[New IEA DSM Task 24 report and webinar: How to co-design a successful hospital behaviour change programme](http://www.ieadsm.org/article/new-iea-dsm-task-24-report-and-webinar-how-to-co-design-a-successful-hospital-behaviour-change-programme/)

IEA DSM Task 24 called “Behaviour Change in DSM” has been researching the complex issue of how to change individual, organisational and societal behaviours for almost 6 years now. In Phase 2 ([“Helping the Behaviour Changers”](http://www.ieadsm.org/task/task-24-phase-2/)) we could finally take our theoretical learnings into practice. Subtask 11 focuses on real-life case studies that show how to utilise the tools developed in the Task 24 toolbox of interventions (Subtask 8) in practice.

We were fortunate to have the second-largest hospital network in North America, [Carolinas HealthCare System](https://www.carolinashealthcare.org/) (CHS) join Subtask 11 in 2016. Together with their energy champion, Kady Cowan (the CHS Sustainability Director), a group of international expert evaluators, and committed *Behaviour Changers* within CHS, we developed a collaborative intervention design, implementation and evaluation process which proved that this approach really works. Preliminary findings have shown up to 30% energy savings in some of the pilot facilities.

Our collaborative process built on the leadership of CHS instigating an *Energy Connect* training programme for building operators. This training programme, together with interviews and surveys of facilities staff showed that there were several barriers to overcome before organisational change was possible. We used the Task 24 *Behaviour Changer Framework* (also dubbed [“the magic carpet of behaviour change”](http://www.ieadsm.org/publication/task-24-subtask-8-the-behaviour-changer-framework/)) to visualise the current energy system in CHS with *Behaviour Changers* who were hospital Decision-makers, energy technology Providers, internal and external Experts, Middle Actors and Kady’s team, as ‘the Conscience’. Using this process, we could identify the various roles and mandates of each actor, their relationships and restrictions. It helped us focus on the *End User* group, building operators, and the behaviours we were trying to address with our interventions.

A second Task 24 workshop, as part of an expert Energy Summit, identified which potential interventions were the most feasible. We decided on 5 major interventions for this pilot which focused on set-point adjustments in the building automation system. At the energy expert workshop, we then co-designed an evaluation regime for these interventions, together with outside experts in sustainability, energy management, engineering, anthropology, hospital and facilities administration and behavioural psychology. The entire process was highly collaborative and followed the [*Collective Impact Approach*](http://www.collaborationforimpact.com/collective-impact/%20), first developed for social entrepreneurs. What this pilot showed is that, rather than choosing an individual model of understanding behaviour, it was more important to bring the right actors and independent experts together with end user representatives. This allowed for a more flexible design process, where many different perspectives and concerns were addressed and included.

[This report](http://www.ieadsm.org/publication/task-24-designing-a-behaviour-change-programme-for-hospital-facilities-staff/) describes the case study and outlines the collective design process for the CHS building operator case study. We believe that this process would help not only other hospital sustainability and energy managers design and improve more successful behaviour change programmes, but that it can also be transferred to other commercial building staff. The evaluation and iteration of the pilot programme is still underway and we will present final results in 2018.

Please join us at our [IEA DSM University webinar](http://go.leonardo-energy.org/171221DSMU37_Join.html)on this exciting case study on December 21, 2017.