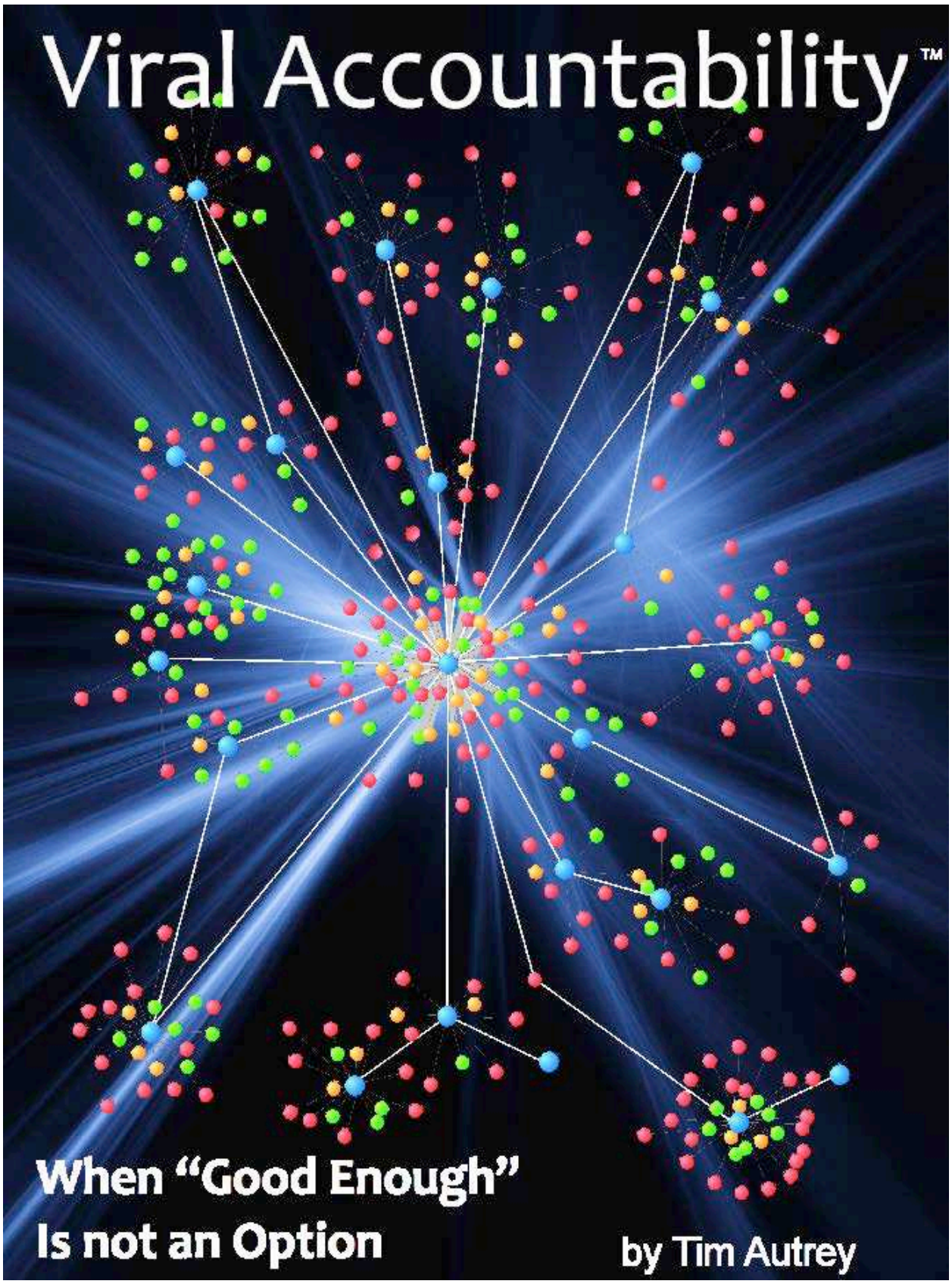

PRACTICING PERFECTION INSTITUTE Event-free, worldwide- one life at a time™

A message from Tim Autrey

I am honored that you have downloaded and are reading this Special Report.

In this Report, I want to introduce you to the concept of Viral Accountability™. It's a concept that we've been using for the past three-and-a-half years with great success.

I recently read a book by Leandro Herrero entitled Viral Change. It brought my awareness to a whole new level of exactly why our approach to minimizing human error has been so successful.

I've written this Report to bring this awareness to you.

Our primary focus at PPI is upon human error and workplace safety; however, no matter what your motivation or focus behind infusing change in your organization- this is the way to do it. It's fast, it's NOT rocket science, and it'll work in any organization staffed with human beings.

I begin our journey together with a couple of great success stories: the story of the phenomenally influential Mothers Against Drunk Driving (MADD) organization, and the story of the amazing turnaround of New York City in the 1990s. I'm using these stories because they explicitly reveal the power of Viral Accountability™.

From there we'll move to understanding the concepts involved with Viral Accountability™. And finally, I am offering you specific insights into how to tap into its power within your own team, business, or organization.

I wish you good learning, and invite you to let me know what you think of this report by commenting on my blog at http://ppiweb.com/home-2/latest-insights/

For freedom from error,

Tim Autrey, Founder/CEO
Practicing Perfection Institute, Inc.

PRACTICING PERFECTION INSTITUTE

Event-free, worldwide- one life at a time™

Please feel free to post this on your blog or email it to whomever you believe would benefit from reading it.

Thank you.

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Cover Graphic Acknowledgement:
The cover graphic of this report has been adapted from that showing the spread of an infectious disease created by the Centers for Disease Control. Location of original graphic:
http://www.orgnet.com/contagion.html

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A Pair of Stories

A Bunch of Small Fires…

Twenty-eight years ago, in May of 1980, 13-year-old Cari Lightner was walking to a church carnival when she was struck down by a drunk driver. Knocked completely out of her shoes, she landed 125 feet away. She never knew what hit her.

Within the next couple of months, Cari's mom, Candy Lightner, and her colleague, Sue Lebraun-Green set up an office in Cari's bedroom. At the time, alcohol was involved in nearly 60 percent of fatal crashes. Candy and Sue committed themselves to doing something…anything they could…about it.

On October 1 of the same year, Candy Lightner and Cindy Lamb (another mother whose 5-month-old daughter, Laura, became a paraplegic as the result of a drunk driving crash) riveted the nation during a national press conference on Capitol Hill.

Now it was personal. On that day, public tolerance of drunk driving in the US changed forever. This was the beginning of a movement that would transform the entire country's attitude about drunk driving. This was the beginning of MADD (Mothers Against Drunk Driving).

In 1980, some 30,000 died or were killed in alcohol related fatalities. In 2006, this number was down to 15,829[1]… Since its beginning, over 300,000 lives have been saved, due in huge part to the tireless and unrelenting efforts of the MADD army of volunteers.

How was this accomplished?

The impassioned efforts begun by a grieving mother and her friend were joined by other grieving mothers, fathers, relatives and friends, who fervently committed themselves to the cause.

Micky Sadoff, MADD's national president from 1989-1991, tells the story of what happened in the early eighties- "MADD was sprouting up in communities all over the country. It wasn't top-down growth. It was a bunch of small fires that started a wildfire."

It Began With a Narrow Focus

In 1979, I spent my first weekend in New York City.

I was in my early twenties. I found "The City" exhilarating, but I also found it scary. Being young and [mostly] broke, there were no cabs for us- we walked and took the subways everywhere. This was a great way to get a feel for the place- the garbage, the street people, the wonderful aromas of the dank subway stairwells and dingy platforms, open solicitations to buy marijuana (amongst other things).

This was quite an experience for a young kid from a small town on the other side of the country!

And talk about unfriendly! I was used to people being nice…to looking you in the eyes and saying "Hi!" when you passed them on the sidewalk. But not in New York City- not in 1979!

You know how there are moments in life that stick in your memory forever? I had one of those during that weekend. It was the middle of the afternoon. We were walking down 42nd Street near 8th Avenue. Surrounded by scary looking people, Pussy Cat Theaters, and guys wanting to sell us 'stuff', I had this sensation- this awareness that we could be attacked by someone, and most likely none of these people would even consider coming to our aid.

And I guess I had reason to be scared. During this period, NYC was averaging well over 2,000 murders and 600,000 serious felonies a year!

The Transformation

Following my few visits in 1979, I didn't return to "The City" until 1996. When I did, I found an entirely different place- a city transformed. It was clean. I felt safe. The Pussy Cat Theaters were gone. And (most notably) the people on the street (even in the subways) were cordial, helpful…and many of them would even return my smiles and say hello!

What happened?

In the late eighties and early nineties, (for some reason) tens of thousands of people stopped committing crimes. Statistically, NYC went from an epidemic of crime to the nation's safest big city.[2]

How Did It Happen?

It began with a single focus, a single change to the environment- rebuilding of the subway system, and this with an initial [much more narrow] focus: elimination of graffiti on the subway trains.

This was a classic exploitation of the "Broken Windows Theory" (the idea that people are more likely to commit crimes in neighborhoods that appear unwatched and uncared for). Eliminating the graffiti was an impulse to the system- a change in the environment that began to change people's context.

The graffiti cleanup on the NYC subways took from 1984 to 1990. In 1990, it was estimated that some 170,000 people per day were "fare jumping" on the system (in other words, riding the subways without paying). This became the next area of focus.

In 1994, when Rudy Guliani was elected mayor, the same approach was applied above ground with a focus on eliminating what were called "quality of life crimes". This began with a focus on arresting people for public urination, then elimination of the aggressive squeegee guys at the intersections demanding money for washing your car windows, and onward.

The essence of this is that a sequential focus on smaller (broken window) issues had a profound impact on the overall environment. As the environment, the external context, changed, people's behaviors changed. At some point, the combined impulses to the "system" reached the point of transformation (also known as the "tipping point" or the "magical upward spiral").

What We Should Learn

First off, what the heck do these stories have to do with transforming your team or organization? I've identified eight elements that created these huge successes. These are the same elements that we have employed in our efforts working with organizations to achieve breakthrough performance improvement.

We consider them to be prerequisites to stellar success.

The Prerequisites of Viral Accountability™

Protagonist

MADD

Candy Lightner and Sue LeBrun-Green started MADD in Cari Lightner's bedroom with one question for themselves and other victims of drunk driving, "How do I not get the runaround from the system?"

Cindy Lamb, whose daughter Laura Lamb became a paraplegic as the result of a drunk driving crash, started a Maryland chapter of MADD.

Cindy joined Candy and changed the country's perception and tolerance of drunk driving. Victims and friends from all over the country joined the cause. Today it is one of the nation's most successful and most impactful charities.

NYC

Criminologist George Kelling (co-author of the Broken Windows theory) was hired as a consultant by the New York Transit Authority (NYTA) in the mid 1980s. He urged them to put the theory into practice.

NYTA hired a new director, David Gunn, to oversee a multibillion-dollar rebuilding of the subway system. His first focus- elimination of graffiti.

In 1990, the NYTA hired William Bratton to head the transit police. His first focus- arresting fare jumpers.

In 1994, Rudy Guliani was elected mayor. He appointed Bratton as head of the NYPD. His first focus- eliminating [small] quality-of-life crimes.

Impulses were being applied to the system- impulses that would have an astounding impact on the environment in New York City

Insights for you and me…

To gain momentum, any positive initiative must have (1) a believer with a purpose to get it going, and (2) a defined initial focus.

Passion

MADD

Whether because of personal trauma, empathy for those who have suffered, or disgust with the status quo, MADD volunteers have been passionate about preventing drunk driving related incidents, helping the victims of drunk driving, and more recently about helping to stem the fallout of under-age drinking.

Some volunteers have been / are so passionate in fact, that they have worked full time for the cause.

In the beginning, they got nothing but the runaround. But their passion ignited a fire that simply could not be ignored.

The results? Over 300,000 lives saved (and counting).

NYC

David Gunn was passionate about the Broken Windows theory, overcoming great resistance to the idea that elimination of graffiti would make any difference. He was spot on. His insistence that, "The graffiti was symbolic of the collapse of the system," and his rabid pursuit of its elimination, was the beginning of the end of the crime epidemic.

William Bratton followed suit by passionately pursuing those exhibiting improper behavior in the subways. The number of ejections from the subway system for improper behavior tripled during his first three months, and arrests for misdemeanors went up five-fold between 1990 and 1994.

Today, New York City is one of the safest big cities in the country.

Insights for you and me…

It's been said that when you reach that deep well where passion lives, nothing is impossible. MADD has proven it. NYC has proven it.

If we have a good idea and pursue it with passion, we become a light to which others are attracted, and from which we can have incredible impact.

Personal

MADD

Nothing can be more personal than the loss or injury of a loved one.

MADD took the raw statistics of drunk driving and made them personal. The victims now had names and faces.

The personal nature of this issue quickly evolved an army of dedicated volunteers across the country.

The emotion brought to the issue of drunk driving by Candy Lightner and Cindy Lamb on October 1, 1980 during a national press conference on Capitol Hill forever transformed public tolerance of drunk driving in the United States.

NYC

David Gunn, William Bratton, and Rudy Guliani made it their personal missions to transform the subways and ultimately the city of New York.

Their ownership of the outcome afforded them the energy to overcome obstacles and opposition.

Between the beginning and the middle of the 1990s, tens of thousands of people in New York City "suddenly" stopped committing crimes.

Insights for you and me…

- Human beings are most committed to personal causes.
- We respond far more to emotions than to numbers and statistics.
- Give people a personal stake, a piece of ownership of the process and the outcome, and their level of energy and commitment will skyrocket.

Proactive

The underlying motivation in each of these stories was to not only prevent bad things from happening, but ultimately, to make things better.

MADD

The initial effort began out of the emotional frustration confronting a legal system that seemed to 'care less' about the victims of drunk driving. In concert with this was a desire to personally help victims in anyway possible.

Efforts then turned proactively toward using the media to obtain major focus and ultimately get laws changed.

More recently, MADD has begun efforts to tackle the issue of underage drinking through information and education.

NYC

It all began with the city's recognition that major upgrades to the subway system were needed.

The proactive nature was in how the key players went about achieving their objectives.

Rather than getting mired in top-down grandiose plans and overtures, they proactively went after specific (and key) elements within the system. They anticipated how each smaller area of focus would impact the system, growing momentum toward the desired outcome.

Insights for you and me…

- Nothing happens unless action is taken
- Start where you are with focused intent
- Do not attempt to tackle everything all at once
- Anticipate the outcome of your actions and your next likely step

Practicable

MADD

MADD did not set out with an initial agenda of establishing a national minimum drinking age of 21 or a national Blood Alcohol Content (BAC) cutoff level of 0.08.

They started by doing what they could: gathering information, finding other victims through classified ads, mailing out newsletters, and answering one question for themselves and other victims: "How do I not get the runaround from the system?"

By tackling one doable issue at a time, the grassroots efforts of these volunteers eventually ended up on Capitol Hill, in the halls of Congress, in the Oval Office, and most importantly, in the minds and hearts of most Americans.

NYC

It was not possible to change the entire subway system all at once, but David Gunn was able to focus intense (and almost immediate) energy on a single issue- graffiti.

William Bratton couldn't effectively go after all crime and undesirable behavior in the subways all at once, but he was able to focus intense energy on one issue- fare jumping.

Above ground, starting in 1994, resources didn't exist to tackle all crime in the streets simultaneously. But resources did exist to go after the misdemeanor quality-of-life issues that were really "bugging" the decent citizens of the city.

And everyone of these was used both as an impulse to the system (to move it in the right direction), as well as a point of leverage for promoting positive momentum.

Insights for you and me…

- The way to 'eat an elephant' is one bite at a time
- Identify your "Broken Windows" and chose one of them as a starting point
- Leverage every success to build momentum toward your "tipping point"

Process

True change cannot be dictated from the top. While vision, direction, and sponsorship must be provided, true change, the kind that changes culture, must work its way upward through the natural networks of the organization.

MADD

At its inception, lawmakers were not giving any serious consideration to drunk driving legislation. While tens of thousands were dying, DUI bill after DUI bill was failing at the state levels. MADD volunteers couldn't even get legislators to return their phone calls. This was in 1980.

With passion, dedication, and an evolving process, chapter after chapter joined the effort.

- By 1982, MADD was 100 chapters strong.
- By 1982, anti-drunk driving legislation had been introduced in 35 states and had passed in 24.
- On July 17, 1984, President Reagan signed the Uniformed Drinking Age Act
- By the end of 1984, MADD had 330 chapters in 47 states

In 1980, alcohol was involved in nearly 60 percent of all traffic fatalities, yet the only officials who seemed to care were law enforcement officers and a handful of researchers. In 1992, a Gallup survey revealed that Americans considered drunk driving to be the number one problem on the nation's highways.

NYC

NYTA officials were aware that the application of graffiti to a subway car was a three-night process in the layup yard on 135th Street in Harlem. They would wait for the 'artists' to complete their work on the third night, show up with their rollers, and paint over it. This sent a message: If you want to spend three nights of your time vandalizing a train, fine. But it's never going to see the light of day.

For the fare jumpers, Bratton started at the stations where fare-beating was the biggest problem. As many as ten plain-clothed police officers would be stationed to nab the fare-beaters one by one, handcuff them, and leave them standing, in a daisy chain on the platform until they had a "full catch". This sent a resounding (and very visible) message.

Insights for you and me…

- None of these actions involved a massive set of changes sent down "from on high"
- The starting point was a simple targeted set of actions
- Each action leveraged and built upon previous actions taken
- The results / outcomes of each action were highly visible, serving to ultimately initiate massive momentum

Persistence

It's been said that persistence is to the character of a person what carbon is to steel.

MADD

A couple of days after her daughter was killed, Candy Lightner found out that the driver of the car was drunk. She went to the DMV to pull the driver's records, but hit a brick wall. The DMV told her they should be talking to judges. The judges referred her to state agencies…

But Candy persisted. In fact, it was actually this "run-around" by the system that laid the foundation for MADD.

NYC

David Gunn met a great deal of opposition in his initial proposals to attack the graffiti issue. He was told that, "Worrying about graffiti at a time when the entire system was close to collapse seems as pointless as scrubbing the decks of the Titanic as it headed toward the iceberg."

But he persisted. As he put it:

"The graffiti was symbolic of the collapse of the system. When you looked at the process of rebuilding the organization and morale, you had to win the battle against graffiti. Without winning that battle, all the management reforms and physical changes just weren't going to happen. We were about to put out new trains that were worth about ten million bucks apiece, and unless we did something to protect them, we knew just what would happen. They would last one day and then they would be vandalized."[3]

Insights for you and me…

- There is nothing more powerful than an idea whose time has come
- The natural tendency of the 'system' is to initially resist great ideas
- Once an idea has been injected, it must be continually reinforced
- Positive reinforcement and recognition of success breeds energy and momentum

Publicity

MADD

It was the national press conference on Capitol Hill on October 1, 1980 that initiated the end to public tolerance of drunk driving.

Through publications and billboards, MADD masterfully used the media to capture the emotions of the public.

As a result, by 1983, 129 new drunk driving laws had passed.

NYC

With each step, information was plastered across the New York Times, the New York Post, on the television channels.

First with the elimination of graffiti. Then with the arrest of the fare jumpers (and anyone else displaying unacceptable behavior in the subways).

The method of handcuffing fare jumpers and gathering them in a daisy chain at the subway entrance sent a loud and clear message.

And when crime statistics began to improve. These were broadcast and announced everywhere.

Insights for you and me…

Success breeds success. Use the power of publicity for positive purposes in whatever capacity is available to you.

So now the Question…

If you are reading this Special Report, you are either (1) wanting to effect positive change in your organization, (2) interested in human behavior and things of the sort, or (3) both.

With this in mind, I now want to ask you a question:

What would life in your organization be like if…

- Once introduced to a genuinely good idea, workers took it and ran with it (not only embracing it, but interjecting their input to make it even better)?

- You were easily able to get senior leadership, middle management, and front line supervision support for your [genuinely good and appropriate] initiatives?

- Workers were obliged to follow appropriate rules, policies, and procedures (even when no one is watching). In addition, workers volunteer their energies and input to fix procedures where needed and streamline processes?

- You had a culture where, rather than spending your time fighting fires and taking care of problems, your work day consisted mostly of keeping up with the positive make-things-better momentum consistently created by your workforce?

What would life be like?

Viral Accountability™

Within the fabric of the two stories at the beginning of this Report lie the key attributes of what we have now come to refer to as, "viral accountability".

What I want to do now is:

1. Briefly take you through a journey of how we came across this concept, what we've discovered along the way, and the results experienced by some of our clients.

2. Help you understand its fundamental elements.

3. Help you understand the specific actions you can take now to harness the power of Viral Accountability™.

The Journey

I've always considered myself to be a bit 'weird'. At the age of ten, I was into reading books like Napoleon Hill's "Think and Grow Rich." I must've read Dale Carnegie's "How to Win Friends and Influence People" at least half a dozen times over the years.

When I was in the US Navy, I wandered into the base library on one boring Saturday (I must've been broke), and came across Abraham Maslow's "Motivation and Personality." I couldn't put it down (pretty weird, huh?).

Books have always been one of my weaknesses. I have tons of them. Amazon.com loves me. But I've not been interested much in novels- always in books about how to give more, do more, be more.

Anyway, this is a long-winded way of letting you know that I've been pretty much a life-long student of human behavior.

Before we go any further, I want to define a term- "human performance".

As you will see in the next few paragraphs, I worked in the US commercial nuclear power industry for approximately 20 years. In the early nineties, that industry put an acute focus on what was termed, "human performance", which predominantly meant the reduction of human error.

I like a bit more broad (and highly technical) definition of the term: Human Performance (HU) is… how we do what we do.

Fast Forward to 1994

As I recall, it was a hot summer afternoon in North Carolina. I was at a whiteboard, explaining my ideas about how to approach this whole "human performance" thing to a couple of department heads.

It was one of those moments when a huge accumulation of thought, study and observation on my part came together in a few bullets on the whiteboard. I

explained to the managers, "And these are the precepts of human performance," as I proceeded to write the following (having never created such a list before):

- Things are the way they are because they got that way
- 84 to 94% of all human error can be directly attributed to process, programmatic, or organizational issues
- People come to work wanting to do a good job
- The people who do the work are the ones who have the answers

Note: I later came to refer to these as the Precepts of Practicing Perfection®. They literally form the foundational philosophy for everything we do.

We did some good things in that overall effort. We opened a few doors of thought. Gave some of the workers a new perspective on their role in the scheme of things. Then, in the middle of it all, came a massive shift in management regime and massive shift in plant focus. That particular effort came to an end.

Fast Forward to 2002

In the summer of 2002, I sat in a meeting with the senior management team of an operating nuclear power plant in the northeastern United States. At this point, I had been in the commercial industry for about 16 years, during which I had a number of positions, each having to do (in some aspect) with doing things better and reducing errors.

At this particular meeting, our goal was simple: Our "human performance" was on par with the rest of the industry, but we knew we could do better. I was a department head myself at this point, and human performance was one of my direct areas of responsibility. Needless to say, I was smack in the 'middle' of this meeting.

My years of interest and self-study in human behavior, combined with my now 16 years of hands-on experience and observation had brought me to that point, and I decided to seize the opportunity. I convinced the management team that I knew how to get to where we wanted to go. They gave me the ball and let me run with it.

Thirty months later, we had reduced the rate of human error at the station by 87.5%. I got lots of recognition, pats on the back, stock options…it was wonderful. But more importantly, I had been given the opportunity to prove that

when feet were put to the concepts I'd been linking together in my brain- they worked (big time)!

And the greatest significance of this story is that human performance at that station continued to get better and better, even after the two senior sponsors and I were long gone. Proving without a doubt that the approach I used actually changed the culture of the organization.

Fast Forward to 2008

So here it is the summer of 2008. We've been in business implementing this approach with clients in different industries and in organizations of varied sizes for 3-1/2 years now. And we've not only been implementing, we've continued to learn- every step of the way.

The results of these efforts have been extraordinary. Here are a few of the recent results our clients have experienced:

Results Report #1

Figure 1 illustrates recently reported results of a major Electrical Generation & Transmission organization in the southwestern United States.

The data compares rates before and after implementation of Practicing Perfection® within the Systems Control and Systems Operations Departments.

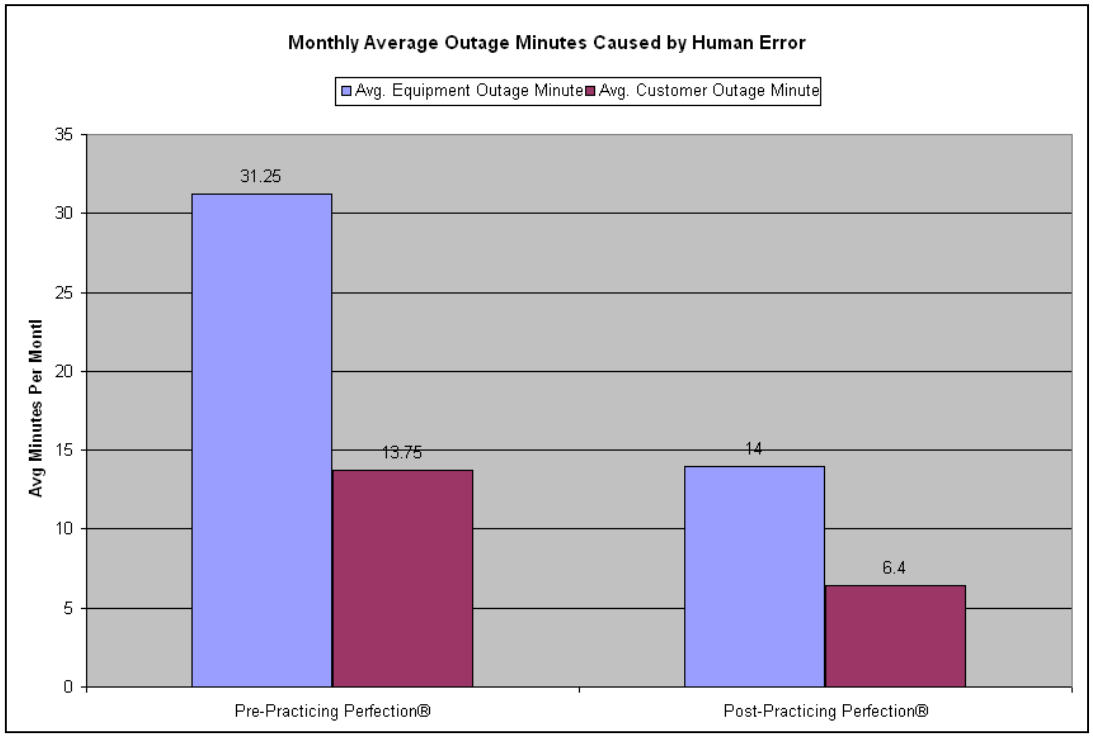


Figure 1

The first set of bars represents the average number of minutes per month of equipment outage caused by human error. This represents a 55.2% improvement in performance.

The second set of bars represents the average number of minutes per month of customer outage caused by human error. This represents a 53.5% improvement in performance.

This organization was also awarded the top Safety Award by its regional association during this period.

Results Report #2

Figures 2 and 3 represent improvements in human error rate for the Transmission Department of a large Electrical Transmission / Distribution organization in the northeastern United States.

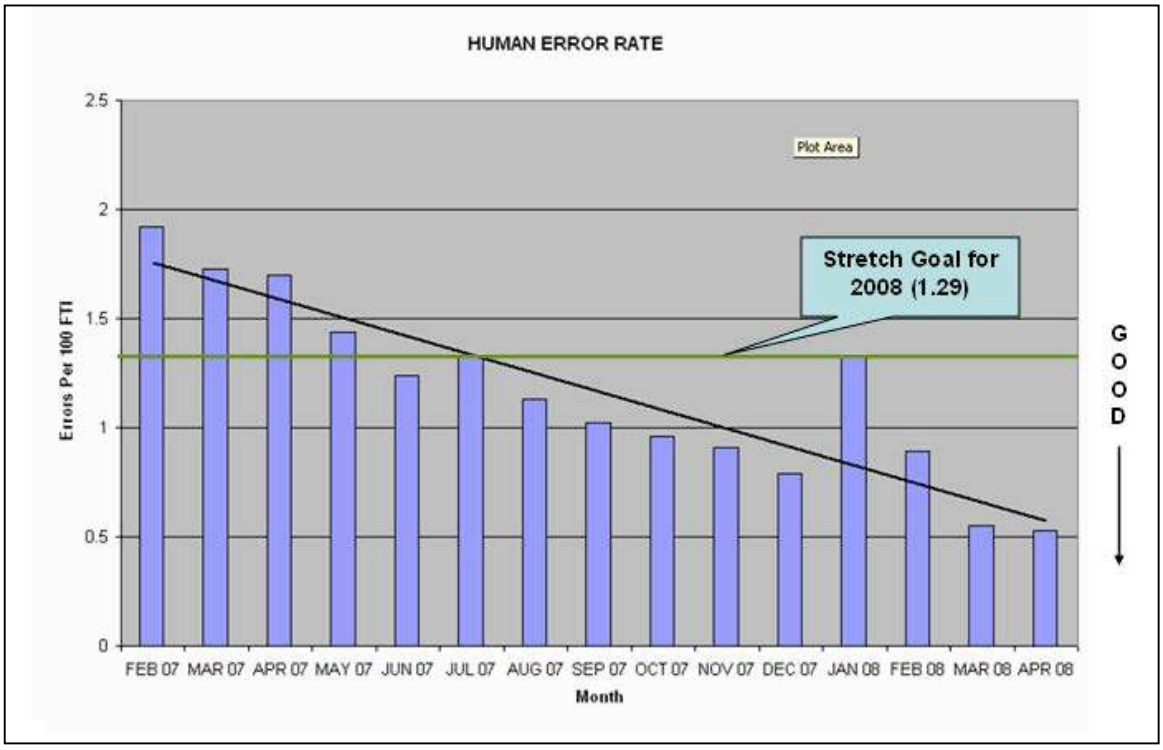


Figure 2

This organization has had tremendous success in reducing human error, both with their in-house and contract workforces during a period of massive capital expansion.

These graphs represent human error rates, as calculated based upon the number of human errors per 100 FTE (200,000 hours worked).

In Figure 2, each bar represents the human error rate per month for the period February 2007 through April 2008. The introduction of Practicing Perfection® within this organization began in the spring of 2007.

The black line represents the error rate trend. The green line represents the Stretch Goal for human error rate. As can be seen, the actual rate is well below the 2008 stretch goal.

Another method of looking at the data is to consider a 12-month rolling average (as shown in Figure 3). This can offer a more global perspective of the trend than simply calculating a rate for each month.

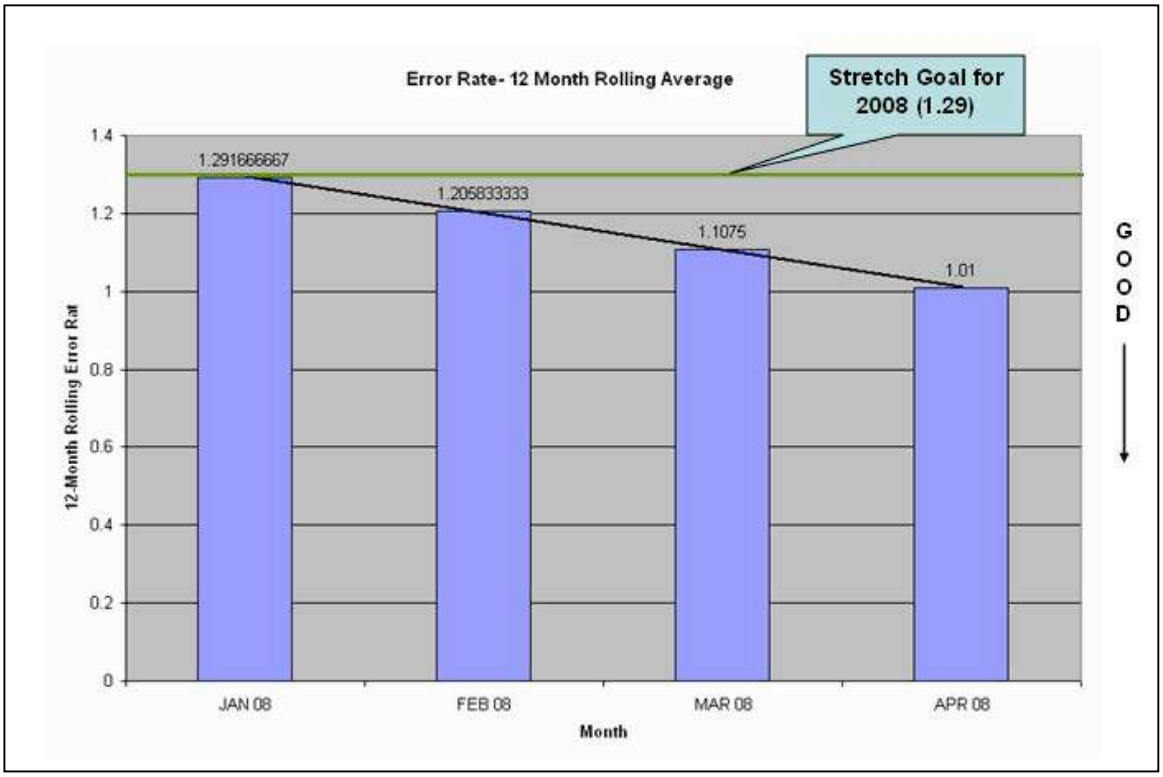


Figure 3

Calculation of these figures began with the twelve months ending through January 2008. As can be seen, the trend is moving well below the 2008 Stretch Goal of 1.29.

Calculated as a percentage of improvement, from February of 2007 through April of 2008, the monthly average dropped from 1.92 to 0.53, representing a 72.4% performance improvement.

Looking at the Rolling Average thus far for 2008, we can see that performance has improved from 1.29 to 1.01, representing a 21.7% reduction in the 12-month error rate during the past four months.

Results Report #3

During the first few months of 2008, PPI assisted a commercial nuclear power station in the United States with development and presentation of a series of four-day Operational Excellence Forums to its Operations staff and key members of other departments.

Shortly after completion of the Forum, the facility was awarded a STRENGTH by the World Association of Nuclear Operators (WANO) for these specific efforts and how they were implemented.

Such an award within the commercial nuclear power industry is considered a strong recommendation that other stations incorporate the same or similar tools and strategies.

It's Always Amazes Me…

The Practicing Perfection Institute, Inc. provides information, training and services at all different levels, depending upon what you, as our client, desires.

This includes everything from free downloadable resources at http://ppiweb.com/, to regular insights on my blog http://ppiweb.com/home-2-3/latest-insights/ to next level collaborative learning programs such as HU Basic Training(http://ppiweb.com/home-2/hu-basic-training/), to PPC (Train the Trainer) Certification, http://ppiweb.com/home-2-3/certification-2/ to full-blown "we do it for you" rollout of the processes (Implementation).

It always amazes me that when we do hands-on training with clients, I'll often have people come up to me and say something like, "You know, there really isn't anything new here, but the way you put all of this together gives it a whole new context." Bingo! That is exactly what this is about- a whole new context.

I specifically remember Becky Findley, a System Operator with the Lower Colorado River Authority (LCRA). Following completion of an onsite training process we call Mastery, she said, "Having come from a commercial nuclear power station that already had the human performance tools in place, I never felt like I had ownership of the program. Now I get it. And I am looking forward to continuing to use these valuable insights and influencing others."

There are particular words/phrases in her statement that identify key aspects of Viral Accountability™: "ownership – now I get it – looking forward to influencing others."

You see, it's virtually impossible to come up with something in the 'management' or 'safety' or 'performance improvement' world today that hasn't already been exposed. The key is in how you put it together…the context of where you're coming from…that makes a monumental difference.

The analogy I like to use for this is the stick and the wheel. Prior to "discovery" of the wheel, there were undoubtedly rocks lying around that were basically round in circumference. Artifacts have also shown that ancient cultures had the ability to bore holes in rocks (such as occurred naturally when grinding grains, etc.).

So think about this: Ancient humans had the shape of wheels available, they had straight sticks lying around, and they knew that holes could be bored into stone. There was 'nothing new' here!

But it was a monumental day when Og (great name for an ancient guy, eh?) had the inclination to take two of these round stones, bore holes through their centers, stick one end of the stick through one stone and the other end through the other stone and voila! Wheels and an axle.

The world would never be the same again.

From our experience, this is what Viral Accountability™ is all about. The 'pieces' are put together in an entirely new context, with a new approach. And the organizations that grab onto it will never be the same again.

So…What the Heck Is It?

Viral Accountability™ is basically an upside down approach. And I'll explain what I mean by that shortly.

Here's the formula:

(PA) * (PL) * (VC) = VA

Where

PA = Proactive Accountability
PL = Peer Leadership
VC = Viral Change
VA = (you guessed it) Viral Accountability™

First off, notice that Viral Accountability™ is the product of the three components (not merely the sum). Once ignited, this is your point of massive transition (or "tipping point" or "magical upward spiral"…whichever term you prefer).

Components Defined

Proactive Accountability (PA)

In the world of Practicing Perfection®, the Precepts form the foundation (which I discussed above in our "jump forward to 1994"). We also have what we call the HU Factor™, which is illustrated in Figure 4.

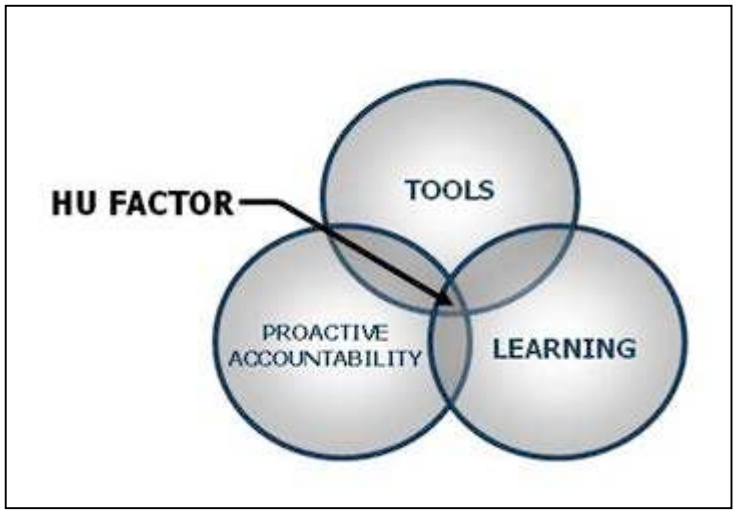


Figure 4

The HU Factor™ identifies the three functional elements of Practicing Perfection®: Tools, Proactive Accountability, and Learning. Where these three intersect is where the 'magic' happens (again, your point of transformation).

Proactive Accountability is our take on "accountability", which has been largely adapted from the work of Roger Connors, Tom Smith and Craig Hickman[4]. We have added the term "proactive" to put things in next-level context.

Proactive Accountability is 360-degree accountability. Yes, we are all fully accountable for the actions we have taken and the decisions we have made- no victim behaviors allowed. The spin we've added; however, is the look ahead, the attitude and mindset of what else can I do to…make things better?

This question, "What else can I do to make things better?" has become the mantra of Proactive Accountability.

Imagine the power of a workforce with this mindset…

Peer Leadership (PL)

We have a new definition for the term "leader". And it has nothing to do with a person's title or where their name falls into a block on the company Org Chart.

In the world of Practicing Perfection®, of next-level performance, a "leader" is:

> *"Any individual who takes personal responsibility for his or her actions and who positively influences the behaviors and actions of others."*

Take a look at the last half of that definition: "…*and who positively influences the behaviors and actions of others*." This is the viral aspect. This is Peer Leadership at its core.

Viral Change (VC)

Here's where this whole thing goes 'upside down' compared to what most who've been working in organizations for any length of time have experienced.

And…I have a confession to make…

This is an area in which I was (until recently) "unconsciously competent". I became consciously competent when I read Viral Change by Leandro Herrero. This is another book, by the way, which I highly recommend, and which has been added as a text book within our PPC Certification Program. (http://ppiweb.com/home-2-3/certification-2/)
Basically, when it comes to initiating change in organizations, we've had it upside down for a LONG time.

> *"The problem is that our stereotypes of 'management of change' or 'cultural change' usually include experiences or images of extremely complicated systems mapped on big flipcharts and encapsulated in a myriad of PowerPoints and Post-its, the content and philosophy of which seems to desperately be trying to emulate quantum physics."*
>
> -Leandro Herrero, Viral Change[5]

Traditional change management (the way most organizations "have always done it") is illustrated in Figure 5:

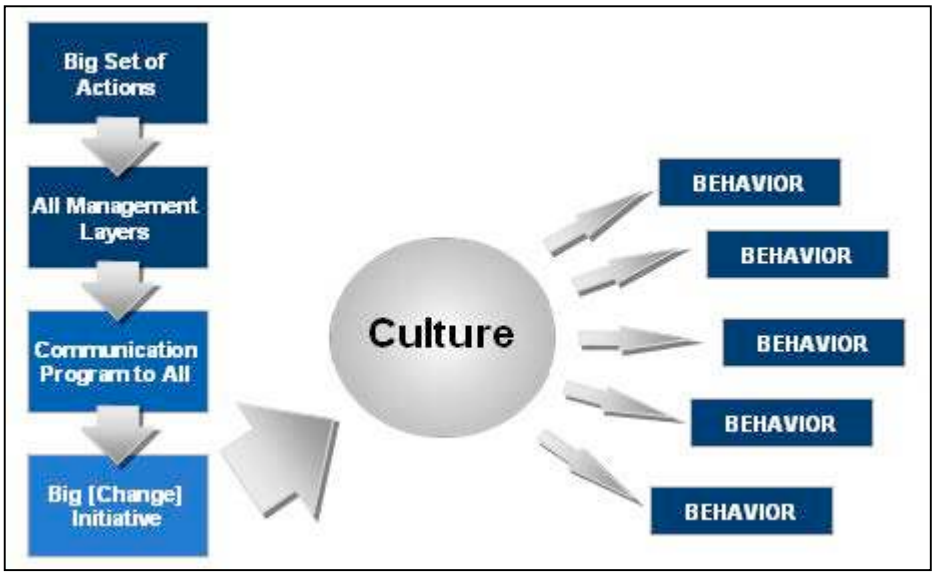


Figure 5

I want to talk through this figure to see if any of this looks familiar to you.

To begin, someone (usually a management committee or a committee commissioned by management) decides on a big set of actions. This is then followed by some type of communiqué through all management layers. Following this, there's typically a massive communications program (which may involve 'training', 'indoctrination', 'indoctrination training', the handing out of trinkets, etc.)

The day of initiative launch arrives, and the organization anticipates [expects] massive culture change, which will then alter the behaviors of the workforce…and everyone will live happily ever after.

Whenever I cover this in live training programs, I am always amused at the response I receive from the participants. Depending upon the mix of the group, it typically includes a few chuckles, a bit of guffawing and harrumphing, some disgusted sighs, and every now and then a 'colorful metaphor' or two.

Why?

Because this most often ends up being classic "program of the day" nonsense!

Why else?

Because it's upside down from the way things actually occur in the 'real world'. When it comes to initiating change in organizations, behavior change does NOT occur as a result of culture change. It actually works just the opposite- culture change is a result of changes in behaviors.

So here's how it really works…

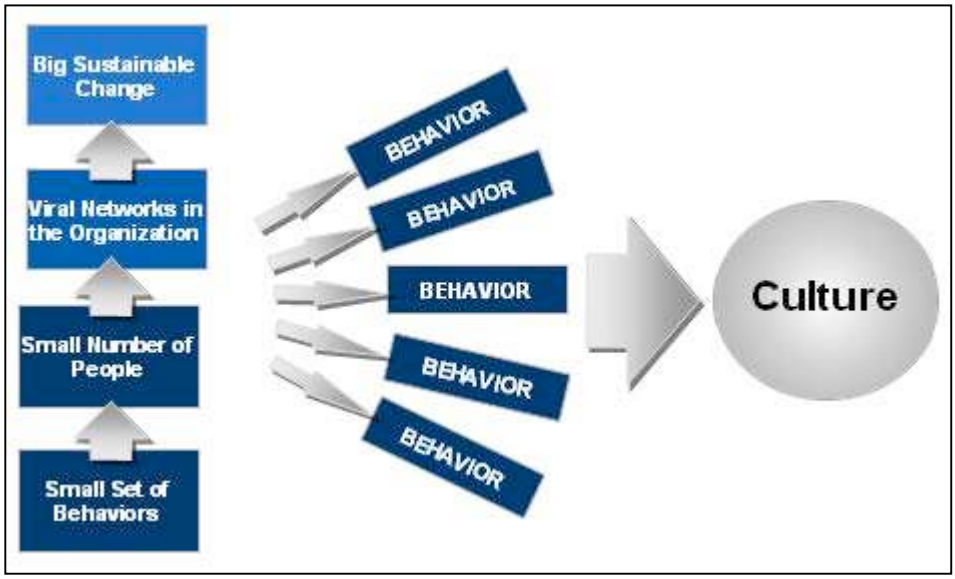


Figure 6

The way change infuses itself through an organization is very similar to the way a virus spreads through a population. It's organic. It grows through informal networks and pathways. Individuals who have no lofty titles on the company Org Chart can (and do) have major impact upon whether a given change "takes" (or not).

This is a very important concept to grasp because it is critical to the success of your performance improvement initiatives.

Think back for just a moment to the NYC story: what did David Gunn do to attack the crime epidemic in New York City? He went after graffiti on the subways!

This was the narrow focus of his initial effort. This was his 'first bite of the elephant'. In the grand scheme of things, it involved a relatively small set of behaviors and a small number of people. It provided a positive impulse to the bigger "system", quickly influencing behaviors (and ultimately changing the culture).

Let's take this example through Figure 6: David Gunn focused on a small set of behaviors (in this case, the use of the subway system and equipment as 'objects du street art' (and gang communications). The number of people involved (the graffiti 'artists') was relatively small. As the 'artists' became disgruntled and discouraged, they talked within their 'community' (through their natural viral networks).

Over time (and in some cases very quickly), behaviors changed, ultimately changing the culture within the system. The skilled artists discovered canvas, oil on board, watercolors, and other avenues of expression. The message was clearly communicated- vandalizing the subways is NOT okay.

> *"The non-linear aspects of life within organizations tell us that you may not need massive interventions or postures by management, but small, concrete, key and meaningful actions that can be seen, imitated, and copied."*
>
> -Leandro Herrero, Viral Change[6]

Now let's put it all together…

Take the power of Proactive Accountability™ (individual attitudes of "what else can I do to make things better?"), and multiply that times the multiplicative force of Peer Leadership (individuals positively influencing the behaviors and actions of others), and NOW…enable the natural networks and influencers within the organization to work their magic by providing the right impulse- focusing on a small set of behaviors with a small number of people.

Do this right, and you've set the stage for a geometric rate of progression. Do this right, and you've set the stage for…Viral Accountability™.

Now for the (Multi) Million Dollar Question:

How Can You Initiate Viral Accountability™ in Your Organization?

The Context of Viral Accountability™

1. **Get your attitude right- what you focus on expands**

   There's a story about a very old and very wise man who lived on the side of the road at the edge of a village. A traveler happened along one afternoon and asked the wise man, "Tell me, Sir, what type of people will I find in this village? It's important for me to know, because I am planning on moving there."

   "Well," asked the wise man, "what type of people were in the village you came from?"

   "They were excellent people," responded the traveler, "loving, caring…absolutely wonderful!"

   The wise man looked at the traveler with a smile, "Well, my friend, you're going to find the same type of people in this village." So happily the traveler went on his way.

   Later that afternoon, another traveler happened along the same road, and approached the wise man. "Tell me, wise man, what kind of people am I going to find in this village? I need to know because I'm moving there."

   The wise man looked at the traveler, "What type of people were in the village you are coming from?"

   "Oh!" responded the traveler, "they were horrible! Dishonest, lazy, good-for-nothings…I wouldn't give a plugged talent for a single one of them!"

   The wise man looked the traveler in the eye, "I am sorry to inform you, but you are going to find the same type of people in this village."

   The lesson? You're gonna find whatever it is you're looking for.

   And beyond this, your intentions, your focus is what for you will eventually come to pass.

   So the first thing you need to do is to get your mind right.

If you're struggling in this area, there are a couple of excellent books listed in the Recommended Reading section of this Report that you should check out.

2. **Don't get bogged down in metrics, analyses, or having to be perfect**

   Data is a good thing. Data is important. Analysis and discovery are critical to progress. But when it comes to human performance, most of what we need to address is NOT rocket science!

   I'll be the first to admit- I am NOT a details guy. Give me the essence of the situation, and at least from the people side of things, I can figure out an effective approach in a short period of time (and we've been very successful helping clients do the same thing).

   First, recognize that our buddy Pareto and his 80/20 rule are alive and well. You're most always going to get 80 percent of your results from 20 percent of your effort. Finish reading this Report and you'll have most of what you need to get going!

3. **Focus your energy where it will yield results**

   Back to the 80/20 thing again…

   Typically, 80% (or more) of the effort in a given change initiative is expended on processes and systems. A strong example of this lies in the world of Behavior Based Safety (BBS), which typically has, as a major component, an extensive observation, coaching and trending component.

   The idea is that if we do a bunch of observations, we can gather a ton of data in a database, and when we have enough data, it will tell us what to focus upon. In the first place, from my experience most of this data is not coded well enough to provide much useful data. Secondly, since BBS is heavily worker oriented, workers often feel like they're "telling" on their buddies by reporting. And third, its UPSIDE DOWN!

   Personnel safety is NOT rocket science. Why not [instead] focus 80% of your efforts on helping people do things right (and do the right things) (aka key specific definable behaviors)?

   Before I move on…a couple of thoughts.

First, BBS has done a lot to improve safety in many organizations, and it's done so through direct workforce involvement. This is a wonderful thing.

However, many organizations I speak with are frustrated. They have either hit a plateau that they can't seem to rise above, or are getting flack from workers due to (1) the excessive focus on reporting (especially when bargaining units are involved) or (2) the endless committee meetings that never seem to accomplish anything. Many are also coming to figure out that BBS is not the end-all cure-all that some consultant along the way convinced them it was.

Second, as I've previously stated, data is a good thing. But it only has value when it's understood and that understanding is put into action.

4. Behaviors determine Culture → Culture determines Results

The culture of an organization is nothing more than the collective behaviors of its members. Somehow we've gotten this all screwed up in the world of management guru-ism.

It's simple- influence the behaviors of the workers. As behaviors genuinely change, so does the culture of the organization. And by the way, there's no 'out' on this. It doesn't matter if you're the CEO, COO, CFO, or have any other lofty (or not so lofty) title. You're part of the deal. Your behaviors (not just your words) are critical.

I don't want to get too far off on a tangent here, but it is a travesty, unfair, unproductive, and hypocritical for "management" to expect certain behaviors from workers and not abide by these behaviors themselves. And yet in the eyes of many employees, this is exactly what is [still] going on.

Okay…back to culture.

If you launch some big initiative to drive results (and you certainly can), by pumping enough time, energy, and money into it, you can drive those results pretty much anywhere you want to. However, if you don't change the culture in the process, driving for results is like pumping water up hill. As soon as you turn off the pump, all that water (and those results) come rushing back down.

Most organizations have experienced this a time or two.

It's a fact: Culture change is the ONLY mechanism for long term sustainable performance improvement. You change your culture by changing the behaviors of your workforce (at all levels).

Why not start with a small focus placed in the right context, allow the natural networks to do their magic, and reap the [huge] system benefits?

5. Your key Point of Leverage- the Front Line Supervisor (FLS)

In our previous Special Report, Beyond Behavior Based Safety I detailed the results of a study that quantified the importance of various factors on the likelihood that a safety accident would occur. The study revealed that the single most influential factor (by far) in preventing an accident from occurring is the front line supervisor.

This is true in all aspects, not just relative to safety. Let me put it this way- the individual who has the greatest impact on how work is actually performed on a day-to-day basis is the front line supervisor (FLS).

Think about it. If I report to you (meaning that you are my FLS), and I come to work wanting to do a good job (which most every worker does), whose expectations am I going to meet or exceed? Yours.

Here's a great example to demonstrate why the FLS (and his or her true priorities and consequent actions) is so important:

It's common in most organizations to hear "management" frequently saying things such as, "Safety is our top priority." This is fine, and appropriate, and it sounds really good.

However, let's say you are my FLS, and your underlying [true] priority is "just get the job done, and get it done on time." When push comes to shove, and I'm running a little behind schedule, and I know I can save some time by cutting a few corners (maybe by running the machine without taking the time to readjust the safety guards), what am I going to be inclined to do?

That's correct… Depending upon you and me and our relationship, I might decide that saving time to speed up the job is worth the small 'risk' of not readjusting the safety guards.

And as long as nobody gets hurt, my behavior gets reinforced by you, my FLS, when I am acknowledged for getting the work done on time.

In the 'real world', this type of thing happens all too frequently. And that which gets reinforced gets repeated. Get the picture?

6. Your Point of Impact

I'm going to keep this brief because I've covered this topic in detail in several other places. For more on this topic, check out these resources:

- Special Report: Mistake Proving Six-Sigma (http://ppiweb.com/home-2-3/special-reports/)

Your Point of Impact, your mechanism for changing the behaviors of other human beings is illustrated in Figure 7.

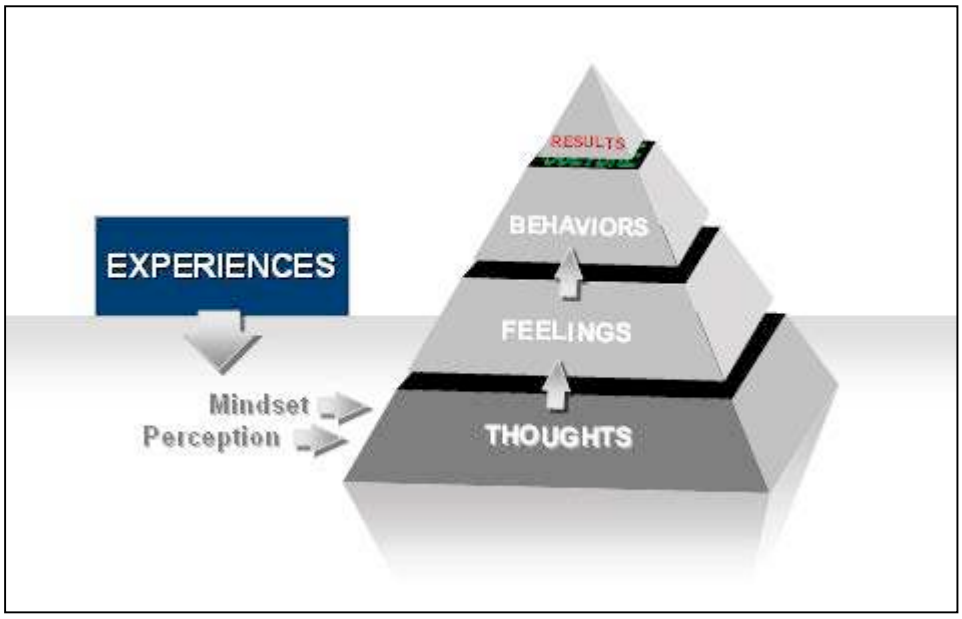


Figure 7

Here's how it works: Throughout the day, every person has a multitude of thoughts. Many of these thoughts generate feelings and these feelings manifest as behaviors.

There are two primary influencers of an individual's thoughts: mindset and perception. As one who wants to modify behaviors, it's important for you to recognize that influencing mindset and perception is your point of impact. And your only true mechanism for creating such influence is through the experiences you provide to that person.

To illustrate, let's go back to the example I used for the front line supervisor. I'm doing a job. I've been told that "safety always comes first," yet I know I'm going to get "yelled at" if I run late (I know this because I've either experienced this before or observed others savoring the experience).

My mindset in this circumstance is that getting "yelled at" is not pleasant (and I therefore do not want to experience it). My perception is that getting the work done on schedule is most important (as long as nobody gets hurt).

This mindset and perception work together to then create a thought that by not taking the time to adjust the safety guards, I can save a few minutes. I internally then balance this against my perception of risk, resulting in a feeling that [in this case] it's okay to cut this simple safety corner because nobody is around to see me do it.

This feeling then manifests as a behavior, and I proceed with the work without adjusting the safety guards.

If I pull this off and no one gets hurt, I have the experience of either being rewarded (or at least not being "yelled at"), which further impacts my mindset and perception, reinforces the behavior (in this case) that cutting safety corners (as long as no one is watching) is okay.

Remember- what get's reinforced gets repeated.

7. Behaviors must be clearly defined and recognizable

If I were to say to you, "Be nice," what would that mean? It might mean something entirely different to you than it does to me.

"Be nice" is a relatively ambiguous term, and I think we'd all agree that in order to be successful at increasing the "niceness" of let's say, our crew, every member of the crew would have to clearly understand (and agree upon) what "be nice" means.

Remember this when you decide to focus on a specific behavior:

(1) You must clearly define and communicate [exactly] what the desired behavior is, and

(2) You must identify and communicate the specific observable actions that demonstrate that behavior

And there's another very important piece to this: Dictating behaviors from above and simply expecting rote compliance may work for awhile (while you're watching), but if that's all there is, this will never take you and your team to anything close to excellence.

For next level performance, the workers themselves need to 'own' the desired behaviors. And the very best way to achieve this is for the workers themselves to identify, define, and agree upon what behaviors are actually desired. Does this sound like 'la la land'?

Well it's not.

At PPI, we've developed a process that accomplishes exactly that. Quite honestly, it's the single most powerful process I've ever seen for changing the culture of a work group (and it does so very quickly).

The process is called the Code of Honor (http://ppiweb.com/home-2-3/code-of-honor/) It's a process that we facilitate with every work group whenever we roll out Practicing Perfection® within an organization.

Here are a couple of resources for you:

- Read about the process and see a sample Code of Honor.
- Watch our video series on our YouTube Channel. https://www.youtube.com/user/ppiweb/featured

Note: The Code of Honor Facilitator's Guide is considered proprietary. It is only intended for our clients and colleagues. Please do not forward this document to others.

8. Remember- it's an Elephant

Changing the culture of your organization is like eating an elephant, and there's only one way to do it- one bite at a time.

Do NOT attempt to tackle everything at once. Clearly define a finite group of behaviors, put them squarely on the table, and let the culture change virally.

Getting Started: How to Initiate Viral Accountability™ in Your Organization

I hope you've grasped the underlying concepts that I've covered so far- the set of principles and correspondent approach we've come to know as Viral Accountability™. I hope you see its potential, and are beginning to consider how you might put its power to work in your organization.

To take this one step further, I want to offer you a step-by-step layout of how we have effectively initiated Viral Accountability™ with our clients.

Figure 8 provides an overview of the entire 'process' as we have experienced it. Following, I provide a bit of insight on each step. Additionally, I've indicated which Prerequisites of Viral Accountability™ are addressed by each of the steps. These are enclosed in brackets at the end of each discussion.

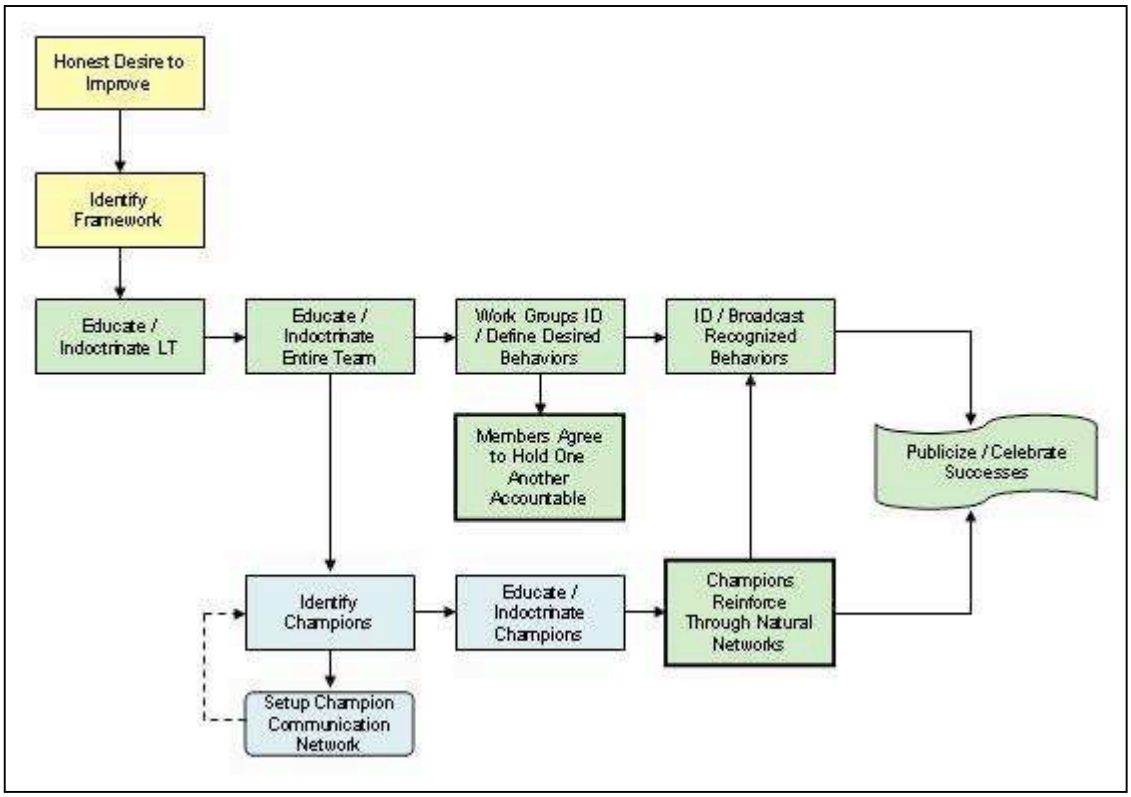


Figure 8

Honest Desire to Improve

In order to begin, there must be an initial impetus.

In our world of human error reduction and safety improvement, we've found that there is typically one of three reasons why an organization embarks on such an effort:

- They are feeling pain (either related to safety, human error, or economic conditions), or
- They are being required to take action by some regulating or governing organization, or
- There is a 'visionary' who 'gets it', and understands the imperative nature of taking performance to the next level

No matter what the basis for initiation, the intention must be honorable and honest in order to succeed. Additionally, we have found it much more desirable (though quite rare to this point) to be in the proactive mode (i.e., the 'visionary who gets it') rather than in the reactionary mode (reacting to pain or regulation).

This is something worth thinking about…

[Protagonist, Passionate, Proactive]

Identify Framework

One of the services we provide is a four-hour indoctrination course on use of the Error Elimination Tools™.

When doing so, after completing a couple of fun and insightful quick exercises, I'll ask the participants, "If in the next four hours, I can provide you with some very simple strategies and tools, which if properly employed will virtually eliminate your potential for making mistakes while doing your work, would you consider that to be a worthwhile investment of your time?"

I always get a resounding affirmative response.

The two introductory exercises and this question let's the participants know right off the bat that (1) we just might have a bit of fun in the next four hours, and (2) they might actually learn something that will help them do their jobs better.

This is a simple example of establishing the framework.

When designing what it is you want to do, you need to clearly identify the framework of the effort. Think of this as 'frame of mind'. Are you doing this to reduce errors? Are you doing this to energize creative behaviors?, etc.

The thing is, if you do not clearly define your framework, it will get defined for you along the way.

Leandro Herrero does a very nice job of explaining and elaborating on frames in Chapter Six of Viral Change.
[Practicable, Process]

Educate / Indoctrinate LT

The Leadership Team must understand and be onboard in order to have a chance for this thing to succeed.

Interestingly enough, this is one of the main challenges expressed by change agents and coordinators.

First off, one of the things that I love about this process is that it can be effectively implemented within a department, team, or crew without full-fledged senior (or even middle management support).

Does this sound like a contradiction?

Here's the deal…

When I rolled out the process at the commercial nuclear power plant in 2002, I was blessed with total and complete senior management support. My challenges existed with some of the middle managers and front line supervisors. So I structured our efforts accordingly.

If you are a change agent or coordinator and you don't have senior management support, find a department head, mid-level manager, or even a front line supervisor that 'gets it', and start there.

If you yourself are a department head, manager or front line supervisor, start with your department, your team, your crew.

Once the positive results begin to show (and they will), others will be asking to jump onboard. We've seen this over and over and

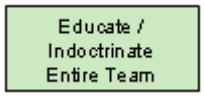
over within organizations.

Ultimately, it's important for the members of whatever leadership team is involved to fully understand (and subsequently support):

- The elements of Viral Accountability™ and how they function
- The framework of the effort
- The desired outcome, associated behaviors, and the actions that demonstrate those behaviors
- Their role as supporters and modelers of the desired behaviors

Here's another critical point: Considering that the front line supervisors are your greatest point of day-to-day leverage, it should be obvious that they are included within the context of 'leadership team' for this effort.

[Protagonist, Process]



Once the leadership team has been indoctrinated, the next step is to indoctrinate the entire vertical slice (including the leaders).

When we roll out Practicing Perfection® within an organization, we begin with two days of training for the leadership team. Every member of the work group then gets two days of training called, "Mastery Training."

During Mastery Training, the leaders of the work group attend along with all other group members.

This has a galvanizing impact on the work group, ensures that everyone has heard the same message (and the workers know it), and sets the stage for development of the work group's Code of Honor.

The main thrust of this step is to:

- Provide participants with a new context (what's possible for them personally and the work group looking forward)
- Identify the importance of their individual roles
- Clearly elucidate and inject the concepts of Proactive Accountability (PA) and Peer Leadership (PL)
- Develop the Code of Honor

[Protagonist, Proactive, Personal, Passionate, Process]

Identify Champions

If you are rolling this out in a group of up to ten or so members, depending upon the dynamics of the group, you can function as the Champion.

In larger groups, designated Champions are critical to your long term success.

The role of a Champion is to function as an overt Peer Leader, actively promoting the desired behaviors.

Champions should usually be at the worker level; however, depending upon passion and personality, it is possible for a Champion to be at virtually any level within the organization.

Who are the right members to be Champions?

When we conduct Mastery Training within organizations, the folks who will make great Champions typically become self-apparent. These are the people who 'get it' and begin to demonstrate extraordinary enthusiasm and interest during the training.

The ideal champion is often the person that starts out with a great deal of skepticism (because this is their general tendency and all of their co-workers know it), goes through a transformation during the training (which happens frequently), and ends up as a huge believer and proponent.

We let the participants know what a Champion is (and does) at the end of Mastery Training and ask for volunteers.

The use of Champions is critical for two reasons:

- These are the folks who will proactively take advantage of the natural communication and influence networks within the organization, and

- Human performance proves as well as anything I've ever seen that gravity works. If you don't keep pumping a little positive energy into it, eventually performance will level off (and may even begin to drop)

[Protagonist, Passionate, Proactive, Personal, Persistence]

Educate / Indoctrinate Champions

Once all Mastery training is completed, we then give the Champions additional training. This includes many of the insights provided during Leadership Team Training, as well as insights and materials for reinforcing and promoting Practicing Perfection®.

[Protagonist, Passionate, Proactive, Personal, Process]

Setup Champion Communication Network

It is important for the Champions to be able to communicate quickly and easily. With technology as it is today, our favorite mechanism for this is to set up a blog that is for use only by The Champions.

[Protagonist, Passionate, Proactive, Personal, Process]

Work Groups ID / Define Desired Behaviors

This is a totally upside down piece of the process (according to prevailing change management wisdom). It is also the most powerful.

Let's say that the framework of your initiative is to reduce errors. You would therefore establish this approach (context) for your training/indoctrination.

Following indoctrination, you then initiate a process where the workers themselves identify and clearly define their desired behaviors to support this new frame [of reference].

This is huge. Why? One word- OWNERSHIP.

The process we use to achieve this is called the Code of Honor, and in all my years of experience, I have never seen anything as singularly powerful at changing the culture of a work group.

Here are some things to keep in mind:

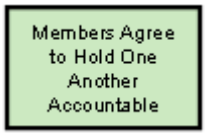
- When working through this process, all members of the workgroup must participate. This means a vertical slice. For example, a shift crew may consist of five workers and a supervisor. All should be present, and all have equal say.

  If you have a larger group, lets say a disbursed group with

a manager, five supervisors and 35 workers, the entire group can do this at the same time (but all must be present).

- This should be done closest to the 'team' concept as possible. For example, in a hospital, it might be most appropriate to have the Emergency Room Team go through this process (vice getting all of the hospital nurses together).
- Nobody gets to 'check out' on this one. Everybody involved must engage one-hundred percent.
- Following an initial brainstorm and distillation process, team members need to be allowed as much time as it takes to refine and clearly define the terminology and expected actions associated with each of the behaviors identified.
- This process requires a skilled facilitator who maintains neutrality during the defining and refining process.

[Protagonist, Passionate, Proactive, Personal, Practicable, Process]



During our facilitation of the Code of Honor, we insist that one specific behavior be included: "Be willing to call and be called."

Work groups will often use their own words, maybe "Be willing to coach and be coached," or something similar; however, the gist must remain the same. This lays accountability right on the table.

Furthermore, it gives permission for workers to 'call' their supervisors should they exhibit behaviors that don't live up to the Code.

Our process is completed by having every team member give permission to every other team member (with a handshake or hug and eyeball-to-eyeball) to hold them accountable for living up to the Code.

This is powerful stuff.
[Personal, Proactive, Process, Persistence]

ID / Broadcast Recognized Behaviors

This is simple- what gets reinforced gets repeated.

We've gone to great lengths at this point to clearly define desired behaviors, and we've agreed on the actions that demonstrate them.

The next element is to recognize and acknowledge when the behaviors are displayed (in other words, recognize people for doing things right!). What a concept!

Unfortunately, this is something I find sorely lacking all too often in many organizations. For some reason, in many organizations, management seems almost eager to root out workers making mistakes or, "not living up to expectations"; however, there are far too few occurrences of acknowledging people for doing things right.

When "impulsing" your culture, i.e., promoting new behaviors, actively look for people exhibiting them and applaud them. I guarantee if you do this, the behaviors will multiply.

[Protagonist, Personal, Proactive, Practicable]

Champions Reinforce Through Natural Networks

If you're not familiar with the power and efficacy of natural networks, I highly recommend that you use these links right now and order these books:

Viral Change by Leandro Herrero
The Tipping Point by Malcolm Gladwell

If you are working with a group larger than ten, Champions are your key to long term success.

[Protagonist, Passion, Personal, Proactive, Practicable, Process, Persistence, Publicity]

Publicize / Celebrate Successes

I was about to do a keynote talk at an "all hands" meeting for one of our clients who had seen tremendous success implementing the Practicing Perfection® Error Elimination Tools™ during the preceding twelve months.

We were going over aspects of what I wanted to present, when I indicated that I wanted to share the success metrics of what had been achieved with the audience (the folks who actually made it

happen).

The response to my suggestion was, "Oh, that'd probably be a good idea. I hadn't thought of that."

Now this is a very savvy client, and a very passionate and dedicated person I was talking with. And yet, for some reason, the idea of publicizing the positive to the workers who made it happen hadn't come to mind.

When you have something good to say, say it!

This is especially true during the early stages of your efforts. Success breeds success. What you focus upon expands. Whenever there is something positive to say, shout it from the rooftops!

[Personal, Proactive, Publicity]

Summary and Conclusions

I hope you've found this introduction to Viral Accountability™ helpful and insightful. This was, after all, my purpose in writing it.

In closing, I want to highlight the key points of this journey known as Viral Accountability™ that, should you decide to take, will lead you and your team…your organization…to entirely new levels of performance.

I would suggest that you use this as a checklist when preparing and implementing your next performance improvement effort.

1. There are eight Prerequisites to Viral Accountability™:

   - ☐ Protagonist
   - ☐ Passion
   - ☐ Personal
   - ☐ Proactive
   - ☐ Practicable
   - ☐ Process
   - ☐ Persistence
   - ☐ Publicity

2. PA * PL * VC = VA

3. Get your attitude right- what you focus on expands

4. Don't get bogged down in metrics, analyses, or having to be perfect

5. Focus your energy where it will yield results (on BEHAVIORS)

6. Behaviors determine Culture → Culture determines Results

7. Your key Point of Leverage is the Front Line Supervisor (FLS)

8. Your Point of Impact lies in the experiences you provide people

9. Desired behaviors must be clearly defined and recognizable

10. Remember- it's an elephant (and the way to eat an elephant is…one bite at a time)

Recommended Reading

Subject-Related Texts

The Tipping Point by Malcolm Gladwell

*Viral Change by Leandro Herrero

*The Oz Principle by Roger Connors, Tom Smith and Craig Hickman

*Human Error by James Reason

*Leaning Into Six Sigma by Barbara Wheat, Chuck Mills, and Mike Carnell

Influence: The Art of Persuasion by Robert B. Cialdini

Winning by Jack Welch
*used as text materials within the PPC Certification Program

Get Your Mind Right Texts

See You at the Top by Zig Ziglar

The Go-Giver by Bob Burg and David Mann

PPI Special Reports

Mistake-Proofing Six Sigma: How to Minimize Project Scope and Reduce Human Error by Tim Autrey and Hank Berry Link : http://ppiweb.com/home-2-3/special-reports/mistake-proofing-six-sigma/
Beyond Behavior-Based Safety: Initiating the Next Cultural Revolution in Process and Personnel Safety by Tim Autrey Link : http://ppiweb.com/home-2-3/special-reports/beyond-behavior-based-safety/

HU-2.0 Video Series

On our membership website PPI membership website

PPI

At the Practicing Perfection Institute, Inc., our mission is very straightforward:

"Event-free, world-wide- one life at a time"

It is our mission to work with professionals such as you to help save lives, keep people from getting hurt, prevent physical and environmental catastrophe, improve productivity, and enhance profitability.

Our primary "frame" or entry point when working with organizations is the reduction of human error and elimination of events. However, the outcome of our work, because of our approach, always ends up being much more than that. Teamwork is enhanced. Morale improves. Worker contribution to making the organization better skyrockets.

This is a great business, and we are proud to pioneering our way through it!

Following is a list of products and services that we offer in support of your success.

- **Online Resources**

  We offer an extensive array of online resources (such as this Special Report). You can access these resources at the following urls:

  - Our corporate homepage- http://www.ppiweb.com
    Here you will find links to instructional videos, (free) downloadable investigation tools, access to all of our Special Reports, articles, products, and access to extensive information on everything we offer.

  - Tim Autrey's Latest Insights blog: http://ppiweb.com/home-2/latest-insights/
    This is where I get to rant and rave about things going on in the world of human performance. Not only is there a bunch of articles and insights for your learning, amusement (and every now and then a bit of inspiration), but you are also invited to comment and get involved in the dialogue of human performance.

- **Professional Study Courses**

  At this point, we have created two Professional Study Courses that truly are the most comprehensive materials available on this topic. In addition, these are not the 'same old stuff' regurgitated. They are chock-full with new approach strategies to help you make not only rapid, but next-level progress.

- The Error Elimination System™ was our initial self-study course. At this time, it is not available for purchase; however, you can acquire it for free when you access the HU-2.0 Professional Study Course listed below.

- **Online Professional Community (HU-2.0 Mastermind)**

  An additional aspect of HU-2.0 is the establishment of a Professional Community that is destined to become the world's foremost Mastermind in the arena of human error reduction and performance improvement.

  Access to the Mastermind is currently being offered through membership on the PPI website. http://www.ppiweb.com

- **PPC Certification**

  This is our flagship opportunity for those truly serious about taking their organizations to the next level of human performance.

  This is an intensive training program consisting of a host of pre-work, and culminating in a five-day intensive hands-on experience with Tim Autrey and fellow colleagues and professionals.

  Successful participants receive the professional designation of PPC (Practicing Perfection Certified).
  At the time of this writing, the next session will be held during the week of November2, 2008 in Los Angeles, California.

  For more details, go here: http://ppiweb.com/home-2/certification-2/

- **Onsite Assistance**

  One of the things we enjoy the most is working directly with organizations to deploy Practicing Perfection® and help them experience the power of Viral Accountability™.

  In larger organizations, we have found the most productive and cost-effective recipe to be:

  - We work directly with you through the full process of rolling out Practicing Perfection® within part of your organization. We call this your Pilot Program. It is generally initiated within one or more departments comprising a total of up to ~150 people.

  - Once we have completed full rollout on a pilot basis, you then send an appropriate number of people through the PPC Certification Program

- Once your PPC-Certified team is in place, than we continue to assist you with Leadership Team training while your team conducts all of the Mastery Training sessions.

For more info, contact us at: ClientCare@ppiweb.com

To conclude…

At PPI, we stand ready to assist you in anyway that we can. Please contact us via any of the following methods:

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Email: mailto:ClientCare@ppiweb.com.

Websites: http://ppiweb.com/

Youtube page: http://www.youtube.com/user/ppiweb/featured

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[1] Source: AlcoholAlert.com
[2] Associated Press, September 19, 2006 (As published by MSNBC.com)
[3] The Tipping Point; Malcolm Gladwell; Little, Browne & Company; 2000
[4] These are the authors of The Oz Principle and Journey to Oz, books which we not only highly recommend, but actually use as text materials in our Leadership Training and Certification programs.
[5] Viral Change, page 12.
[6] Viral Change, page 144