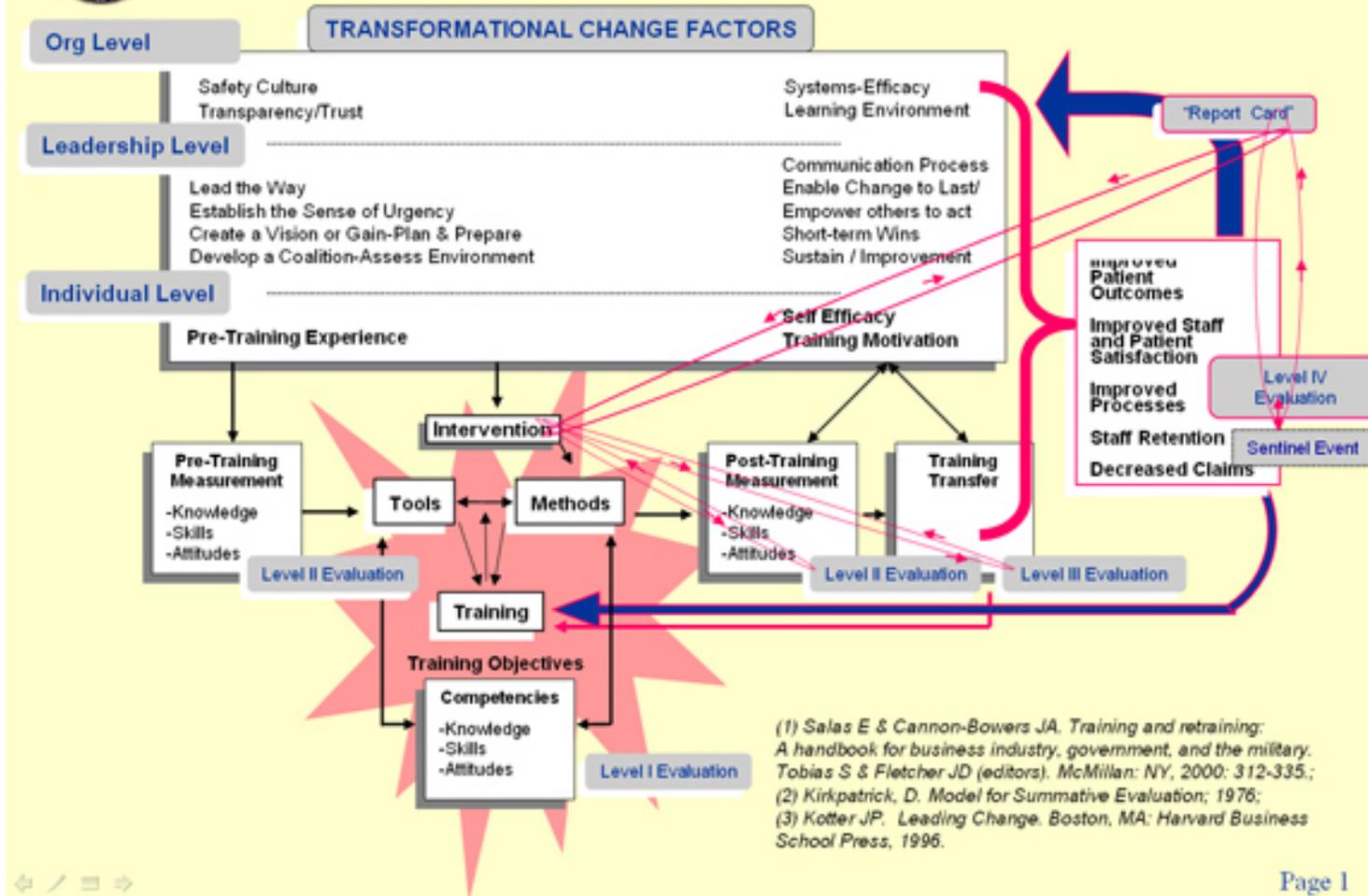




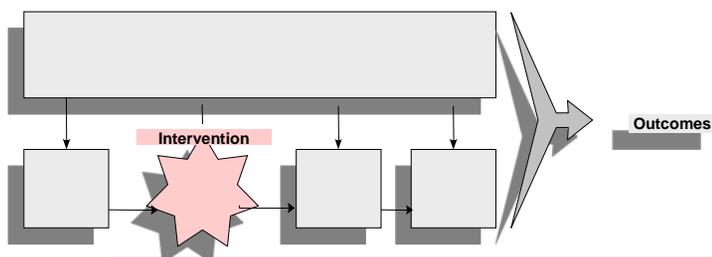
Model for Change



Designing for Safety: Military Health System's Approach to Change

Rooted in decades of aviation research, the transition of formal teamwork into healthcare began with thoughtfully designed curriculum and team training and implementation work. Lessons learned combined with caregiver feedback indicated, however, new strategies and methodologies were necessary to provide the customized organizational actions and resources necessary to effectively implement and sustain team-driven evaluation-based change.

Leveraging over two decades of research and practical application of teamwork in military settings and more than 5 years of medical team training, DoD couples experience, expertise with a commitment to evaluation and on-going teamwork exploration.



Experience and Expertise

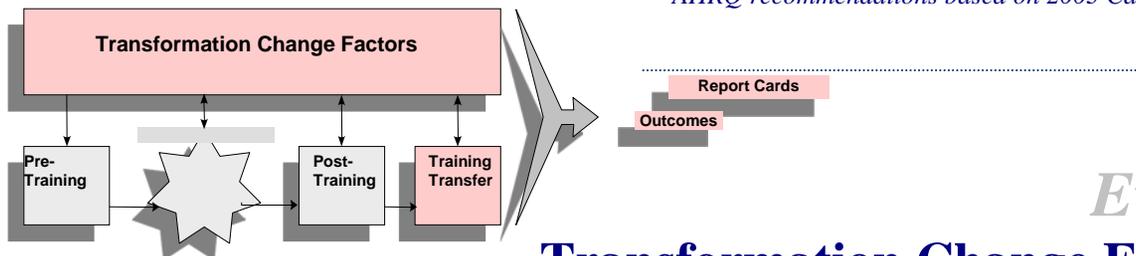
Intervention Design*

Training & Implementation: Department of Defense scientific and the practical work of Subject Matter Experts, Leaders and Staff provided the underpinnings of second generation team training & implementation development and redesign strategies

- Standardized Team Knowledge, Skills and Attitudes (KSAs)
- Practice-Specific Training Requirements
- Existing Teamwork Training Knowledge Leveraged
- Standardized Training Specifications

With the largest healthcare team trained force in the world, experience indicates training and training evaluation are difficult to sustain without the support and structure provided by organizational actions of culture change. With the duty to design for safety, “preventing error means designing the healthcare system at all levels to make it safety.” IOM, 1999, more work was needed.

**AHRQ recommendations based on 2003 Case Study Analysis performed by American Institutes for Research*



Evaluation and Exploration

Transformation Change Factors*

Leveraging lessons learned, a transformational change factors construct model was designed. This heuristic systems approach to creating a culture of safety is a blueprint which remains dynamic over time. The construct, comprised of the theory of Salas (training), Kirkpatrick (evaluation), and Kotter (culture change), provides a shared mental model for members at all levels of an organization. Individuals can visualize the impact of their role on the structure and process of patient safety initiatives, how roles overlap and how work together in the larger sense of patient care teams to provide the integrated approach necessary for achieving a safety net for healthcare systems.