This is NOT Hospital Improvement, without changing Behavior

By Tom Fee & Johanna Thomas, PhD, Verity Partners LLC

Belgian painter René Magritte is famous for a picture titled The Treachery of Images, in which he states that a drawing of a pipe is not a pipe. **Why?** Because the drawing is just a design, it does not provide the function and feel of a pipe. Neither does it explain the many uses and diversity of pipes. Even if it listed the steps of how to use a pipe, generic instructions fail to describe how people smoke a pipe. Although it seems realistic, a picture of a pipe is a poor two dimensional image that fails to show the real behavior of people using it.

This is NOT a Pipe

Other than that smoking is a health issue that is only cured by a behavioral approach, this illustration provides insight into why so many healthcare improvement projects fail to provide lasting results. According to the Wall Street Journal, "Recent studies suggest that nearly 60% of all corporate Six Sigma initiatives fail to yield the desired results."

The reason for poor Lean Six Sigma results is typically that, "they typically start off well, generating excitement and great progress, but all too often fail to have a lasting impact as participants gradually lose motivation and fall back into old habits.[1]" **Does this sound familiar?** Many projects begin energetically and get completed, but six months later there are few sustained results or signs that show that the projects ever happened.

"Fall back into old habits" is another way of saying that the projects changed the process, but failed to change people's behavior and achieve desired outcomes. Behavior is a powerful force. If you don't change it, nothing else will change. The famous leadership guru Peter Drucker stated that, "Culture eats strategy for breakfast." The corollary is that "Behavior eats process for lunch."

A case in point. In 2011, a small southeastern health system hired a performance improvement (PI) engineer to bring Lean Six Sigma capabilities to their organization. The PI expert quickly hired another engineer and began training all of the managers and clinicians in Lean Six Sigma workshops that took over 20,000 management hours, a $1,000,000+ time investment. Each participant had to identify a Lean opportunity, lead the project and document the savings. They launched over 200 Lean projects in less than three years and the PI Director documented over $300 million in savings, as well as other qualitative improvements. Each completed project followed Lean phase, process and work steps and, each included implementation training, communication, incentives and monitoring.

Even so, after three years the system CFO could not show more than $10 million in bottom line financial savings and much of this came from a downsizing program that was not directly attributed to Lean project initiatives.

What happened to the $300 million in savings? When is hospital improvement NOT hospital improvement? When staff reverts to old behavior because they:

- Do not understand or cannot assimilate the new behavior required
- Do not experience real outcomes (in quality, service, satisfaction or economics)
- Cannot see benefits (individual consequences) from the new practices
- Have not received the team support required to implement the improvement
- Are not getting reinforced for the new behaviors required for a new role or system
- Are being pressured by competing values or systems to use the old behavior

Somehow many performance improvements just don't produce lasting results. ***Why is that?***

This is NOT Healthcare
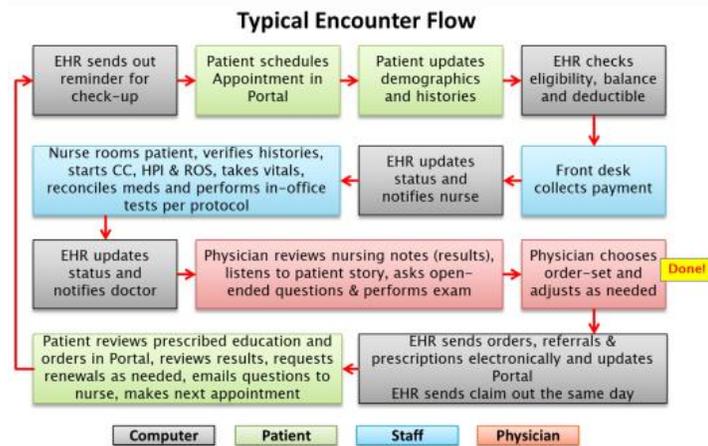
Just like the famous pipe, this second illustration shows a better healthcare process design that is NOT better healthcare. Similarly, the process improvement (engineering) approach misses the function, diversity and behavior required to make it real and make it stick. Process and systems improvement projects focus on a generic process map that lacks the richness, diversity and exceptions that drive the current work flow. Like "this is NOT a pipe" these approaches are two dimensional and generic. The resulting future process design "streamlines" the major activities without addressing the informal exceptions, behavior and routines. Lacking these insights, the test environment demonstrates the savings of the new approach while minimizing the disruptions and diversity of the actual working environment. The project claims success and leaves the implementation for managers to muddle through. Invariably, the pilot results cannot be replicated in real work life. Unless you address the underlying work realities and habits, the reemergence of old behaviors will eat the new process for breakfast, lunch and dinner.

The third illustration shows that a generic doctor that is NOT a doctor. ***Why?*** Everyone works differently based on their own idiosyncratic learning and behavior. Most job descriptions are a generic list of tasks that do not begin to describe the role, critical behaviors and complexity of the actual position.

This is NOT a Doctor

When the work of one doctor is studied, only one doctor's work activities are understood. And unless the physician's cues, behaviors and consequences are studied, others cannot understand what it will take to "persuade" that doctor to change. To develop performance improvements that are effective for most people one must study the behavior of many people. This reveals the critical behavior that drives desired outcomes and helps design the cues, behavior and reinforcement that will motivate and sustain new behavior.

Structural (engineering) work analysis and design is thought to be important because it can provide insight into the physical facility, flow, tools and job that provide new structures that support the new performance. Unfortunately, "you can lead a horse to water, but you cannot make it drink." To get the "horse to drink" they have developed Change Management methods. This approach includes didactic techniques for communication, training and incentives. Yet, these change tools rarely address the underlying behavioral drivers.

A typical Change Management approach states that if you provide a drinking trough, tell the horse to drink, teach it how to drink and pay it to drink, then it will drink. But, *what if* the horse's typical daily routine and other competing priorities make it difficult for it to drink at the trough that was provided? *What will happen?* The horse will go back to the water source that better suits his behavior. In the same way, your staff regularly abandons a new process and returns to their old behavior within six months of implementation. A key tenet of behavioral science is that "the only behavior you can change is your own." So behavioral experts help people adopt new behavior by focusing on changing the prompts and anchors that reinforce it.

In our experience, behavior is often the key problem (not structure). And so, performance improvement experts often attack behavioral problems with structural engineering techniques, because "if all you have is a hammer everything looks like a nail." *Do your performance experts have the training and experience to address behavior change?* Appling the science behind human behavior is typically an advanced field of practice, techniques and expertise. Behavioral science is like Medicine (heal the body) to Lean Six Sigma's Surgery (remove what's unnecessary to health and wellness.) Like Medicine and Surgery, Behavioral Science and Lean Six Sigma are practices that can be complementary. Yet, few performance improvement practitioners have a working knowledge of behavioral science. They dismiss it as worthless "team building" drills or say meaningless clichés like "change the people or change the people." Luckily for your health and risk management, surgeons do not dismiss internists so easily.

BEHAVIORAL EXAMPLE of IMPROVING DELAYED DISCHARGES and LOS

A 200-bed suburban hospital was having trouble with high lengths of stay (LOS) and late inpatient discharges. Local Care Coordination management got involved with a System level initiative to implement guidelines for standardizing Multidisciplinary Rounds (MDRs.) Local Care Coordination initiated a Lean Six Sigma project, interviewed physicians and assessed the current bedside discharge planning routine. Hospitalists complained about the bedside discharge meetings length of time and the lack of integration with other physicians. Nursing management identified that physicians were not setting discharge dates and delayed writing their discharge orders.

The Lean project team identified that the bedside process was ineffective. At that point, Care Coordination implemented a Centralized MDR Model, a new discharge process that reorganized discharge planning as a daily central meeting. Participants included providers, charge nurses, care coordinators (RNs and MSWs) and ancillary liaisons (Rehab Services and Pharmacy.) Participants met daily to establish a discharge plan, set an expected discharge date, identify discharge obstacles and coordinate services to meet the discharge goal. They developed a meeting process to facilitate, organize and communicate patient discharge issues.

The new daily Central MDR meetings reduced provider time to only 15 minutes to review the15-20 inpatients under their care. Yet, everyone else now had to attend a two hour daily session. Although centralization had addressed the perceived physician issues of time and integration, it disenfranchised bedside nursing. The new process and format didn't enable the team to achieve desired outcomes (70% of discharges before 1:00 PM or reduced LOS.) Amazingly, physicians were indifferent to the new meeting process. Most importantly, no one changed their behavior and the LOS and late discharges remained at historical levels.

The executive team asked two behavioral experts for help. They worked with the physicians and staff to assess the desired outcomes, accountability, behaviors and motivation. Then the team worked to clarify roles, align outcomes with strategic goals, create effective prompts for behavior, align consequences with desired outcomes and provide weekly feedback on attaining the goal. People appreciated the clearer roles, simpler tools, aligned goals, focused behaviors, improved relationships and immediate feedback on attaining goals. The new roles and behaviors aligned with their values and the outcomes clearly supported organization goals.

Many of the discharge initiatives and activities met their goals in a matter of weeks after implementation. People were comfortable with their roles and performing critical behaviors: providers setting discharge dates, nurses driving discharges, care coordinators expediting placement, ancillary techs prioritizing discharge tests and patients/families were included in discharge communication. Most importantly, by understanding and embracing their new behaviors the staff was able to sustain the new performance levels.

Since behavioral science is a comprehensive field, improvement practitioners cannot easily adopt and apply the techniques by attending a few workshops. Just as surgeons cannot become internists overnight by learning a few new tricks (e.g., opioids for pain, antibiotics for infection.)   Behavior Science and Lean Six Sigma approaches may look similar, they both require that one define, measure, analyze, improve and monitor the issue. This leads to the problem of process improvement experts trying to apply behavioral techniques using their structural approach and failing. Although behavioral tools are radically different, people who do not understand them try to use them like their old familiar hammer. And trying to use a hammer to apply glue like a nail can get messy, fast.

Behavior change can occur quickly. Efforts focus on improving desired actions that achieve desired outcomes, not designing process, so there is less upfront development and planning time. It is based on changing the expected outcomes and behavior by aligning the prompts and rewards that reinforce it.   After only two-to-four weeks of baseline performance assessment a behavior change expert can develop an effective behavioral intervention and demonstrate its effectiveness in a patient care unit. Many behavioral changes can be completed in ninety days using an "agile" approach to monitor and improve interventional cues or prompts, tools and anchors or rewards. Behavioral change targets outcomes and reinforces results by reporting achievement from baseline performance that is clear to everyone involved. This approach is comfortable to most clinicians who have been trained to change patient behavior (versus engineering statistical reports.)

If you are disappointed with your organization's ability to make performance improvements stick, then you should add behavioral science methods to your repertoire of change tools. This does not require abandoning a Lean Six Sigma or other performance improvement approaches. Those Structural and Behavioral approaches each have their strengths in organizing and improving the effectiveness of healthcare organizations. Used collaboratively and in concert they provide a powerful combination to engage the human side of success.

Note 1: WSJ. Where Process Improvement Projects Go Wrong, January 25, 2010.

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