Amy K Rosen

List of Publications by Year
in descending order

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137 papers	4,338 citations	147801 31 h-index	123424 61 g-index
137 all docs	137 docs citations	137 times ranked	4188 citing authors

#	Article	IF	Citations
1	Comparing Postoperative Readmission Rates Between Veterans Receiving Total Knee Arthroplasty in the Veterans Health Administration Versus Community Care. Medical Care, 2022, 60, 178-186.	2.4	5
2	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.	1.7	5
3	Influence of Autoimmune Antibody Testing on the Use of Immunotherapy on an Inpatient Neurology Service. Neurohospitalist, The, 2021, 11, 214-220.	0.8	3
4	Partnership Forum. Medical Care, 2021, 59, S232-S241.	2.4	2
5	Comparing Driving Miles for Department of Veterans Affairsâ€“delivered Versus Department of Veterans Affairsâ€“purchased Cataract Surgery. Medical Care, 2021, 59, S307-S313.	2.4	7
6	Did Access to Care Improve Since Passage of the Veterans Choice Act?. Medical Care, 2021, 59, S270-S278.	2.4	26
7	Rural Veteransâ€™ Experiences With Outpatient Care in the Veterans Health Administration Versus Community Care. Medical Care, 2021, 59, S286-S291.	2.4	6
8	Comparing Complication Rates After Elective Total Knee Arthroplasty Delivered Or Purchased By The VA. Health Affairs, 2021, 40, 1312-1320.	5.2	9
9	Disparities in Utilization of Ambulatory Cholecystectomy: Results From Three States. Journal of Surgical Research, 2021, 266, 373-382.	1.6	7
10	Estimating the Cost of Surgical Care Purchased in the Community by the Veterans Health Administration. MDM Policy and Practice, 2021, 6, 238146832110579.	0.9	6
11	Health Care Needs of Incarcerated Patients: A Case Study at a Large Urban Hospital. Journal of Correctional Health Care, 2021, 27, 272-279.	0.5	0
12	The Changing Dynamics of Providing Health Care to Older Veterans in the 21st Century: How Do We Best Serve Those Who Have Borne the Battle?. The Public Policy and Aging Report, 2020, 30, 3-5.	1.1	3
13	Veteransâ€™ Experiences With Outpatient Care: Comparing The Veterans Affairs System WithÂCommunity-Based Care. Health Affairs, 2020, 39, 1368-1376.	5.2	30
14	Association of Race, Health Insurance Status, and Household Income With Location and Outcomes of Ambulatory Surgery Among Adult Patients in 2 US States. JAMA Surgery, 2020, 155, 1123.	4.3	35
15	Comparing cataract surgery complication rates in veterans receiving VA and community care. Health Services Research, 2020, 55, 690-700.	2.0	15
16	A cardiovascular disease risk prediction algorithm for use with the Medicare current beneficiary survey. Health Services Research, 2020, 55, 568-577.	2.0	4
17	Comparison of a Potential Hospital Quality Metric With Existing Metrics for Surgical Qualityâ€“Associated Readmission. JAMA Network Open, 2019, 2, e191313.	5.9	18
18	Preoperative opioid use and postoperative pain associated with surgical readmissions. American Journal of Surgery, 2019, 218, 828-835.	1.8	18

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19	Emergency Department Use After Outpatient Surgery Among Dually Enrolled VA and Medicare Patients. Quality Management in Health Care, 2019, 28, 191-199.	0.8	2
20	Association between postoperative opioid use and outpatient surgical adverse events. American Journal of Surgery, 2019, 217, 605-612.	1.8	3
21	Factors Associated with Hospital Admission after Outpatient Surgery in the Veterans Health Administration. Health Services Research, 2018, 53, 3855-3880.	2.0	12
22	Association of Postoperative Readmissions With Surgical Quality Using a Delphi Consensus Process to Identify Relevant Diagnosis Codes. JAMA Surgery, 2018, 153, 728.	4.3	24
23	Caprini Risk Model Decreases Venous Thromboembolism Rates in Thoracic Surgery Cancer Patients. Annals of Thoracic Surgery, 2018, 105, 879-885.	1.3	46
24	Improving detection of intraoperative medical errors (iMEs) and intraoperative adverse events (iAEs) and their contribution to postoperative outcomes. American Journal of Surgery, 2018, 216, 846-850.	1.8	6
25	Differences in Risk Scores of Veterans Receiving Community Care Purchased by the Veterans Health Administration. Health Services Research, 2018, 53, 5438-5454.	2.0	29
26	Development of an Adverse Event Surveillance Model for Outpatient Surgery in the Veterans Health Administration. Health Services Research, 2018, 53, 4507-4528.	2.0	7
27	Quality Comes with the (Anatomic) Territory: Evaluating the Impact of Surgeon Operative Mix on Patient Outcomes After Pancreaticoduodenectomy. Annals of Surgical Oncology, 2018, 25, 3795-3803.	1.5	19
28	The Patient Safety Indicator Perioperative Pulmonary Embolism or Deep Vein Thrombosis: Is there associated surveillance bias in the Veterans Health Administration?. American Journal of Surgery, 2018, 216, 974-979.	1.8	2
29	Stage at presentation for incarcerated patients at a single urban tertiary care center.. Journal of Clinical Oncology, 2018, 36, e18649-e18649.	1.6	0
30	Hospital Readmissions after Surgery: How Important Are Hospital and Specialty Factors?. Journal of the American College of Surgeons, 2017, 224, 515-523.	0.5	14
31	Comparing definitions of outpatient surgery: Implications for quality measurement. American Journal of Surgery, 2017, 214, 186-192.	1.8	3
32	Detection and potential consequences of intraoperative adverse events: A pilot study in the veterans health administration. American Journal of Surgery, 2017, 214, 786-791.	1.8	3
33	Does adding clinical data to administrative data improve agreement among hospital quality measures?. Healthcare, 2017, 5, 112-118.	1.3	1
34	Trends in the Purchase of Surgical Care in the Community by the Veterans Health Administration. Medical Care, 2017, 55, S45-S52.	2.4	8
35	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
36	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.	2.4	20

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37	Using Harmâ€Based Weights for the <scp>AHRQ</scp> Patient Safety for Selected Indicators Composite (<scp>PSI</scp>â€90): Does It Affect Assessment of Hospital Performance and Financial Penalties in Veterans Health Administration Hospitals?. Health Services Research, 2016, 51, 2140-2157.	2.0	8
38	Identifying adverse events after outpatient surgery: improving measurement of patient safety. BMJ Quality and Safety, 2016, 25, 3-5.	3.7	5
39	Association Between Postoperative Admission and Location of Hernia Surgery. JAMA Surgery, 2016, 151, 1187.	4.3	6
40	Surgeonsâ€™ Disclosures of Clinical Adverse Events. JAMA Surgery, 2016, 151, 1015.	4.3	15
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.	2.2	5
42	Response to: â€˜Misinterpretation of meaning and intended use of potentially preventable readmissionsâ€™ by Goldfieldet al. BMJ Quality and Safety, 2016, 25, 208-209.	3.7	0
43	Postoperative 30-day Readmission. Annals of Surgery, 2016, 264, 621-631.	4.2	56
44	An Exploration of System-Level Factors and the Geographic Variation in Bariatric Surgery Utilization. Obesity Surgery, 2016, 26, 1635-1638.	2.1	8
45	Measuring readmissions after surgery: do different methods tell the same story?. American Journal of Surgery, 2016, 212, 24-33.	1.8	7
46	Partnering With VA Stakeholders to Develop a Comprehensive Patient Safety Data Display. American Journal of Medical Quality, 2016, 31, 178-186.	0.5	3
47	Improving Pregnancy Outcomes through Maternity Care Coordination: A Systematic Review. Women's Health Issues, 2016, 26, 87-99.	2.0	40
48	Sustained Use of Patient Portal Features and Improvements in Diabetes Physiological Measures. Journal of Medical Internet Research, 2016, 18, e179.	4.3	97
49	What Is the Value of Adding Medicare Data in Estimating VA Hospital Readmission Rates?. Health Services Research, 2015, 50, 40-57.	2.0	16
50	Identifying Previously Undetected Harm. Quality Management in Health Care, 2015, 24, 140-146.	0.8	11
51	Trends in acute myocardial infarction hospitalizations: Are we seeing the whole picture?. American Heart Journal, 2015, 170, 1211-1219.	2.7	30
52	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.	3.7	16
53	The Agency for Healthcare Research and Quality Inpatient Quality Indicator #11 overall mortality rate does not accurately assess mortality risk after abdominal aortic aneurysm repair. Journal of Vascular Surgery, 2015, 61, 44-49.	1.1	4
54	Using Estimated True Safety Event Rates versus Flagged Safety Event Rates: Does It Change Hospital Profiling and Payment?. Health Services Research, 2014, 49, 1426-1445.	2.0	15

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55	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.	0.5	5
56	Examining the Validity of AHRQâ€™s Patient Safety Indicators (PSIs). Medical Care Research and Review, 2014, 71, 599-618.	2.1	7
57	A Probability Metric for Identifying High-Performing Facilities. Medical Care, 2014, 52, 1030-1036.	2.4	5
58	Medical and Surgical Readmissions in the Veterans Health Administration. Medical Care, 2014, 52, 243-249.	2.4	32
59	Using a Composite Readmission Measure to Assess Surgical Quality in the Veterans Health Administration. JAMA Surgery, 2014, 149, 1206.	4.3	6
60	Measuring Surgical Quality. JAMA Surgery, 2014, 149, 1210.	4.3	6
61	Using AHRQ Patient Safety Indicators to Detect Postdischarge Adverse Events in the Veterans Health Administration. American Journal of Medical Quality, 2014, 29, 213-219.	0.5	8
62	Outcomes reported by the Vascular Quality Initiative and the National Surgical Quality Improvement Program are not comparable. Journal of Vascular Surgery, 2014, 60, 152-159.e3.	1.1	42
63	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.	1.8	25
64	Using a Virtual Breakthrough Series Collaborative to Reduce Postoperative Respiratory Failure in 16 Veterans Health Administration Hospitals. Joint Commission Journal on Quality and Patient Safety, 2014, 40, 11-AP6.	0.7	16
65	Assessing the Effects of the 2003 Resident Duty Hours Reform on Internal Medicine Board Scores. Academic Medicine, 2014, 89, 644-651.	1.6	15
66	Teaching Hospital Five-Year Mortality Trends in the Wake of Duty Hour Reforms. Journal of General Internal Medicine, 2013, 28, 1048-1055.	2.6	16
67	Teaching Hospital Financial Status and Patient Outcomes Following <scp>ACGME</scp> Duty Hour Reform. Health Services Research, 2013, 48, 476-498.	2.0	9
68	Improving the identification of Postoperative Wound Dehiscence missed by the Patient Safety Indicator algorithm. American Journal of Surgery, 2013, 205, 674-680.	1.8	8
69	Improving Identification of Postoperative Respiratory Failure Missed by the Patient Safety Indicator Algorithm. American Journal of Medical Quality, 2013, 28, 315-323.	0.5	5
70	Development and Testing of Tools to Detect Ambulatory Surgical Adverse Events. Journal of Patient Safety, 2013, 9, 96-102.	1.7	19
71	Quality improvement for patient safety. Health Care Management Review, 2013, 38, 40-50.	1.4	6
72	Examining the Relationship Between Processes of Care and Selected AHRQ Patient Safety Indicators Postoperative Wound Dehiscence and Accidental Puncture or Laceration Using the VA Electronic Medical Record. American Journal of Medical Quality, 2013, 28, 206-213.	0.5	4

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73	Examining the Impact of the AHRQ Patient Safety Indicators (PSIs) on the Veterans Health Administration. Medical Care, 2013, 51, 37-44.	2.4	50
74	Improving Patient Care Through Leadership Engagement with Frontline Staff: A Department of Veterans Affairs Case Study. Joint Commission Journal on Quality and Patient Safety, 2013, 39, 349-360.	0.7	10
75	Using the patient safety indicators to detect potential safety events among US veterans with psychotic disorders: clinical and research implications. International Journal for Quality in Health Care, 2012, 24, 321-329.	1.8	10
76	Validating the Patient Safety Indicators in the Veterans Health Administration. Medical Care, 2012, 50, 74-85.	2.4	94
77	Is Development of Postoperative Venous Thromboembolism Related to Thromboprophylaxis Use? A Case-Control Study in the Veterans Health Administration. Joint Commission Journal on Quality and Patient Safety, 2012, 38, 348-AP2.	0.7	2
78	Automated Identification of Postoperative Complications Within an Electronic Medical Record Using Natural Language Processing. JAMA - Journal of the American Medical Association, 2011, 306, 848-55.	7.4	386
79	Validity of Selected Patient Safety Indicators: Opportunities and Concerns. Journal of the American College of Surgeons, 2011, 212, 924-934.	0.5	112
80	How Valid is the AHRQ Patient Safety Indicator â€œPostoperative Hemorrhage or Hematomaâ€?. Journal of the American College of Surgeons, 2011, 212, 946-953e2.	0.5	29
81	How Valid is the AHRQ Patient Safety Indicator â€œPostoperative Respiratory Failureâ€?. Journal of the American College of Surgeons, 2011, 212, 935-945.	0.5	35
82	Positive Predictive Value of the AHRQ Patient Safety Indicator â€œPostoperative Sepsisâ€: Implications for Practice and Policy. Journal of the American College of Surgeons, 2011, 212, 954-961.	0.5	28
83	Validating the Patient Safety Indicators in the Veterans Health Administration: Are They Ready for Prime Time?. Journal of the American College of Surgeons, 2011, 212, 921-923.	0.5	13
84	How Valid is the AHRQ Patient Safety Indicator â€œPostoperative Physiologic and Metabolic Derangementâ€?. Journal of the American College of Surgeons, 2011, 212, 968-976e2.	0.5	19
85	Positive Predictive Value of the AHRQ Patient Safety Indicator â€œPostoperative Wound Dehiscenceâ€• Journal of the American College of Surgeons, 2011, 212, 962-967.	0.5	25
86	Detecting Patient Safety Indicators: How Valid Is â€œForeign Body Left During Procedureâ€•in the Veterans Health Administration?. Journal of the American College of Surgeons, 2011, 212, 977-983.	0.5	27
87	Validity of the AHRQ Patient Safety Indicator â€œCentral Venous Catheter-Related Bloodstream Infectionsâ€• Journal of the American College of Surgeons, 2011, 212, 984-990.	0.5	32
88	The Impact of Resident Duty Hour Reform on Hospital Readmission Rates Among Medicare Beneficiaries. Journal of General Internal Medicine, 2011, 26, 405-411.	2.6	26
89	Applying Trigger Tools to Detect Adverse Events Associated With Outpatient Surgery. Journal of Patient Safety, 2011, 7, 45-59.	1.7	19
90	Trends in the Inpatient Quality Indicators. Medical Care, 2010, 48, 694-702.	2.4	13

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91	Residency Training at a Crossroads: Duty-Hour Standards 2010. Annals of Internal Medicine, 2010, 153, 826.	3.9	15
92	Improving Risk Adjustment of Self-Reported Mental Health Outcomes. Journal of Behavioral Health Services and Research, 2010, 37, 291-306.	1.4	10
93	Testing the Association Between Patient Safety Indicators and Hospital Structural Characteristics in VA and Nonfederal Hospitals. Medical Care Research and Review, 2010, 67, 321-341.	2.1	26
94	Development of trigger tools for surveillance of adverse events in ambulatory surgery. BMJ Quality and Safety, 2010, 19, 425-429.	3.7	24
95	Hospital Safety Climate and Safety Outcomes: Is There a Relationship in the VA?. Medical Care Research and Review, 2010, 67, 590-608.	2.1	48
96	Effects of Resident Duty Hour Reform on Surgical and Procedural Patient Safety Indicators Among Hospitalized Veterans Health Administration and Medicare Patients. Medical Care, 2009, 47, 723-731.	2.4	77
97	Did Duty Hour Reform Lead to Better Outcomes Among the Highest Risk Patients?. Journal of General Internal Medicine, 2009, 24, 1149-1155.	2.6	75
98	Validity of Selected AHRQ Patient Safety Indicators Based on VA National Surgical Quality Improvement Program Data. Health Services Research, 2009, 44, 182-204.	2.0	146
99	Comparing Safety Climate between Two Populations of Hospitals in the United States. Health Services Research, 2009, 44, 1563-1583.	2.0	31
100	Relationship of Hospital Organizational Culture to Patient Safety Climate in the Veterans Health Administration. Medical Care Research and Review, 2009, 66, 320-338.	2.1	87
101	Prolonged Hospital Stay and the Resident Duty Hour Rules of 2003. Medical Care, 2009, 47, 1191-1200.	2.4	35
102	An Overview of Patient Safety Climate in the VA. Health Services Research, 2008, 43, 1263-1284.	2.0	63
103	Using Patient Safety Indicators to Estimate the Impact of Potential Adverse Events on Outcomes. Medical Care Research and Review, 2008, 65, 67-87.	2.1	79
104	Recruitment of Hospitals for a Safety Climate Study: Facilitators and Barriers. Joint Commission Journal on Quality and Patient Safety, 2008, 34, 275-284.	0.7	10
105	Mortality Among Hospitalized Medicare Beneficiaries in the First 2 Years Following ACGME Resident Duty Hour Reform. JAMA - Journal of the American Medical Association, 2007, 298, 975.	7.4	291
106	Mortality Among Patients in VA Hospitals in the First 2 Years Following ACGME Resident Duty Hour Reform. JAMA - Journal of the American Medical Association, 2007, 298, 984.	7.4	214
107	Failure-to-Rescue. Medical Care, 2007, 45, 918-925.	2.4	272
108	Workforce Perceptions of Hospital Safety Culture: Development and Validation of the Patient Safety Climate in Healthcare Organizations Survey. Health Services Research, 2007, 42, 1999-2021.	2.0	176

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109	Development and Validation of a Psychiatric Case-Mix System. Medical Care, 2006, 44, 568-580.	2.4	24
110	Evaluating risk-adjustment methodologies for patients with mental health and substance abuse disorders in the veterans health administration. International Journal of Healthcare Technology and Management, 2006, 7, 43.	0.1	5
111	Tracking Rates of Patient Safety Indicators Over Time. Medical Care, 2006, 44, 850-861.	2.4	42
112	Enhancing Patient Safety through Organizational Learning: Are Patient Safety Indicators a Step in the Right Direction?. Health Services Research, 2006, 41, 1633-1653.	2.0	54
113	Performance of statistical models to predict mental health and substance abuse cost. BMC Medical Research Methodology, 2006, 6, 53.	3.1	33
114	Evaluating the Patient Safety Indicators. Medical Care, 2005, 43, 873-884.	2.4	106
115	Purchasing or Providing Nursing Home Care: Can Quality of Care Data Provide Guidance. Journal of the American Geriatrics Society, 2005, 53, 603-608.	2.6	18
116	Dual-System Use: Are There Implications for Risk Adjustment and Quality Assessment?. American Journal of Medical Quality, 2005, 20, 182-194.	0.5	33
117	Identifying Future High-Healthcare Users. Disease Management and Health Outcomes, 2005, 13, 117-127.	0.4	11
118	Evaluating diagnosis-based risk-adjustment methods in a population with spinal cord dysfunction. Archives of Physical Medicine and Rehabilitation, 2004, 85, 218-226.	0.9	7
119	Case-Mix Adjusting Performance Measures in a Veteran Population: Pharmacy- and Diagnosis-Based Approaches. Health Services Research, 2003, 38, 1319-1338.	2.0	28
120	Applying a Risk-Adjustment Framework to Primary Care: Can We Improve on Existing Measures?. Annals of Family Medicine, 2003, 1, 44-51.	1.9	52
121	Applying Diagnostic Cost Groups to Examine the Disease Burden of VA Facilities: Comparing the Six â€œEvaluating VA Costsâ€•Study Sites With Other VA Sites and Medicare. Medical Care, 2003, 41, II-91.	2.4	13
122	Title is missing!. Medical Care, 2003, 41, 753-760.	2.4	11
123	Title is missing!. Medical Care, 2003, 41, II-91-II-102.	2.4	3
124	Do Different Case-Mix Measures Affect Assessments of Provider Efficiency?. Journal of Ambulatory Care Management, 2003, 26, 229-242.	1.1	20
125	Predicting Costs of Care Using a Pharmacy-Based Measure Risk Adjustment in a Veteran Population. Medical Care, 2003, 41, 753-760.	2.4	90
126	Diagnostic Cost Groups (DCGs) and Concurrent Utilization among Patients with Substance Abuse Disorders. Health Services Research, 2002, 37, 1079-1103.	2.0	23

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127	Title is missing!. Health Services and Outcomes Research Methodology, 2002, 3, 57-73.	1.8	6
128	Title is missing!. Health Services and Outcomes Research Methodology, 2002, 3, 267-277.	1.8	4
129	Profiling resource use: do different outcomes affect assessments of provider efficiency?. American Journal of Managed Care, 2002, 8, 1105-15.	1.1	3
130	Evaluating Diagnosis-Based Case-Mix Measures: How Well Do They Apply to the VA Population?. Medical Care, 2001, 39, 692-704.	2.4	63
131	Risk Adjustment for Measuring Health Outcomes: An Application in VA Long term Care. American Journal of Medical Quality, 2001, 16, 118-127.	0.5	26
132	Correlation of Risk Adjustment Measures Based on Diagnoses and Patient Self-Reported Health Status. Health Services and Outcomes Research Methodology, 2000, 1, 251-265.	1.8	8
133	Does Diagnostic Information Contribute to Predicting Functional Decline in Long-Term Care?. Medical Care, 2000, 38, 647-659.	2.4	16
134	Episodes of Care: Theoretical Frameworks Versus Current Operational Realities. The Joint Commission Journal on Quality Improvement, 1999, 25, 111-128.	1.5	23
135	Developing Episodes of Care for Adult Asthma Patients: A Cautionary Tale*â€. American Journal of Medical Quality, 1998, 13, 25-35.	0.5	7
136	Developing a Tool for Analyzing Medical Care Utilization of Adult Asthma Patients in Indemnity and Managed Care Plans: Can an Episodes of Care Framework Be Used?. American Journal of Medical Quality, 1998, 13, 203-212.	0.5	7
137	Ambulatory care casemix measures. Journal of General Internal Medicine, 1995, 10, 162-170.	2.6	14