

Change Management = Changing Behavior

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DM Direct, November 23, 2007

Martin Flynn, the CIO of Metropolitan Hospital, sat back heavily in his chair. Sharon Eldridge, the senior project lead, had just brought him some unnerving news. The hospital was introducing a computerized data entry system -long overdue. For the system to be financially feasible, all the physicians needed to use it. If they didn't - if the MDs used workarounds, or got someone else to enter the information for them - the system wouldn't be cost-effective. But that wasn't the bad news...

The bad news was what Sharon found when she researched the success records of other hospitals that had introduced a similar data entry system. No other hospital enjoyed much, if any, success in getting physicians on board with such a system. In fact, in the best-case scenario, it had taken three years for another hospital to get 100 percent of the MDs to use the system regularly.

Not for the first time, Martin thought, "The technical stuff is easy -I just wish we could take the humans out of the equation." He knew that his team was savvy about how to manage change. He also knew the stats -on average, about 70 percent of IT projects fail to meet their objectives.

The business community has learned a lot about managing change in the past two decades. Much has been published about robust change management models: some have three steps to change, some four, some seven. Most have merit and are based on how people have grappled with the monumental challenge of organizational change. But despite well-laid plans and sophisticated communication packages, change still stalls out. Why?

Martin was a pro; he had led significant changes in the past, and knew that there would be some reluctance to using the new system. He thought they were well-prepared: "We've got a great communication plan, and the training department has all the modules in place." But Sharon told him, "The IT department at West Monroe Hospital brought in the best change management consultants that we know. I saw their communication and training plan. All of that looked good to me -they'd done their homework." Still, it wasn't enough. Physicians simply did not cooperate.

Martin pulled his team together to work on the problem. After the usual comments, he said, "Why don't people just get it -why don't they just do it? It just makes sense."

The Science of Behavior

Why can it be so difficult for people to change?

Behaviors - doing anything - follow a predictable "ABC" sequence: the behavior is preceded by an "antecedent" (A), which is the trigger or stimulus for the

behavior. Then the behavior (B) happens. And finally, the behavior is followed by some consequence (C) to the person. The sequence is invariably A -B -C. Research tells us that consequences (C's) have by far the most powerful effect on changing behavior. Antecedents (A's) are important, too, but are most forceful when they are paired with a meaningful consequence (C).

Applied behavioral science uses a tool called the ABC Analysis to study what precedes or triggers a behavior (A's), what the behavior actually is (B), and what the consequences (C's) of it are to the performer, and then taking action to make sure the most effective consequences are used to reinforce the behavior. These and other techniques have been translated into easy-to-use tools for managing change at any level, including software development, and in large-scale organizational change such as introducing new technologies organization-wide.

A new team member, Fred Gehring, spoke up. Fred asked some straightforward questions: "Who are the key people involved?" Martin thought, "Fred gets the award for asking the obvious this week." The answer was clearly the MDs. "Who else?" The nursing staff, of course, and especially the head nurses. "If we look at it from the point of view of the MDs -what's in it for them? If I'm a doctor, why should I use the new system? If I'm a head nurse, why should I encourage the doctor to use the system?"

Sally Dunn, Metropolitan's CFO, impatiently responded to Fred's question, "Fred, you know that we'll save a lot of money with this new system, and our patient care will improve. That benefits all of us, the medical and nursing staff, not to mention the patients."

Fred wasn't satisfied. "If I'm a physician -and I have my routine of how I chart a patient's status, order tests and drugs-why should I change? If I'm a head nurse, and the doctors have to rely on me to get their orders implemented, why would I give up that control, that authority?"

Fred was on to something. In fact, he put his finger precisely on the problem. In West Monroe Hospital, the training staff had trained the physicians (which the Metropolitan team was planning to do). But the nursing staff was cut out of the loop, unless they offered to input the data to the system for the doctors! At West Monroe, the nurses took over data entry for the docs, and the physicians had been all too glad to hand over the data entry to the nursing staff. No wonder it failed.

Fred then proposed something radical: "Let's go out and ask the physicians what's most important to them. And let's ask the nurses, too. Let's find out how both of them feel about our design." (Metropolitan's design planned to have the doctors input the data at their patient's bedside.)

From both the staff at West Monroe and Metropolitan, here's what the change implementation team found:

- *For the MDs, it was most important that their orders be acted on quickly and accurately, and that execution of their orders be reported to them ASAP.*
- *The physicians weren't comfortable entering data into the computer system in the patient's room.*
- *The nursing staff wanted to be recognized for their experience, nursing skills and judgment.*
- *Doctors have a preferred set of drugs that they typically prescribe, and they like it when there is a ready supply of those at hand.*

Based on this new information, the change implementation team made a few changes in the plan for rolling out the system, as well as some modifications to the software.

First, the software system:

1. *In the newly redesigned system, the first screen that an MD saw when logging into the system was a summary of whether and when all her previous orders had been carried out.*
2. *The system was modified to collect information on the drugs the physician typically ordered, and that information was sent directly to the pharmacy department.*

Next, modifications to the social system:

1. *The head nurses were to be trained on the system, and then the head nurses would train the physicians.*
2. *The site at which the MDs entered the data into the system was relocated near their break room, which was also by the head nurse's office.*
3. *Small local pharmacies with sufficient supplies of the doctors' preferred drugs were placed on each hospital floor.*
4. *For the first six months of implementation, 10 percent of all cost savings were to be given back to the medical and nursing staff on each floor for them to use as they saw fit in buying equipment for their area.*

The result? The software system was fully implemented in a record-setting ten days.

What had happened here? The ABCs of behavioral science had been applied to the situation, successfully.

Behavior Has Consequences

For every behavior or action, we know that one or more things precede it, set the stage, prompt it, or "trigger it" - the antecedent (A). At Metropolitan Hospital, some of the A's were the communication and training programs (they set the stage for behavior). The desired new behavior (B) was for MDs to enter patient information and requests for tests and drug treatments into the computer system - by themselves. The key to success was to understand what was important to the MDs and the nursing staff and to ensure that they received direct, positive consequences (C's) for the new behavior.

All behavior is rational. If that statement seems laughable, look at it from the point of view of the person who's doing the behavior. "If I do B, then C happens. What's the impact of C on me?" For example, your behavior might be to diet, and the consequence is to lose weight - that's what's in it for you. Consequences make a behavior either more or less likely to occur in the future.

Unfortunately, despite the learnings of behavioral science, in most organizational change efforts, antecedents are emphasized-like announcements, training and communications. These things are important, but not sufficient to achieve change. What is usually lacking is:

1. Understanding of how the people who are being asked to change actually experience the consequences of changing.
2. Adjustments to the social or technical systems to introduce consequences that will encourage and reward the desired new behavior.

One difficulty of applying the science of behavior to individual, team or organizational change is to see things from the point of view of whoever is being asked to change. This means not just speculating on how they "should" feel or react, but actually investigating, accepting and working with the reality of how they really will experience the change. The ultimate test of a consequence lies in its effect. Does it make the behavior more or less likely to happen in the future?

The most potent consequences are those that are timely (occur very soon after the behavior), important to the person, and have a high probability of occurring. The screen that physicians saw on login is a good example: it delivered a strong consequence to them for logging in (gave them essential info immediately). And the consequence was immediate, and they could count on it happening each time they signed on.

So, the next time you are faced with implementing a change in behavior, try to analyze the consequences for the person who must change their behavior. Step out of the "how things should be" swamp and into the real world - how things actually are. The consequences to you, your career and your organization could be great.

** The story in this article is true, but all names and dialogue are fictitious.*