EXPERIENCE EXCHANGE

Effectively utilizing wellness and engagement surveys

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ABSTRACT

Wellness and engagement in busy and complex healthcare systems are challenging. Much has been written about how individual healthcare workers can prevent their own burnout and improve wellness as well as the role of institutional and organizational goals to promote engagement and wellness. However, while there is clearly not one explanation or one solution for this problem, there is also not one standard approach to assessing these important issues, though surveys are most commonly used to assess the characteristics of the workplace. We suggest a framework of strategies for effective use of surveys to improve employee wellness and engagement based on practical experience that involve operational next steps organizations and programs can take after surveys as well as contextualizing the information they provide. These steps include adapting and leveraging quality improvement (QI) tools customarily used for patient safety for the purpose of wellness and engagement.

Key Words: Wellness, Engagement, Healthcare systems surveys, Organizational culture

1. INTRODUCTION

The healthcare environment is a complex and multilayered ecosystem with a diversity of individuals and perspectives. It is also a setting of high stakes, intense pressure, and chronic stress where wellness and resilience have suffered over the past decades. In addition to patient care and research, academic health systems with overlapping educational missions may encompass medical schools, graduate medical education programs, and nursing and allied health professional training. Thus, there are many stakeholders and perspectives from students and care providers to ancillary staff and patients, all with their own competing goals and agendas.

Evaluations and assessments of the healthcare environment targeting different populations abound. Patients are surveyed about their perceptions of care. Medical students are asked to assess their learning environment.[1–6] Wellness and engagement are assessed among healthcare employees, physicians, nurses, residents, students, fellows, and staff.[7–10] Additionally, residents and fellows are surveyed through ACGME and AMA related to their learning environment, training program, and wellness.[11–13] Each administrator in the healthcare organization is focused on improving the survey results of their constituency. Maintaining the view that each of these stakeholders is its own silo does not promote the engagement and wellness of all as effectively as stepping out of the silo and seeing the stakeholders in a matrix.

The survey, defined as a general view, examination, or description, is the common tool used to assess wellness, engagement, and satisfaction of all stakeholders in the healthcare environment. Surveys are not meant to provide definitive answers which are directly acted upon. However, their results are often used as the single vital sign of the population or environment, not as a screening tool to identify potential issues which require a deeper appraisal. Survey results should be considered in conjunction with other assessments to pro-

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vide a more holistic rendition of the scope of the problem. While health institutions accrue this data on multiple populations through a variety of scales and metrics, these results are rarely aggregated to provide a complete 360 evaluation of our healthcare systems. This prevents the acknowledgement that the responses from the different groups may simply represent different facets of the same stone.

Healthcare organizations are very systematic in evaluation of lapses in clinical care, patient safety failures, and medical errors.[14] This same level of intensity needs to be used in the evaluation of the culture of health systems. The tools used in industry and healthcare for patient safety and improvement can be used to improve the healthcare environment for all of the stakeholders together rather than for one group at a time.

Improvement in wellness, satisfaction and engagement requires work at the healthcare organizational level and at the national level to be most effective at decreasing burnout, improving wellness and increasing engagement.[15,16] Individual institutions must be willing to commit to critical introspection of their culture. National organizations must create supportive structures to move in the direction of positive environments. In this article, we describe specific steps for how to effectively act on wellness and engagement surveys in your institution. We have drawn on our experience in healthcare with medical student, resident, and physician engagement and wellness (see Table 1).

Table 1. Tips for institutions and national organizations

Tips for the institution	Tips for the institution and national organizations
Tip 1: Develop specific goals and objectives for the survey	**Tip 7:** Align questions with institutional and national goals
Tip 2: Use surveys only as screening tools	**Tip 8:** Organize issues systematically using tools such as stoplight reports
Tip 3: Do a deep dive to fully understand the issue identified in the survey	**Tip 9:** Recognize that, for one group to improve, other groups often need to improve as well
Tip 4: Consider all relevant information about an issue, not just the survey results	**Tip 10:** Establish and share best practices
Tip 5: Use tools from patient safety to address issues	**Tip 11:** Create iterative dialogue between institutions and national organizations
Tip 6: Select non-partisan group facilitators	**Tip 12:** Follow up on survey results to ensure resolution of the issue

2. SPECIFIC STEPS FOR HOW TO EFFECTIVELY ACT ON WELLNESS AND ENGAGEMENT SURVEYS

1. When using a survey tool, develop specific goals and objectives for using the tool. It is not helpful to take all the survey questions, throw them against a wall, and see what sticks. While it may be tempting to dive into question development directly, a more thoughtful approach, considering what the institution values and how to formulate targeted questions, may be more high-yield. This methodology recognizes that healthcare systems cannot tackle all problems with similar resources and that prioritization is necessary to effectively address those areas of greatest concern. The survey content also reflects the organization that delivers it and itself sends a message. Thus, the survey must be thought of as a representation of the values and priorities of the institution.

Example: A healthcare organization may decide that they want to prioritize issues related to diversity, equity, and inclusion. They would then select questions that best address healthcare providers' experience in the workplace of an inclusive, accepting environment. They may decide to eliminate some questions that are not specifically related to the organization focus that year to maintain a reasonable length and assure completion of the survey.

2. Use the surveys as they are designed. They are screening tools to assess an environment that provides a general view, examination, or description; they are not meant to provide definitive answers. Surveys for wellness, burnout, work and learning environment abound. They can certainly signal areas of concern or highlight particular issues but they are limited in that surveys are usually multiple-choice and are framed by the language used in the question. They are not designed to provide a comprehensive picture of the healthcare environment but rather only a superficial view. However, the results of surveys are often interpreted in isolation without developing a full picture of the problem.

Example: Surveys may show that physicians feel there are patient safety issues with the health system. Taken at face

value, this could mean that there are broad, systemic issues but, if there is a more holistic approach and knowledge of the practice, it could be identified that there is one specific problem that needs to be addressed but that patient safety in general has been optimized. A superficial view of the survey question would not uncover the truth of the situation.

3. Use the information obtained by the surveys to drill down on areas that need further evaluation/assessment. Additional diagnostics need to be utilized to fully understand the scope of the problem uncovered by surveys. Since the survey does not provide in-depth information, secondary means of evaluation are necessary. These could include focus group meetings with representatives of specific subpopulations to assess the specific areas of concern. Typically, focus groups take individuals out of their workplace and are set up as stand-alone meetings. Leadership rounding where medical educators or hospital leadership directly meet with individuals in the clinical work environment is another valuable tool. Committees with diverse representation can provide a reporting structure and an open forum for discussion and can supplement focus groups. Regardless of the methodologies chosen to elucidate the nature of the issues, it is important to do the additional detective work to illuminate the nature of the problem.

Example: To follow up from the example in #2, leaders can take smaller groups of individuals and discuss with them where they feel issues of patient safety lie. They can query their safety reporting systems and look for trends. Leaders can continually open dialogues by meeting with nurse, physicians, and others on the floors where they work to begin safe conversations and establish relationships.

4. Leadership must consider all groups' survey results in toto and not in isolation. Information gathered from all surveyed parties must be considered. Solutions created need to optimize conditions for all involved. Crafting solutions that benefit the medical students to the detriment of the residents falls short of meeting everyone's goals. Getting representatives of the major stakeholder groups impacted by decisions together in one room has the best potential to create changes that do not actively exclude a group. A committee with designees representing all the relevant stakeholders should then meet at regular intervals to discuss common themes and remedies, improving transparency and building consensus.

Example: If residents are reporting that a particular ambulatory site is not providing an optimal educational experience, the first response from medical educators would be to pull the trainees from that site. However, that may be a signal that there are other issues at that site. Perhaps those physicians are now short-staffed because two medical assistants left and have not been replaced so that their work-load is increased and the patient flow is hindered. Another educational example could involve the timing of teaching rounds in the hospital. The residents may prefer a later rounding time but the attending physicians realize that this may delay some patients' discharges. Rather than just adopting one solution or the other, recognizing that there are numerous stakeholders allow more complete solutions to be developed.

Table 2. Tools of QI methodology

QI methodology
Root case analyses (RCA)
Healthcare failure mode effect analysis (HFMEA)
A3 report
5 Whys
Plan-Do-Study-Act (PDSA)
Fishbone diagram

5. Tools in quality improvement (QI) and patient safety can be employed to uncover underlying themes and issues and solutions. QI methodology allows for more long-term strategic plans and not just quick fixes. There are many useful tools in patient safety and quality improvement to allow a 360 degree view of an issue. (see Table 2) These tools systematically approach a problem without bias or incrimination but rather assess the systems' issues that contribute to a given outcome. In healthcare, we are already very familiar with these techniques in patient safety. We need to repurpose and re-appropriate these techniques to address flaws in the system related to burnout, wellness, and engagement. For example, RCAs are commonly used when there is an untoward patient safety event. Similarly, the creation of a fishbone diagram seeks to methodically categorize all the contributions leading to an undesired result (see Figure 1). The benefit of using these tools is not only that they are tried and true in the world of patient safety but that they require an open-minded approach to problems (see Table 2).

Example: Figure 1 shows how patient safety methodology can be used to assess the numerous contributions to the end result of an issue from technological issues to workload, from documentation requirements to misaligned expectations.

6. Recognize when it is important to have a non-partisan facilitator for group discussions. Leaders may need to involve additional individuals to assist in maximizing the group discussions and problem solving. This may include someone who is not directly involved with the present issue but can influence change and offers another perspective. Issues may also arise that are beyond the scope of one leader to remedy and knowing who else should be involved in affecting transformation of an environment can be driven by effective collaborations.

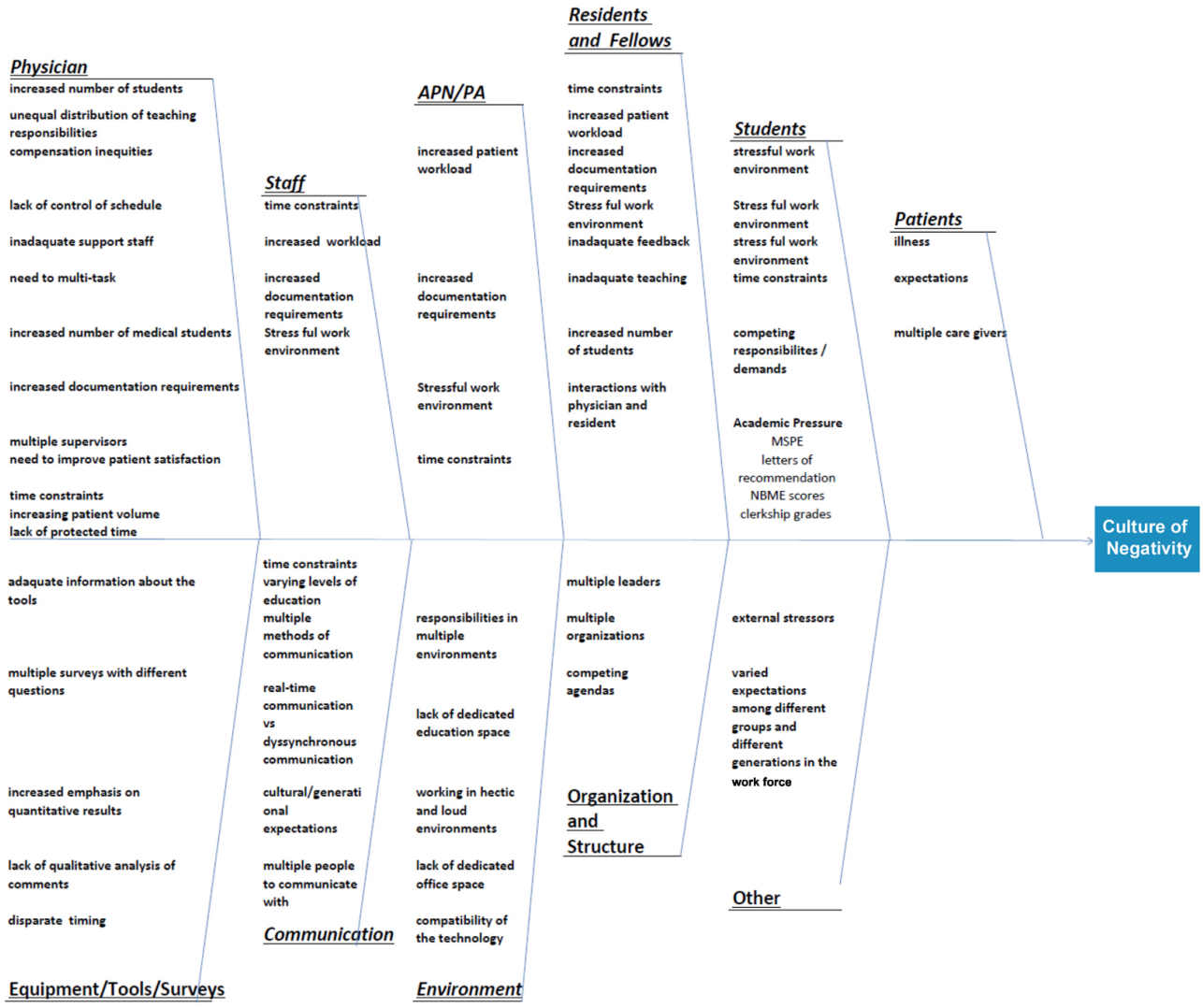

Figure 1. Example of a fishbone diagram to address institutional culture

Example: Conflict may arise within a department but those embedded in the problem may not be able to see the downstream effects of their actions or appreciate the role of that department in the larger health system. Bringing in outside perspectives can shift the conversation and guide solutions that address the specific departmental problems while also engaging other departments that interact with them. This can be through group meetings, inviting others to share their thoughts, or there may be other leaders at the institution adept at navigating challenging conversations who can be brought it to facilitate team-building.

7. Align survey questions with institutional priorities in addition to national priorities. The areas of continuous review should be agreed upon among all constituents involved in creating and administering the survey. Certain topics should be queried in a similar manner at least annually or every other year to assess the effects of change. For example, if burnout is identified as a particular problem in an institution, the same questions should be offered each year because even subtle changes in questions may be interpreted differently by respondents. Additionally, stakeholders should reach consensus on which topics are of particular interest to the institution such as the hidden curriculum, mistreatment, engagement, or work environment and prioritize which areas to address first. National organizations can participate by recommending inclusion of specific questions that would allow for better assessment of learning environments, burnout, and engagement within individual institutions and across institutions. They can promote and communicate strategies that organizations are using in their improvement efforts so that individual institutions do not have to recreate the wheel but can learn and improve from the efforts of others.

Example: If the organizational approach adopted by an institution is to highlight issues of burnout, questions on the

survey should be modeled after validated scales and should use the same verbiage different times and among different groups to allow for comparison. If a medical school wants to address perceived mistreatment of the students, questions should also assess the residents' experiences since they are also learners. Questions that address the attending physicians' experiences should also be included in an analysis to allow for consideration of stressful impacts across the continuum of the health system.

8. Stakeholder groups need to use standardized reporting methods such as stoplight reports to follow gains made by the organization over time to highlight the cumulative accomplishments. There is often a short institutional memory because of turnover. Additionally, the volume of changes may get diluted. Methods of tracking gains such as stoplight reports can clearly demonstrate improvement over time. Clearly seeing improvement can lead to the necessary culture change. While culture change is the goal, incremental steps should be valued. They are more easily recognized and they show progress, responsiveness of the leadership, and commitment to transformation.

Example: Departments can post, physically or electronically, progress made on issues and why other issues may not be able to be solved at that time. Concerns that are green were completely rectified and those that are yellow are being worked through. There will be some red issues that could not be corrected at that time. Addressing the "why" helps everyone to understand the larger framework and the considerations that come into play with every decision. Providers will feel their voice is being heard and actionable changes are resulting.

9. Stakeholders must be truly invested in advancements in other divisions, departments, and programs. For a health system to succeed, everyone must want to contribute to the betterment of the institution as a whole. While each leader understandably desires the success of their own group, they must also fully understand that the success of one group is dependent and intertwined with the success of other groups and the organization as a whole. Institutions should make continuing efforts to emphasize the interconnection among all in the institution and shift away from more self-serving interactions to more collaboration. There needs to be recognition that any solution to an issue will impact others and a wide perspective should be considered when implementing change, recognizing that the organization is built on the strength of all members and that solutions must take into consideration the needs of the whole.

Example: While groups in healthcare will understandably focus on their "backyards," providing perspective on the impacts of their decisions on others can change the conversation and help move toward mutually beneficial solutions. For example, if all the emergency room admissions are being called in to the admitting physician at the end of a shift, there will be a bottleneck and patients will not be seen as quickly, they will have delays in care, and the accepting physician will be overwhelmed. If the hospitalist and ER physicians work together, they may find that dispersing the admissions throughout the day will result in faster turnaround time, quicker discharges from the ER, and greater patient satisfaction. Both physician groups can reap the benefits with a more collegial solution being applied.

10. There should be transparency in reporting survey results and dissemination of clear best practices. Results of surveys and the information from individual institutions need to be compiled. From this, best practices for continuous quality improvement can be developed for all stakeholders. Because institutions are reluctant to reveal their shortcomings, unbiased national groups should take the lead in developing and disseminating common themes and best practices to solve them.

Example: Many surveys are created by large organizations that survey a vast swath of healthcare systems. If healthcare leaders understood national trends in the data, it could help inform more practical solutions as well as guiding national initiatives. For example, if, in the setting of the pandemic, many more physicians report that they will be leaving the workforce in a survey, the institution can have the foundational knowledge to know whether this is a national trend of workforce attrition or a regional/local phenomenon.

11. There needs to be bi-directional dialogue between national organizations which develop surveys and institutions and individuals who complete these surveys. Organizations which develop surveys should be open and receptive to input from frontline providers and should make modifications in survey tools which would adequately capture their experience. Ideally, responses to questions that impact clinicians should be acted on and should affect healthcare policy. For example, if clinicians cite difficulty with the electronic medical record and identify it as a key driver of burnout, there should be efforts to ameliorate these effects. Similarly, national organizations should come to consensus about priorities and initiatives. They should discuss and align national goals for medical education and for health systems to avoid mixed messaging or, worst, conflicting priorities. When objectives are then agreed upon, the work of optimization can then be streamlined and focused on these common goals.

Example: The current payment model of relative value units can frequently be in direct conflict with the patient satisfac-

tion and with CMS-mandate to train the next generation of physicians. If national organizations agreed that training future physicians was a priority, then an academic RVU could be created that would apply broadly and would protect health systems from creating a patchwork of policies.

12. Follow up on the survey results. Make sure there is a plan to readdress the group that was surveyed to assess progress or areas in need of continued improvement. It is important to document the initial results, the changes, and the outcomes for all stakeholders so that the appropriate next steps can be made. Just as in the world of patient safety, following up on issues repeatedly ensures that the intervention was actually effective. Because of the complex nature of health systems, a change in one component of that system could have unanticipated and untoward effects on others in the system and leaders need to be mindful of this. It is not sufficient to introduce a change and then walk away but rather to continually engage participants in iterative dialogue and improvements.

Example: Just as in any Plan-Do-Study-Act (PDSA) cycle, continual evaluation is important to see if changes enacted in response to a survey question have the intended consequence. If a group responds that they have difficulties with documentation requirements in the electronic medical record (EMR) and that their efficiency would be optimized with scribes, leaders should reassess groups at regular intervals to see if their survey results improve along with measures of efficiency. If they still report problems with the EMR, there should be a deeper dive to assess if scribes were in fact the correct answer to the problem.

Certainly, all the above is predicated on the receipt of honest, reflective answers among individuals with the time and resources to thoughtfully complete a survey. Although most large organizational surveys are designed to be anonymous, specific details could be provided that can trace back to an individual. Similarly, if they work in a very small department, there may be defining features that could allow individual identification. However, creating a safe and just culture for patients is predicated on honesty and reporting patient safety events and near misses. We should all seek the same truthful reporting in surveys meant to better the environment.

Additionally, it is rare to achieve a 100% response rate. The responses of those individuals that do not respond could be incredibly valuable, representing someone who is so satisfied their work that they have nothing to complain about or, alternatively, someone who is so stressed, disheartened, and overwhelmed that they cannot find the energy to respond. Both extremes possess unique insights but, as a starting point and even with these limitations, employing surveys to their best utility should be the goal of organizations that seek to optimize wellness and engagement among their staff.

3. Conclusions

Wellness and engagement are important institutional goals which should be approached with the same scientific rigor as other areas of medicine. When assessing these with surveys, institutions and organizations need to recognize their limitations and implement appropriate next steps. National governing bodies which institute health policy should be aware of the implications of using survey data such as patient experience data and ensure alignment with healthcare priorities.

Conflicts of Interest Disclosure

The authors declare they have no conflicts of interest.

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