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The Missing Link in Improvement Capability

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"It'll never work."

Anyone that has been inspired by a great idea, only to have it marginalized or rejected by peers will understand the frustration of trying to move their organization forward in an environment of diverse stakeholders and strategies. The industry is replete with examples of performance improvement efforts gone bad, and so it is perhaps no surprise that organizations and their cultures have given way to ambivalence, cynicism or outright rejection of any efforts aimed at quality improvement. While healthcare organizations have a clear and transparent process for implementing new technology, the process of initiating a performance improvement initiative is fraught with challenges from skeptics, detractors and people that simply do not want to change. Recognizing that no amount of technology will fix a broken process, leaders are left to struggle to identify the missing ingredient in their efforts to improve.

The objective of this article is to demonstrate to healthcare leaders that there is a vital and important element to recognize in their efforts to improve and, if ignored, can result in wasted effort, frustration and suboptimized outcomes. This element is "the missing ingredient" in almost every failed improvement initiative we've studied in over 15 years of working with healthcare organizations.

"What's in it for me?"

We assume that healthcare leaders are already familiar with the need to translate initiatives into benefits for their staff and patients. We further assume leaders recognize that no matter how elegant or advanced their vision for improvement, nothing will change unless the will to change is present, and staff accept the proposed solution. There are multiple variations on the argument that:

$$E = Q \times A$$

Where the effectiveness of any solution (E), is a function of the quality of solution (Q)

and the acceptance (A) by those whose support is needed to implement it. These are all givens and their introduction here contributes nothing new to the conversation of what makes improvement capability possible.

What is new is the recognition that "acceptance to change" and "ability to change" are not only different, but that the move from one stage to the other can be predicted empirically with tools available to leaders today. Leaders need not articulate a vision and hope for the best, nor gamble with efforts to improve with no guarantee of success; on the contrary, leaders can create the perfect winning hand every time by understanding and applying the principles of what we call "behavioral intelligence."

By understanding not only how people behave but why they behave in a certain way, we can understand and accurately predict how accepting of change they'll be — or not. And what we've seen among healthcare organizations is that there is often a profound difference that separates leaders from followers in terms of embracing change. Behavioral intelligence exercises allow leaders to take full inventory of their direct reports and determine whether support or resistance can be anticipated when they wish to introduce dramatic change. This structured approach benefits not only the leader; all participants become aware of the impact of behavioral intelligence on the group dynamic.

"Now is not a good time."

As much as we would like to believe it, what we know from behavior studies is that most people are not very adventurous. Consider that of 310 million Americans, only 110 million have valid passports. Subtract from this amount the number of passports that have never been used, or those buried in a drawer, and we can safely assume that less than 30 percent of Americans are prepared to undertake an adventure of their own. So what

makes us think they would want to join us on our adventure? The next time you hear the popular objections above, ask yourself if the source would ever readily embrace the improvement opportunity being considered.

To be sure, there is a natural tendency for people to avoid certain types of adventure. By understanding behavioral intelligence, we can assess the risk and scale of resistance to change before undertaking an effort to mobilize resources toward improvement.

"I didn't know it was going to be this hard."

The importance of this work was borne out of research into the difficulties healthcare organizations faced when attempting to implement robust Lean and Six Sigma initiatives. Well-intentioned managers would launch any number of complaints or excuses when unable to advance or complete projects. We set about to understand this problem and to counsel leaders on how to best respond to this dilemma, applying the concepts of behavioral intelligence.

In order to apply the behavioral intelligence methodology, it was first necessary to understand the possible range of work-related behaviors and values. For the past several years, we've worked with a tool that is strongly validated and has a track record of consistently providing accurate and actionable data regarding narrowly defined workplace behaviors. The assessment is designed to provide data in over 12 separate areas of behavior and values. With that data in hand, we can provide a very clear picture of whom in the organization would likely embrace the inevitable changes that a performance improvement or strategic initiative would require, and who would be resistant to such change.

We also know that performance improvement makes certain demands on people who undergo training and project work as part

of the program's deployment. By creating a benchmark of behavioral demands and rewards that a performance improvement initiative would entail, we could advise our clients about which potential participants would be in the strongest position to meet those demands (and feel the most rewarded), and which ones would require additional support in order to be successful. Several leaders have more recently taken to advising those well-intentioned candidates to sit out the first round of training and play an observer role, or to participate on a team rather than to lead it.

This exercise has uncovered a wealth of information about the people in organizations we've worked with, and enabled our clients to put the right people on the bus and ensure a greater degree of success in implementing their improvement initiatives.

The stigma of Sigma

It was a little more than 10 years ago that Six Sigma entered the healthcare vernacular, but it has taken much longer for it to be embraced by an industry that had grown skeptical of similar methods, and even today far fewer than half of hospitals are using it properly. In light of what we've now learned about the link between behavioral intelligence and improvement capability, one must ask if attitudes toward Six Sigma are objective and fair. After all, independent studies consistently point to returns of 6:1 or more from properly executed Six Sigma projects.

The fact is, the Six Sigma approach offers more compelling returns than any other performance improvement method, not only due to the rigor of the method, but the credibility with which results are reported. How many other methods can offer a statistically significant result with a "p value" under .05! (p values reveal the likelihood that an improvement is due to random chance, where .05 represents a 95 percent confidence level that the improvement is real and legitimate).

Unfortunately, in the rush to implement Six Sigma programs, many leaders failed to recognize "the missing ingredient," — that is, the ability of staff to effectively understand and apply it. What resulted in those situations was merely a case of "tool seduction," while staff became frustrated, demoralized and bitter toward the improvement effort overall.

"How can we get there from here?"

An epiphany in the career of Mark Herzog,

CEO of Holy Family Health in Manitowoc, Wis., came in 2010 when his organization first applied the use of behavioral intelligence to understand why their own efforts at performance improvement often hit roadblocks. "We could not figure out why staff was often reticent to embrace our early efforts at Lean and Six Sigma," he recalls. "Then we discovered our incomplete understanding of the culture, beliefs and behaviors they brought with them to the work environment."

The problem at Holy Family was one we see very often in healthcare organizations, that of a marked difference in how change is perceived by management and by the employees who would be responsible for execution. When we analyzed the behaviors and values of the senior management team, we found a group of leaders who initiated and embraced purposeful change, had a strong sense of urgency in implementing those changes and felt motivated by the prospect of showing a significant and measurable return on investment. Among other employees, however, a different picture often emerged. This was a large group of people who were not nearly as enthusiastic about change as the management group. They were likely to see change as a threat to their personal security and didn't easily warm to the idea of moving away from what they knew and understood and towards something that was unknown. And the motivational part? It was best summed up by one member of this group: "I didn't choose a career in healthcare because I wanted to see how much money I could make. I chose this career because I want to help people. The bottom line is not part of my job."

This same sentiment was frequently expressed throughout the non-executive group. Moreover, the data we gathered on this group indicated that some were actually de-motivated by the idea of having to focus on the bottom line. They saw this as a direct conflict with their own personal reward system.
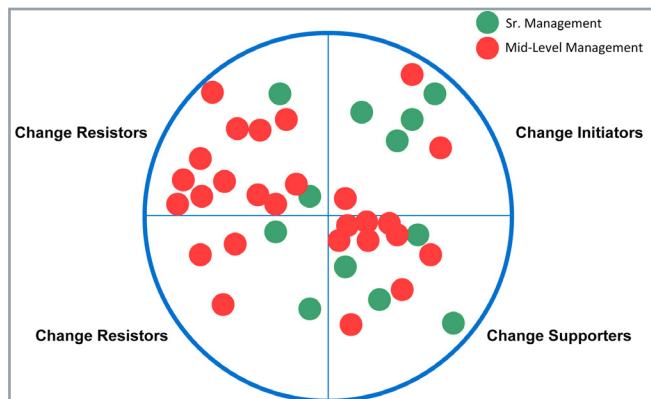
Equipped with this knowledge, management had only two choices: abandon any plans that necessitated non-incremental change and capitulate to the motivational needs of staff or figure out ways to frame the argument for change more emotionally attractive and engage the energy of the people who would be charged with implementing their strategic initiatives. Management chose the latter approach and set about reframing the case for change in terms that would resonate with staff employees.

By taking a data-driven and behaviorally intelligent approach to implementing change to existing systems and structures, management was able to make employees feel rewarded and motivated instead of threatened, insecure and disconnected. By all accounts the course correction worked: According to Mr. Herzog, HFM experienced a 51 percent improvement in how staff answered the survey question, "I feel a part of HFM and am excited about its future," with 87 percent of physicians indicating "I have confidence and trust in HFM's leadership."

"I didn't sign up for this."

The experience at Holy Family is not unique. The challenge, however, is in equipping leaders to see the signs of potential resistance, or a "not my job" mentality and to deal with these issues proactively. "We've seen the same pattern over and over, in every organization where we've deployed these assessments," recalls John Delmatoff, president of Pathfinder Coaching, who, together with Creative Healthcare, spearheaded development of the proprietary approach. "But with the approach we've developed, leaders can finally get ahead of the curve and guide their staff toward a common vision."

It is unfortunate so many leaders with a great vision and passion for improvement get stymied when it comes to engaging the right people, the right way. Modern behavioral science proves this unnecessary. It is time to leverage that knowledge. And as anybody working in healthcare performance improvement will tell you — we have a lot of work to do. ∎