How Dysfunction Shows Up in Non-Profit Healthcare and Why SEAM May Be the Answer to Overcoming It

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Abstract

Non-profit healthcare organizations are mission driven and seek to provide benefit for the communities in which they serve. This paper outlines the author's self-reflection that led to the identification of many examples of dysfunctions that result from the TFW virus within non-profit healthcare organizations. The author includes an assessment on why other change methodologies have fallen short by not addressing the organizational dysfunctions prior to implementation. SEAM is presented as being a pre-requisite to employing any other change management methodologies. The author explores the apparent innate compatibility of SEAM with non-profit healthcare.

Key Words: healthcare, non-profit healthcare, SEAM, TFW virus, change management, change management methodologies.

In this article I will examine Socio-Economic Approach to Management (SEAM) concepts through my lens of practicing OD within nonprofit healthcare and how it has challenged my thinking about leading successful organizational change. I am committed to the OD values of respect and inclusion, collaboration, authenticity, self-awareness, and empowerment. I seek opportunities to work at organizations with compatible values and within industries where it is easy to explain the good provided to a community. I found this compatibility within the healthcare industry. I have been fortunate to work for three great non-profit healthcare organizations, serving predominantly as an internal organization development (OD) and learning practitioner and leader for the past 17 years. I have attended three different change management training experiences, one internally developed and two that involved a certification process with an external vendor.

My knowledge of SEAM is limited to attending the first US based conference at the University of St. Thomas in 2012 and reading articles (Conbere & Heorhiadi, 2017; Conbere & Heorhiadi, 2016a, 2016b; Conbere & Heorhiadi, 2015; Heorhiadi, Conbere, & Hazelbaker, 2014; Heorhiadi & Hartl, 2016; Ollestad, 2016). I have not been a part of a SEAM intervention at any organization. My approach to this article will be similar to Matthew Ollestad's (2016). After a

brief primer on SEAM, I will outline my observations of dysfunctions/the TFW virus within healthcare, offer my observations of why the change methodologies I have learned and applied within healthcare may be falling short and how SEAM may be an effective vaccine. While I imagine most of my observations would hold true in a for-profit healthcare organization, my lens is non-profit.

An Overview of SEAM

Influenced by his accounting background and OD founders and thought leaders, Kurt Lewin, Rensis Likert, Douglas MacGregor and Chris Argyris, Henri Savall developed SEAM in Lyon, France in the early 1970s. Savall uses a quarter to illustrate SEAM's single focus – on one side is George Washington, representing a person or socio, on the other side it says quarter dollar, representing economics. One side does not exist separate from the other – socio-economic illustrates the whole. The principles of SEAM are that organizational dysfunctions result in hidden costs, an organization's task is to develop human potential, and poor management is a major dysfunction (Conbere & Heorhiadi, 2015). These dysfunctions are symptoms of the TFW virus.

The TFW virus represents what SEAM posits as outdated thinking based on the tenets developed by early 20th century management scholars Frederick Taylor (1856-1915), Henri Fayol (1841-1925) and Max Weber (1864-1920). The name of the virus is formed by taking the first letter of the last names of each of these management scholars. The TFW virus mental model of management focuses on the separation between design and execution of work, specialization, hierarchy, and bureaucracy that de-humanizes work and leads to beliefs that employees are no different than other forms of capital and that life and work exist as separate entities. SEAM defines these dysfunctions that lead to hidden costs and can be seen in organizations as *separation, heartless processes, depersonalization, elitism,* and *blindness* (Heorhiadi, Conbere, & Hazelbaker, 2014) and as *magical thinking* (Conbere & Heorhiadi, 2016). The root causes of these dysfunctions fall into five categories: lack of steering by leaders (aligning coworkers and resources with strategic goals); lack of synchronization (being pulled in multiple and different directions); lack of negotiation; lack of cleaning up (added more change, policies, etc. without discarding the old); and poor information systems to carry clear messages throughout the organization (Heorhiadi & Hartl, 2017).

The SEAM intervention appears straightforward. It begins with an intervention reminiscent of Lewin's Action Research, but with the addition of some specific tools (i.e. internal-external strategic plan, priority action plan, time assessment tool and the competency grid), educating leaders on the principles and process of SEAM, and coaching leaders throughout the effort (Conbere & Heorhiadi 2017, 2015). Savall claims that SEAM has had 1833 successful change interventions and only 2 failed in 42 years (Conbere & Heorhiadi, 2017). Conbere and Heorhiadi (2015) contend that SEAM is still generally unknown in the US due to it being a

French creation, only recently being translated into English, and to the division between the academy and practice in France. In the US the separation of academy and practice presents a similar challenge since the predominant management model represented by the TFW virus is still taught in management schools.

Observing Dysfunction within Non-Profit Healthcare

I must honor the OD value of self-awareness and admit that I have been blind to the TFW virus within the healthcare organizations in which I have worked. I would expect to find the TFW Virus within the iron ore mining industry (Ollestad, 2016). As mission driven, committed to offer good to the community and with noble, patient and co-worker focused mission statements and values, I thought non-profit healthcare might be immune to the TFW Virus. Of course, no organization is perfect, and I have surely observed a lot of dysfunctions over my 17 years in healthcare. It felt harsh to qualify them as *separation, heartless processes, depersonalization,* and *elitism*. As someone who thinks from an appreciative lens, I have tried with limited success to use Appreciated Inquiry as a change methodology. Appreciative Inquiry has never seemed to completely work in my organizations. Appreciative Inquiry's lack of success made sense when Heorhiadi said, "it is hard to dream when you are sick" (personal communication, 10/4/17).

As I read more and learned more about SEAM, I realized that I was suffering from *blindness* (Heorhiadi, Conbere, & Hazelbaker, 2014). I resonated with Heorhiadi & Hartl's (2017) metaphor of the parable of The Poisoned Well being used to explain how the TFW Virus invades an organization. "Clever and reasonable ideas look strange through the eyes of those who are mad" (Heorhiadi & Hartl, 2016, p. 56). The following statement resonated as well, "the purpose of not-for-profit organizations is achieving their missions, and employees even in these organizations are human capital to serve the organization mission" (Conbere & Heorhiadi, 2016a). Let us pretend I did not drink from the poisoned well. Below I outline how I now see several of these dysfunctions present within the healthcare industry.

While there is a movement within healthcare education for inter-professional learning experiences, *separation* as a dysfunction clearly exists and the silos are numerous - doctors versus nurses, clinical versus non-clinical coworkers, acute care settings versus ambulatory settings, specialty versus specialty, department versus department, etc. This comes with varied resource allocations and all of the repercussions of siloed thinking and practice. While not specific to healthcare, the growing divide in generations along with all of the stereotypical qualities attributed to each group also creates division. New (younger) nurses are often described as "not having the same work ethic" as the more experienced (older) nurses.

The dysfunction entitled *heartless processes* was a harsh term to tackle. I thought for sure these did not happen within non-profit healthcare settings in which I have worked. As I reflect objectively, this dysfunction does exist within the nonprofit healthcare setting. Staffing practices

appear heartless – being short-staffed leads to hard-to-manage patient care loads. A ratio of 5 patients to a nurse or 8 patients per tech are not uncommon and often the ratio is higher. There are often expectations of hourly rounding with a checklist of items to be completed each time, to respond quickly to call lights and to track everything in an electronic health record. Nurses and techs often do not take lunch breaks and complain of hardly being able to use the restroom. Granted the values of healthcare are pretty lofty and hard for any self-aware, developed leader to exemplify consistently, but any leader who espouses the values and does not live them out in their actions will yield heartless management practices.

The TFW virus leads organizations to think employees are tools to earn profit, or as capital. Even in non-profit organizations employees can become human capital to achieve the organizational mission (Conbere & Heorhiadi, 2017). I think any organization that refers to coworkers as "human capital" yields heartless thinking and processes. I have heard this term used within all three healthcare organizations in which I have worked.

While technology has greatly improved the access to health information, making the patient/consumer more knowledgeable and ideally more engaged in their healthcare, many providers would argue that is has added a barrier to communication. I recall a chief nursing officer reporting that an internal study revealed that only 24% the nurses' time was spent with patients (personal correspondence, 2016). Many nurses say they were called to the work to care for others, and if they are spending such a small portion of their time with the patients they are caring for, it will definitely lead to the dysfunction of *depersonalization* as the nurses often cite more time with the computer charting than with interaction with the patient.

The dysfunction of *elitism* shows up in administration versus other coworkers and doctors versus all other healthcare providers. People at higher levels of administration get access to information and to bonuses for the work predominantly done at the lowest levels of the organization. Physicians are often not required to attend orientation or leadership development programs because "their time is too valuable." I do not think this is self-imposed elitism, but it is a result of the system. While likely infected with the TFW virus as well, state and federal organizations (e.g. the Center for Medicaid and Medicare Services – CMS) and the Joint Commission exist to help ensure healthcare organizations are providing safe, quality care. As they give feedback, I often hear defensive postures like "they are out to make an example of our organization" or "that surveyor is out for our organization." I think this definitely represents defensiveness and elitism that mask the dysfunctions within the organization.

The way of looking at dysfunctions that resonated with me the most, is *magical thinking* Conbere & Heorhiadi, 2016a) which contributes to leaders who cannot translate ideas into strategy and the strategy that is not being translated into effective action. Magical thinking is when a person has more work to do than can reasonably be done (Conbere & Heorhiadi, 2017). "The TFW virus fosters the belief that employees really should be obedient to their bosses, and if

they cannot measure up, then there is something wrong with them. The people, infected by the TFW virus, accept the premise that doing the impossible can be done and thus should be done" (Conbere & Heorhiadi, 2017, p. 30). Burnout is a rapidly growing concern within healthcare. I wholeheartedly agree that "sometimes people want to do, or are being told to do, more than they can achieve" (Conbere & Heorhiadi, 2016a, p. 30).

The quest to do more with less is rampant in healthcare. It is formally referred to as the triple aim – to give a great patient experience with high quality at the lowest cost. LEAN methodologies are often seen as the way to achieve the triple aim. While the tenets of LEAN (e.g., respect for and involvement of those closest to the work) are compatible with SEAM, the fact that LEAN is employed with in organizations infected with outdated management theory and by practitioners not necessarily attuned to managing the human side of change, LEAN efforts often result in heartless processes, depersonalization, and magical thinking.

I have also seen challenges with understanding the articulation of organization strategy, let alone translating it to effective action. Often employees cannot articulate how their work helps to achieve organization goals. One of the three healthcare organizations in which I have worked was more successful at translating strategy into goals. Even at that organization, many of the goals were not truly achievable and realistic using the SMART (specific, measurable, achievable, realistic, and time bound) goal setting construct. Magical thinking was at play. I think these challenges force us to focus a lot of our time on low-hanging fruit. "Picking low-hanging fruit is not necessarily bad, but it often leads to ignoring the organization's more significant problems. Metaphorically, many organizations fail to climb the ladder to reach the top of the tree, where the sweeter, sun-ripened fruit is usually found. Because low-hanging fruit is poorly exposed to the sun, they are subject to rot and disease, which weaken the entire tree." (Heorhiadi & Hartl, 2017, p. 58). I have personally fallen victim to magical thinking, often taking on more and more tasks, and then the quality of my work suffered.

This was a hard section for me to write, I wanted to defend and give the other side of the story to every dysfunction I saw. However, as my sight becomes clearer, I know that I merely scratched the surface on the dysfunctions that exist within healthcare. I find comfort and hope knowing that no one wants to get infected with a virus and when they find out they are, they seek treatment. That said, identifying the TFW virus is not easy and requires self-awareness and a willingness to face one's blindness. I recently went to a patient experience summit hosted by Cleveland Clinic challenging healthcare organizations to strive for the quadruple aim – patient experience, high quality, low cost and a fourth aim, coworker experience (Patient Experience Conference, May 2017). This experience gives me hope that the tide is changing, and the people processes will be equal to the economic processes. Organizational change methodologies have been introduced as the answer to managing "the people side of change." I will explore how they are on the right track but note where they have fallen short in my experience in the next section

in light of magical thinking and leaders not being able to translate ideas into strategy and strategy into effective action.

How Other Change Methodologies Have Fallen Short

I have learned valuable knowledge, tools and skills from all of the change management sessions I have attended. While I agree that "the method alone is not the key, it is the way it is implemented" (Conbere & Heorhiadi, 2017), as I learn more about SEAM I am enlightened by the fact that the "major difference between SEAM and traditional change management is that in SEAM, *before* [emphasis added] any change initiatives are launched, an organization first collects information about the processes or 'functions' that are not working well and their costs…SEAM encourages leaders to consider the 'high-hanging fruit' – the issues that most influence their organizations' overall health and effectiveness" (Heorhiadi & Hartl, 2017, p.56-58).

In Prosci's research (2012), the number one obstacle to change is "ineffective change management sponsorship from senior leaders" (p. 16) and Implementation Management Associates (IMA) state in their manual that "sponsorship is the most important factor in ensuring fast and successful implementation" (2014, p. 23). The BJC Healthcare model begins with leading the way and the training manual (2009, p. 4) states that common mistakes are leaders' behaviors do not match their exhortations (i.e. heartless process) and leaders fail to keep priorities clear or shift to other goals (i.e. magical thinking). Within SEAM language, this equates to the lack of steering and lack of synchronization, and a lack of cleaning up (Conbere & Heorhiadi, 2017; Heorhiadi & Hartl, 2017). When leaders have an inability to focus, have short lifespan of ideas, have an inability to make decisions effectively, it is impossible to translate ideas into strategy that become organization wide change efforts. If a leader is lucky to be able to translate ideas into strategy, then not having enough time for implementation, not having enough authority, not having managerial skills, and being overwhelmed make it impossible to move toward effective action (Conbere & Heorhiadi, 2017).

IMA stated "organizational stress can have a cumulative impact, affecting the organizations ability to handle additional changes. Unless a conscious effort is made to understand the impact of past implementations practices and lessons learned, mistakes are likely to be repeated…" (2009, p. 15). While all three methodologies recommend doing an organizational assessment, these tools assess the level of organizational stress, the clarity of priorities, etc. but they don't offer any tools to address when the organizational stress for change is invariably high and the clarity of priorities is invariably low. The SEAM tools of the internal-external strategic plan, the priority action plan, the time assessment tool and competency grid when facilitated across organization silos appear to offer the organizational clarity and when coupled with coaching. It feels like the prerequisite work that is needed to fully employ the change implementation process and tools I have been trained to employ.

Concluding Thoughts - Why SEAM Is Compatible With Non-Profit Healthcare

I have heard many "mission and margin are equally important" messages in my years in non-profit healthcare. It is a message stressed by leaders with whom I have worked that we cannot have one without the other. Particularly within Catholic non-profit healthcare tradition, "pitting mission against margin is a false dichotomy—one that does not serve the ministry" (Talone, 2004, p. 14). This sounds familiar and congruent to Henri Savall's quarter metaphor to explain SEAM. Catholic healthcare is in the relationship business and it is important to measure the impact on employees, consumers and the community. "These intangible, but nonetheless real assets count when one is engaging in the budgeting reflection process. Although these intangibles might not appear on Excel spreadsheets, they clearly belong in the decision-making equation that should be a part of any mission-based financial planning process" (Talone, 2004, p 16). The SEAM process includes a way to quantify these intangibles, what Savall would refer to as hidden costs.

While specialization has impacted the lens of healthcare, the diagnosis process is built on finding the root cause of disease, so using the SEAM approach to get to the root cause of dysfunctions should be appealing. Dysfunctions and hidden costs are compatible with waste that LEAN seeks to eliminate. Competency based development is popular within healthcare, so the competency grid tool would be attractive. No one can deny the existence of silos and burnout within healthcare so a methodology that addresses these in a meaningful way would be welcomed. The fact that "SEAM does not blame people, it focuses only on changing the system" (Conbere and Heorhiadi, p. 32) would appeal to "Just Culture" proponents within healthcare. Finally, the belief in human potential should appeal to the espoused values of all three healthcare organizations in which I have worked.

I struggled with defensiveness (i.e. blindness) throughout the preparation for writing this article. It was hard for me to accept how such passionate healthcare workers could accept dysfunctions. I am convinced in the potential of SEAM to address the dysfunctions within healthcare, to be the vaccine to the TFW virus. It would require a skilled external consultant to help lead the methodology. I cannot be a prophet in my own land, but I can be a disciple. I would welcome learning more and exposing myself and healthcare leaders to SEAM thinking and processes. I can imagine the transformational learning that could come from the process (Conbere & Heorhiadi, 2016b). I wholeheartedly agree that "for SEAM to work, the organization must be ready to accept the changes in management that is at the heart of the SEAM process. Perhaps it is time for [healthcare] organizations in the US and Canada to explore the effectiveness of SEAM" (Conbere & Heorhiadi, 2015. p, 37). This review will change and influence my practice as an internal OD consultant. Even without bringing in SEAM consultants, I feel more equipped to identify and name dysfunctions that devalue employees that in turn lead to hidden costs that prevent organizations from fully realizing their business goals. This will help better inform my OD practice and to help me lead more effective OD interventions.

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