

Peter J Pronovost

List of Publications by Year in descending order

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Version: 2024-02-01

121
papers

10,190
citations

126708

33
h-index

33814

99
g-index

122
all docs

122
docs citations

122
times ranked

8644
citing authors

#	ARTICLE	IF	CITATIONS
1	Digital Health: Unlocking Value in a Post-Pandemic World. <i>Population Health Management</i> , 2022, 25, 11-22.	0.8	20
2	Stratifying for Value: An Updated Population Health Risk Stratification Approach. <i>Population Health Management</i> , 2022, 25, 91-99.	0.8	4
3	Spine centers of excellence: a systematic review and single-institution description of a spine center of excellence. <i>Journal of Spine Surgery</i> , 2022, 8, 44-53.	0.6	2
4	What counts as a voiceable concern in decisions about speaking out in hospitals: A qualitative study. <i>Journal of Health Services Research and Policy</i> , 2022, 27, 88-95.	0.8	5
5	Achieving Large-Scale Quality Improvement in Primary Care Annual Wellness Visits and Hierarchical Condition Coding. <i>Journal of General Internal Medicine</i> , 2022, 37, 1457-1462.	1.3	4
6	What Is a Center of Excellence?. <i>Population Health Management</i> , 2022, 25, 561-567.	0.8	3
7	The Unrecognized Impact of Anxiety in Complex and Costly Patients. <i>Population Health Management</i> , 2022, , .	0.8	0
8	Effect of No-Charge Coronary Artery Calcium Scoring on Cardiovascular Prevention. <i>American Journal of Cardiology</i> , 2022, 174, 40-47.	0.7	6
9	Improvements in Hospital Adverse Event Rates. <i>JAMA - Journal of the American Medical Association</i> , 2022, 328, 148.	3.8	7
10	Use of Telemedicine to Improve Interfacility Communication and Aid in Triage of Patients with Intracerebral Hemorrhage: A Pilot Study. <i>World Neurosurgery</i> , 2021, 147, e189-e199.	0.7	1
11	Making a Dent in the Trillion-Dollar Problem: Toward Zero Defects. <i>NEJM Catalyst</i> , 2021, 2, .	0.4	14
12	American College of Surgeons Efforts in Support of Value-Based Metricsâ€™ Reply. <i>JAMA Oncology</i> , 2021, 7, 307.	3.4	0
13	Ensuring Quality in the Era of Virtual Care. <i>JAMA - Journal of the American Medical Association</i> , 2021, 325, 429.	3.8	66
14	Eliminating Defects in Behavioral Health Treatment. <i>Psychiatric Services</i> , 2021, 72, 213-215.	1.1	4
15	Smart agent system for insulin infusion protocol management: a simulation-based human factors evaluation study. <i>BMJ Quality and Safety</i> , 2021, 30, bmjqs-2020-011420.	1.8	1
16	Eliminating Missed Opportunities for Patients with Type 2 Diabetes. <i>Trends in Endocrinology and Metabolism</i> , 2021, 32, 257-259.	3.1	2
17	Designing for Value in Specialty Referrals: A New Framework for Eliminating Defects and Wicked Problems. <i>NEJM Catalyst</i> , 2021, 2, .	0.4	0
18	The role of the informal and formal organisation in voice about concerns in healthcare: A qualitative interview study. <i>Social Science and Medicine</i> , 2021, 280, 114050.	1.8	11

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19	Social Factors Predictive of Intensive Care Utilization in Technology-Dependent Children, a Retrospective Multicenter Cohort Study. <i>Frontiers in Pediatrics</i> , 2021, 9, 721353.	0.9	6
20	Redesigning Kidney Disease Care to Improve Value Delivery. <i>Population Health Management</i> , 2021, , .	0.8	0
21	Diagnostic Errors, Health Disparities, and Artificial Intelligence. <i>JAMA Health Forum</i> , 2021, 2, e212430.	1.0	11
22	Central versus Local Quality Efforts: The Need for Both. <i>Journal of the American Board of Family Medicine</i> , 2021, 34, 1038-1041.	0.8	5
23	Labeling Complex and Costly Patients as “Unimpactable”: A Morally Questionable Practice Likely to Worsen Inequities. <i>Population Health Management</i> , 2021, , .	0.8	1
24	Leading with love: learning and shared accountability. <i>Journal of Health Organization and Management</i> , 2021, ahead-of-print, .	0.6	1
25	Automation and interoperability of a nurse-managed insulin infusion protocol as a model to improve safety and efficiency in the delivery of high-alert medications. <i>Journal of Patient Safety and Risk Management</i> , 2020, 25, 5-14.	0.4	4
26	Time to Focus on Value-Based Metrics for Cancer Care?. <i>JAMA Oncology</i> , 2020, 6, 1325.	3.4	4
27	How systems engineering can improve care in the ICU. <i>Journal of Clinical Anesthesia</i> , 2020, 66, 109966.	0.7	0
28	Wasteful Health Care Spending in the United States. <i>JAMA - Journal of the American Medical Association</i> , 2020, 323, 895.	3.8	2
29	Towards improving hospital workflows: An evaluation of resources to mobilize patients. <i>Journal of Nursing Management</i> , 2019, 27, 27-34.	1.4	7
30	Geographically Localized Medicine House-Staff Teams and Patient Satisfaction. <i>Journal of Patient Experience</i> , 2019, 6, 46-52.	0.4	1
31	Malpractice litigation, quality improvement, and the University Hospitals Obstetric Quality Network. <i>Journal of Patient Safety and Risk Management</i> , 2019, 24, 196-206.	0.4	1
32	Value of hospital resources for effective pressure injury prevention: a cost-effectiveness analysis. <i>BMJ Quality and Safety</i> , 2019, 28, 132-141.	1.8	77
33	A framework for operationalizing risk: A practical approach to patient safety. <i>Journal of Healthcare Risk Management: the Journal of the American Society for Healthcare Risk Management</i> , 2018, 38, 38-46.	0.3	7
34	Next level of board accountability in health care quality. <i>Journal of Health Organization and Management</i> , 2018, 32, 2-8.	0.6	9
35	Latent risk assessment tool for health care leaders. <i>Journal of Healthcare Risk Management: the Journal of the American Society for Healthcare Risk Management</i> , 2018, 38, 36-46.	0.3	7
36	Making soft intelligence hard: a multi-site qualitative study of challenges relating to voice about safety concerns. <i>BMJ Quality and Safety</i> , 2018, 27, 710-717.	1.8	46

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37	Development and validation of a prediction model for insulin-associated hypoglycemia in non-critically ill hospitalized adults. <i>BMJ Open Diabetes Research and Care</i> , 2018, 6, e000499.	1.2	42
38	Frailty, hospital volume, and failure to rescue after head and neck cancer surgery. <i>Laryngoscope</i> , 2018, 128, 1365-1370.	1.1	23
39	Missed Doses of Venous Thromboembolism (VTE) Prophylaxis at Community Hospitals: Cause for Alarm. <i>Journal of General Internal Medicine</i> , 2018, 33, 19-20.	1.3	17
40	Addressing the multisectoral impact of pressure injuries in the USA, UK and abroad. <i>BMJ Quality and Safety</i> , 2018, 27, 171-173.	1.8	24
41	Establishing a Culture of Patient Safety, Quality, and Service in Plastic Surgery. <i>Journal of Patient Safety</i> , 2018, Publish Ahead of Print, e1553-e1558.	0.7	7
42	Effect of Real-time Patient-Centered Education Bundle on Administration of Venous Thromboembolism Prevention in Hospitalized Patients. <i>JAMA Network Open</i> , 2018, 1, e184741.	2.8	29
43	Sensor-based measurement of critical care nursing workload: Unobtrusive measures of nursing activity complement traditional task and patient level indicators of workload to predict perceived exertion. <i>PLoS ONE</i> , 2018, 13, e0204819.	1.1	25
44	We Should Measure What Matters in Bundled Payment Programs. <i>Annals of Internal Medicine</i> , 2018, 168, 735.	2.0	3
45	Unintended consequences of quality improvement programs on the prevention of hospital-acquired conditions: Avoiding the temptation to bite into low-hanging fruit. <i>Journal of Patient Safety and Risk Management</i> , 2018, 23, 123-127.	0.4	4
46	Improving healthcare value through clinical community and supply chain collaboration. <i>Healthcare</i> , 2017, 5, 1-5.	0.6	12
47	Reducing preventable harm: observations on minimizing bloodstream infections. <i>Journal of Health Organization and Management</i> , 2017, 31, 2-9.	0.6	11
48	Re-examining high reliability: actively organising for safety. <i>BMJ Quality and Safety</i> , 2017, 26, 248-251.	1.8	89
49	An Ethnographic Study of Health Information Technology Use in Three Intensive Care Units. <i>Health Services Research</i> , 2017, 52, 1330-1348.	1.0	16
50	Towards high-reliability organising in healthcare: a strategy for building organisational capacity. <i>BMJ Quality and Safety</i> , 2017, 26, 663-670.	1.8	26
51	A Preoperative Medical History and Physical Should Not Be a Requirement for All Cataract Patients. <i>Journal of General Internal Medicine</i> , 2017, 32, 813-814.	1.3	14
52	Commentary on: Report on Mortality from Gluteal Fat Grafting: Recommendations from the ASERF Task Force. <i>Aesthetic Surgery Journal</i> , 2017, 37, 811-813.	0.9	8
53	Can reverse innovation catalyse better value health care?. <i>The Lancet Global Health</i> , 2017, 5, e967-e968.	2.9	17
54	Use of Implementation Science for a Sustained Reduction of Central-Line-Associated Bloodstream Infections in a High-Volume, Regional Burn Unit. <i>Infection Control and Hospital Epidemiology</i> , 2017, 38, 1306-1311.	1.0	14

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55	What a Real Preoccupation With Failure Could Look Like. <i>Quality Management in Health Care</i> , 2017, 26, 171-172.	0.4	0
56	Mastery of Care-toward Communitarian Regulation. <i>Annals of Surgery</i> , 2017, 265, 271-272.	2.1	2
57	Time for Transparent Standards in Quality Reporting by Health Care Organizations. <i>JAMA - Journal of the American Medical Association</i> , 2017, 318, 701.	3.8	6
58	Implementation of the World Health Organization Trauma Care Checklist Program in 11 Centers Across Multiple Economic Strata: Effect on Care Process Measures. <i>World Journal of Surgery</i> , 2017, 41, 954-962.	0.8	57
59	A Typology of ICU Patients and Families from the Clinician Perspective: Toward Improving Communication. <i>Health Communication</i> , 2017, 32, 777-783.	1.8	8
60	The role of South-North partnerships in promoting shared learning and knowledge transfer. <i>Globalization and Health</i> , 2017, 13, 64.	2.4	23
61	Reconsidering Hospital Readmission Measures. <i>Journal of Hospital Medicine</i> , 2017, 12, 1009-1011.	0.7	5
62	Effectiveness of two distinct web-based education tools for bedside nurses on medication administration practice for venous thromboembolism prevention: A randomized clinical trial. <i>PLoS ONE</i> , 2017, 12, e0181664.	1.1	32
63	Changing the narratives for patient safety. <i>Bulletin of the World Health Organization</i> , 2017, 95, 478-480.	1.5	5
64	Integrating traditional biomedical and high reliability organisation approaches: solving puzzles and problems. <i>BMJ Leader</i> , 2017, 1, 64-65.	0.8	1
65	The Johns Hopkins Venous Thromboembolism Collaborative: Multidisciplinary team approach to achieve perfect prophylaxis. <i>Journal of Hospital Medicine</i> , 2016, 11, S8-S14.	0.7	30
66	Sustaining Reliability on Accountability Measures at The Johns Hopkins Hospital. <i>Joint Commission Journal on Quality and Patient Safety</i> , 2016, 42, 51-AP2.	0.4	11
67	Toward a Safer Health Care System. <i>JAMA - Journal of the American Medical Association</i> , 2016, 315, 1831.	3.8	32
68	Handoffs, safety culture, and practices: evidence from the hospital survey on patient safety culture. <i>BMC Health Services Research</i> , 2016, 16, 254.	0.9	93
69	Toward Eliminating All Harms. <i>Quality Management in Health Care</i> , 2016, 25, 185-186.	0.4	2
70	Management's Discussion and Analysis: A tool for advancing quality and safety. <i>Healthcare</i> , 2016, 4, 129-131.	0.6	6
71	Sustaining Reductions in Central Line-Associated Bloodstream Infections in Michigan Intensive Care Units. <i>American Journal of Medical Quality</i> , 2016, 31, 197-202.	0.2	78
72	Patient safety and the problem of many hands. <i>BMJ Quality and Safety</i> , 2016, 25, 485-488.	1.8	92

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73	Establishing an Ambulatory Medicine Quality and Safety Oversight Structure: Leveraging the Fractal Model. <i>Academic Medicine</i> , 2016, 91, 962-966.	0.8	14
74	Fifteen years after <i>To Err is Human</i> : a success story to learn from: Table 1. <i>BMJ Quality and Safety</i> , 2016, 25, 396-399.	1.8	61
75	Developing a Measure of Value in Health Care. <i>Value in Health</i> , 2016, 19, 323-325.	0.1	40
76	Editorial: Toward More Reliable Processes in Health Care. <i>Joint Commission Journal on Quality and Patient Safety</i> , 2015, 41, 3.	0.4	4
77	Republished: How to study improvement interventions: a brief overview of possible study types. <i>Postgraduate Medical Journal</i> , 2015, 91, 343-354.	0.9	36
78	The Armstrong Institute. <i>Academic Medicine</i> , 2015, 90, 1331-1339.	0.8	32
79	Creating a High-Reliability Health Care System. <i>Academic Medicine</i> , 2015, 90, 165-172.	0.8	54
80	From Shame to Guilt to Love. <i>JAMA - Journal of the American Medical Association</i> , 2015, 314, 2507.	3.8	10
81	How to study improvement interventions: a brief overview of possible study types: Table 1. <i>BMJ Quality and Safety</i> , 2015, 24, 325-336.	1.8	210
82	Sustaining quality improvement during data lag: A qualitative study in a perioperative setting. <i>Perioperative Care and Operating Room Management</i> , 2015, 1, 2-8.	0.2	3
83	Hospital Volume and Failure to Rescue after Head and Neck Cancer Surgery. <i>Otolaryngology - Head and Neck Surgery</i> , 2015, 152, 783-789.	1.1	35
84	A targeted real-time early warning score (TREWScore) for septic shock. <i>Science Translational Medicine</i> , 2015, 7, 299ra122.	5.8	389
85	Attending Physician Performance Measure Scores and Resident Physicians' Ordering Practices. <i>JAMA Surgery</i> , 2015, 150, 813.	2.2	30
86	Training for Identity, Not Behavior, in Quality and Safety. <i>American Journal of Medical Quality</i> , 2015, 30, 91-92.	0.2	0
87	Cost-effectiveness of a quality improvement programme to reduce central line-associated bloodstream infections in intensive care units in the USA. <i>BMJ Open</i> , 2014, 4, e006065-e006065.	0.8	26
88	Usability and perceived usefulness of personal health records for preventive health care: A case study focusing on patients' and primary care providers' perspectives. <i>Applied Ergonomics</i> , 2014, 45, 613-628.	1.7	65
89	Young and Reckless? Greater Standardization and Transparency of Performance Is Needed for Pediatric Performance Measures. <i>Academic Pediatrics</i> , 2014, 14, S15-S16.	1.0	2
90	Did Hospital Engagement Networks Actually Improve Care?. <i>New England Journal of Medicine</i> , 2014, 371, 691-693.	13.9	29

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91	From Heroism to Safe Design. <i>Anesthesiology</i> , 2014, 120, 526-529.	1.3	29
92	Creating a fractal-based quality management infrastructure. <i>Journal of Health Organization and Management</i> , 2014, 28, 576-586.	0.6	38
93	Ensuring That Guidelines Help Reduce Patient Harm. <i>Journal of Oncology Practice</i> , 2013, 9, e172-e173.	2.5	8
94	Demonstrating High Reliability on Accountability Measures at The Johns Hopkins Hospital. <i>Joint Commission Journal on Quality and Patient Safety</i> , 2013, 39, 531-AP5.	0.4	30
95	Do performance measures help healthcare?. <i>Hospital Peer Review</i> , 2013, 38, 73-6.	0.2	0
96	Preventing Patient Harms Through Systems of Care. <i>JAMA - Journal of the American Medical Association</i> , 2012, 308, 769.	3.8	60
97	Overview of progress in patient safety. <i>American Journal of Obstetrics and Gynecology</i> , 2011, 204, 5-10.	0.7	72
98	A Physician Management Infrastructure. <i>JAMA - Journal of the American Medical Association</i> , 2011, 305, 500.	3.8	15
99	A Research Framework for Reducing Preventable Patient Harm. <i>Clinical Infectious Diseases</i> , 2011, 52, 507-513.	2.9	27
100	Zero tolerance. Hospital executives play a key role in defeating deadly infections. <i>Modern Healthcare</i> , 2011, Suppl, 58.	0.0	0
101	How can clinicians measure safety and quality in acute care?. <i>International Journal of Nursing Studies</i> , 2011, 48, 347-55.	2.5	1
102	Viewing Health Care Delivery as Science: Challenges, Benefits, and Policy Implications. <i>Health Services Research</i> , 2010, 45, 1508-1522.	1.0	21
103	Learning Accountability for Patient Outcomes. <i>JAMA - Journal of the American Medical Association</i> , 2010, 304, 204.	3.8	33
104	Sustaining reductions in catheter related bloodstream infections in Michigan intensive care units: observational study. <i>BMJ: British Medical Journal</i> , 2010, 340, c309-c309.	2.4	432
105	We Need Leaders. <i>Anesthesiology</i> , 2010, 112, 779-785.	1.3	9
106	Framework for Patient Safety Research and Improvement. <i>Circulation</i> , 2009, 119, 330-337.	1.6	159
107	Measurement of Quality and Assurance of Safety in the Critically Ill. <i>Clinics in Chest Medicine</i> , 2009, 30, 169-179.	0.8	17
108	Improving patient safety in intensive care units in Michigan. <i>Journal of Critical Care</i> , 2008, 23, 207-221.	1.0	284

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109	The Wisdom and Justice of Not Paying for "Preventable Complications" JAMA - Journal of the American Medical Association, 2008, 299, 2197.	3.8	130
110	Improving the Quality of Measurement and Evaluation in Quality Improvement Efforts. American Journal of Medical Quality, 2008, 23, 143-146.	0.2	20
111	Pulmonary vs Nonpulmonary Sepsis and Mortality in Acute Lung Injury. Chest, 2008, 134, 534-538.	0.4	48
112	Translating evidence into practice: a model for large scale knowledge translation. BMJ: British Medical Journal, 2008, 337, a1714-a1714.	2.4	432
113	The GAAP in Quality Measurement and Reporting. JAMA - Journal of the American Medical Association, 2007, 298, 1800.	3.8	83
114	A Framework for Health Care Organizations to Develop and Evaluate a Safety Scorecard. JAMA - Journal of the American Medical Association, 2007, 298, 2063.	3.8	24
115	The organization of intensive care unit physician services*. Critical Care Medicine, 2007, 35, 2256-E11.	0.4	77
116	Impact of the Leapfrog Group's intensive care unit physician staffing standard. Journal of Critical Care, 2007, 22, 89-96.e24.	1.0	36
117	An Intervention to Decrease Catheter-Related Bloodstream Infections in the ICU. New England Journal of Medicine, 2006, 355, 2725-2732.	13.9	4,369
118	Improving ICU care: it takes a team. Healthcare Executive, 2005, 20, 14-6, 18, 20 passim.	0.0	6
119	Senior Executive Adopt-a-Work Unit: A Model for Safety Improvement. Joint Commission Journal on Quality and Safety, 2004, 30, 59-68.	1.3	108
120	Physician Staffing Patterns and Clinical Outcomes in Critically Ill Patients. JAMA - Journal of the American Medical Association, 2002, 288, 2151.	3.8	1,291
121	Building safety into ICU care. Journal of Critical Care, 2002, 17, 78-85.	1.0	83