"Key to the SEAM improvement process is the belief that members of the department often have the knowledge needed to correct problems in the department. As result, solutions about what and how to improve come from the employees and are not imposed from the top."

CASE STUDY

A SEAM Intervention in a Rural Health Care System

By John Conbere and Alla Heorhiadi

More than a decade ago, we were introduced to the Socio-Economic Approach to Management (SEAM), a method of organizational change that originated in France in 1973 as result of doctoral research of Henri Savall. Since then, we have been learning and writing about SEAM and consulting using this method. In 2011 we wrote an *OD Practitioner* article, the first in a series, in which we introduced the reader to SEAM, describing its values, rooted in American and British OD, and pointing out similarities and differences. Later, in 2014, we dissected the common traditional model of management and argued that SEAM challenges some traditional management practices that lead to organizational problems. Practicing SEAM allowed us to gather more data and inform our theoretical claims. Based on our consulting in organizations, in 2015 we wrote an article in which we explored reasons of why SEAM has remained relatively unknown in the US despite its more than 40-year track record of successful interventions. Our database of examples grew, and in 2017 we described a series of practices that subvert organizational change efforts and how SEAM responds to them.

All our written work on SEAM so far has followed the same formula—we explained some SEAM concepts and used examples from our consulting practice to illustrate them. This article is written differently—it is a case study, in which we describe the process and outcomes of a SEAM intervention in a medical center in rural Wisconsin. This case study gives the reader a chance to go beyond theory and see what a SEAM intervention looks like in practice.

Methodology

Every SEAM intervention serves as a research case study, which over time helps to validate and improve the socio-economic theory (Conbere & Heorhiadi, 2018a, Savall & Zardet, 2008). During a SEAM intervention, consultants, or in SEAM language *intervener-researchers,* help organizations improve and conduct research. They gather and analyze data, and report the qualitative, quantitative and financial changes in the organization. The data are collected through interviews with employees, observation and document review, followed by in-depth analysis of organizational dysfunctions and calculation of hidden costs in each department involved in SEAM. The findings are presented to all employees, involved in the SEAM process, which serves as a validation tool. In this intervention, we, the authors, were the intervener-researchers, or SEAM consultants.

The intervention in the medical center is still in progress. To date, 13 departments have gone through a diagnostic phase of SEAM, during which data were gathered and analyzed (see *Figure 1*). This paper's focus is the process of the intervention in the leadership group and one of the departments, the Business Office, which

began SEAM in spring 2016. Other departments followed the same process, although, except for the Diagnostic Imaging department, they do not have data yet about financial savings. Analysis of savings occurs no sooner than a year after the beginning of the intervention. The year-long period allows enough time to make changes and measure the effect of the implementation.

A Brief Overview of the SEAM Intervention Process

This paper does not provide a full theory of SEAM. Those who desire to know more about SEAM, may find more information in our other work (Conbere & Heorhiadi, 2018a, 2017, 2015, 2014, 2011), and in the seminal work of the SEAM founders (Savall & Zardet, 2008). However, to help the reader follow the case study, here are a few basic SEAM principles and the flow of the SEAM intervention process.

Basic principles. SEAM is built on the premise that the dominant mental model of management is flawed in at least two ways (Heorhiadi, Conbere, & Hazelbaker, 2014). One flaw is that modern accounting does not consider several costs, referred to as hidden costs; therefore, many leaders do not have accurate information when making decisions. Another flaw is that the traditional beliefs about people and work that underlie modern management are destructive. Thus, to be highly effective, many organization's leaders need to change their beliefs about management.

These premises influence the way SEAM approaches organizational change. Rather than starting with changing an organization's structures (e.g., org charts, rules, and processes, the number of employees) or behaviors (how employees behave), SEAM consultants focus on what does not work well (organizational dysfunctions) and how much the organization loses due to these dysfunctions (hidden costs). In any given organization, there can be thousands of dysfunctions and hidden costs can range between $20,000 and $80,000 per employee per year. The goal of SEAM is to reduce dysfunctions and hidden costs, and to channel the savings in time and money into developing the potential of the people in the organization. Employees from all levels of the organization participate in creating the changes that they think are needed, which creates a stronger sense of empowerment and trust.

The flow of a SEAM intervention. A SEAM intervention includes three vectors of the improvement process: (1) an organizational change intervention, (2) teaching managers SEAM management tools, and (3) coaching leaders on implementation of strategic decisions to support the change. The intervention starts at the top leadership level of the organization, and cascades through the whole organization, department by department, until all silos embrace SEAM.

The intervention begins with interviewing at least one-third of the members of a department. A month later consultants do the first feedback session, called the Mirror Effect, in which the consultants feed back to employees a compilation of dysfunctions as seen by employees, categorized according to the socio-economic theory, as well as present calculation of the hidden costs associated with these dysfunctions.

A month after the Mirror Effect, the consultants conduct the second feedback session, the Expert Opinion, in which they describe the root causes of the dysfunctions and suggest several *"baskets,"* or clusters of issues for improvement. After this step, members of the department choose baskets on which they would like to work and form project groups. Consultants assist project groups or projects leads monthly through training and coaching.

Key to the SEAM improvement process is the belief that members of the department often have the knowledge needed to correct problems in the department. As result, solutions about what and how to improve come from the employees and are not imposed from the top. The process is transparent and participative, which contributes to the increase of employee engagement. Identifying and releasing hidden costs helps to increase overall organizational effectiveness.

The SEAM Intervention in a Rural Medical Center

The Site Description

The hub of the St. Croix Regional Medical Center (SCRMC) is located in St. Croix Falls, a city of 2,093 people and 967 households in Wisconsin. The medical center consists of a 25-bed hospital, a large primary care clinic, and several specialty clinics in the St. Croix Falls facility. In addition, there are five clinics in small towns between 15 and 50 miles away. One clinic is in Minnesota; the rest are in Wisconsin. The medical center has been growing rapidly, from 457 employees in 2015 to 735 employees in 2017. Most of the growth has been in the St. Croix Falls facility. At the beginning of the SEAM intervention, many of the primary care physicians were members of a separate medical group that worked with SCRMC. In 2017, the medical group dissolved, and the physicians became employees of SCRMC.

The Beginning of the SEAM Intervention: The Executive Council

In January 2016, the consultants met with the Executive Council (EC) of the medical center and explained the basics of SEAM. A few things about SEAM looked appealing to the CEO and the EC members. First, SEAM's rigorous approach, based on a 40-year track record of success matched the evidence-based mentality of healthcare professionals. Second, SEAM works with the whole organization by engaging all employees and increasing their ownership of the change process. Third, SEAM's focus on dysfunctions and hidden costs would show how much money the organization loses due to organizational inefficiency. Fourth, SEAM was compatible with other organizational effectiveness approaches, such as Studer or Lean, with which many employees were familiar. Finally, the CEO especially liked the idea of a natural and well-paced process of culture change; as for him this was the priority:

> At first, my intention was to focus on patient experience and quality. Later, I realized that the ultimate focus had to

be on the organizational culture. The culture needed to be transformed to make the organization more effective. (Dobosenski, 2018, p. 14)

The issues. The SEAM intervention began with the Executive Council, which at that time consisted of six members. All members of the EC were interviewed individually. Their quotes were analyzed and categorized by the types of organizational dysfunctions. The issues were obvious. The EC members did not trust each other, and thus did not always speak up if they had an idea or saw an issue of concern. They were not sure about the reaction of their peers because the medical center was notorious for its "culture of blame." When something did not work well, the immediate response was to find out whom to blame rather than to address the cause of the problem. As a group, the EC members used their time poorly, taking on more work than they could do and doing a lot of operational activities, which did not leave enough time for working on strategy.

During the Mirror Effect session all EC members were quiet. Nothing from what they heard was new for them. Yet, the way the information was categorized and presented, delivered a strong message. Later one member of the EC reflected,

> During the Mirror Effect, the team realized some issues that caused much frustration for us. Each of us worked long hours and very hard, yet as a team we were not successful. We did not have the right data to make informed decisions, and often we would make decisions without including all stakeholders. We lacked effective and timely communication and cooperation between silos and departments. We did not consistently hold our employees and managers accountable. We did not have a process in place to manage conflict, nor were we comfortable dealing with it. The Mirror Effect shocked us in that it shattered our illusion that we, as organizational leaders, were effective. (Jensen, 2018, p. 27)

Root causes of organizational problems. A month later the consultants delivered the Expert Opinion. It was time to take a systemic look at the problems raised during the Mirror Effect and outline directions of improvement work. While there were many dysfunctions presented in the Mirror Effect, they were only the symptoms of a few major root causes. Looking at organizational problems through the lens of root causes allows to detach people from the system's problems, and thus remove the blame from people who in most cases work hard.

One of the causes was *lack of steering*. The EC was not doing a good job of steering the organization. In SEAM language, steering means leading and managing to ensure that the efforts of departments and individuals are aligned to achieve the strategic goals of the organization. The EC members did not steer their direct reports effectively. In the medical center, when plans were made, the implementation of these plans was weak. Not everyone in the EC had the same understanding of their roles. The EC decision-making process was neither clear, nor effective.

Because the EC did not steer the organization, work of the different silos was not synchronized. *Lack of synchronization* is failure to coordinate the organizational processes and align actors' efforts in achieving organizational goals. As result, while individually employees or some parts of the organization worked very hard, their work was not synchronized or coordinated with other parts of the organization. As result, the energy from their effort evaporated and the organization was not effective.

Poor information systems resulted from the lack of synchronization. Organizational members did not have accurate information needed to do their work well. For example, computer systems did not always work properly, managers did not share information needed for staff to excel, departments did not share information with each other, and employees at the bottom of the hierarchy did not report to their managers issues due to fear of being punished, and leaders did not have data about hidden costs.

One of the root causes often ignored in many organizations is *lack of clean up*. An example of lack of clean up can be seen when an organization implements new instructions, rules, or practices but does not review or eliminated old practices and does not communicate about new changes. As a result, different parts of an organization live by different rules, some of which might be contradictory. Organizational hoarding, intentional and unintentional, exacerbates the problem of lack of cleaning. With intentional hoarding, an organization is reluctant to discard anything in case something might be needed in the future or because the organization has followed the policy for years. Unintentional hoarding happens when the organization does not make time to review the old processes.

In the EC, lack of clean up took a form of adding more work without removing any tasks from people's duties. The EC members were caught by magical thinking. Magical thinking may take different forms and one of them is believing that one can do more than is possible in the allotted time (Conbere & Heorhiadi, 2016). Moreover, the EC members set an unhealthy example for their employees.

The inability the EC members to say what they think lead to *lack of negotiation*, another root cause. Holding back information and ideas in fear that they might be attacked or perceived as not having any merit, did not help the deliberations of the EC.

Improvement work. To address the root causes and help the EC be more effective, the consultants suggested 4 baskets. Each basket consisted of a series of smaller improvement projects. For example, Basket 1 was about improving how EC members manage and communicate about EC decisions and strategy with the rest of the medical center. Smaller tasks within this basket included setting the priorities, helping direct reports learn how to prioritize their work, develop a fair and transparent decision-making process, develop the process of communicating

these decisions throughout the organization. Basket 2 was to agree on the role of the EC members. Smaller projects within this basket included: developing criteria for who should be in the EC; setting clear expectations for EC members, and designing a productive way to deal with disagreements and differences of opinions. The reflection of one EC member gives an idea of their work on these baskets:

> As we began working on Basket 1, at first it seemed very easy to us. Two months later, we reported to the consultants that we completed the basket. The consultants helped us recognize that the basket was not completed, as we resolved only some superficial problems, without addressing deeper issues. We dealt with symptoms and not underlying causes. For example, we were unable to be completely honest with each other at times, which had a detrimental effect on the whole organization. We, as a team, tended to avoid conflict and when we disagreed with others, we were reluctant and uncomfortable to challenge them. By the way, one of the projects in the basket was about identifying a healthy process to work with different opinions. So, we had to start over in identifying different pieces of the problem and addressing them one by one. (Jensen, 2018, p. 28)

A suggested third basket was to develop and implement a plan to have more positive and collaborative relationship with all providers. This basket was resolved, not through SEAM, but through the dissolution of the outside medical group and incorporation of its physicians into the medical center. Some old tensions and dysfunctions in the medical center stemmed from having many physicians come from a separate medical group. The Board finally decided to act, which led to dissolution of the outside medical group, and its physicians became employees of the St. Croix Reginal Medical Center. While it may look like SEAM had nothing to do with the formation of a new board and one

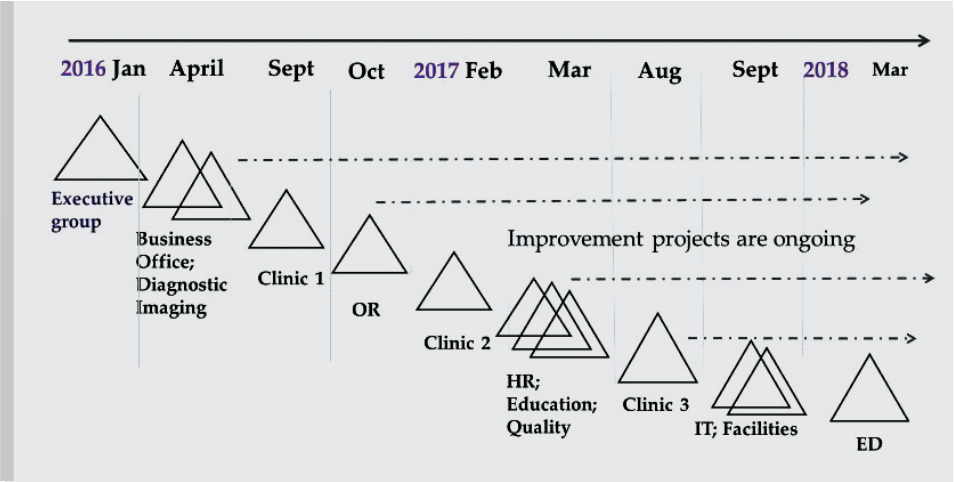

Figure 1. Time line of the ongoing SEAM intervention in the medical center

medical group, the CEO credited the SEAM process for identifying dysfunctions on the EC-Board level. The SEAM intervention with the EC became the impetus that led the Board to make changes.

Two and a half years after the beginning of the intervention, one can see some significant changes in the EC. As of 2018, membership has changed. Two leaders chose to leave, and a new Chief Administrative Officer has been added. The culture of the EC is different. Members can talk more openly. The discussions are much more focused on strategic directions and not operational issues. When the group shifts into what they see as micro-managing operations, they help themselves to get back on track of steering. EC members are highly aware of the danger of magical thinking and strive to make work expectations reasonable both for themselves and other employees. Yet what is more important, four out of five EC members led SEAM interventions in their departments. As result, they learned new information about their departments, and they have an experiential understand of SEAM. The CEO has attended every Mirror Effect and Expert Opinion session in every department. He has been telling employees of those departments that this is exactly the same process as the EC went through. His presence sends a strong message to employees—the leadership has invested in and is supportive of the change.

Cascading Down to Silos—the Business Office

Two months later after the beginning of the SEAM intervention in the leadership group, the intervention began in the Business Office. The CFO, a member of the EC, was strongly supportive of the SEAM intervention in the Business Office because this department had been a source of many problems, complaints, and high turnover. In the medical center, the Business Office had a reputation as being a difficult and unpleasant place to work.

The interviewing began in April 2016. About 40 employees worked in the Business Office, and the majority were interviewed. The interviews and focus groups identified a highly fearful group of employees, who expected to be punished if they complained or did not agree with the director. The consultants heard many comments like these:

"When we identify the problem, we get backlashed, and get blamed, rather working together with other silos as a team."

"Some employees in billing go home and cry because they are so overwhelmed with many things to do and because they are told only negatives, and they do not know where to go for help."

"People are afraid that they will be reprimanded if they speak openly. They go to a co-worker and talk instead of going to a supervisor, and the co-worker passes what they thought they heard. So, information gets distorted. "

"We have some ideas, but there is no follow-through. When you bring things up to supervisors, they belittle you. We do not want to talk about things anymore because we do not want confrontation. Basically, you come to work, do your work, keep your mouth shut."

After categorizing interview data and clustering them by the types of

dysfunctions, the consultants delivered the Mirror Effect. All the complaints were presented, nothing was hidden. The patterns of the comments were obvious. First, the management practices of the director were perceived by many as demeaning and belittling. That hurt morale, and led to a very high level of turnover, which cost over $50,000 per person for hiring and training. Second, the employees felt like they were continuously asked to do more work, without being relieved of any tasks. Third, the medical center, as an organization, did not support the internal cooperation needed to provide accurate data to the Business Office. For example, the office needed to get accurate coding from physicians and other departments, so the coders and billers could do their work well. Yet not every department responded to the Business Office's requests in a timely or professional manner.

The conservative estimate of the cost of dysfunctions in the department was $2,744,241.

At the Expert Opinion, the consultants summarized the major concerns of the staff and identified the root causes. There was not enough steering from top leadership, the Executive Council. Leaders of the medical center have not modeled and nurtured cooperation within the Business Office nor with the Business Office and other departments and clinics. As result, managers, supervisors, and employees of the Business Office had not developed a culture of collaboration within the Business Office and with outside departments. People throughout the Business Office did not have a culture in which they could negotiate to meet their needs in the workplace. Lack of cooperation with insurance companies and other healthcare systems led to poor information systems. As changes were made, the old systems have not had enough "clean up." For example, there were three separate billing systems that did not talk to each other, and people spend much time in filling in numbers manually.

Five baskets were proposed, and the staff choose two baskets to begin improvements. One basket was to analyze the sources of de-motivation that lead to turnover and a "culture of blame," and to create a new departmental culture in which every person felt valued and respected. Another basket focused on cleaning up old processes and developing processes and procedures before new ventures begin.

Even though the consultants met with the project groups leaders monthly, at first the baskets moved slowly. Most people did not believe change was possible. It turned out that the former director was sabotaging some of the SEAM work. The CFO had been working with the director to improve her management performance and the consultants provided SEAM coaching and supervisory training. Yet after 6 months of coaching, the CFO kept receiving information about the negative impact that the director had on the culture of the office, and the CFO decided to terminate the director.

Once employees realized they would be allowed to make improvements to work processes, work on the baskets was enthusiastically embraced. The basket to improve morale and remove the culture of blame led to monthly pulse surveys shared with all members of the office. Simplifying the work processes led to reducing wasted time and using this time to do projects that were long time overdue. Having the people make the changes, rather than having the leadership create all the processes, proved to be a tremendous morale booster.

After two years, morale and work climate, and thus employee engagement, in the Business Office greatly improved. One employee, who quit three years ago due to the poor work climate, after hearing of the changes in the department, returned to the Business Office. The results of the baskets were making more inroads to the identified dysfunctions, as shown by the recalculation of hidden costs (see *Table 2*).

Outcomes of the SEAM Intervention: Financial Data

Every department that was added into the change process (*Figure 1*) has followed the same process—data collection, data analysis and calculation of hidden costs, first feedback session, Mirror Effect, second feedback session, Expert Opinion, taking on baskets with improvement projects. The only unit, in which hidden costs were not calculated, was the EC. Most of hidden costs happen at the operational level, and the senior leadership group is supposed to do strategic tasks.

To calculate hidden costs, the consultants followed several steps. First, they assessed the interviews for signs of potential hidden costs. Second, they reviewed organizational data looking for the indicators of hidden costs, such as records of employee turnover, overtime payments, or occupational injuries. Third, the consultants interviewed employees with the knowledge of the occurrence, frequency, and financial implications of the dysfunctions. After the hidden cost interviews, the consultants determined the financial losses from dysfunctions.

Hidden costs take different forms, all of which lead to negative financial consequences for the organization. There are six categories of hidden costs, four of which represent waste in the present time. Wasted money is financial value of resources consumed due to dysfunctions. Wasted time is the value of wasted time due to dysfunctions, time that could have been used productively. Overpaying means paying someone to do the work that ought to be done by someone with a lower qualifications or salary. Missed productivity is potential earnings that were not achieved because of dysfunctions

Two more categories of hidden costs refer to potential losses in the future. One is undeveloped potential, earnings that will not be achieved because dysfunctions prevent their creation. The other category refers to risks, the potential losses that might happen because of dysfunctions. *Table 1* includes hidden costs, originally calculated, as the departments went through the SEAM interventions.

Recalculating hidden costs occurred after a year of SEAM work to give enough time for the change process to take effect. By the spring of 2018, the Business Office went through two recalculations of hidden costs and the Diagnostic Imaging department went through one. The financial data show that for the Business

Table 1. *Hidden costs identified in the initial assessment in the following departments and clinics of the medical center* (does not include risks**)*

Unit	Overpaying	Wasted time	Wasted money	Missed productivity	Undeveloped potential	Total
Diagnostic Imaging	$19,141	$529,585	$3,100			$551,826
Business Office	$38,977	$1,900,136	$805,128			$2,744,241
Surgery	$3,840	$235,395	$137,555	$1,648		$378,438
Clinic 1	$284,326	$82,746	$56,351	$61,391	$295,837	$780,651
Clinic 2	$20,840	$328,722		$298,948		$648,510
Employee Services & Edu		$564,897	$3,045			$567,942
Quality		$154,841	$10,563			$165,404
Clinic 3	$2,394	$508,647	$31,971	$507,674		$1,050,686
IT*	$4,905	$358,378				$363,283
Facilities	$10,089	$40,622	$17,887	$50,280		$118,878
Emergency		$508,235	$44,579	$132,639		$685,453
Total	$384,512	$5,212,204	$1,110,179	$1,052,580	$295,837	$8,055,312

* Note that the amount of hidden costs was within the range of hidden costs that are found in other organizations.

** The risk of a major security breach in Information Technology was estimated to cost at least $17,000,000.

Table 2. *Savings in 2 departments of the medical center after two years of SEAM*

	Year	Hidden costs, $	Savings, $
Business office	2016	2,744,241	
	2017	1,925,469	
	2018	836,306	
			1,137,097
Diagnostic Imaging	2016	551,826	
	2017	445,728	
			106,098
Total savings, $			1,243,195

Office and Diagnostic Imaging the collective savings were $1,243,195, which is a reduction of hidden costs of 37.7%.

Outcomes of the SEAM Intervention: Quantitative Data

Turnover in the Business Office was expensive, since each new employee needs extensive training to be able to master the computer systems, federal regulations, and demands of each insurance company. Turnover in the Business Office was reduced by more than 50%

Accounts Receivable (AR) days are the number of days before a customer invoice is collected. AR days were reduced from 97 to 66 days per year. As a result, days with sufficient cash on hand increased from 63 to 105, and days of debt was reduced from 27 to 15.

Outcomes of the SEAM Intervention: Qualitative Data

Qualitative data were gathered by interviews, observations, presentations by SCRMC members and surveys collected by departments. The data led to several conclusions.

Increased engagement of employees. When SEAM began, many saw SEAM as the "CEO's thing," meaning it would be a brief fad, a "flavor of the month," which soon would be replaced by another fad. As SEAM progressed, more employees were involved in change projects. Because many projects are cross-departmental, employees learned about what other departments were doing and what problems they had. Employees became much more skilled in resolving issues and differences through negotiation. Several leaders have observed that it is easy to recognize people who are familiar with SEAM and who are not. People who went through SEAM are more cooperative, and more willing to resolve

problems constructively. People who have not been involved in SEAM yet tend to be more defensive and blaming when talking about problems. By the winter of 2018, SEAM became much more trusted. As the CEO put it jokingly, "SEAM is now in vogue." Many leaders want to have the SEAM intervention in their department or clinic.

Improved Morale and Climate. Employees reported through interviews and pulse surveys that morale has improved. More employees feel trusted by leaders. The change in morale has led to better cooperation in many departments and clinics. People became more willing to help or explain things to their peers. *Table 3* reproduces an excerpt from a pulse survey to show the change in climate in the Business Office.

Table 3. *Business Office pulse survey results in first year (an excerpt)*

Question	April 2016	November 2016	February 2017
I feel I can ask questions	31.4%	50.0%	90.0%
I feel supported	31.4%	47.2%	89.3%
I trust	32.4%	77.6%	95.9%
I am not afraid to speak up	35.1%	59.0%	85.7%

Transforming Culture. In the medical center, the culture of blame was pervasive. People avoided identifying problems out of fear that they would be blamed, or concern that they might lead someone else to be blamed. Employees who were introduced to SEAM, became willing to identify problems. Their response became, "How do we fix the problem, and who are the stakeholders to be involved in problem solving?"

Participating or leading baskets taught employees to resolve issues through negotiation, which is becoming a new cultural behavior in the organization. Being able to change things and seeing results from their baskets rebuilt employees' trust in leadership. The CEO reflected,

> I witnessed the outcome of SEAM in my organization - culture change. This culture change was not imposed; it happened not because someone proclaimed it. It was an iterative process—people began to believe they are heard and respected. And because they felt heard and respected, they took ownership of change, they took on new initiatives, and modeled change for those who still did not go through the SEAM intervention. (Dobosenski, 2018, p. 24)

Strengthened Mid-Level Leadership. The SEAM process brought to the surface a common problem in rural healthcare organizations, which is the lack of management and leadership skills. Physician or nursing leaders usually are not taught to be effective managers and leaders. Most mid-level managers and supervisors of the medical center rose through the ranks without much training about how to be a good manager.

Training managers about SEAM management tools and coaching them through the change process is built into the SEAM intervention. Directors, managers, and supervisors of the departments involved in SEAM received training and coaching monthly for a year, which helped them become better leaders. However, SEAM did not move fast enough through silos to cover the need to strengthen mid-level management in departments that were not part of SEAM yet.

The need to build strong leadership was obvious among nurses. Nurses are trained to put patient care their top priority, which is excellent for the patient. However, when a nurse manager puts patient care ahead of managing, then the organization suffers. The unintended consequence was erosion of the organizational efficiency undermines individual patient care. Recognition of the weakness of management skills led to the creation of the Nurse Leadership Academy.

The first cohort of the Nurse Leadership Academy was composed of a variety of nursing positions - senior managers, department directors and supervisors and clinic directors. As affirmed by the consultants' observations and testimony of the participants, by the end of six sessions, the nurse leaders had a clear and shared understanding of management and gained confidence in their ability to carry out their roles.

Reduced Magical Thinking. Magical thinking is the delusional, and often unconscious, belief that one can do the impossible (Conbere & Heorhiadi, 2016). Before SEAM, magical thinking in the medical center was rampant—people progressively took on more work without having resources to do the work; people were asked to do work without the needed training, nurse managers were supposed to manage well while working full time as a nurse. Employees were not aware how their magical thinking had a destructive effect on their productivity and organizational effectiveness. They did not realize that their commitment to doing things without having sufficient resources, skills, or time created dysfunctions. Learning about and using the SEAM management tools helped managers to be more time conscious and realistic about setting priorities.

Evidence of the reduced magical thinking can be seen in the increased number of employees, who when asked to do more work, respond, "I will do what you ask. Now let us agree on what I will cut from my workload to free up time for this new task." Their managers, versed in SEAM, negotiate workload rather than assuming people can always do more without decreasing quality.

Value on Investment: A Holistic Assessment of Changes in SCRMC

Value on investment, which the authors define as the economic and socio results of investing in change, includes financial, and quantitative and qualitative measures (*Table 4*). If only the financial data were demonstrated, the SEAM intervention in SCRMC would show itself to be a healthy return on investment. However, measuring the savings from reducing hidden costs while being a useful assessment of any intervention, is incomplete. One can achieve short term savings by cutting

Table 4. *Outcomes of the SEAM Intervention in the Medical Center*

SEAM Outcomes		
Financial data	**Quantitative data**	**Qualitative data**
Reduced hidden costs in 2 departments by 37.7%	Reduced turnover by over 50% in Business Office	Increased engagement of employees
Savings of $1,243,195 in 2 departments	Reduced AR Days - 97 ➠ 66	Improved morale and climate
	Increased Days Cash on Hand - 63 ➠ 105	Transformed culture of blame
	Reduced Days of Debt - 27 ➠ 15	Strengthened mid-level leadership
		Reduced magical thinking
		Improved patient services & patient experience*
		Reduced risks*

* These outcomes were not elaborated in the narrative due to the journal's space constraints.

employees, but over the long term, such reductions destroy effectiveness and profit. Socio-economic theory posits that developing the potential of each employee is the key to organizational effectiveness and sustainable growth.

The qualitative outcomes mentioned above are examples of developing human potential. These kinds of changes are the drivers of positive and sustainable growth. The quantitative and financial outcomes are signs of increased economic health. All three kinds of outcomes are necessary. To consider any one outcome without the others is to create a distorted vision of what happens in organizations.

Conclusion

To compete with other healthcare organizations, the St. Croix Regional Medical Center had to simultaneously increase patient experience, improve the quality of services provided, reduce overall costs and increase organizational effectiveness. To achieve these goals, the medical center had to change the way it operated. This meant changing the deep beliefs, or cultural assumptions, that led to the dysfunctions.

At the time of writing, 13 departments of SCRMC have experienced SEAM, including the top leadership group. The SEAM intervention is steadily cascading through the medical center. The number of employees involved in SEAM will approach 50% in the fall of 2018. The outcomes, as measured by financial, quantitative and qualitative data, suggest that the SEAM process has been successful, as it prompted the cultural changes and led to financial gains.

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