Course Paper Description
Leadership for Change and Patient Safety and Quality Improvement
603.721.86

The course paper is an opportunity for you to explore a specific change, leadership, or management issue that is of interest and importance to you. You are encouraged to structure your paper using the Problem, Causes, Alternatives, and Net Benefits (PCAN) approach to communicating, as described below.

Step 1: Problem identification and description. Identify and describe a patient safety and quality challenge. What problem will you be trying to solve, and why is it important to different stakeholders (i.e., patients, healthcare workers, administrators, the general public, etc.).

This can take one of two general forms: 1) analysis of a specific organization, or 2) analysis of general industry trends and practices. If you currently have professional responsibilities related to safety and quality, this paper can focus on your particular context and draw from your experiences and analysis of your organization, much like a case analysis. If you currently do not have this type of access, you can focus on industry priorities and draw from the literature and published case studies.

The challenge you address can be technical or clinical in nature or related to workforce or patient-centered care issues.

Remember: The goal of the paper is to think through how change, leadership, and management issues impact the current and future states of this challenge. Choose your problem with that in mind (i.e., where these issues play a significant role).

Sources to draw from:

1. Your own experiences working within a healthcare setting, if you have relevant past or present experiences. This can use internal data or strategic priorities. Of course, do not share privileged internal data in your course paper. This is a chance to analyze a persistent problem in your organization and generate a plan for making progress.
2. Industry sources that help to identify safety and quality priorities:
    a. Agency for healthcare research and quality
    b. National Quality Forum
    c. Joint Commission Patient Safety Alerts
    d. ECRI Institute
    e. Institute for Safe Medication Practices

Issues to discuss:

- Who does this issue impact, and how?

- What is the nature of the safety or quality challenge? Is it technically complex, resource intensive, involve patient or staff attitudes or preferences, etc.?
- Is there existing evidence-based strategies or guidelines? If so, are they widely used?
- Is this a new issues or priority, or a long-standing challenge? If new, what has driven focus on this issue? If long standing, what solutions have been tried to date?

Step 2: Analyze the causes. What organizational issues are driving this patient safety issue? Explore a change, management, and leadership concepts related to the current state of the industry (or your organization).

Sources to draw from:

- If analyzing your own organization, interviews with stakeholders
- Reaching out to professionals with experience in this issue
- The research literature
- Industry documents
- Agency for Healthcare Research and Quality Patient Safety Network (e.g., WebM&M analyses)
- Robert Wood Johnson Foundation 'Why not the best' case studies

Issues to discuss:

- What are the barriers and potential facilitators (missing or not) of change impacting progress in this challenge?
- What does the leadership structure around this issue look like? Who are the leaders, what are their roles and functions? What organizational structures influence this challenge.
- What types of leadership behaviors have an impact on the current state of this challenge?
- Are there management system challenges around this issue?
- Are there accountability system issues involved? Consider goal setting, goal communication, measurement and feedback, establishing contingencies for meeting or not meeting goals, formal or informal learning systems, or allocation of time and resources to priorities.

Step 3: Propose alternatives. What is a better way of addressing this safety and quality challenge? Here, you are proposing a path to the 'desired future state'. Based on your analysis, what would that desired future state look like, and how would you propose getting there? This can involve new management systems and leadership practices, as well as a process for implementing these changes.

Sources to draw from:

- Course readings and resources.
- Any research and industry literature related to improving the management and leadership of safety and quality.

Issues to discuss:

- Are there management system components that need to be introduce or altered in order to realize improvements?
- Are there leadership practices that need to be changed? New or different structures of leadership? Leadership behaviors or capacities that need to be developed?
- What is your approach to implementing this change? What are the critical steps or phases in your process and how would they be carried out?

Step 4: Articulate the net benefits of adopting the alternative. If the world (or your organization) were to adopt the strategies you've proposed above, what would happen? What does the desired future state look like? Here you are creating the vision of the future that should drive adoption of your ideas. Don't forget appeals to 'hearts and minds' (i.e., the rational / deliberative system, and the affective / emotional system).