

DIY BBS – Making It Work on a Global Scale

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Abstract

This paper will discuss how a multinational firm launched their global behavior-based safety (BBS) initiative using fundamental BBS principles while allowing for site-specific needs. The authors will highlight key BBS concepts deployed, corporate requirements, and address the successes along with the challenges and limitations of the approach. Examples will be provided of the assessment tools used to evaluate program implementation effectiveness and observation quality.

Background

Behavioral based safety (BBS) can have several meanings to different people. To safety practitioners, BBS could be seen as another approach available to reinforce a safety program or could be viewed as an integral part of a company's existing safety program. Employees could view BBS as another co-worker watching them work and an opportunity to make workplace suggestions. Business leaders could see BBS as a key strategy to improve safety and company culture. These are some of the positive experiences; however there are negative impressions as well. It has been one author's experience that negative impressions of BBS are related to poor planning, execution and lack of goals. Regardless of the perception of the BBS program it is important to have a common understanding among key players (site and corporate leaders, safety professionals, union leaders, human resources, risk and financial managers) of the basic principles of behavior modification. Also, key players need to realize how these principles transfer to safety activities and the resources needed – time, human, and money, to carry out a successful BBS project.

The principles of behavior modification have been used in educational and clinical settings for more than 50 years and about 25 years ago were introduced to the safety profession; particularly the thought that safety related behaviors can be changed (i.e. taking less risk) by

using the principle operant conditioning (antecedent, behavior and consequence – ABC model¹). Basically, if consequences are positive, a person will perform the observable action repeatedly to achieve additional, positive feedback. The positive consequence becomes the antecedent triggering the behavior the next time similar circumstances are presented. Basically, humans search for reinforcing, positive consequences and will behave in such a manner as to seek out this potential opportunity for positive reinforcement.

Another prominent approach used in behavior modification is the concept of understanding what is expected. The thought is that if a person knows what is expected, the chances of performing the desired behaviors (what is expected) are increased. Again, people seek situations where positive reinforcement is provided. The elements of this approach are:

- Precise expectation – understanding of desired behavior
- Intervention – explanation of expectation, training or demonstration of task
- Observe action – watch person perform assignment or task
- Assess if expectation was met – did observable action meet desired expectation

Making BBS Work

This concept is especially important when transferring behavior modification principles to safety expectations. If, for example, a worker is told to lift correctly some employees may use proper body mechanics, some may use equipment to assist them with the task, while others will not perform as expected. The word “correctly” is vague in this application. There are several characteristics that would describe a “correct lift” and could include:

- Bent knees,
- Chin up,
- Spine in neutral posture,
- Load placement, or
- Use of mechanical material handling equipment.

In this example, the key is to precisely identify the desired behaviors and actions expected when lifting objects. Once done, the expectation can be communicated to employees. Manual material handling has distinct criteria to follow to reduce lifting related risks, while mechanical material handling has its own risk – cranes and hoists operation, as an example. Both situations call for the worker to “lift correctly”. Both have unique, actionable items that could be observed to determine if expectations are met. Appendix A contains a critical behavior list.

The primary objective of a BBS program is to reduce the number and potential of workplace injuries that negatively impact operational costs. To reach this objective, BBS models typically follow a continuous improvement model containing the following elements:

1. Identify “at risk” behaviors leading to injury,
2. Define desired behaviors to prevent injury (prepare observer checklist),

¹ Antecedent = trigger causing action, Behavior = observable action, Consequence = result of observable action; Consequences can be positive or negative; the consequence then becomes the antecedent and the cycle continues

3. Assess if desired behaviors are exhibited and offer prompt feedback on observed actions (peer to peer observation),
4. Trend data, and
5. Initiate change (corrective action) and monitor progress.

The five items above, along with the basic principles mentioned previously (precise expectation, intervention, observation, and assess) cannot be separated from each other when deploying a BBS project. The two concepts are the underpinnings of the overall objective to influence injury reduction efforts. Appendix B shows the relationship.

The checklist is an essential tool in a BBS process, especially for novice observers. A checklist can be designed not only to collect BBS observation data, it can contain tips for the observers, reference to work instruction documents, photos showing desired postures, and demographic information to assist with the monitoring of the BBS process. Below is a list of observer instructions that could be placed on a BBS checklist.

1. Notify supervisor you are going to be completing an observation in their area
2. Introduce yourself to worker being observed
3. Review checklist with worker prior to the observation (state and reinforce desired expectations)
4. Stand in safe place and complete observation
5. Complete feedback session (start with “safe” items, transition to concerns)
6. Ask for improvement ideas or commitment to alter behavior (reduce risk)
7. Submit completed form for data collection

Having a list of instructions will encourage consistent observer behavior when completing observations. Again, another example illustrating how the principle of knowing what is expected to promote desired actions is incorporated into the various tasks of BBS – this time targeting the observers’ actions.

Using BBS to Improve the Workplace

Making the assumption that observer’s have been properly educated about the objectives and goals of the initiative, about their role, and the technical safety elements of the items they are expected to address during an observation, reviewing data trends and devising improvement strategies is the next area of focus. It has been the authors’ experience that analyzing the data, communicating trends and sharing improvement strategies is essential and many times the power of this information is underutilized. Managing observation data via spreadsheet quickly becomes inefficient and this can contribute to a poorly executed process

For those wanting a turnkey option for data collection, software is available. For those wanting to build their own BBS collection tool using database application is recommended. At a minimum the database used should be able to report on the BBS process goals set for the initiative, as well as observer specific items and workplace solution implementation. Below is a list of metrics to consider when selecting or building BBS trending and tracking tools:

- Number of completed observation – total count and by individual observer
- Percent Safe – by department and item

- Individual Observer Percent Safe – does variation exist by checklist item (i.e. are all items noted as 100% safe)

For those charged with BBS program oversight, managing data and the participants is important to ensure the process continually identifies and reacts to the most pressing “at risk” items. Software features that could assist with the oversight include:

- Date Range Feature – track pre and post improvement scores by checklist item (i.e. did the solution influence the safe and at risk behaviors noted)
- Comments – suggestions for improvement in terms of physical conditions and individual worker actions
- Behavior Inventory – ability to change checklist to assess new risks
- Observer List – ability to track former and current observers in the event comment clarification or refresher training is needed

Exhibit 1 shows the features available to a BBS program administrator². The smaller buttons on the lower portion of the Main Menu (“Edit Database Content”) are accessible only for BBS process administrator. The various features allow the BBS administrator to update the items on the checklist, maintain a current observer list, customize checklists by departments, etc.

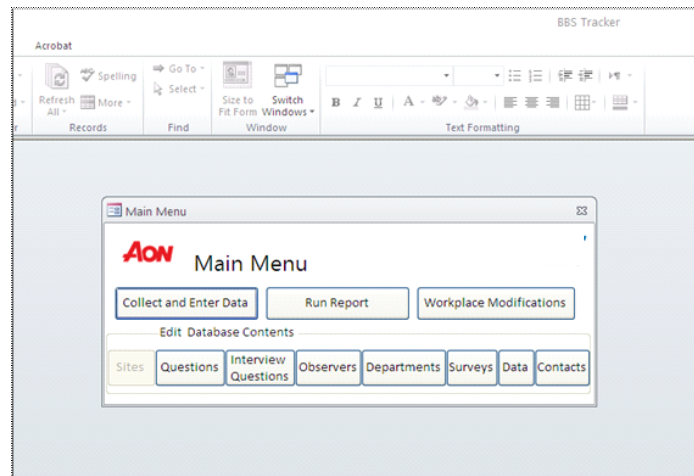


Exhibit 1. Screenshot of BBS Administrator’s Entry Point to BBS Process Tracking Tool

Another important feature to consider is the connection of BBS software to internal work order and email systems. If a workplace modification is needed, the BBS process may benefit from having the trained observer enter the solution in the BBS tracking tool and having it linked directly to the email or work order system when the item is submitted. Exhibit 2 shows the observer’s entry point to this BBS process tool. In this exhibit, the observer would prepare the observation checklist by selecting the “Collect and Enter Data” button. Once open, the observer can select the location they report to and the appropriate checklist is populated, the observer

² The “Edit Database Contents” button is pass code protected and provided to the BBS program administrator only.

would print the checklist and enter the findings of completed observations. If workplace modifications are needed, the observer can access this feature in one of two ways – one being by opening the “Workplace Modification” button or while the observer is completing the data entry from the observation. For this particular database, the observer is responsible for entering their observation data directly and as a result database use must be considered when training observers about their role.

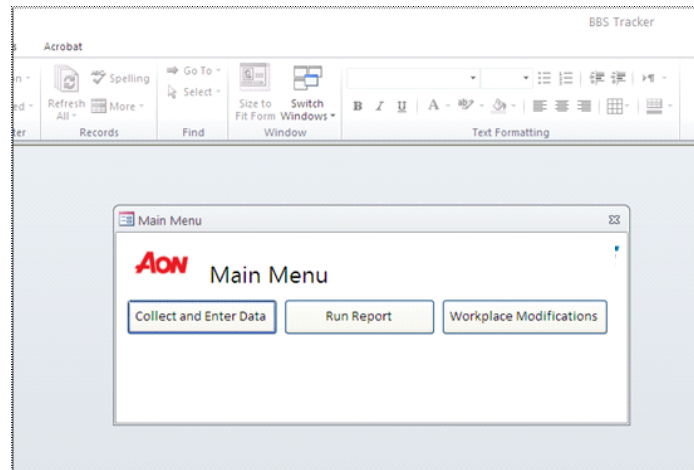


Exhibit 2. Screenshot of Observer’s Entry Point to BBS Process Tracking Tool

BBS Process Calibration

As with any process or initiative introduced, it makes sense to audit the various elements. When reviewing a BBS process there are several elements to consider as part of the audit. Elements related to goal achievement, communication, observer training program, observer quality, and adherence to program requirements. Below are the items typically covered in BBS process audits and Appendix C shows the primary elements of a BBS process evaluation with examples of the types of items assessed.

1. Steering Team Formation & Function
2. Observer & Key Player Training
3. Observation Data Trends
4. In Plant Observations
5. Corrective Action Planning Process
6. Information & Results Sharing
7. BBS Policy Guidelines

When selecting which components should be audited, consideration should be given to available resources (human and capital) for solution deployment. If, for example, it is uncovered that observation data is not being tabulated for results reporting, a simple solution may be to designate an employee to complete this task and set up a time to educate them about the available database. If it is learned that there is no database available, the solution to obtain software may require funding and additional approvals (i.e. corporate IT staff approval) resulting in more time for solution deployment. Another element for review could be directed toward the quality of

feedback provided during the observation. A straightforward solution to assess the quality would be to “shadow” a trained observer and offer suggestions individually for improvement. A 3rd party vendor could complete this task or it could be done internally. There are positive and negative points for each approach – cost being one variable. Completing this task internally will cost less, however the opportunity to learn about other processes is lost. Using a 3rd party can be beneficial in terms of staff competency, ability to share various approaches, and knowledge transfer directly to those involved.

In the next section of the paper, the approach used by TE Connectivity to evaluate their BBS process and observer feedback is discussed.

The TE Connectivity Story

TE Connectivity (TE) is a global manufacturer and supplier of electronics and connectivity solutions serving variety of markets including:

- Automotive,
- Aerospace and defense,
- Energy,
- Consumer electronics,
- Industrial applications, and
- Telecommunications.

The company has manufacturing plants in over 50 countries with a third of the workforce in China. Manufacturing processes, with their own unique safety concerns are equally diverse at TE and fall into the following categories:

- Molding,
- High-speed stamping,
- Plating,
- Assembly,
- Extrusion,
- Compounding,
- Electron-beaming,
- Undersea fiber optic cable manufacturing, and
- Undersea cable laying operations.

TE was formally known as Tyco Electronics and prior to becoming its own company in 2007, was part of Tyco International. Fiscal year 2012 sales were \$13.25 billion U.S.

Like other companies the TE safety program evolved and matured over the years. Early on corporate environmental health and safety (EHS) reported to the legal department and the focus reflected that alignment with attention to regulatory compliance. In 2008 EHS moved under operations opening new opportunities to expand the program and effectively address key risks such as ergonomics, machine guarding, and more. Operational leadership embraced their ownership role in safety and the program began its integration into the company’s operational excellence program known as TE Operating Advantage (TEOA.) Today, audit for regulatory and

TE standards compliance remains strong but is part of a more comprehensive program that is owned by operations, driven by the TE safety management system, and valued at the senior management level.

A global employee perception survey in 2008 and a smaller “pulse” survey in 2010 determined that acceptance and respect for the TE safety program was on the rise. The TE vision was to create “a culture where management owns and values safety and employees care about their own safety and the safety of others.” The first half of that ideal was maturing so now it was time to create opportunities for TE employees to embrace their role.

Behavioral safety was introduced at the beginning of fiscal year 2011. The goal was to implement a process at each manufacturing plant and distribution center in the company and to establish a cadence of observations and conversations that could be self-sustaining. Business unit leaders were given maximum flexibility in the design of their programs as long as they met certain base requirements:

1. The program must define safe and “at-risk” behavior so the employee knows what is acceptable and expected. Certainly not all of this work would be known up front so the process needed to capture information in both categories on an ongoing basis. This information could then be folded back into training sessions and BBS observation checklists.
2. The development of checklist to guide the observer. Checklists would be further customized to departments and tasks and evolve over time to keep the questions, conversations, and interactions fresh.
3. Each site would create and maintain a behavioral safety team with a BBS program leader; ideally, not the assigned site safety professional.
4. 10% of the workforce up to a maximum number would be trained and supported as skilled observers. The skilled observer ranks would be encouraged to rotate to ensure new opportunities for employee engagement in safety.
5. A minimum number of observations per trained observer would be completed and tracked each month. After the first year sites would be free to adjust their schedule up or down as long as it was focused on achieving self-sustainability of observations and conversations.
6. Most importantly, the process would focus on the quality of the conversation between the observer and the person being observed. This item will be discussed later in more detail.

At the business unit level the EHS leader was free to use any viable program that met these requirements. They could purchase and implement an existing program, hire a consultant to create a program, develop their own in-house, partner with another business unit or even shamelessly steal another business unit’s program. The program would not be one-size-fits-all dictated and administered by corporate. The downside of allowing the site to implement their own approach is that the responsibility this placed on business units to perform with minimal direction and oversight, however and hopefully with support of corporate EHS staff. It is the author’s opinion that success for the long term, or failure for that matter, is dependent on the level of support provided.

Cultural differences were another matter to be addressed in the TE launch. In the EU, the behavioral safety program required negotiation and acceptance by the works councils. This slowed the introduction in some countries and created a longer rollout period. What was hoped to be a 12-month introduction and rollout across the globe extended up to 18 months in some plants.

Flexibility of the TE program allowed and encouraged plants to have peer-to-peer observations. This was not always viewed as positive in unionized environments so managers and supervisors, as the only observers, became the accepted norm at any location whose culture was more accepting of this model. In some Eastern Bloc countries the term, “observer,” retains a very negative connotation. Attention to this sensibility was critical and sites decided to choose other titles for the roll such as “champion.” TE corporate managers and our designated BBS third party vendor partners (Aon Global Risk Consulting) are careful in using these terms as well. In China, high turnover of the workforce is the major obstacle in attempting to achieve a level of accountability and sustainability in any program or initiative.

Quality Assurance

2011 was the introduction and rollout year for BBS. Goals were established holding sites and business units accountable for program implementation and quarterly milestones were set and tracked:

- Quarter 1: Selection and introduction of the site program by the business unit safety leader; observer and awareness training developed.
- Quarter 2: Program introduced to sites; awareness training completed for all employees and specialized training completed for designated observers; observations could begin when ready but not required.
- Quarter 3: Observations began; results tracked and communicated.
- Quarter 4: Business unit management to begin assessment of the effectiveness of implementation; develop plan for ongoing assessment in the next fiscal year.

It was quickly determined the business units and locations were going to require ongoing support for the BBS process to take root and be effective for the long term. TE had successfully partnered with Aon Global Risk Consulting (Aon) on other global implementation projects (i.e. ergonomic injury prevention) and selected Aon to support the BBS initiative. During the sophomore year of the program, Aon consultants were sent into 12 TE locations across the globe with the specific goal of assessing the quality of the conversation during the BBS process and provide refresher training where required. The approach followed this format:

1. 12 manufacturing plants across the world were selected among recommendations made by the TE business units.
2. Wherever possible Aon consultants either spoke the local language or used translators to address any language barrier issues.
3. Up to 12 of the best and most engaged TE BBS observers were selected at each site to receive one-to-one coaching from Aon. In this step the Aon consultant would shadow the TE observer while they conducted an observation and engaged in conversation with the other employee. The observation was allowed to flow from beginning to end without interference from the Aon consultant.
4. Afterward, the Aon consultant and the TE observer sat down in a separate room for a review and coaching on what went well and what might need improvement.
5. A second observation was then held to see if the TE observer was able to put the coaching to effective use in a new observation and conversation.
6. All other skilled observers at the site received refresher training from the Aon consultant in a classroom setting.

This process was completed over two consecutive days to ensure all shifts were adequately covered. A final site report was drafted by Aon after each visit and shared with TE safety management, as well as, a post visit follow up call with all parties to discuss lessons learned.

The Conversation

The quality of the conversation holds the key to employee engagement in the process. Engaging in meaningful conversations does not come naturally to many however it is critical to the success of the program, especially if success is to be measured by a sustainable change in behavior across the organization. It is more natural for two people to fall into a comfort zone of discussion where they focus on some other thing like a broken handle on a machine that needs to be fixed rather than the individual's behavior of continuing to operate their machine with the broken handle. Without constant assessment of the quality of the observation and conversation, reports come back that only note the handle needs to be repaired and not that we came to agreement that I have the power and the responsibility to not operate my machine with a broken handle.

To try and make this interaction between two people meaningful and comfortable at the same time a few clarifications needed to be made for all involved. First, this is a process where we want to "catch" people doing things safely. The vast majority of time people will be working as instructed, wearing the correct PPE, using the right tools, and not taking short cuts. Talking with someone you don't know very well will be easier when both parties know the focus will be on what you are doing safely, rather than trying to catch something wrong. There should never be a requirement to turn in a quota of unsafe or "at-risk" behaviors. The second clarification is amnesty. As long as an observer is engaged in the behavioral safety observation process, the person being observed will not be disciplined for any "at-risk" behavior. A sure way to kill a behavioral safety program is to allow even the perception that discipline will be used. All conversations and cooperation will cease and behavioral safety will have leave negative impressions years to come. This does not mean safety violations are ignored, it simply means the discipline is address via the site's protocol (i.e. supervisor, not the BBS observer). In other words, discipline must remain a necessary part of any viable safety program. At TE discipline remains in force for fault as determined post incident or injury and for defined significant "at-risk" behavior observed while not engaged in the behavioral safety process. This distinction is made clear at the outset and ongoing to ensure employee understanding.

Continuous Improvement

A few best practices from the various plants and business units are now becoming standard practice among others without intervention from corporate. Checklists are used to help keep the observer on track and focused in on acceptable and at-risk behaviors. To aid the conversation some locations have added no more than two well-written questions to the bottom of each checklist to help kick start a stalled conversation but also as a means of soliciting verbal feedback from the observed beyond a simple yes or no, or I don't know. Below are two examples of the questions asked at the end of the observation:

- "What shortcuts have you taken to make your job go faster or easier?"
- "Tell me what you think are the hazards and risks of performing your work."

A question bank is maintained and questions rotated, again, all in an effort to keep the conversation fresh.

Additionally, all sites use a random selection process so that observers are not keying in on only observing and having conversations with their friends or from observing in the same department over and over.

Layered process audit (LPA) is now being introduced as a means to ensure higher levels of management are engaged in the program in addition to be practiced observers. These audits are not another layer of observation but rather a vehicle to help with quality assurance and typically asked by operational team leaders. Here are some sample questions:

- Are the observations occurring in your area?
- Is the observation process of value to you?
- Are you receiving the amount of communication you expect?

We discovered that communication of results was a weakness across the company. Employees being observed and engaging in conversation were not sure if their involvement was worth the effort because they did not see the results. The TEOA program had all the tools necessary to address this weakness for a quick and easy fix. Daily GO (Get Organized) meetings are held on all shifts with all employees so introducing BBS results, as in, percent safe for a department or the whole plant, began immediately. Additionally, BBS goals and performance was added to TEOA communication boards and electronic bulletin board and CCTV monitors throughout each plant.

China posed a challenge due to geography. TE has one third of its global workforce in China and the BBS quality assurance process is managed by a corporate EHS leader who is on the ground in Shanghai. A corporate resource is also used for EMEA (staff based in U.K). In the Americas, all business unit leaders perform the Aon / TE quality process in their plants throughout the year as their schedule permits.

Moving Forward

The 2012 quality assurance partnership with Aon was well received by all participating plants across the company; so much so it is being repeated at another 12 plants throughout 2013. Ultimately, not every plant can be touched every year with this two-day coaching and refresher training program, but certainly they can be over a 3-year cycle. Continuous focus on the quality of the observation and specifically the conversation is the key to a successful BBS implementation and ongoing support in plants will help make this happen.

Any BBS process will produce two outcomes, but not always at the same time. First a list of “things” may be created. These things are the conditions that the observed employee brings up and the observer jots down for follow-up and repair by someone else. Finding and addressing conditions is not a bad thing in and of itself but it is not fundamental to the BBS goal. It should be treated as a nice, secondary outcome. Core to the process is the engagement and conversation that two employees had. Questions an observer can ask after to gauge their observation quality could include:

- Were safe behaviors identified and discussed actually observed?
- Did I, as the observer address “at-risk” behavior observed?
- As the observer, did I help lead the conversation so my co-worker felt part of the solution?

- Is it possible through our combined cooperation that we may have laid a few seeds of positive behavioral change that will one day be repeated with little thought?

Done well, these conversations should be allowed to drift away into the air as all conversations do. What was discussed does not necessarily need to be written down and shared unless the two parties agree that it is important. Change comes when these conversations are brief, meaningful, engaging, and two-way; and when there is a certainly level of finality to the discussion between two people.

At TE the vision is that one day, the structure of BBS will fade away – checklists and will no longer be necessary. Conversations will be continuous, free-flowing, occurring up and down the command, and in any country or region. And that all employees will embrace responsibility for their own safety as well as the safety of others.

Appendix A: Behavior Listing

Vague	More Precise
Lift Correctly	• Bends knees when lifting objects from below knee height
	• Spine maintained straight and maintained in natural S-shape curve
	• Using handles to grip object being lifted
Appropriate Personal Protective Equipment Used	• Ear plugs fully inserted into ears; ear muffs fully cover ears
	• Safety glasses have ANSI Z87 stamp
	• Face shield and safety glasses worn when dispensing or working with liquid chemicals
Operate Forklift Properly	• When parked, brake engaged, forks on floor
	• Stops and follows traffic signals at doorways, intersections, etc.
	• Daily inspection completed and documented

Appendix B: Relationship Among Behavior Modification, Continuous Improvement and BBS Project & Observer Tasks

Behavior Modification Concept	Continuous Improvement Model	BBS Project and Observer Tasks
Precise Expectation	Identify at risk behaviors leading to injury	<ul style="list-style-type: none"> Review work instructions and related policies Determine loss history, near miss, 1st aid trends Review completed incident investigation reports to identify contributing behavioral factors
	Define desired behaviors to prevent injury	<ul style="list-style-type: none"> Prepare observer checklist Test checklist by completing several observations
Intervention	Define desired behaviors to prevent injury	Prior to making the observation: <ul style="list-style-type: none"> Review checklist with worker being observed Discuss work practices or instructions to follow Demonstrate desired actions
Observe Action	Assess if desired behaviors are exhibited	During the observation: <ul style="list-style-type: none"> Complete checklist Write supporting comments to promote feedback Identify potential workplace improvements
	Offer prompt feedback on observed actions	After the observation is done: <ul style="list-style-type: none"> Begin feedback with positive comments – state what the worker did that was safe when compared to the checklist Transition to areas of concern by stating concerns (at risk, unsafe) noted on checklist – state what was observed that conflicts with checklist item Ask for ideas to reduce injury potential for noted concerns
Assess If Exception Was Met	Offer prompt feedback on observed actions	<ul style="list-style-type: none"> Discuss completed observation checklist items
	Trend data	<ul style="list-style-type: none"> Review complete checklists from all observations and trend by checklist item, department or other demographics
	Initiate change (corrective action)	<ul style="list-style-type: none"> Based on trends, devise solution strategy and implement (process trends) Based on individual feedback ask worker to change behaviors Review training programs to ensure materials presented align with desired behaviors
	Monitor progress	<ul style="list-style-type: none"> Workplace solution implementation project plan status Individual follow up on suggested behavior changes Review data trends post solution implementation

Appendix C: BBS Process Audit Elements

BBS Process Elements	Sample Assessment Criteria
Steering Team Formation & Function	<ul style="list-style-type: none"> • Process goals and key player roles set and communicated throughout company • Action item tracking log kept (process and corrective actions) • Results report made 2 times per year to management, risk, and safety (<i>activity status, actual v. goal, etc.</i>)
Observer & Key Player Training	<ul style="list-style-type: none"> • Observation mechanics training provided prior to in plant observations – observers, supervisors, and steering team • E-learning system used to track and document training events • BBS trends used to adjust workshop objectives
Observation Data Trends	<ul style="list-style-type: none"> • Solutions documented and accessible to other sites (database, Best Practices) • Data posted throughout site and reviewed during formal, all associate meetings • Observers given formal "credit" (performance review) for participation in BBS process
In Plan Observations	<ul style="list-style-type: none"> • Used effective feedback strategies (<i>use of checklist, answered questions, non-threatening postures, etc.</i>) • Other hazards identified and documented on checklist • Imminent danger situations addressed (<i>as appropriate</i>)
Corrective Action Planning Process	<ul style="list-style-type: none"> • Re-evaluation of corrective actions completed to ensure solution worked • Production data noted to track workplace gains resulting from BBS changes • Solutions documented and accessible to other sites (<i>database, best practices</i>)
Information & Results Sharing	<ul style="list-style-type: none"> • BBS steering team uses metrics for process improvement planning to reduce risk exposure and related costs • Website used to communicate process within company/mentioned on public website • Database used to store and retrieve data for reporting purposes
BBS Policy Guidelines	<ul style="list-style-type: none"> • Written guideline / statement updated in past year • Roles articulated in document for observers, site leaders, BBS leaders, risk, S&H, engineering, associates, etc.

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