



## Prescriptions for Excellence in Health Care Newsletter Supplement

A collaboration between Jefferson School of Population  
Health and Eli Lilly and Company

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Volume 1 | Issue 1

Article 5

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Fall 2007

# The Patient Safety Leadership Fellowship: Creating Change Agents

Deborah Bohr, MPH

*Director of Special Projects for the Health Research and Educational Trust of the American Hospital Association, Chicago, IL*

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### Recommended Citation

Bohr, MPH, Deborah (2007) "The Patient Safety Leadership Fellowship: Creating Change Agents," *Prescriptions for Excellence in Health Care Newsletter Supplement*: Vol. 1 : Iss. 1 , Article 5.

Available at: <http://jdc.jefferson.edu/pehc/vol1/iss1/5>

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# Prescriptions for Excellence in HEALTH CARE

A COLLABORATION BETWEEN JEFFERSON MEDICAL COLLEGE AND ELI LILLY AND CO.

## The Patient Safety Leadership Fellowship: Creating Change Agents

By Deborah Bohr, MPH

*“An unexpected outcome of the Fellowship was developing a community of experts to whom I can turn when faced with a patient safety challenge in my own organization. The support and advice provided by the other Fellows was—and continues to be—indispensable. The front line perspective of the Fellows provides ‘real world’ balance to the theoretical, academic lessons of the program. When in the trenches, the support and advice of my Fellowship colleagues helps me navigate in my day-to-day work.”*

— Kathy Leonhardt, MD, MPH, Associate Medical Director,  
Care Management, Aurora Health Care, Elm Grove, Wisconsin

Leadership is widely recognized as a—if not the most—critical element in a successful patient safety program. In cooperation with the National Patient Safety Foundation, the Health Research and Educational Trust launched the Patient Safety Leadership Fellowship in 2002 to help prepare the next generation of health care leaders to champion a culture of safety and make it a reality. Partners in this effort are the American Hospital Association, the American Organization of Nurse Executives, the American Society for Hospital Risk Managers, and the Society for Hospital Medicine.

Since 2002, more than 150 Fellows have graduated from this program. Fellows return to their organizations with the skills, models, and leadership capabilities needed

to spearhead improvement projects, create culture change, and establish long-term strategic planning for safety in their organizations.

### What Is the Patient Safety Leadership Fellowship?

The Patient Safety Leadership Fellowship is an intensive 12-month learning experience that develops leadership competencies and advances patient safety science in health care through a dynamic, highly participatory, and structured learning community. Fellows are exposed to a broad array of tools, strategies, and methodologies in the field of patient safety.

The Fellowship brings together participants through leadership retreats, a meeting held in conjunction with the National Patient

Safety Foundation Congress, and a virtual learning community in which Fellows learn from, and interact with, expert faculty. Everything in the Fellowship is designed to support Fellows' implementation of important projects in their own organizations. A significant portion of the Fellowship curriculum focuses on how to engage others in their organizations both through their passion for patient safety and through their technical skills.

### What Do the Fellows Learn?

The coursework includes self-study modules and face-to-face meetings designed to support each Fellow's Action Learning Project. The core curriculum covers 6 major areas. The first, *what creates safe health care systems*, explores what a safe organization looks like, as well as the epidemiology of patient safety. The second area focuses on *leadership, collaboration, and complexity* and is designed to build skill sets for the innovation and adaptation necessary for advancing patient safety in a multidisciplinary environment. Fellows learn the nature of complex change and how to use a systems approach to advance patient safety.

The *path to a culture of safety*, the third module, explores the diverse subcultures within each health care organization, and

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identifies what can impede or enhance the development of a culture of high reliability and safety. The fourth module, *lessons from inside and outside health care*, addresses fundamental safety concerns, principles, and practices, focusing on industries where safety depends on coordinated team action and factors that influence human performance.

The fifth module deals with *disclosure, reporting, and transparency*. It teaches Fellows how to effectively report errors, how to disclose errors to patients and other key stakeholders, and how to promote transparency throughout the system. The sixth and final module addresses *the business case for creating cultures of safety*, helping Fellows to understand and measure the relationship between safety, quality, and cost.

### Who Becomes A Fellow?

The Fellows are a diverse group of motivated and innovative health care leaders whose positions involve safety, quality, and risk: namely executive officers, medical officers, nurse executives, risk officers, physicians, nurse practitioners, infection control practitioners, pharmacy leaders, quality improvement leaders, and other health care professionals. Selection criteria for Fellows include prior training and experience and/or demonstrated interest in working to develop and implement patient safety initiatives, and an Action Learning Project proposal that uses a collaborative, problem-solving approach for integrating patient safety initiatives at the applicant's

organization. Preference is given to teams from the same institution. References from 2 peers with personal knowledge of an applicant's leadership abilities and knowledge of patient safety science are required, along with a letter of support from senior leadership or the board of the applicant's organization, which authorizes release time for the Fellowship and other support.

### Action Learning Projects

Each Fellow or team has an Action Learning Project, which is the heart of the program. Each project focuses on advancing patient safety and health outcomes and is designed to address a priority of the Fellow's organization. Fellows are asked to provide a midyear and final report to their organization's executives and/or board, in addition to their learning community of Fellows.

Over the past 5 years, the Fellows' Action Learning Projects have clustered into 6 main categories: (1) error reporting/data collection systems, (2) the use of technology and medication administration, (3) improving clinical communication and coordination, (4) building organizational awareness and culture change, (5) building patient safety awareness through partnerships, and (6) staff training and development.

An example of an Action Learning Project is *Improving Patient Safety Transitions* (Jane Foley, MHCA, Director of Operations, Cardiology/Critical Care; Kathleen P. Murray, Director, Process Improvement, Healthcare Quality; Gary B. Schweon, MSN, Director, Administration and Special Projects; and Julius Yang, MD, PhD, Medical Director. Beth Israel Deaconess Medical Center,

Boston, MA.) This project team sought to promote process, system, culture, and technology change to ensure seamless, safe, and efficient passage for patients across the many transitions during their hospital experience (eg, from the intensive care unit or the operating room to a regular floor in the hospital). The project addressed improvement opportunities in key areas such as primary team responsibility, transfer of responsibility, sign-out/handoff processes, and the care of "boarders" from one environment to another.

Examples of other Action Learning Projects include *Creating an Organizational Culture Supporting Patient Safety*, *Learning from Medical Errors*, *Training Medical Residents in Patient Safety*, and *Patient Safety and Toyota Work Principles*. Select papers developed from these projects will be submitted for peer review and consideration of publication in a special Health Research and Educational Trust section of the *American Journal of Medical Quality*.

### Fellowship Advisors and Faculty

A hallmark of the Fellowship is the personalized attention and mentoring by nationally recognized faculty and program advisors. A list of the faculty can be seen on the Fellowship's web page: <http://www.hret.org/hret/about/pslf.html>.

### Fellowship Alumni Association

The Fellowship is an ongoing journey rather than a onetime experience. The Fellowship Alumni Association fosters lifelong connections and provides access to an influential network

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of health care leaders and safety researchers. Fellows can continue their learning through active involvement, networking, and educational opportunities with the Alumni Association.

In summary, the goals of this Fellowship are to advance the theory and practice of transformational leadership in patient safety. The program supports Fellows in learning how to take action in a framework that emphasizes innovation, understands complexity, builds personal mastery, and facilitates a change agenda within their organizations. To achieve this mission-critical work, Patient Safety Leadership Fellows first explore what right things to do, and in doing those things right, ultimately transform health care.

*Deborah Bohr, MPH is Director of Special Projects for the Health Research and Educational Trust of the American Hospital Association, Chicago, IL. She can be reached at [dbohr@aha.org](mailto:dbohr@aha.org).*