Institute *for* Healthcare Improvement

IHI Patient Safety and Quality for Emerging Leaders

March–June 2025

Program Agenda

IHI online courses with coaching combine self-directed content (released sequentially via the IHI Education Platform) and live instruction (facilitated by expert IHI faculty via Zoom). This offering consists of nine self-directed modules and six live online sessions.

Please mark your calendar for the following live online sessions, each of which will occur from 11:00 AM – 12:00 PM ET (4:00 – 5:00 PM BST/GMT)

- March 27
- April 10, 24
- May 8, 22
- June 5

All content will be available for six weeks following the conclusion of the program.

Program Overview

IHI Patient Safety and Quality for Emerging Leaders is designed to enhance your skills and advance your effectiveness as an emerging leader in patient safety, quality, and quality improvement. For leaders looking to upskill their staff, this course will provide a great environment for learning with time for participants to discuss how they will apply their new knowledge. This comprehensive program includes nine self-directed modules and six live sessions, providing a blend of asynchronous learning and live virtual coaching. All content will be accessible for six weeks following the conclusion of the program, ensuring you have ample time to absorb and apply the knowledge.

As a result of the program, you will be able to:

- Analyze relationships and concepts in patient safety and quality.
- Describe the impact of external Influences on your organization's patient safety and quality agenda.
- Leverage the systems and processes for effective safety event management and learning.
- Identify your role in promoting and sustaining a culture of safety in your department and across the system.
- Explain quality and safety measures effectively and how quality Improvement can be of great benefit in prioritizing and improving those opportunities.

Module 0: Welcome and Preparation for the Course	
Objectives	1. Distinguish the varying roles and responsibilities of patient safety, quality and quality improvement professionals. 2. Identify the key terminology that will be used throughout the course. 3. Examine the roles and responsibilities of safety professionals using a safety event case study.

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Self-Directed Module	Begins March 3, 2025 Complete by March 27, 2025

Module 1: Understanding the Intersections of Safety, Quality and Quality Improvement	
Objectives	1. Describe the relationships between harm, error, safety, quality, systems and high reliability. 2. Define the concepts of Safety 1, 2, and 3 and discuss key differences of each approach.
Self-Directed Module	Begins March 3 Complete by March 27
Live Online Session	March 27; 11:00 AM – 12:00 PM ET / 4:00 – 5:00 PM GMT/BST

Module 2: Accreditation, Regulation, and Oversight of Quality Safety in Health Care	
Objectives	1. Recognize the numerous regulatory, accrediting, and payor entities external to healthcare delivery organizations that shape the work of patient safety/quality analysts. 2. Describe typical interactions with these entities, and the implications for your organizations.
Self-Directed Module	Begins March 27 Complete by April 10
Live Online Session	April 10; 11:00 AM – 12:00 PM ET / 4:00 – 5:00 PM GMT/BST

Module 3: How Do We Measure Outcomes?

Objectives	1. Recognize the categories of quality and safety measures. 2. Describe commonly used safety and quality metrics that may be used at your organization. 3. Identify where metrics are collected and analyzed and how to develop the partnerships needed to improve them. 4. Discuss measurement burden and how a better understanding of data can support prioritization.
Self-Directed Module	Begins September April 10 Complete by April 24

Module 4: Responding to and Learning from Near Misses & Events : Part 1	
Objectives	1. Describe systems and processes for identifying and reporting events 2. Identify systems & processes for learning from near misses and safety events. 3. Analyze safety events individually and in aggregate, recognizing the value of each approach. 4. Discuss comprehensive closed-loop communication process for reporting safety events.
Self-Directed Module	Begins April 10 Complete by April 24

Module 5: Responding and Learning from Near Misses & Events: Part 2	
Objectives	1. Discuss the importance of strength of intervention to mitigate recurrence of serious safety events. 2. Describe how to support individuals involved in a safety event. 3. Identify how organizations can learn and improve systems and processes by analyzing and responding to serious safety events.
Self-Directed Module	Begins April 10 Complete by April 24
Live Online Session	April 24; 11:00 AM – 12:00 PM ET / 4:00 – 5:00 PM GMT/BST

Institute for Healthcare Improvement

IHI Patient Safety and Quality for Emerging Leaders

March–June 2025

Module 6: Building a Culture of Safety	
Objectives	1. Recognize your role as a safety professional in promoting a culture of safety. 2. Describe the elements of a culture of safety. 3. Identify the threats to, and promoters of, a culture of safety.
Self-Directed Module	Begins April 24 Complete by May 8
Live Online Session	May 8; 11:00 AM – 12:00 PM / 4:00 – 5:00 PM GMT/BST

Module 7: Understanding QI and Variation	
Objectives	1. Explain the difference between normal and special cause variation. 2. Describe how interpreting (and visualizing) data can support sense making of data. 3. Demonstrate how to promote a constructive dialogue around concerning data points using the identification of special cause variation.
Self-Directed Module	Begins May 8 Complete by May 22

Module 8: Categorizing Measures	
Objectives	1. Recognize the value of categorizing the safety and quality measures. 2. Describe the difference and importance between quality control, quality assurance, and quality improvement in setting priorities. 3. Identify the types of supports that are needed to drive each of those functions.
Self-Directed Module	Begins May 8 Complete by May 22
Live Online Session	May 22; 11:00 AM – 12:00 PM ET / 4:00 – 5:00 PM GMT/BST

Institute for Healthcare Improvement

IHI Patient Safety and Quality for Emerging Leaders

March–June 2025

Module 9: Your Role in Supporting Daily Safety Work	
Objectives	1. Describe your role in improving patient safety in their organization. 2. Detail ways in which you can become a more effective patient safety professional through information sharing and building partnerships.
Self-Directed Module	Begins May 22 Complete by June 5
Live Online Session	June 5; 11:00 AM – 12:00 PM ET / 4:00 – 5:00 PM GMT/BST

Faculty

Jesse McCall, MBA, is Senior Director and Improvement Advisor for the Institute for Healthcare Improvement (IHI). He coaches individuals and organizations through the process of improvement which includes the data-driven identification of strategic improvement priorities, development of operational systems to support improvement, and the building of practical improvement capability necessary for staff to get results that matter. Jesse also has extensive experience in coaching organizations to engage clinical staff to reduce burnout and foster joy in work. Jesse joined IHI in 2007 and over his tenure has designed, executed, and evaluated programs and projects around the world. Jesse is also a Teaching Fellow at The Harvard T.H. Chan School of Public Health and has expertise in practical application of the science of improvement, staff engagement and wellness, program and product development, marketing and communications, customer relationship management, and large-scale initiative operations. He received his undergraduate degree in Business Administration from Northeastern University in Boston and MBA from the UMASS Amherst Isenberg School of Management.

Jessica Behrhorst, MPH, CPPS, CPQH, CPHRM, Quality, Safety and HRO Consultant, Aptive Resources, works in the areas of patient safety, workforce safety, and high reliability. She is faculty for the IHI Patient Safety Executive Development Program and on Redesigning Event Review with Root Cause Analysis and Action (RCA2). Prior to Joining Aptive Resources she served as the Senior Director at the Institute for Healthcare Improvement (IHI). She has also served as the Assistant Vice President of Quality & Patient Safety at Ochsner Health System where she helped set the strategic priorities in quality and patient safety and oversaw various projects involving patient safety,

performance improvement, regulatory readiness, ambulatory nursing, and quality outcomes. She has presented her work on RCA2 and Improving the Culture of Safety at various regional and national meetings. She has also worked on research projects involving reduction in Sepsis mortality and access to healthcare for underserved populations. Jessica received her bachelor's degree from Tulane University and her Master of Public Health Degree from the Louisiana State University School of Public Health. She is a Certified Professional in Patient Safety (CPPS), a Certified Professional in Healthcare Quality (CPHQ) and a Certified Professional in Healthcare Risk Management (CPHRM).

Lauge Sokol-Hessner, MD, CPPS, is a practicing clinician, educator, researcher, innovator, and leader in patient safety & quality improvement. He has operational quality & safety experience as a former Senior Medical Director of Patient Safety at Beth Israel Deaconess Medical Center in Boston. He's passionate about helping develop the next generation of leaders in quality and safety and is a former quality & safety fellowship program director and masters program course director at Harvard Medical School. Currently he is: a Clinical Associate Professor of Medicine and an attending hospitalist at the University of Washington (UW) & Harborview Medical Centers; a Quality Improvement Mentor at the UW Medicine Center for Scholarship in Patient Care Quality and Safety; and the Associate Director for the Collaborative for Accountability and Improvement and a Faculty Coach for the PACT Collaborative, both roles where he helps lead national work to sustain and spread more proactive, ethical, person-centered responses after harm events.

Srikant Iyer, MD, MPH, is the Chief Quality Officer and Chief of Emergency Services for Children's Healthcare of Atlanta (CHOA), and Professor at the Emory University School of Medicine. He is also a member of the Quality Committee of the Board at CHOA, as well as a Trustee on The Children's Care Network Board. Prior to these roles, Dr. Iyer was responsible for leading a portfolio of work related to Cincinnati Children's efforts to improve community and population health. He served as Vice President of Medical Affairs for Tri State Child Health Services (PHO), Assistant Vice President for the Health Network by Cincinnati Children's (a risk-based payment model for children covered by Medicaid) and was the Co-Leader for the Community Health Initiative at Cincinnati Children's. He was an Associate Professor of Pediatrics with a joint appointment in the James M. Anderson Center for Health Systems Excellence and the Division of Emergency Medicine at Cincinnati Children's. He has led several large, successful improvement efforts at varying levels of the system. On a national level, he served as the Improvement Advisor for the National Pediatric Cardiology Quality Improvement Collaborative, sponsored by the Joint Commission on Congenital Heart Disease. Additionally, he has been as an Innovation Advisor to the Center for Medicare and Medicaid Innovation. He has served as a mentor for faculty interested in a path of

improvement leadership and has been a Teaching Faculty in several improvement courses.

Pat Folcarelli RN, MA, PhD is the Sr. Vice President for Patient Care Services and the Cynthia and Robert J. Lepofsky Chief Nursing Officer at Beth Israel Deaconess Medical Center. Pat rejoined BIDMC in November after serving for 3 years as Vice President for Patient Safety at CRICO the insurance captive for the 35 Harvard affiliated institutions. In her CRICO role Pat assisted with strategic and operational patient safety solutions. Prior to joining CRICO in 2020, Dr. Folcarelli worked in various roles at Beth Israel Deaconess Medical Center (BIDMC) for more than 30 years both in nursing leadership roles and in the area of patient safety and health care quality finally serving as the Vice President for Health Care Quality.