Johns Hopkins Medicine Charts Successful Path for Improving Patient Safety at Large Health Systems

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Clear goals, strong leadership and infrastructure, staff engagement, and transparent reporting methods are key for complex health care systems seeking to establish successful patient safety performance improvements, according to a Johns Hopkins study published in the journal *Academic Medicine* in December.

Led by Peter Pronovost, senior vice president for patient safety and quality at Johns Hopkins Medicine and director of the Armstrong Institute for Patient Safety and Quality, the researchers examined the model used by the Johns Hopkins Health System to improve the use of core measures — recommended, well-researched processes for treating patients who require surgery or suffer heart attacks, heart failure, pneumonia or serious conditions. The health system planned to achieve 96 percent compliance on seven best practice measures at five of its member hospitals. Two years after the plan's implementation, the participating hospitals successfully obtained 96 percent compliance on six of the seven targeted measures.

While large, integrated health systems offer opportunities to provide a continuum of care for patients, Pronovost and his co-authors found that these complex structures can also lead to coordination challenges. To alleviate these challenges, the health system identified key areas on which to focus their improvement initiatives.

When establishing a patient safety improvement target, the researchers identified that organizations first need a commitment from leadership to invest in organizational structures and governance to hold member institutions accountable. Leaders from Johns Hopkins Medicine formed the Armstrong Institute to coordinate research, training and operations for quality improvement efforts across the organization. Clinical work groups responsible for target measures reported progress to the Johns Hopkins Medicine Patient Safety and Quality Board Committee.

Better communications and identification of specific opportunities for improvement, according to the study, were also critical for success. "By creating these clinical work groups and communities comprised of nurses, physicians, pharmacists, information technology specialists, quality improvement experts and other patient care providers, we fostered learning and collaboration among teams and were able to identify process barriers," says Pronovost.

Establishing a transparent reporting system is a third success factor, according to the study. Each clinical unit, department and hospital was responsible for reporting on its performance. Hospitals failing to meeting 96 percent compliance in one or more of the safety targets triggered a four-level review process, with repeated misses escalated to higher levels of leadership for review and possible auditing.

About the Armstrong Institute

Established in 2011, the Armstrong Institute works to improve clinical outcomes while reducing waste in health care delivery both at Johns Hopkins and around the world. Led by Pronovost, the Armstrong Institute's mission is to partner with patients, their loved ones and others to eliminate preventable harm, continuously improve patient outcomes and experience, and reduce waste in health care delivery.