longer length of stay for mental health emergency department patients. <i>Journal of Emergency Medicine</i> , <b>2014</b> , 47, 412-9                                                                                            | 1.5  | 37 |
| 142 | An Image Analysis Resource for Cancer Research: PIIP-Pathology Image Informatics Platform for Visualization, Analysis, and Management. <i>Cancer Research</i> , <b>2017</b> , 77, e83-e86                                                                | 10.1 | 36 |
| 141 | Interactive questioning in critical care during handovers: a transcript analysis of communication behaviours by physicians, nurses and nurse practitioners. <i>BMJ Quality and Safety</i> , <b>2014</b> , 23, 483-9                                      | 5.4  | 34 |
| 140 | Voice loops as cooperative aids in space shuttle mission control <b>1996</b> ,                                                                                                                                                                           |      | 30 |
| 139 | An evaluation of the Veterans Health Administration's clinical reminders system: a national survey of generalists. <i>Journal of General Internal Medicine</i> , <b>2008</b> , 23, 392-8                                                                 | 4    | 28 |
| 138 | Fifteen best practice recommendations for bar-code medication administration in the Veterans Health Administration. <i>Joint Commission Journal on Quality and Safety</i> , <b>2004</b> , 30, 355-65                                                     |      | 27 |
| 137 | Technical evaluation, testing, and validation of the usability of electronic health records                                                                                                                                                              |      | 26 |
| 136 | Changes in medical errors with a handoff program. <i>New England Journal of Medicine</i> , <b>2015</b> , 372, 490-1                                                                                                                                      | 59.2 | 25 |
| 135 | Hospital Patient Room Design: The Issues Facing 23 Occupational Groups Who Work in Medical/Surgical Patient Rooms. <i>Herd</i> , <b>2015</b> , 8, 98-114                                                                                                 | 2.4  | 25 |
| 134 | Finding Decision Support Requirements for Effective Intelligence Analysis Tools. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>2005</b> , 49, 297-301                                                                              | 0.4  | 25 |
| 133 | Workarounds to Intended Use of Health Information Technology: A Narrative Review of the Human Factors Engineering Literature. <i>Human Factors</i> , <b>2018</b> , 60, 281-292                                                                           | 3.8  | 24 |
| 132 | Visualization framework of macrocognition functions. <i>Cognition, Technology and Work</i> , <b>2012</b> , 14, 221-227                                                                                                                                   | 7.9  | 24 |

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| 131 | Situation Awareness and Interruption Handling During Medication Administration. <i>Western Journal of Nursing Research</i> , <b>2014</b> , 36, 891-916                                                                                                        | 2   | 23 |
| 130 | Beyond "communication failure". <i>Annals of Emergency Medicine</i> , <b>2009</b> , 53, 711-2                                                                                                                                                                 | 2.1 | 23 |
| 129 | Sources of variation in primary care clinical workflow: implications for the design of cognitive support. <i>Health Informatics Journal</i> , <b>2014</b> , 20, 35-49                                                                                         | 3   | 21 |
| 128 | Comparison of extent of use, information accuracy, and functions for manual and electronic patient status boards. <i>International Journal of Medical Informatics</i> , <b>2010</b> , 79, 817-23                                                              | 5.3 | 21 |
| 127 | Associations Among Nurse Fatigue, Individual Nurse Factors, and Aspects of the Nursing Practice Environment. <i>Journal of Nursing Administration</i> , <b>2018</b> , 48, 642-648                                                                             | 1.6 | 21 |
| 126 | Challenges for Cognition in Intelligence Analysis. <i>Journal of Cognitive Engineering and Decision Making</i> , <b>2007</b> , 1, 75-97                                                                                                                       | 2.5 | 17 |
| 125 | Meeting Patient Expectations During Hospitalization: A Grounded Theoretical Analysis of Patient-Centered Room Elements. <i>Herd</i> , <b>2017</b> , 10, 95-110                                                                                                | 2.4 | 16 |
| 124 | Cognitive Engineering                                                                                                                                                                                                                                         |     | 16 |
| 123 | Comparing the Effectiveness of Alerts and Dynamically Annotated Visualizations (DAVs) in Improving Clinical Decision Making. <i>Human Factors</i> , <b>2015</b> , 57, 1002-14                                                                                 | 3.8 | 15 |
| 122 | Enhancing electronic health record usability in pediatric patient care: a scenario-based approach. <i>Joint Commission Journal on Quality and Patient Safety</i> , <b>2013</b> , 39, 129-35                                                                   | 1.4 | 14 |
| 121 | Integrating Electronic Health Records into Clinical Workflow: An Application of Human Factors Modeling Methods to Ambulatory Care. <i>Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare</i> , <b>2014</b> , 3, 170-177 | 0.5 | 13 |
| 120 | Collaborating-or "Selling" Patients? A Conceptual Framework for Emergency Department-to-Inpatient Handoff Negotiations. <i>Joint Commission Journal on Quality and Patient Safety</i> , <b>2015</b> , 41, 134-43                                              | 1.4 | 13 |
| 119 | Elicitation by critiquing as a cognitive task analysis methodology. <i>Cognition, Technology and Work</i> , <b>2006</b> , 8, 90-102                                                                                                                           | 2.9 | 13 |
| 118 | A Survey Study of Benefits and Limitations of using CellaVision <sup>®</sup> DM96 for Peripheral Blood Differentials. <i>Clinical Laboratory Science: Journal of the American Society for Medical Technology</i> , <b>2014</b> , 27, 32-39                    |     | 12 |
| 117 | The effects of health information technology change over time: a study of Tele-ICU functions. <i>Applied Clinical Informatics</i> , <b>2012</b> , 3, 239-47                                                                                                   | 3.1 | 11 |
| 116 | Handoffs During Nursing Shift Changes in Acute Care. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>2005</b> , 49, 1057-1061                                                                                                             | 0.4 | 11 |
| 115 | Applying Human Factors Principles to Mitigate Usability Issues Related to Embedded Assumptions in Health Information Technology Design. <i>JMIR Human Factors</i> , <b>2014</b> , 1, e3                                                                       | 2.5 | 11 |
| 114 | A simulation-based embedded probe technique for human-computer interaction evaluation. <i>Cognition, Technology and Work</i> , <b>2004</b> , 6, 197                                                                                                           | 2.9 | 10 |

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| 113 | Using Cognitive Task Analysis (CTA) to Seed Design Concepts for Intelligence Analysts Under Data Overload. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>2001</b> , 45, 439-443                         | 0.4 | 10 |
| 112 | Using human factors methods to design a new interface for an electronic medical record <b>2007</b> , 640-4                                                                                                                    | 0.7 | 10 |
| 111 | Characterizing a Naturalistic Decision Making Phenomenon: Loss of System Resilience Associated with Implementation of New Technology. <i>Journal of Cognitive Engineering and Decision Making</i> , <b>2016</b> , 10, 229-243 | 2.5 | 9  |
| 110 | Clinical Reminders: Why Don't they use them?. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>2004</b> , 48, 1651-1655                                                                                    | 0.4 | 9  |
| 109 | Developing Evidence-Based Design Guidelines for Medical/Surgical Hospital Patient Rooms That Meet the Needs of Staff, Patients, and Visitors. <i>Herd</i> , <b>2020</b> , 13, 145-178                                         | 2.4 | 9  |
| 108 | Macro cognition in the Healthcare Built Environment (mHCBE): A Focused Ethnographic Study of "Neighborhoods" in a Pediatric Intensive Care Unit. <i>Herd</i> , <b>2018</b> , 11, 104-123                                      | 2.4 | 8  |
| 107 | Strategies for improving communication in the emergency department: mediums and messages in a noisy environment. <i>Joint Commission Journal on Quality and Patient Safety</i> , <b>2013</b> , 39, 279-86                     | 1.4 | 8  |
| 106 | Registered nurses' judgments of the classification and risk level of patient care errors. <i>Journal of Nursing Care Quality</i> , <b>2011</b> , 26, 302-10                                                                   | 1.7 | 8  |
| 105 | The "New Look" approach to patient safety: a guide for clinical nurse specialist leadership. <i>Clinical Nurse Specialist</i> , <b>2002</b> , 16, 247-53; quiz, 254-5                                                         | 0.6 | 8  |
| 104 | Improving Clinical Workflow in Ambulatory Care: Implemented Recommendations in an Innovation Prototype for the Veteran's Health Administration. <i>EGEMS (Washington, DC)</i> , <b>2015</b> , 3, 1149                         | 2.2 | 8  |
| 103 | Perceived Effectiveness, Self-efficacy, and Social Support for Oral Appliance Therapy Among Older Veterans With Obstructive Sleep Apnea. <i>Clinical Therapeutics</i> , <b>2016</b> , 38, 2407-2415                           | 3.5 | 8  |
| 102 | Using timbre to improve performance of larger auditory alarm sets. <i>Ergonomics</i> , <b>2019</b> , 62, 1617-1629                                                                                                            | 2.9 | 8  |
| 101 | Mixed Reality in Medical Education: A Narrative Literature Review. <i>Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare</i> , <b>2019</b> , 8, 28-32                                   | 0.5 | 7  |
| 100 | Implementation science for ambulatory care safety: a novel method to develop context-sensitive interventions to reduce quality gaps in monitoring high-risk patients. <i>Implementation Science</i> , <b>2017</b> , 12, 79    | 8.4 | 6  |
| 99  | Reducing delays to diagnosis in ambulatory care settings: A macro cognition perspective. <i>Applied Ergonomics</i> , <b>2020</b> , 82, 102965                                                                                 | 4.2 | 6  |
| 98  | Determining the rate of change in exposure to ionizing radiation from CT Scans: a database analysis from one hospital. <i>Journal of the American College of Radiology</i> , <b>2014</b> , 11, 703-8                          | 3.5 | 5  |
| 97  | Supporting the Cognitive Work of Information Analysis and Synthesis: A Study of the Military Intelligence Domain. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>2007</b> , 51, 348-352                  | 0.4 | 5  |
| 96  | Integrating electronic health records into clinical workflow : an application of human factors modeling methods to ambulatory care                                                                                            |     | 5  |

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| 95 | Differences in coder and physician perspectives on the transition to ICD-10-CM/PCS: A survey study. <i>Health Policy and Technology</i> , <b>2016</b> , 5, 251-259                                                                                             | 4.8 | 5 |
| 94 | Patients Are Knowledge Workers in the Clinical Information Space. <i>Applied Clinical Informatics</i> , <b>2021</b> , 12, 133-140                                                                                                                              | 3.1 | 5 |
| 93 | APPLYING HUMAN FACTORS ENGINEERING TO IMPROVE USABILITY AND WORKFLOW IN PATHOLOGY INFORMATICS. <i>Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare</i> , <b>2017</b> , 6, 23-27                                        | 0.5 | 4 |
| 92 | Value and Usage of a Workaround Artifact: A Cognitive Work Analysis of "Brains" Use by Hospital Nurses. <i>Journal of Cognitive Engineering and Decision Making</i> , <b>2019</b> , 13, 67-80                                                                  | 2.5 | 4 |
| 91 | CLUSTERING AND PRIORITIZING PATIENT SAFETY ISSUES DURING EHR IMPLEMENTATION AND UPGRADES IN HOSPITAL SETTINGS. <i>Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare</i> , <b>2017</b> , 6, 125-131                      | 0.5 | 4 |
| 90 | A Grounded Theoretical Analysis of Room Elements Desired by Family Members and Visitors of Hospitalized Patients: Implications for Medical/Surgical Hospital Patient Room Design. <i>Herd</i> , <b>2019</b> , 12, 124-144                                      | 2.4 | 4 |
| 89 | Barriers to Infection Control due to Hospital Patient Room Factors: A Secondary Analysis of Focus Group and Interview Transcripts. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>2014</b> , 58, 1266-1270                                | 0.4 | 4 |
| 88 | Barriers and Facilitators to Timely Admission and Transfer of Patients from an Emergency Department to an Intensive Care Unit. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>2011</b> , 55, 763-767                                      | 0.4 | 4 |
| 87 | The need for a broader view of human factors in the surgical domain. <i>Archives of Surgery</i> , <b>2011</b> , 146, 631-2                                                                                                                                     |     | 4 |
| 86 | Technology support of the handover: promoting observability, flexibility and efficiency. <i>BMJ Quality and Safety</i> , <b>2012</b> , 21 Suppl 1, i19-21                                                                                                      | 5.4 | 4 |
| 85 | Bridging the Gap between User-Centered Intentions and Actual Design Practice. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>1996</b> , 40, 967-971                                                                                       | 0.4 | 4 |
| 84 | Shifts in Functions of a New Technology over Time: An Analysis of Logged Electronic Intensive Care Unit Interventions. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>2008</b> , 52, 870-874                                              | 0.4 | 4 |
| 83 | Judging Sufficiency: How Professional Intelligence Analysts Assess Analytical Rigor. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>2007</b> , 51, 318-322                                                                                | 0.4 | 4 |
| 82 | Collaborative Cross-Checking to Enhance Resilience. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>2005</b> , 49, 512-516                                                                                                                 | 0.4 | 4 |
| 81 | Efficacy of a patient decision aid for improving person-centered decision-making by older adults with obstructive sleep apnea. <i>Journal of Clinical Sleep Medicine</i> , <b>2021</b> , 17, 121-128                                                           | 3.1 | 4 |
| 80 | Patient-Provider Communication With Older Adults About Sleep Apnea Diagnosis and Treatment. <i>Behavioral Sleep Medicine</i> , <b>2017</b> , 15, 423-437                                                                                                       | 4.2 | 3 |
| 79 | Patient-Reported Usability of Positive Airway Pressure Equipment Is Associated With Adherence in Older Adults. <i>Sleep</i> , <b>2017</b> , 40,                                                                                                                | 1.1 | 3 |
| 78 | USE PREFERENCES FOR CONTINUOUS CARDIAC AND RESPIRATORY MONITORING SYSTEMS IN HOSPITALS: A SURVEY OF PATIENTS AND FAMILY CAREGIVERS. <i>Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare</i> , <b>2018</b> , 7, 123-128 | 0.5 | 3 |



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| 77 | Towards computer-assisted coding: A case study of charge by documentation software at an endoscopy clinic. <i>Health Policy and Technology</i> , <b>2014</b> , 3, 208-214                                                                                    | 4.8 | 3 |
| 76 | Safe Practice Recommendations for the Use of Copy-Forward with Nursing Flow Sheets in Hospital Settings. <i>Joint Commission Journal on Quality and Patient Safety</i> , <b>2017</b> , 43, 375-385                                                           | 1.4 | 3 |
| 75 | Repeating Human Performance Themes in Five Health Care Adverse Events. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>2002</b> , 46, 1418-1422                                                                                          | 0.4 | 3 |
| 74 | Architects and interior designers perspectives on hospital patient rooms designed by the people who work in these rooms. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>2016</b> , 60, 588-592                                          | 0.4 | 3 |
| 73 | Predicting mortality with applied machine learning: Can we get there?. <i>Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare</i> , <b>2019</b> , 8, 115-119                                                            | 0.5 | 3 |
| 72 | A Qualitative Analysis of Outpatient Medication Use in Community Settings: Observed Safety Vulnerabilities and Recommendations for Improved Patient Safety. <i>Journal of Patient Safety</i> , <b>2021</b> , 17, e335-e342                                   | 1.9 | 3 |
| 71 | A Roundtable Discussion: Improving the 'Alarm Problem' Will Require Much More Than Just Reducing the Number of Alarms. <i>Biomedical Instrumentation and Technology</i> , <b>2018</b> , 52, 454-461                                                          | 0.4 | 3 |
| 70 | Identifying and Monitoring Respiratory Compromise: Report from the Rules and Algorithms Working Group. <i>Biomedical Instrumentation and Technology</i> , <b>2019</b> , 53, 110-123                                                                          | 0.4 | 2 |
| 69 | Patient-Centered Handovers: Ethnographic Observations of Attending and Resident Physicians: Ethnographic Observations of Attending and Resident Physicians. <i>Quality Management in Health Care</i> , <b>2016</b> , 25, 225-230                             | 1   | 2 |
| 68 | Patterns in Cooperative Cognition. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>1998</b> , 42, 263-266                                                                                                                                | 0.4 | 2 |
| 67 | Can We Ever Escape from Data Overload? A Cognitive Systems Diagnosis. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>1999</b> , 43, 174-178                                                                                             | 0.4 | 2 |
| 66 | A Simulation Study of Computer-Supported Inferential Analysis Under Data Overload. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>1999</b> , 43, 364-368                                                                                | 0.4 | 2 |
| 65 | Descriptive Usability Study of CirrODS: Clinical Decision and Workflow Support Tool for Management of Patients With Cirrhosis. <i>JMIR Medical Informatics</i> , <b>2019</b> , 7, e13627                                                                     | 3.6 | 2 |
| 64 | Comparative Effectiveness of Best Practice Alerts with Active and Passive Presentations: A Retrospective Study. <i>Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare</i> , <b>2020</b> , 9, 105-109                   | 0.5 | 2 |
| 63 | Applying Human Factors Engineering to Address the Telemetry Alarm Problem in a Large Medical Center. <i>Human Factors</i> , <b>2021</b> , 187208211018883                                                                                                    | 3.8 | 2 |
| 62 | Lessons from the Glass Cockpit: Innovation in Alarm Systems to Support Cognitive Work. <i>Biomedical Instrumentation and Technology</i> , <b>2021</b> , 55, 29-40                                                                                            | 0.4 | 2 |
| 61 | Opportunities for Inpatient Room Designs That Facilitate Imaging Professionals in Providing Diagnostic Patient Care: A Mixed Methods Study. <i>Journal of Diagnostic Medical Sonography</i> , <b>2018</b> , 34, 329-340                                      | 0.4 | 2 |
| 60 | HOW NURSES IDENTIFY HOSPITALIZED PATIENTS ON THEIR PERSONAL NOTES: FINDINGS FROM ANALYZING 'BRAINS' HEADERS WITH MULTIPLE RATERS. <i>Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare</i> , <b>2018</b> , 7, 205-209 | 0.5 | 2 |

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| 59 | A MIXED METHODS APPROACH TO TAILORING EVIDENCE-BASED GUIDANCE FOR ANTIBIOTIC STEWARDSHIP TO ONE MEDICAL SYSTEM. <i>Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare</i> , <b>2018</b> , 7, 224-231                           | 0.5 | 2 |
| 58 | The Environmental Services Perspective on Hospital Room Design: A Mixed-Methods Approach. <i>Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare</i> , <b>2017</b> , 6, 104-108                                                 | 0.5 | 1 |
| 57 | Promoting Patient Safety with Human Factors Methods: Practical Approaches to Current Medication Management Issues. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>2016</b> , 60, 647-651                                                        | 0.4 | 1 |
| 56 | Development of a Program Promoting Person-Centered Care of Older Adults with Sleep Apnea. <i>Journal of the American Geriatrics Society</i> , <b>2019</b> , 67, 2204-2207                                                                                            | 5.6 | 1 |
| 55 | Detecting Differences in Communication During Two Types of Patient Handovers: A Linguistic Construct Categorization Approach. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>2014</b> , 58, 1262-1265                                           | 0.4 | 1 |
| 54 | The Human Factors of Intelligence Analysis. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>2015</b> , 59, 130-134                                                                                                                               | 0.4 | 1 |
| 53 | Integrating Electronic Health Records Into Clinical Workflow: An Application of Human Factors Modeling Methods to Two Specialty Care Areas. <i>Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare</i> , <b>2015</b> , 4, 42-49 | 0.5 | 1 |
| 52 | Barriers and Facilitators Affecting the Adoption of Ceiling Lift Interventions in Nursing Homes. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>2014</b> , 58, 1405-1409                                                                        | 0.4 | 1 |
| 51 | Identifying Emergent Thought Leaders. <i>Lecture Notes in Computer Science</i> , <b>2014</b> , 51-58                                                                                                                                                                 | 0.9 | 1 |
| 50 | Differences in Macrocognition Strategies With Face to Face and Distributed Teams. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>2012</b> , 56, 282-286                                                                                         | 0.4 | 1 |
| 49 | Insights from Applying Rigor Metric to Healthcare Incident Investigations. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>2008</b> , 52, 1766-1770                                                                                              | 0.4 | 1 |
| 48 | Structured Interdisciplinary Communication Strategies in Four ICUs: An Observational Study. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>2006</b> , 50, 929-933                                                                               | 0.4 | 1 |
| 47 | Comparing Findings from Cognitive Engineering Evaluations. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>2003</b> , 47, 483-487                                                                                                                | 0.4 | 1 |
| 46 | New Arctic Air Crash Aftermath Role-Play Simulation—Orchestrating a Fundamental Surprise. <i>Proceedings of the Human Factors and Ergonomics Society</i> , <b>2001</b> , 45, 371-375                                                                                 | 0.4 | 1 |
| 45 | SCHEDULING DELAYED TREATMENT AND SURGERIES POST-PANDEMIC: A STAKEHOLDER ANALYSIS. <i>Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare</i> , <b>2020</b> , 9, 10-14                                                           | 0.5 | 1 |
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